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**Privileging Voices of Parents influenced by their Adolescent's Relationship
with Substances: Interpretative Description of Generative Dialogue in a
Collaborative Group Process**

Proefschrift

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ten overstaan van een door het college voor promoties aangewezen commissie
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door

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Abstract

This qualitative study involved an exploration of dialogue generated within a collaborative group therapy process for parents influenced by their adolescent's relationship with substances. Parents experience social and emotional impacts when caring for a teen actively involved with alcohol and/or other drugs. Deterred by perceived stigma and shame, some parents may hesitate to reach out to traditional formal support. When parents do access services, experiences of blame, exclusion, and hierarchical expert directives contribute to isolation and unmet needs. In this study, I reference social constructionist philosophy, providing an account of how historical and cultural contexts have influenced knowledge and conventional understandings of adolescent substance use, treatment, and parenting. I provide an overview of collaborative therapy and aspects of a collaborative group approach for parents influenced by their adolescent's involvement with substances. I applied an interpretive description methodology through which I illuminate descriptions of dialogue generated within a collaborative group therapy program called *Recognizing Resilience*. I explored parents' accounts of the meaning of this dialogue in relation to their experiences of their adolescent's substance use. From my inquiry I learned that the process of participating in dialogue contributed to experiences of commonality and re-authored accounts of a problem-saturated story about parenting a teen involved with substances. Parents identified that they were able to release themselves from notions of singular cause and fix and developed a perceived freedom to experience multiplicity and possibility in regards to their experience of self, others, and their teens. Substance use systems can utilize collaborative therapy as a means to facilitate dialogical and relational practices.

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To all of my colleagues, friends, and family I thank you for enriching my life and contributing to this moment in time of learning and celebration.

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Chapter One: Introduction

With tears in her eyes she described her son. Gifted, talented, smart, charismatic, and friendly—characteristics noticeably framed in the past tense of “he was.” She talked about how she had recently found him lying on his bedroom floor, empty “2-6¹” prominently displayed on his dresser. She described putting him to bed, quietly shutting his bedroom door, and throwing away the bottle. “What am I supposed to do?” she asked the attentive others. “I’ve tried everything. I’ve done the best I can.” Her eyes met another parent’s, they held each other’s gaze with a fixed exchange. “I am so exhausted she whispered as she began to softly weep.”

Excerpt from Stephanie’s Reflexivity Journal (March 7, 2013)

Many adolescents will experiment with substances without experiencing or developing considerable challenge (Catalano, Haggerty, Hawkins, & Elgin, 2011; Di Clemente, 2006). However, for youth who do engage in the regular use of substances, harmful consequences and concerns may occur (Jackson & Mannix, 2003). The effects of these consequences can be difficult, disrupting the emotional health and wellbeing of parents and caregivers (Copello & Templeton, 2012). During this period of the human lifespan, when alcohol and other drugs become part of the landscape, there can be a significant impact on parents (Copello & Templeton, 2012).

Socially, historically, and culturally constructed discourses impact how parents perceive, understand, and respond to their son or daughter’s use of substances. Projecting “truths” and objective fact, dominant addiction theories contribute to disparate dichotomies of adolescent substance use knowledge, leaving some parents unsure as they balance attempts to address their adolescent’s substance use and try to preserve and promote health of their family and themselves as caregivers (Usher, Jackson, & O’Brien, 2005). *Hang on, let go, keep close, cast out*, are debates based on contesting ideas supported by convoluted political, social, historical, medicalized, and morally driven, multilayered monologues (Anderson, 2007) of substances and substance use.

Prevailing descriptions of substance use, adolescence, and parenting stem from hierarchically oriented expert positions involving problem-focused categorization of behaviour (Ungar, 2004). By explicitly and implicitly defining what is perceived to be normal or healthy, taken-for-granted knowledge within discursive traditions influences what is considered to be, and responded to as, abnormal and unhealthy. Perceptions of truth, good, and/or right, create what is considered to be false, not good or wrong. (Gergen, McNamee, & Barrett, 2001). Attitudes, values, and beliefs generated by socially constructed descriptions of substances, substance use, adolescence, and parenting, craft positions influencing the responses of individuals, parents, families, communities, and systems.

Dominant truths inspire stigma and shame, fear and panic, blame and guilt. As a result, parents may find themselves stuck, lost in rigid pathways of language, meaning, and knowledge. Often desperate to reach out for support, yet confused by overwhelming formal declarations of best practice, truth, and fact, parents may hesitate as to which line of understanding to grab hold. When declarations and individualistic claims of substance

¹ 2-6 is a Canadian slang to describe a 26 ounce (750ml) bottle of alcohol.

use intervention and understanding conflict with values and beliefs pertaining to parenting, identity, culture, and perspective, parents may find themselves in a constraining and futile narrative, silenced by dejecting and disempowering pathways to constructed benchmarks of health and social acceptability.

In my experience as a youth and family counsellor I have come to recognize a pervasive language in the field of adolescent substance use that I would characterize as dismissive and undermining of capacity and competency to adapt, overcome, and flourish. I have engaged in conversation with many professionals who regularly pathologize those using substances. I have observed traditional systems blame and trivialize the other², reticent to hear³ the voices of those engaged in the use of substances and those involved in their lives.

My Work as a Counsellor

Working with Youth.

For many years I have marveled at the time in the lifespan between childhood and adulthood. This wondrous period of life called adolescence, and dynamic persons called teenagers, have been sources of vigor and conduits of intrigue. During the start of my career, a young adult myself, I focused my work and post-secondary studies on supporting teens “at risk.” I recognized oppressive conditions and social, community, and familial factors that were implicated in the development into maturity, creating stumbling blocks for what I considered to be socially accepted health-enhancing behaviours.

I began my career with an understanding of my role as being one to save, to be the expert to fix, the social artist to create change in the lives and conditions of others. As years have passed, as conversations have unfolded, as my eyes have opened to possibility beyond some of my traditionalist learning—well frankly, when I realized that waving my magic wand was not working—I began to participate in something striking. Rather than focusing on the cause of hindrance, the impact of stumbling blocks, I began to partner with teens sharing in conversations about their ability to overcome, to cope with, and to adapt to the challenges that they faced. I started to become curious about what it was within them, around them, before and beyond them that was contributing to what I later learned was called “resiliency” (Ungar, 2009b).

Instead of listening to conversations with an ear to fix the problems, disabilities, disorders, and distress I once believed to see, I started to listen for the glimmers within dialogue suggesting ability, competency, hope, and a desire to hang on to and stick with life. I found that when I would reflect these aspects of the talk, or hold a mirror to them, the youth I was working with could see something different—not deficit, but possibility. As I heard the youth tell their stories I began to see past singular truths and notice many explanations, ideas, and perspectives.

² Youth and families accessing services.

³ Although systems may invite voice in order to “listen” to the expressed needs and interests of their primary client populations, listening is much different than hearing (S. St. George, personal communication, June 20, 2012). Listening is an intentional activity directed at a focused content in contrast to hearing which does not exclude nor reject content but attends to all that is expressed.

Working with Parents.

Having worked with teenagers for a number of years, I began to recognize the importance of collaborating with parents. Receiving numerous “help my kid” phone calls, I began to wonder about the experience of parents. I became curious about the impacts of raising a teenager, specifically, the impacts of raising a teenager in relationship with substances. Witnessing competing concomitant thoughts of “hang on,” “hold out,” “hit bottom,” “cushion the fall,” “attach,” “detach,” I came to be aware of dueling dilemmas and struggles to find a truth—knowledge that would fix or solve the difficulties faced by the adolescent and the worry faced by the parent.

I witnessed many parents reaching out for formal resources. Interactions with these external supports often contributed to an experience of feeling dejected, blamed, muted, and alone. I heard parents describe receiving disconsolate messages from systems suggesting that they let go, kick out, incarcerate their teens, or to alternatively hold on while funding expensive boot camps, residential programs, and distant treatment facilities. Some parents resonated with a tough-love, hitting rock bottom, boot camp, medicalized treatment discourse while others wanted to have an alternative. I also began to hear parents describe their inner turmoil when faced with the dualities of holding on and letting go and the subsequent powerlessness when external systems forced either of these positions. Seeing parents inundated with strong directives and mixed messages, I began to recognize that many formal adolescent substance use services provide parents with few opportunities to speak and be heard. Feeling misunderstood and unheard, parents retreated to the isolated constraints of silence and the powerless shadows of dissonance. As a service provider witnessing the impacts of this formal, expert-based discourse, I started to wonder about generative potentials of engaging in dialogue with parents.

Over the course of the last few years, I have shifted the bulk of my counselling work from youth to parents. I have begun participating as a curious, attentive, and appreciative partner in dialogue. Having had many interactions with parents during both individual and group therapeutic contexts, I have come to recognize a number of themes emerging from our dialogue.

Validation.

In my many meetings with parents and teens I have heard desperate pleas and insatiable needs to be heard, recognized, and affirmed—parents wanting someone to say to them that they are doing the best that they can. I have seen eyes frantic to hear “you are a good mom,” or “you are a good dad.” I have seen these eyes well with overwhelming emotion when the words are spoken, relief spilling out of red, stressed, anxious eyes.

Connection.

In my involvement in therapeutic parent groups I have heard deep grief—grief that shakes the body, grief that draws no breath, only unfulfilling gulps for air. Within these grasping gulps I have heard painful acknowledgements of loneliness, fear, and abandonment. I have witnessed the magic of connection in a moment, as one parent chokes, “I have no one, I am alone,” and I have seen another parent stretch out her own

arms and wrap them around the body of the other, speaking firmly, “you are not alone, you have me.”

Social Justice and Control.

I have seen parents slamming fists on tables, angry, demanding answers as to what the system can do for them and for their teens. I have seen parents begging for someone, anyone, to step in, to “save” their children. Feeling powerless, hopeless, and terrified I have seen parents grasping for control, driving down dark streets looking for their kids, reaching out to their teen’s peers, knocking on drug dealers’ doors, ransacking bedrooms and backpacks, scrutinizing emails and text messages, vigilantly searching for answers, desperately searching for solutions. I have noticed the confused struggle of parents negotiating with and compromising values and beliefs in an effort to hang on to their seemingly tenuous relationship with their teen, and often, with other family members.

Fear.

I have witnessed fear and anguish as parents describe the influence of substances in their teen’s lives. I have heard parents provide descriptions of alcohol and other drugs as being “evil,” “controlling,” “deadly,” “incapacitating.” I have listened to parents express sentiments heavily drenched with worry about initial exposure transpiring into life-long dependencies—fatalistic descriptions incessantly bludgeoning many of the parents with whom I have partnered.

Blame.

I have heard parents describe ruminating thoughts pointing a finger of blame towards themselves. “I should have...,” “I could have...,” and “if only...,” thoughts offering no reprieve to the mind of the worried parent. I have heard parents recount conversations with others, including education, health, and justice professionals, family, and friends that subtly, and sometimes blatantly, have placed blame squarely on the shoulders of the parent.

Hope.

Throughout my counselling practice I have been privy to unfolding narratives describing parents’ experiences of fear, anger, and stress: stories that described the gradual fading of optimism and the bleak consuming shadow of aching. Within these narratives often existed a slight flicker, a brief description that acknowledged that no shadow can exist without some form of light casting a subtle ray of hope, a ray of hope, perhaps, momentarily muted⁴.

⁴ This description was provided by Griffin Russell, my colleague and friend. Griffin has partnered with me since 2008 facilitating a collaborative group practice with parents affected by their adolescent’s relationship with substances.

What I Perceive As Being a Problem: Dissonance from Dominant Discourse

Those in the field of psychology and the broader context of social science have influenced our understandings of what is considered to be knowledge (Sprague, 2005). Sciences delineate linear descriptions of development, behavioural characteristics, and traits on what has come to be viewed as “official standards of normality” (Sprague, 2005, p. 37). Practices of classifying and categorizing the diversity of human behaviour and action create systems of monitoring, judgment, discipline, and surveillance (Madigan, 2011). Foucault as cited in Sprague (2005) said that “[power/knowledge] are inextricably linked: power is enacted through the organization of knowledge and knowledge is constructed as a form of domination” (p. 36).

Approaches to address adolescent substance use are varied. Some stem from theoretical underpinnings referencing medical and disease discourses, socially framed biopsychosocial domains, criminalized moral beliefs, psychosocial adaptive considerations, learning theories, or religious suppositions (Capuzzi & Stauffer, 2008). Many theoretical paradigms involve edicts influenced by standardized methods, and declarations of truth and orientational allegiance. Some approaches feature notions such as abstinence, tough-love, hitting bottom, recovery, and/or formalized treatment. When operating from these theoretical orientations, practitioners place direct responsibility for the problem and any treatment outcome within the individual youth and their parents (Jackson & Mannix, 2003).

Generally, parents access formal treatment programming in the pursuit of answers and solutions for their son or daughter’s substance use (Copello & Templeton, 2012). The broader cultural context of the expert position within formalized treatment programs has created and sustains a hierarchical dynamic in service delivery. Hierarchical structures situate the practitioner in a position of having the answer and/or knowing the solution. Practitioners adopting expert positions instigate dichotomies of either/or, right/wrong, and good/bad. Traditional practices focus on individuals as having capacity and deficits based on objective accounts of reality—quantifiable benchmarks of can/cannot, excel/or not, know/or not (McNamee, 2004). Often social service programs focus on problem saturated descriptions (Ditrano & Silverstein, 2006, p. 365).

Such dichotomies and deficit-based narratives influence the construction of stigma. Societal stigma and judgment contribute to exclusionary practices and parent experiences of inability and blame (Jackson & Mannix, 2003). As a result, the potentials of dialogical interactions are limited and parents are talked at, directed to, and imparted on by privileged voices and service agendas. Anderson (2007) refers to this dynamic in communication as “the dialogical-monological distinction” (p. 41). Monologue in communication refers to a lack of a contributing listener (Volshinov as cited in Seikkula & Olson, 2006). Although on a micro level service providers may extend the invitation to parents to express their thoughts and ideas, on a macro level, social attitudes, values, and abstract beliefs may rescind the invitation implicitly suggesting that parents do not have the authority to say. This overarching societal projection closes dialogue, empowers stuck truths, and exacerbates shame, fear, and isolation.

The broader collective of helping professionals share common agreements, assumptions, and knowledge. However perspectives amongst individuals and groups of varying cultural and historical backgrounds can be diverse. What knowledge, truth, and

traditions exist for one parent may be different for another parent. Gergen (2009b) said, “By embracing Truth we eliminate the voices of all of those who do not view the world in the same way” (p. xvi). Dissonance in relationship may emerge when those in the helping profession speak from positions (McNamee, 2004) declaring truths that are inconsistent with the perspectives of others. When left uncorroborated, perspectives of service providers and perspectives of those engaged in the support may be disconnected (Ditrano & Silverstein, 2006) and parents and caregivers alienated from therapeutic resources.

Many youth and family substance use programs do not contain dimensions of practice for engaging parents as conversational partners in the consultation or collaborative development of programming (Copello & Templeton, 2012). Programming is often targeted towards the individual adolescent. Furthermore, parents are not consistently offered support for themselves as affected caregivers (Jackson & Mannix, 2003). Usher, Jackson, and O’Brien (2007) suggest that “the continued support of the family unit offers the adolescent who abuses substances the best chance of survival so strategies must be developed to help the parents and the family support the adolescent” (p. 429). In her discussion of her 2004 review of macro-level family programming, Pulleyblank-Coffey (as cited in Madsen, 2009), raised concerns about the overall lack of conversation in formal helping services that recognize parents’ capacity and resiliency. As a result, when parents access formal services, experiences of blame, exclusion, and top-down expert monologue may contribute to unmet needs (Jackson & Mannix, 2003; Usher et al., 2007).

What I Perceive to be Possibility: Social Constructionism and Collaborative Therapy with Parents Influenced by Their Adolescent’s Substance Use

“If our experience of our lives is only given structure and meaning by language, and if these meanings are not fixed but constantly changing, sought after and struggled for, then our experience is potentially open to an infinite number of possible meanings or constructions.”

(Burr, 2003, p. 57)

Social Constructionism.

Currently parent voices are drowned out by hegemonic and essentialist claims. However, if given access to speak, these voices may contribute to additional perspectives and understandings. Given a forum to be heard, these voices might state “you’d be surprised,”⁵ as they describe potential of considering all possibilities while encouraging openness to generating new and perhaps more hopeful and culturally relevant notions of adolescent substance use, parenting, and adolescent substance use treatment. From Gergen and Gergen (2010), ““Problems’ don’t exist in the world for all to see; rather we

⁵ “You’d be surprised” was the phrase written on a cardboard sign of a street-involved youth I met in 2011. When I asked him what I would be surprised about, he went on to tell me that most people do not realize that many youth on the street have comparable literacy levels to people not involved in street activities. He explained that the general assumption of the “masses” was limiting and exclusive of elaborate capacity and competency-based descriptions of how he, and many youth in his community, would describe themselves.

construct worlds of ‘the good’ and deem those events that stand in the way of achieving what we value as ‘a problem.’ Could all that we construct as ‘problems’ not be reconstructed as ‘opportunities?’” (p. 12).

What might happen if we were provided with opportunity to consider knowledge as being socially constructed? We could reconsider taken-for-granted understandings and concrete and standardized beliefs of adolescent substance use. In addition, we could don a critical and questioning lens about monological knowledge described as “truth,” fundamental and definitive (Anderson, 2012b; Burr, 2003). We may explore the influence of social and political contexts contributing to conventional knowledge (Gergen, 2009a) and recognize the constitutive nature of language. Parents and potentially systems might come to challenge, accept, reject, or re-imagine what we know and believe and perhaps elucidate less observed and emerging descriptions of adolescent substance use. I do not think that this would mean we would disqualify or reject existing ideas of knowledge (Gergen, 2009a). However, I believe that having this perspective might invite curiosity and uncertainty— notions conducive to generating possibility in addition to, or other than, existing claims of truth (McNamee & Shotter, 2003).

By considering a social constructionist philosophy, practitioners would become concerned about the processes with which knowledge and meaning are created. To facilitate such processes, practitioners might provide parents with dialogical resources (S. McNamee, personal communication, June 8, 2013) and opportunities to tell their stories, perspectives, and ideas about adolescent substance use. The hierarchical position of expert could shift and parents and other caregivers would be recognized and included as contributors in the generation of knowledge. What parents and practitioners create in collaborative interchange might influence how each comes to understand and experience adolescent substance use. By fostering collaborative practices, parents may emerge as makers of parenting conventions as opposed to consumers of parenting conventions (S. Bava, personal communication, December 16, 2011).

Collaborative Therapy.

Collaborative practices are associated with dialogue—interchange constructing meaning and new possibilities of understanding. It is through conversation that we “create what we desire and what we believe the future can be” (Lord, 2011, p. 33). As explained by Gergen (2009b), “It is through collaborative action that all meaning emerges” (p. 53). I believe that parents have much to say and that few opportunities have been provided with which to listen. If practitioners were to engage as conversational partners, parents and practitioners may participate in a process of developing narratives that open possibilities of knowledge while liberating parents from boundaries of constraint built by monologic dichotomies (Anderson, 2007) of positivist discourse.

An inclusive collaborative therapy stance may offer a partnered, parent-directed paradigm shift (Madsen, 2009; Miller & Rollnick, 2002) to bridge dissonance and dispel stigma, exclusion, and isolation. Collaborative helping within the context of youth and family substance use services may nurture partnership by eliciting and honouring parental wisdom and capacity. A collaborative stance may impel those involved in the youth and family substance use treatment system to be accountable for tailoring services to the unique needs and desires of adolescents and parents (Madsen, 2009).

History of a Collaborative Therapeutic Group.

In 2008, I began working as a youth and family counsellor with Discovery Youth and Family Substance Use Services, a direct service of the Vancouver Island Health Authority on Vancouver Island, British Columbia, Canada. Having been required to facilitate ongoing cohorts of an 8-week standardized psycho-educational parenting program, I began to recognize dissonance with the parent population I was serving. What I learned from parent participants' post-group evaluations was that although they desired to be a part of a group in order to learn more about how to support their adolescents, most felt that the facilitator-imparted content was largely irrelevant. In addition, parents felt that my structured group agenda left few opportunities for parent-to-parent conversation. As a result, parents explained that their needs for connection and peer support were often unmet. Many ended the group with further questions, continued confusion, and enhanced frustration pertaining to how to help their teen. I also began to recognize my own discomfort with my agenda of delivering directives as opposed to facilitating conversation from within the group. I realized after a few rounds of similar experiences and feedback that I wanted to try something different.

In 2009, I, along with my colleague Griffin Russell, began facilitating an initial parent group cohort in a 6-week closed group we titled, *Recognizing Resilience*. *Recognizing Resilience* is based on a collaborative therapy process. Within such a process we join with participants in mutual exploration and meaning-making. By drawing from a collaborative practice stance (Anderson, 2012a) we invite people to engage with each other in a shared inquiry about their experiences and their concerns (Yalom & Leszcz, 2005). Parents are recognized as experts of their lives, teachers of their own experience (Anderson, 2007). We facilitate dialogical processes by holding attention to emergent knowledge and ideas born out of parent conversation. Collaborative therapy involves mutual agenda setting; "Therapeutic collaboration is a stance that implicitly and explicitly opens therapy decisions and other activities to the client for participation on a par with the therapist" (St. George & Wulff, 2007, p. 403).

Our therapeutic intention of the *Recognizing Resilience* group does not involve a standardized, pre-determined outcome nor a universal measurable standard of change. In regards to collaborative therapy, St. George and Wulff (2007) explain that "collaborators come together in mutual endeavors such that each person's contribution is validated and used to generate even more possibilities for action or change that will result in some benefit for all involved" (p. 406).

I believe a collaborative therapy stance and a social constructionist philosophy can be applied to inspire rich descriptions of adolescence, substance use, and parenting. I see group therapy as a dialogical resource for developing interchange amongst a population encountering stigma, exclusion, and isolation. By providing not only the invitation to speak but also the context with which to be heard, collaborative group practice may be one potential for supporting parents to construct narratives as they seek ways to negotiate caring for their adolescents.

My Inquiry

Throughout the process of writing my dissertation, I have attended to the needs of multiple readers. I wanted to write so that my project would be useful to parents, academics, and practitioners. Although you, as a reader, may find pieces that have more relevancy than others, my greater intention is to express how important it is to include parent voices and what could happen when parents are invited into a particular dialogical process within youth and family substance use treatment programs.

Having participated in and witnessed the impact of conventional approaches to adolescent substance use treatment, I began to seek ways to partner with parents in shared endeavors to create conversational space (McNamee, 2004) for constructing new ways of thinking and taking action. My previous and current conversations with parents have inspired my research interests. Some of these conversations have faded into distant echoes, some have more recently shaped my frame of reference, but all have been influentially resounding. Throughout this project I have aimed to create space for discussion that draws attention to the emic accounts of parents engaging in dialogue with each other during a group process. As well, I attempted to make public conversations that have gone unacknowledged and unheard—the dialogue and language that, I believe, will enrich a field of practice currently perplexed, confused, and grasping. By offering an additional option of support, a resource beyond an archetypal modernist approach, I hope to support practitioners, and systems to hear parent wisdom while opening space for multiplicity and dialogue from which we could extract alternative potentials and possibilities for parents, their adolescents, and professionals in the helping role.

For the purpose of my dissertation inquiry I hosted *Recognizing Resilience*, a collaborative group therapy process in which I attended to conversation relating to adolescent substance use. I partnered with parents to foster connections and conversations amongst group members, as well as utilized a research methodology to illuminate dialogue born out of group interchange. In addition, I offered exploration into how parents make meaning of the dialogue in relation to their experiences of their son or daughter's use of substances. I wanted to explore what is generated through a conversational process free of directives, expert-based knowledge, and hierarchical agendas. As I was unable to identify previously recorded research of conversation constructed in a collaborative orientated group process and meaning-making in relation to such conversation, my inquiry is an attempt to inspire awareness, as well as curiosity, of dialogical possibilities with a specific, underrepresented parent group. I explored three questions:

What dialogue do parents of adolescents in relationship with substances create when they are involved in a collaborative group process?

What meaning does the dialogue created in this collaborative group process have in relation to parents' experiences of their adolescent's substance use?

What conditions in a collaborative group process inspired dialogical conversation for parents influenced by their adolescent's use of substances?

Throughout my inquiry I share my perspective on the polysemous descriptions of parents participating in formal adolescent substance use programming by detailing an

unconventional, inclusive, and evolving collaborative approach to supporting parents of adolescents actively using substances. I offer strength-based, capacity focused descriptions from which to consider adolescence, substance use, and the role of parents and caregivers. I hope that by paying attention to voiced perspectives of parents, practitioners and system stakeholders might be motivated to move beyond the overwhelming and constraining descriptions of adolescent substance use, and be influenced by potentials of multiplicity, hopefulness, and capacity-based beliefs.

Method: Interpretive Description

I based my study on the qualitative method of interpretive description (Thorne, 2008) in order to gather depths of understanding and interpretations of the meanings of the complex group dialogue that took place. Using interpretive description as a method required that I illuminate phenomena and articulate subjective meaning of experience while constructing understanding and knowledge applicable to professional disciplines (Thorne, 2008). As interpretive description is an applied research method I intentionally articulate the connection between interpretations and descriptions of phenomena to direct clinical practice. By gathering accounts of experience from parent participants, I disseminate descriptions of dialogue and meaning for the practical application of the broader youth and family substance use treatment system.

As interpretive description as a method has a social constructionist philosophical influence I was provoked to be curious about the subjective nature of meaning-making, experience, and knowledge construction. My exploration enhanced my understanding of parent experience beyond descriptions of normality and positivist notions about objective facts (Berg, 2009; Holliday, 2007; Thorne, 2008). To pursue such an inquiry, I was obliged to be continually reflexive about my own influence on the interpretation of data as well as on the generative, dialogical process of research on the lived experience of the study participants. I articulate my thoughts about researcher influence and subjectivity of experience throughout the process of my research collection, conceptualization, and reporting.

A Word about Words

Learning of social constructionist philosophy inspired me to be continually cognizant of my reflection on, and awareness of, words (Gergen, 2009a). The ways in which words are used and socially construed construct meaning. The meanings we assign to words such as addiction, addict, dependence, disease, harm reduction, problem, abuse, risk, junkie, tough-love, enabling, treatment, relapse, and rehabilitation can stigmatize and inform, validate and alienate, connect and disconnect, oppress and empower (Perry & Reist, 2006). The existing lexicon of substance use terminology is deeply embedded within attitudes and values facilitating stereotypes and moral judgments. Stuck within claims of truth stemming from established concepts of substance use etiology and treatment, words often become associated with beliefs about substance use, people involved in substance use, and how people respond to substance use (Miller & Carroll, 2006). Although we may not be able to create shared meaning and mutually agreed upon knowledge regarding substance use, we may impede continued exclusion and open space

for finding alternatives by recognizing and acknowledging a diversity of perspectives, meanings, understandings, and cultural and historical traditions (Perry & Reist, 2006).

Within the following pages, certain words are present as descriptors of the information and experience that I shared. I was mindful of the impact of words and aware that although words on their own are empty vessels (Gergen, 2009a), when filled with cultural and historical context, truth claims, values, attitudes, and pervasive societal knowledge, they can have impactful meaning. Words come to life within the relationships they are used (Gergen, 2009a).

For the purposes of this project, the words substance use, include a spectrum ranging from experimentation to problematic use and dependence. Dependence, as explained by Maté (2009) is described as the ongoing engagement or preoccupation with the use of substances, the ongoing use of the substance despite harms, and cravings and dissatisfaction when the substance is not immediately available. Substance refers to psychoactive drugs such as licit drugs including, alcohol and medications, and illicit drugs including, marijuana, cocaine, heroin, and methamphetamines used for the purpose of altering mood. Although youth may experience dependence to non-drug related activities and behaviours such as video gaming, eating, sex, and work, I explicitly refer to drug-related use and dependence. My assumption however, is that a significant piece of this project, including the concepts of collaborative group practices could be translated to support parents affected by their adolescent's involvement in other behavioural dependencies.

The word, adolescence, and accompanying word, adolescent, are used to describe a phase of life within the human lifespan. The phase of adolescence will be considered to begin at the age of puberty, a natural condition that in traditional Western knowledge surfaces around the age of 12. Adolescence will encompass those years until the age of majority, which in Canada is currently age 18, a cultural construct (Feixa, 2011). The word, parent, will describe biologically connected parental figures and caregivers, as well as "carers" who may be participating in a parenting capacity and are not biologically related (Copello & Templeton, 2012). Caregivers might include grandparents and extended family, while carers may be foster care providers and other significant adults within an adolescent's life.

I describe collaborative therapy in further detail throughout this piece, however for the purpose of a conceptual definition, collaborative therapy may be considered to be a therapist's "way of being" (Anderson, 2007, p. 41) in therapy influenced by a postmodern philosophical stance that invites relational dialogue and mutual inquiry. The postmodern assumption of collaborative therapy involves a reexamining of knowledge and an interactive process of language to generate meaning and understanding through relationally engaged dialogue (Anderson, 2007). I use the term, dialogical conversation, in reference to social interchange, a relational form of conversation through which meaning and understanding is generated, interpreted, clarified, and revised (Anderson, 2007). Dialogue refers to a process of trying to understand from the perspective of the other (Anderson, 2009). I also use the terms, practitioner and facilitator, to describe those formally working within individual or group therapy in youth and family substance use treatment programming.

Chapter Two: Exploring Dominant Narratives and the Potentials of Dialogical Practices

The literature review of a research study has a number of purposes (Creswell, 1994). Through a literature review the author shares with the reader a larger aspect of current dialogue pertaining to the topic. In addition, the author articulates for the reader the importance about the study of interest (Creswell, 1994). According to Thorne (2008), “If the products of our inquiries are to have empirical advantage in comparison to the products of opinion, persuasion, or even fiction [as researchers] it behooves us to ensure that our arguments for the value of each new study within the larger context of an evolving body of accessible knowledge are solid, coherent, and reasonable” (p. 43).

The purpose of my literature review is to provide you with a context and rationale for my inquiry with parents of teens involved in substance use. In order to frame my research inquiry I provide both specific and general understandings from scholarly activities in the area of youth and family substance use treatment. I summarize existing research related to my study and broader theory contributing to the experience of parents involved in adolescent substance use treatment. I also offer a methodological review detailing methods and definitions (Creswell, 1994) of a collaborative group therapy practice.

I begin my review of the literature by exploring the cultural and historical ideology of adolescent substance use and treatment. I offer a description of formal youth and family substance use programming. I explore existing research contributing to our understandings of parents’ experiences of adolescent substance use and treatment. Continuing, I identify and deconstruct disparate silos of dominant addiction discourse. I reference social constructionist philosophy, providing an account of how historical and cultural contexts have influenced essentialist knowledge and conventional understandings of adolescent substance use, treatment, and parenting. I provide an overview of collaborative practice and aspects of a collaborative group approach for parents influenced by their adolescent’s involvement with substances. Importantly, my intention here is to demonstrate a logic trail (Thorne, 2008) for my inquiry by describing both the context and delivery of individualistic modernist practices in youth and family substance use treatment and the importance of exploring multiplicity by elucidating parent voices and generative dialogue in a collaborative therapy group.

Adolescent Substance Use and The Construct of Addiction: Discursive Telling of a Problem-Saturated Story

“There is nothing in the mind that is not first of all in society.”
(Vygotsky as cited in Gergen, 2009b, p. 78).

The ways in which we conceptualize adolescent substance use are social constructions. How we have come to communicate and make meaning of adolescent substance use has been influenced by historically, politically, and morally induced agendas favoring certain practices and ways of life. Although existing knowledge

includes relatively new and emergent descriptions of adolescent substance use, previous generations have laid a foundation for how we have come to build understanding and assign credibility to this topic.

From a social constructionist frame of reference, knowledge is born out of relational activities and generative language processes (Anderson, 2007). This means, how we understand and respond to actions and behaviours may be open for interpretation. If we recognize that meaning and understanding are subjectively influenced, we may question whether phenomena is found or made, fixed or unique (Pearce, 2009). As practitioners, parents, families, communities, scholars, politicians, and adolescents, we may reflect on how we have come to perceive and ascribe meaning to existing truths (Gergen & Gergen, 2003). Critically reflecting on how people have generated descriptions and explanations may unveil opportunity to generate plurality of perspectives.

When we consider phenomenon such as addiction and adolescence as being made, more varied and multifarious responses may be generated (Pearce, 2009). As explained by Gergen (2009b), “It is not that social constructionist ideas annihilate self-truth, objectivity, science, and morality—rather, the constructionist dialogues ask us to move beyond simplistic commitments, and consider the pitfalls as well as the promises of our traditions” (p. 30). Rather than trying to determine what is “true,” we can take the opportunity to consider and reframe what is useful. We become compelled to wonder, “who is it helping to think of the world in this way?” (S. Bava, personal communication, December 16, 2011). Pearce (2009) has said, “Our capacity for wonder is enhanced if we see the events and objects of our social world as made” (p. 34).

Historical Context of Adolescent Substance Use: The Industrial Revolution and Legal Moralism

“The extent to which drug addiction has spread over the land is beyond belief. The youth, curious as to its effects, is offered a pinch of heroin, morphine or cocaine and, with incredible rapidity, he finds himself in the clutches of a habit, and held as stubbornly as a devil-fish envelops its victim with its tentacles.”

(Murphy, 1922, p. 82)

Within my own practice as a youth and family counsellor, I have often been drawn to focus on the future. I think about the future lives of the youth and families I work with, my future endeavors as a practitioner, and the future innovations of my field of practice. My conceptualizations of the future have included concrete potentials of *what could be*. Alternatively, the concept of the past has lingered as an abstract reflection of *how far we have come*.

It was not until I read *Social Constructionism* by Vivien Burr (2003) that I started to wonder more about the past. I started to consider what historical influences might be contributing to my current field of practice and prevailing ideas about youth substance use. I started to wonder about what scientific, social, and political institutions might have been involved in constructing conventional knowledge and what agendas might have driven such involvement. I also started to question how my work has perpetuated these constructions and adopted such knowledge under the guise of taken-for-granted truth.

Within the following section I delve into a description of historical, cultural, social, and economic building blocks, that over the course of a century have contributed to the construction of ideas now saturating our existing views of what adolescent substance use means and in turn implies. My hope within this section is to paint a picture of how people-powered movements have influenced the definition and associated meaning of adolescence and addiction as well as generated norms describing benchmarks and milestones, and beliefs associated with deficit and deviance outside the periphery of these norms. I highlight how concepts influenced by moral, political, and social efforts have contributed to parent experiences of, and responses to, adolescent substance use behaviour.

History.

Conventional understandings of both addiction and adolescence grew within social circumstances emerging at the beginning of the 19th century (Room, 2009). The construct of addiction transpired out of descriptions of excessive substance use as being problematic and a diagnosable disease (Alexander, 2001; Kandall, 2010; Levine, 1978). The construct of adolescence was inspired by behavioural interests of a developing science of psychology and Stanley G. Hall's notions of storm and stress as being universal characteristics of a distinct phase in the human lifespan (Arnett, 2006). Historical accounts prior to the 19th century provide a picture of alcohol as being a common part of daily family and community life (Okrent, 2010) and of childhood as being dramatically different than the high degree of protectiveness over young people today (Epstein, 2010; Ungar, 2009a).

The Industrial Revolution was a significant turning point in the history of humankind. Mechanized labour commenced the process of mass production (Hackett, 1992) contributing to social and economic conditions associated with a capitalist, free market climate. This climate required a self-controlled labour force, therefore perpetuating movements to eliminate interferences such as alcohol and other drugs, which might have hindered or impaired such notions of self-control (Alexander, 2010; Levine, 1978). Marie McCormic suggested that the effects of the Industrial Revolution precipitated what came to be understood as addiction, despite the absence of such description for similar behaviours prior to the Industrial Revolution (as cited in Room, 2009).

What was once referred to as "the Good Creature of God" (Peele, 2010, p. 374) in a short period of time, came to be called demon rum (Alexander, 2010; Okrent, 2010). In 1914, Richmond Hobson, US House of Representatives stated,

If a family or a nation is sober, nature in its normal course will cause them to rise to a higher civilization. If a family or a nation, on the other hand, is debauched by liquor, it must decline and ultimately perish. (Okrent, 2010, p. 7)

On June 30, 1864, Canada's Temperance Act was passed (Pound, 2005). However, following a Royal Commission report in 1895 concluding that restrictive laws did not impede the sale of liquor, Parliament decided against Federal prohibition (Pound, 2005). By the early 20th century however, the Temperance Movement had prevailed as most provinces voted to prohibit the distribution and consumption of alcohol (Okrent, 2010).

Social and economic conditions of the Industrial Revolution have also influenced our current understandings of what has come to be called adolescence (Chen &

Farruggia, 2002; Epstein, 2010; Saltman, 2005). Prior to the Industrial Revolution children and adults participated in the home together supporting family agricultural, household, and trade pursuits. With the boom of the Industrial Revolution the labour market exploded and a flood of rural children and young adults flocked to urban settings (Alexander, 2001). Children and young adults required few skills and little pay, making them of great appeal to a developing upper class. However, upon leaving familiar ways of rural life, family, and community, young labourers found isolated and restrictive positions in often dangerous and despotic working conditions (Okrent, 2010). The burgeoning free market economy fed the financial purse strings of an exclusive upper class perpetuating disconnection, devaluation, and disenfranchisement of an exploited labour force (Alexander, 2010).

During the late 19th century, an emerging child welfare movement was established to protect children from lethal working conditions, insignificant wages, malnutrition, and deplorable living situations (Epstein, 2010). The Canadian Government began imparting legislation to reduce workdays and to increase age restrictions of the child labour workforce. By the early 1900s, amidst the forces of mechanized labour, children had come to be viewed as vulnerable and in need of adult protection (Epstein, 2010; Pound, 2005). Accordingly, the age in which children were conceptualized as children lengthened to include everyone under 18.

During this same period of time, labour unions began to emerge as prominent facets of the industrialized workforce. With children, youth, and immigrant groups providing inexpensive labour, the job market began to constrict and union members began to strike. Union efforts and labour laws created a moratorium on the adolescent worker prohibiting involvement in what had come to be perceived as adult responsibilities (Koops & Zuckerman, 2003).

Efforts to restrict adolescents from participating in the consumption of alcohol arose alongside efforts to restrict the involvement of children and youth in labour markets. Social and moral activists began disseminating knowledge about the impact, consequences, and outcomes of adolescent substance use. Dr. James Hamilton said, “Addiction is present mainly in youths from 16 to 21. This is really the development age, and boys and girls are forever wrecked in this period” (as cited in Murphy, 1922, p. 92). The Temperance Movement instilled a deep-seated fear that problematic substance use unanimously evolved into irreversible addiction. Youth were barred from consuming alcohol after Prohibition in 1933 (Epstein, 2010).

The effect of the stock market crash on October 24, 1929, and ensuing Great Depression stalled momentum and credibility of the contentious Temperance Movement (Okrent, 2010). Political dishonesty, failed enforcement efforts, increased crime, black market activities, and excessive alcohol consumption brought attention to the movement’s contribution to propelling alcohol use rather than preventing it (Levine, 1978). Subsequently, efforts began to shift towards regulating other substances.

Legal Reform.

Opium and other narcotics such as cocaine were readily prescribed during the 19th century (Ferentzy, 2001). Only when opium and other substances were attributed to minority social groups such as the Chinese, was legislation created (Montigny, 2011). Early drug sanctions were a result of legal moralism, influenced by moral panic and

perceived threat to values and behaviours of dominant society by minority groups of differing ethnic, socioeconomic, and religious backgrounds (Montigny, 2011). The inception of Canadian drug laws may be attributed to “the fears of the Canadian white Anglo-Saxon middle class during the latter decades of the nineteenth century and the early decades of the twentieth century, when industrialization and immigration stimulated widespread concern” (Montigny, 2011, p. 6). Offering a way in which to monitor, structure, and punish groups contradicting dominant tradition, legal reform became a way to regulate and ensure compliance of immigrant and other minority populations, including youth. “The taking of drugs is undoubtedly the cause of a great deal of crime because people under its influence have no more idea of responsibility of what is right or wrong than an animal” (Murphy, 1922, p. 38).

During the 1960s a youth counterculture movement representing peace, experimentation, social advocacy, and resolve in the longstanding Vietnam War began to develop (Martel, 2011). With the emergence of lysergic acid diethylamide (LSD) and increasing use of marijuana, social interest groups composed of parents, government, educators, and businesses, began prompting youth focused intervention (Martel, 2011). In the tradition of implementing public policy in order to preserve and protect, LSD became illegal (Martel, 2011). Drugs were described as being responsible for youth behaviour that deviated from dominant social values and norms (Montigny, 2011). Subsequently, based on recommendations from provincial government organizations, drug education became a component in elementary and secondary educational curricula (Martel, 2011).

In 1961, the United Nations Office on Drugs and Crime (UNODC) developed the Single Convention on Narcotic Drugs, a global convention specifically orientated towards prohibiting the use and production of illicit substances for non-medical purposes (Room & Rueter, 2012). In an attempt to protect the public from the perceived “evils” of narcotics, the convention criminalized the sale, production, and use of cocaine, marijuana, and heroin (Bruun, Pan, & Rexed as cited in Room & Rueter, 2012). During this same year Canada passed the Narcotic Control Act and later Controlled Drug and Substances Act (Canadian Foundation for Drug Policy, 2001). Both acts have followed suit with drug control systems described by the Single Convention on Narcotic Drugs and subsequent amendments.

Canadian legislation currently includes enforced punitive measures as a response to the use, production, and sale of illicit substances. Should an individual be found in possession of an illicit substance, measures for contravening can be more severe than consequences of violent crimes such as kidnapping and murder (Montigny, 2011; Room & Rueter, 2012). Such consequences highlight the vilification of trafficking and criminalization of substance users when compared to sentences for other indictable offences (Canadian Foundation for Drug Policy, 2001; Room & Rueter, 2012).

Despite having such strong legal sanctions, Canada has recently adopted harm reduction practices (Alexander, 2010). Alexander (2010) said, “unlike treatment, prevention, and law enforcement, harm reduction is not designed to reduce the incidence of addiction” (p. 22). The concept of harm reduction is based on the assumption that substance use falls on a continuum from abstinence to problematic use and any steps that reduce the quantity, frequency, and harms associated with substance use should be recognized and supported (Connors, Donovan, & Di Clemente, 2001). Harm reduction efforts have included the implementation of educational programs, needle exchange

initiatives, and safe injection sites. However, continued disparity amongst United Nations (UN) communities, such as the United States, a country with a strong opposition towards harm reduction, has contributed to political debate within Canada about the use of harm reduction practices (Room & Rueter, 2012).

Regardless of concerted efforts to prevent, control, and treat substance dependence over the course of the last 2 centuries, prevalence of substance dependence has increased and emergence of non-drug dependencies (work, food, gambling, sex, technology) have pervaded Western culture (Alexander, 2010). According to Beauchesne (2011), legal moralism and a billion dollar “War on Drugs” have failed in prevention and intervention of substance use, exacerbating the situation by blazing pathways for illegal drug trade and black market trafficking. Despite the repeal of Prohibitionist movements, the temperance ideology of alcohol and other drugs as being evil and the enemy continues to saturate both Western and global addiction beliefs (Peele, 2010). These beliefs have been translated into what have become normative understandings of substance use and dependence, directly influencing how helping professionals and parents respond to adolescent substance use.

In Relationship with Alcohol and/or Other Drugs: Adolescents and Substances

I watch her recount the story. She describes the office as dark and cramped with an overhead florescent light flickering above. I watch her face tense, her mouth quiver, determined to not allow the tears to break through. She said her son sat next to her, his head was down and his hat covered eyes that had not kept the tears at bay. She recounted how the principal had leaned back in a creaking office chair and repeated “your behaviour is not welcome in my school. I cannot allow people like you under this roof.” The principal then turned to her and the words came softly yet deafeningly “until your son gets his drug issue under control this school has no place for him anymore.” She shook her head and explained that she had had so much to say, so many defenses and assertions. She said she wanted to fight for her son, plead his case, and defend his, and her, honour. The fight was there, yet as she grappled with a loss for words she said she looked at the principal and recognized the crossed arms and sullen brow. She realized that were no words, no assurances, no gestures of understanding, only a closed door, a stale silence, and the incessant flicker of a faulty bulb.

Excerpt from Stephanie’s Reflexivity Journal (March 14, 2013)

Moral panic, spurred over a century ago by the Temperance Movement and social climate of the Industrial Revolution, still permeates adolescent substance use narratives. Efforts by media and government portraying substance use as being criminal and morally corrupt have contributed to a vilification of substances and substance use, perpetuating an erroneous understanding of youth using substances as being deviant or weak, and the enemy (Alexander, 2010). Generalized ideas of instability, risk, and impulsivity saturate descriptions of the period of life called adolescence and how we interpret an adolescent’s relationship with substances. In the following section I provide some current data on the prevalence of adolescent substance use. I offer an account of how youth are believed to be involved with alcohol and other drugs.

Prevalence

Many people first experiment with alcohol and/or other drugs during adolescence (Chung & Martin, 2011). Teens engage with substances for a variety of reasons: curiosity; accessibility; desires for a new experience; to feel high; to be included in social networks; to demonstrate opposition to adult authority; to assert independence; to cope with difficult situations, feelings, and experiences; for relief from symptoms of a mental distress (Smith, Stewart, Peled, Poon, & Saewyc, 2009). Alcohol, tobacco, and cannabis are most frequently used by the general youth population (Canadian Centre on Substance Use [CCSA], 2007). Although illicit substances are often a primary focus of attention, use of prescription medication has also significantly increased over the course of the last decade. Use of medication to treat depression and attention deficit disorder (ADD) have doubled from 2007 to 2010 (Epstein, 2010).

In 2007, Health Canada published the *Canadian Addiction Survey (CAS)*, a detailed and extensive national study of Canadian's use of alcohol and other drugs. Researchers, collecting data via phone surveys, identified alcohol as being the most commonly used substance by Canadian youth aged 15-24. Of surveyed respondents, 90.8% indicated having used alcohol with 82.9% having used in the last 12 months. The mean age of first use of alcohol was found to be 15.6 years. The CAS reported that almost 27% of youth aged 15-19 smoked cigarettes, at least occasionally. Of the youth surveyed, 61.4% reported using cannabis with 37% having used in the past 12 months. In regards to use of other substances, 16.4% of surveyed youth reported use of hallucinogens, 12.5% reported use of cocaine, 11.9% reported use of ecstasy, 9.8% reported use of speed, and 1.8% acknowledged use of inhalants. Poly-drug use, or use of different substances concurrently, was found to be a prominent feature of youth substance use patterns: 98.7% of youth who reported use of cannabis also reported use of alcohol and 91.3% of youth who used other illicit substances also reported use of cannabis.

The Canadian Centre on Substance Abuse (CCSA), *Cross Canada Report on Student Alcohol and Drug Use* (2011), surveyed youth aged 12-18 from all provinces within Canada. The majority of those in grades 7 to 10 reported never having tried marijuana though prevalence rates increased from grade 7 to 12, with as many as half of grade 12 students reporting use of marijuana within the previous year. Researchers found that past year use of alcohol nearly doubled that of marijuana. Although research in school settings might elicit data about descriptions of youth's experiences with substances, surveys completed with student samples cannot be generalized to explain patterns of broader youth populations including street involved and disenfranchised youth.

From 1998-2003, the Public Health Agency of Canada ([PHAC], 2006, 2010) participated in a comprehensive surveillance of street involved youth in Canada, a marginalized population that had, prior to the study, been relatively unknown. The *Enhanced Surveillance of Canadian Street Youth (E-SYS)* project gathered data pertaining to determinants of health such as sexually transmitted infections, substance use prevalence, and antecedents to street engagement. Of street involved youth surveyed, as many as 95% had used at least one non-injection drug and 20% reporting injecting drugs. These youth reported conflict with parents as the predominant reason for leaving home.

Most adolescents who experiment with substances do not follow an ongoing trajectory of continued use or dependence (Catalano et al., 2011; Di Clemente, 2006). The researchers of one study (Hingson et al. as cited in Catalano et al., 2011) suggest that two-thirds of adolescents who try a substance do not develop a dependency on substances. However, a minority of adolescents who engage in the use of substances will move past experimentation onto experiencing problematic effects and challenges related to substance dependency (Usher et al., 2005). For those who do develop dependence, (Chung & Maisto as cited in Kaminer & Winters, 2011), several years of use and abuse cycles may be more common than exceptional.

Parental Experiences of Adolescent Substance Use

The health and wellbeing of parents and families are considerably impacted by an adolescent's involvement with substances (Jackson, Usher, & O'Brien (2006). Through my current counselling practice I have heard from parents anecdotal depictions of grief, anger, helplessness, frustration, confusion, exhaustion, physical illness, financial burden, and relationship tension. Despite the gravity of how some experience adolescent substance use, researchers have only recently begun to inquire into the impact of this experience on parents and families.

In 2005, Butler and Bauld conducted a small qualitative study, one part of a national evaluation of adolescent substance use services in England. The researchers used semi-structured interviews in order to elicit parental descriptions of caregiving an adolescent in relationship with heroin. From their sample of 11 parents (9 mothers, 1 father, and 1 parent set), Butler and Bauld identified thematic accounts of family conflict, parental distress, and confusion pertaining to whether to ask their adolescent to leave the home or stay, as well as parental sense of isolation due to embarrassment, guilt, and judgment. Parents also described financial, physical, and health impacts.

In their narrative study, designed to understand the effects of adolescent substance use on family life, Jackson et al. (2006) explored the experiences of 18 parents affected by their teen's use of substances. Thematic analysis highlighted emic accounts of parental experiences of stress and exhaustion, isolation, shame, and blame. Parents described struggling with a loss of trust, a sense of betrayal, and resentment dealing with the consequences of the substance use—the physical, emotional, and social harms perceived to be caused by the teen and inflicted upon the family.

Usher et al. (2007) employed a phenomenological hermeneutic approach in their study in which they explored the lived experiences of parents of adolescents using substances. They gathered descriptions of understanding from a purposive sample of 18 parents, self-identified as parenting an adolescent with serious and ongoing challenges with illicit substances. Phenomenological analysis of parent narratives revealed eight predominant themes. Parents described struggles confirming suspicions of substance use, difficulty setting limits, stress dealing with consequences of substance use, blame and shame, efforts to minimize associated harm to the adolescent and family, grief, guilt, and challenges to take care of self as a parent. Similar to other aforementioned studies, Usher et al. (2007) captured distress and torment associated with parenting an adolescent actively engaged in problematic substance use.

Orford, Velleman, Copello, Templeton, and Ibanga (2010) summarized findings of nine qualitative studies from countries including Italy, Mexico, England, and

Australia. The authors identified common elements of experiences living with a relative involved in substance use. Summarizing prominent themes, Orford et al. (2010) highlighted family members' experiences of stress, isolation, uncertainty, worry, and fear. Further, the authors heard from parents similar stories of strain on relationship with their adolescents and marriages. The collective experience of parents involved in the studies included descriptions of anger at the family member and concomitant descriptions of guilt that emanated from feeling anger toward the family member and feeling responsible for the substance use behaviour.

Jackson and Mannix (2003) conducted an exploratory-descriptive study in order to learn how a sample of 12 mothers had experienced their adolescent's use of substances. Narratives detailed mothers' experiences and reactions in learning about their adolescents' substance use. Mothers described experiences of shock and denial, as well as "constant vigilance" (p. 172), as they took action to modify their son or daughter's behaviour through both punitive and supportive steps. Fear and worry about potential escalation and consequences of continued substance use pervaded the experiences of these participating mothers. This fear and worry was related to uncertainty about how to respond in a manner to mitigate what mothers expected to be potential future effects. As described by respondents, the family's efforts to modify the adolescent's behaviour were "unsuccessful in all cases" (p. 173). Mothers expressed difficulty maintaining the functioning of the family unit as a whole, describing impacts of aggression, violence, and irritability from the child actively engaged with substances. In addition, mothers expressed difficulty witnessing their teens dropping out of sports, school, and other healthy activities, and discussed significant worry about their child being imprisoned, "beyond the reach of their love and care" (p. 175). Recognizing failed attempts to modify behaviour, enforce cessation and abstinence of substance use, mothers offered insight into their own experience of having to acknowledge the complexity of the behaviour and in turn described how they began to reconstruct dreams, aspirations, and relationships with their children. Their focus shifted from the drug and from correcting behaviour to building relationships by recognizing strengths in the teen's life.

As I reviewed the above accounts of parent experience I grew increasingly curious. I wondered how conditions beyond the dynamic between the parent and teen are influencing how parents are experiencing their teen's relationship with substances. For example, what contributes to the experience of isolation, or the intensity of fear and worry? Why do parents feel responsible for the substance use behaviour (Orford et al., 2010)? How did the parent participants in the study from Jackson and Mannix (2003) move through "constant vigilance" (p. 72) and what influences contributed to new perspectives of strength and relationship? These questions are not questions that I specifically pose in my inquiry, however they are the impetus for why I have become so interested in the interrelatedness of broader discourses, dialogical process, and collaborative therapeutic practices.

The Domination of Normativity: Prevailing Perspectives of Adolescent Substance Use

"In the last years of the eighteenth century, European culture outlined a structure that has not yet been unraveled; we are only just beginning to disentangle a few of the threads, which are still so unknown to us that we immediately assume them to be either

marvelously new or absolutely archaic, whereas for two hundred years (not less, yet not much more) they have constituted the dark, but firm web of our experience.”
(Foucault as cited in Levine, 1978, p. 1)

“To declare The Truth is to set language into a deep freeze, and thus reduce the realm of possibilities for new meanings to emerge.”
(Gergen & Gergen, 2010, p. 25).

Some of the first stories I hear from parents during individual counselling sessions include details about when their teen began using substances, how the substance has influenced the teen and family, and what parents are concerned about in regards to the future. I often hear interpretations of how parents understand their teen’s relationship with substances such as, “my son has an addictive personality,” “addiction is in the family genes,” “addiction is an attempt to self-medicate mental illness.” Following each account of “why” I quite often am told about what might happen if the substance use continues: “He is going to become an addict,” “I will lose her for good.”

As I have previously mentioned, I am curious about what theoretical conjecture contributes to parents’ descriptions about substance dependence. On a broader social level, I am drawn to wonder how understandings have come to be privileged, and how our allegiance to claims of truth have aided and/or hindered our experience of substance use. As I attempted to explore what dialogue parents might create in a collaborative group process, I felt it was important to identify what broader theoretical postulations may be contributing to such dialogue.

Theory.

Throughout the last century there has been a proliferation of substance use research, theory, and discussion. Through specific research traditions we construct related theoretical frameworks to use in our descriptions of the cause, trajectory, outcome, and treatment of adolescent substance use. The notion of “theory” is based on a retrospective, predetermined lens, described by Shotter (as cited in Anderson, 2007): “Theories are aimed, ultimately, at justifying or legitimating a proposed course of action by providing it with an already agreed grounding or basis” (p. 6). Often theories contain a specific and concentrated focus, generalizing overarching assumptions, and formulaic methods to be applied to groups of people identified as possessing certain characteristics.

Despite considerable investment in the intellectual pursuit of understanding adolescent substance use and dependence, consensus has yet to be achieved (Alexander, 2010). Debates persist pertaining to the prevention, control, and treatment of adolescent substance use. Theoretical contributions to the field of substance dependence exist primarily within dichotomous silos including perspectives of individual characteristics or social influence, biological or psychological impairment, powerlessness or free will, medicalized or moral debates, as well as person-centered or expert-directed interventions (Alexander, 2010). With little empirical evidence then, theoretical constructs have been created and given credence by communities of prominent scholars dedicated to their own proposed paradigms (Kuhn as cited in Alexander, 2010). No model of dependence “can claim uncontroversial validity” (Morse, 2004, p. 441).

Theoretical descriptions include not only explanation of phenomena but also implicit and explicit responses derived from these understandings. For example, responses inherent within medical discourse involve diagnosis and treatment. Responses inherent within morally influenced discourse involve disciplinary measures including punishment (Pearce, 2009). It is not surprising then that our theoretically orientated responses to adolescent substance use have influence on the lived experience of parents and adolescents (Neimeyer, 1998).

In the following section I detail a number of dominant and conventional theoretical notions that have become the grounding for responses to adolescent substance use. Each theoretical construct includes depictions of causation, treatment, and outcome. Along with these descriptions are deeply embedded suggestions pertaining to how the substance, the adolescent, the parent, and the helping professional may be involved in adolescent dependency formation and prolongation. As I learned about specific theoretical accounts for understanding adolescent substance use, I philosophically wondered,

- *What voices have been traditionally privileged in the construction of substance use and dependence discourse?*
- *How else might we make sense of adolescent substance use?*

Disease Perspectives and Treatment Approaches.

“Medicalization occurs when human problems or experiences become defined as medical problems, usually in terms of illnesses, diseases, or syndromes. In general, sociologists who study medicalization emphasize the processes by which a particular diagnosis is developed, becomes accepted as medically valid, and gets used to define and treat patients’ problems.”

(Conrad & Barker, 2010, p. 74).

The notion of substance dependence as a disease rooted within the individual has become widely accepted in Western culture (Peele, 2007). First endorsed by the American Medical Association (AMA) in 1956, the notion of dependence as a condition of illness, a sickness, or disease has permeated conventional wisdom of alcohol and other drug addiction (Hart & Ksir, 2011). The medical model of addiction has come, for many, to be considered a valid and scientific understanding of substance dependence and acclaimed as the prevailing and official view of addiction (Alexander, 2001, 2010; Peele, 2007).

The medical model of addiction places the source of the problem of substance dependence within cognitive and biological functions of the individual using substances. For example, as it pertains to adolescence, the problem would be characterized as a condition that resides within the adolescent (American Psychological Association [APA], 2000). Dependence is situated in the interaction between the substance and compromised

functions of the person (see Figure 1).

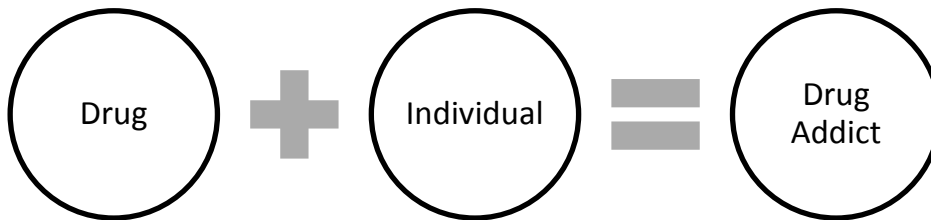


Figure 1. The medical model paradigm (Alexander, 2010).

The person who is dependent is said to exhibit standardized characteristics such as tolerance (reduced effect and need for increased amounts of a substance), withdrawal, compulsive pursuit of the drug, and problematic physical and/or psychological consequences (APA, 2000). Dependence is considered to be out of a person's control, a drug induced illness, and, in more recent understandings, a chronic brain disorder (Hart & Ksir, 2011; Maté, 2009; Morse, 2004).

From the medical vantage point the only solution for substance dependence is abstinence (Ferenyzy, 2011). Individual treatment success is attributed to adherence to prescribed programming focused on achieving abstinence, while treatment failure is deemed a function of the individual's lack of compliance to medical directives (Ferenyzy, 2011). Measures to inspire abstinence may involve tough-love, hitting rock bottom, alleging to 12 Step notions, and avoiding enabling (Ferenyzy, 2011). Peter Ferenyzy proposes an interesting twist to the disease model: if substance dependence is conceptualized as a disease, it is perhaps the only disease that seems to require that a person hit a bottom before he/she can be receptive to treatment. "With no other medical condition—not even mental illness or neurosis—is the governing idea that the disease must be allowed to cause a great deal of damage in order to prepare someone for help" (p. 1).

Alcoholics Anonymous (AA) and other 12 Step groups such as Narcotics Anonymous (NA) are dominant sources of doctrine for individuals seeking recovery (Ferenyzy, 2011). The 12 Step traditions are structured by specific beliefs about dependence (Strang, Babor, Caulkins, Bernedikt, Foxcroft, & Humphreys, 2012) in which addiction is described as a progressive disease that will, unless treated, get worse over time; a disease characterized by denial, requiring constant attention and dedication. Further, those with the disease of addiction are said to be powerless over the disease and require help. Those with the disease of addiction are told that they are afflicted with a disease from which they will never recover (Alcoholics Anonymous, 2001).

The medical model of addiction is privileged by the medical community and recovery cultures such as AA and NA. The expert directives of medical institutions influence how parents might come to view and respond to their teen's substance use. Abstinence is promoted as the only treatment and those unable to maintain abstinence face a progressive disease that follows a universal and unwavering predetermined pathway. This rigid and linear view stunts the potential development of alternate pathways and trajectories for youth and parents to conceptualize cause, treatment, and outcome of adolescent substance use.

The notion of an independent, autonomous self is a construction of the modernist era (Neimeyer, 1998). Individualist culture of Western society re-enforces the self as instigating and influencing substance use and dependence. Focusing attention on singular descriptions of cause and outcome limits practitioners, parents, and others from considering additional influences and more multi-faceted determinants embedded within the context of environment and/or community (Alexander, 2010). Singular descriptions can limit system approaches and parent responses.

Moral Perspective and Treatment Approach.

The moral model of dependence is also pervasive within Western culture (Alexander, 2010). Driven primarily by political and social policy, the moral model of addiction highlights substance dependence as a behavioural problem resulting from a moral failing of the individual to pursue a socially constructed right versus wrong (Morse, 2004). Consequently, adolescents involved in substance use are usually described as bad, delinquent, and weak.

From a moral perspective, adolescents are described as needing to hit rock bottom to garner perspective of the unacceptability of their behaviour and the need for change. In order to seek treatment an adolescent is said to need to experience the effect of forces preceding an intervention including contact with the criminal justice system, loss of employment, loss of loved ones, and/or loss of health (Bickel & Potenza, 2006). Rock bottom is often described as somewhat of a tactical arrangement brought to reality by withdrawing affections and a strict awareness of enabling—eliminating interactions contributing to socially deviant behaviour. Despite prompts to provide love and affection to promote health and wellness during infancy and childhood, morally influenced responses imply disconnection and disassociation as being qualities to rectify problematic adolescent substance use.

Traditional forms of residential treatment were originally structured by justice systems as a coercive and punitive measure (Brendtro, VanBockern, & Brokenleg, 2002). Criminal justice systems continue to mandate treatment; for example, the majority of youth residing in publicly funded substance use treatment programs are court-ordered (Dennis et al. as cited in Chung & Martin, 2011). Although mandated residential treatment and incarceration are utilized as methods for rectifying behaviour, efficacy of such forced programming has yet to be determined (Chassin, Knight, Vargas-Chanes, Lesoa, & Naranjo, 2009).

The moral model of addiction includes only deficit-based descriptions of the dependent person, and punitive and problem-focused descriptions of treatment. Further, implied connotations of choice and behavioural weakness or moral failing emphasized in the moral model may prevent both adolescents and parents from accessing support (Koski-Jannes, Hirschovits-Gerz, & Pennonen, 2012). Stigma, shame, blame, and guilt are ripe within this particular concept in turn affecting not only the safety of those seeking help, but those in relationship with the help-seeker (Koski-Jannes et al., 2012). With limited scope to consider additional influences or contexts of adolescent substance use, the moral model perpetuates descriptions of delinquency and dichotomies of bad and good currently constraining parent voices in adolescent substance use treatment systems.

Social Theoretical Perspectives and Treatment Approach.

“It’s not a problem of the youth. It’s a symptom of the broader malaise in society.”
(Vollant as cited in Clibbon, 2012)

A social lens of addiction is constructed by theories that include the socioeconomic, familial, political, cultural contexts that may be factors in an adolescent’s protection against or progression towards substance involvement. Di Clemente (2006) suggested that adolescents are less likely to develop problematic use of substances and may be more able to mitigate the risk and harm associated with substance use if they have access to broader environmental, economic, social, and cultural resources. Faced with the proposition that multiple factors may be influencing the health and wellness of the developing adolescent, parents and practitioners can consider external variables and multilayered meanings of behaviour.

Considering the broader context of influence, adolescent substance use is postulated as serving an adaptive and integrative function within distressful and challenging conditions. “For many children, patterns of deviance are healthy adaptations that permit them to survive unhealthy circumstances” (Ungar, 2004, p. 6). Qualitative studies by Panter-Brick, McAdam-Crisp, Aptekar, and Kironyo, and Felsman (as cited in Ungar et al., 2009b) describe the capacity of children to overcome adversity by pursuing “unconventional” opportunities to secure basic physical and emotional needs. These pursuits might include activities not considered to be health-enhancing by traditional definitions, but nevertheless may be attempts by adolescents to survive and thrive (Ungar, 2009b). Alexander (2001) states “even the most harmful substitute lifestyles serve an adaptive function” (p. 4).

According to Alexander (2010), dependence, inclusive of behavioural dependence, may be an adaptive response attributed to dislocation and disconnection perpetuated by free market society. He associates the adaptive soothing of substance use to the degree of isolation, individualism, and capitalist enterprise within community. “Addiction is neither a disease nor a moral failure, but a narrowly focused lifestyle with an intensity that partially compensates for a lack of adequate psychosocial integration” (Alexander, 2010).

Descriptions stemming from socially framed concepts of addiction treatment move beyond pharmacological ideals of cessation, detailing the influence of nurturing relational attachment and connection (Maté, 2009). Wei, Heckman, Gay, and Weeks (2011) used a naturalistic longitudinal design in order to understand psychosocial correlates of motivation in adolescents completing residential treatment. Wei et al. sampled 68 adolescents using self-administered questionnaires. Researchers identified that participants’ motivation to maintain change was associated with their sense of social integration and attachment. Social integration, within the context of family and community, may mitigate the risk to engage in use of substances as well as the risk of continued use of substances.

The role of the family is a common aspect of the social perspective of youth substance dependence. However, views on the role of families are varied. For example, Moos (2006) described substance dependence as the “syndrome of growing up in a high risk family” (Moos, 2006, p. 185). He has said that strong attachments with family

“motivate individuals to engage in responsible behaviour and refrain from substance use and other deviant pursuits” (p. 182). Moos describes the role of parental monitoring, attachment, nurturing, control, use of substances, separation and divorce, and discipline as being causative of youth substance use. His solution offers multiplicity beyond the mono-focus of one intervention; however, he places emphasis on prescribing a strong therapeutic bond with, and monitoring by, a formal counsellor, residential treatment, and allegiance to a recovery model. The unspoken narrative of this pervasive blame-laden story suggests that family bonds and parental controls are the antecedent to deviant behaviour and the external system of care provided by service providers and treatment groups are required for health enhancing change.

Unlike the medical and moral models of addiction, a social lens reflects the importance of including families when addressing the effects of adolescent substance use. Foxcroft and Tsertsvadze (2011) conducted a systemic review of 12 family-based programs designed to reduce the impacts of adolescent substance use and dependence. The authors identified that those programs designed in response to the social and cultural context of the family were found to have the most impact on outcome.

A Natural Recovery Perspective: The Absence of a Formal Treatment Approach.

Many researchers and social scientists have strongly refuted that adolescents with dependencies on alcohol and/or other drugs can “outgrow. . .and moderate their drinking” (Peele, 2010, p. 375). However, despite conjecture situated within the medical, moral, and even social model of addiction, natural recovery occurs exclusive of formal and structured treatment programming (Di Clemente, 2006). Di Clemente suggests that “natural change appears related to maturation in individuals who have capacity, personal history, and enriched or less problematic environments that foster and support exiting from problematic use of substances” (p. 85). Perkonigg, Rumpf, and Wittchen (2009) conducted a longitudinal study of 3000 youth aged 14-24 in Germany, in order to explore rates of natural recovery in adolescents. The authors noted over the course of 5 years, natural recovery or remission from substance dependence was common. In their 2005 study of 45,000 Americans, the National Institute of Alcohol Abuse and Alcoholism (NIAAA) found that of the respondents canvassed, most people resolved substance use concerns without formal treatment resources. According to Alexander (2010), field and clinical studies of natural recovery indicate that as many as three-quarters of people who become dependent on substances during their adolescence recover from their dependence without receiving any formal treatment support at all. Recovery without medical intervention is more common than recovery through formal treatment (Alexander, 2010; Ferentzy, 2011).

Simply put, the natural recovery perspective of dependence could be translated by practitioners and parents as meaning that the majority of teenagers will outgrow problematic use. In contrast to other prevailing theoretical assertions, the notion of natural recovery suggests possibilities beyond the commonly accepted viewpoint of a life-long trajectory of substance dependence illness (Peele, 2010). As a result, some parents may feel reassured by the potential impermanence of dependence. However, despite such a potential, parents, as I have previously noted, experience significant distress when their son or daughter is actively using substances. Therefore, I believe

parents should not be dismissed or invalidated regardless of how long substance use is influencing their parenting experience.

Parent Experiences of Dominant Adolescent Substance Use Perspectives

In the previous section I provided for you an outline and description of primary perspectives of adolescent substance use. My intention was to compare and contrast various aspects of each perspective. I now take the opportunity to discuss the problem that can occur when these distinct theories collide.

Theories, attitudes, assumptions, and notions imbedded in dominant addiction discourse can be confusing for parents as they consider the “best” ways to respond to their adolescent’s use of substances. As parents venture through difficult terrain paved by essentialist descriptions of substance dependence and directions for intervention, we may witness parents’ journeys hindered by gaps in their travels—gaps broadened by conflicting values, incongruent system directives, and unmet needs for support.

Parents receive diverse, sometimes contrasting, messages from systems, professionals, community, and others involved in formal and informal contexts. Parents navigate strong societal messages of how to respond to adolescent substance use behaviour (Jackson & Mannix, 2003). Many face dichotomies when broaching their adolescent’s involvement with substances as they find themselves faced with contrasting theoretical assumptions and contradictory ideas of how to respond.

Parents are often positioned to choose from *either/or* options derived from prevailing beliefs leaving confusion and mistrust in the space in between the two. Usher, Jackson, and O’Brien (2005) describe parental dilemmas such as asking adolescents to leave the family home countered by yearnings to hang on to the adolescent, to comfort, and heal. In his inquiry into family responses, Pearson (2000) identified ways in which families tend to respond to adolescent family members engaged in problematic substance use including directly and explicitly dealing with the substance use concern, tolerating the substance use concern, or developing dissonance and withdrawing from their teen. For parents this may be perplexing, particularly when they wish to neither tolerate nor withdraw from the behaviour or their child.

Traditional knowledge is often framed around a taken-for-granted truth weighted with importance and credence privileged by institutions of influential power, supported by research, and validated by those who say so. These ideas provide insight and perspective, however, they also tend to limit alternative perspectives, stories, beliefs, and wonderings of families and parents (Madigan, 2011). Parents are constrained from imparting their own meanings, explanations, and experience. Parents may also struggle with a sense of powerlessness to explore addiction beyond conventional understandings and to tell their stories outside of what boundaries are constructed by theoretical declarations and truths (Jackson & Mannix, 2003).

As we continue to engage in taken-for-granted descriptions of adolescent substance use we are likely adding to a “culture of blame” (Jackson et al., 2006, p. 329). Assumptions doled out by broader institutions of knowledge and claims of cause, effect, and outcome contribute to parent’s experiences of blame, shame, and perceived judgment (Jackson et al., 2006), consequently increasing the parental sense of isolation and guilt (Butler & Bauld, 2005; Usher et al., 2005; Jackson et al., 2006; Usher et al., 2007; Choate, 2011). Parents lives are constructed by the stories dominating adolescent

substance use discourses (Madigan, 2011; Madsen, 2007). Well-aware of the substance use narratives, parents feel caught between constraining benchmarks, comparing and contrasting themselves to prevailing notions of good parent/bad parent, healthy teenager/sick teenager (Butler & Bauld, 2005). Jackson et al. (2006) said, “There is a general perception in the community that drug abuse and addiction are the result of bad parenting” (p. 328).

When any of us accepts a position, such as bad parent or failure, we are bound to experience the world and ourselves from this perspective (Burr, 2003). “Our subjective experience of ourselves, of being the person we take ourselves to be, is given by the variety of subject positions, some permanent, some temporary and some fleeting, that we take up in discourse” (p. 120). When a practitioner holds the belief that a parent has not lived up to commonly held expectations or positions, the practitioner runs the risk of discounting alternative stories based on what “skills, competencies, beliefs, values, commitments, and abilities that the person has achieved” (Madigan, 2011, p. 80).

Rather than placing the weight of blame and focus on the effect of parental responses on teens, those in the field of youth substance use may generate alternative descriptions of adolescent substance use concepts by considering how parental experiences are being shaped within a broader context of community, environmental, political, cultural, and historical influences. Practitioners and parents can enter into conversation that extends beyond black and white ideas and dichotomies and explore multi-faceted avenues of grey. When we extend beyond a singular answer or truth, we can enter into a dialogue that moves beyond cause and effect, blame, deficit and pathology, shame, and guilt. Most importantly, by stepping outside direct cause and effect correlations, behavioural descriptions of good/bad, right/wrong, and treatment benchmarks of success/failure, practitioners and system stakeholders might begin to influence the emotional and social consequences of blame. Noted by Usher et al. (2007), “Above all, the current culture of blaming the victim and the family must cease and be replaced with a culture where the family unit is valued for the opportunities it provides for recovery” (p. 429).

Parent Experiences of Formal Substance Use Treatment Approaches

As we talked he shared, “Yesterday I drove around. I drove and drove and just cried. I had nowhere to go, I didn’t know who to talk to. . I just drove.” “You are welcome to call me,” I said. He gazed out the window. “I didn’t want to bother you,” he replied. “I know you guys are busy and I didn’t want to take up your time.” He slumped in the chair and held his head in his hands. My stomach sank as I stared at him and wondered what I had done to communicate that I was not available to this parent. What was contributing to this parent’s experience of not feeling as though he had someone to talk to—that his experience was not important? Where have these messages come from?

Excerpt from Stephanie’s Reflexivity Journal (March 28, 2013).

I have not always attended to the therapeutic needs of parents and caregivers. As I mentioned in Chapter One, my earliest work as a youth counsellor centred almost solely on the experience of the individual youth. At that time I had subscribed to the notion that the “problem” was to be fixed within the youth and that the “answer” would come from what I contributed as the practitioner. With such a focus on the youth I readily neglected

to consider the experience of the parent. This is of course quite different from the values and attitudes I have come to develop in clinical practice, yet not far off from how many parents have experienced youth-orientated programming.

In speaking with a parent not long ago, I was told a story of a mother's struggle with a youth serving agency. The mother recounted her interaction with a practitioner providing clinical counselling and case management for her 14-year-old daughter. As she had done on many occasions, the mother sat for the duration of her daughter's weekly counselling appointment in a waiting room. After an hour the daughter and counsellor emerged from behind the closed door of the counselling office. The mother was approached and was told by the counsellor that her rules and expectations were too much for the anxious daughter. In front of her teen, the mother was told to lighten up or risk escalating what the counsellor referred to as her daughter's behavioural risks. The mother said she felt undermined, powerless, and angry. "I can't even parent my daughter how I want to parent her," she said, "and who is there for me?" she asked.

From the learning I have achieved in my previous work with youth and more recent work with parents, I have come to assert that formal service options should be provided, not only for adolescents engaged in substance use, but also for affected parents (Usher et al., 2005). Copello and Templeton (2012) referred to parents affected by their adolescent's substance use as a distinct population potentially requiring and benefiting from support. It is important for parents to be provided with access to formal treatment services in order to receive assistance to address, modify, and/or cope with their adolescent's use of substances (Choate, 2011).

According to Copello and Templeton (2012), many "carers" (p. 1) do not access service. Jackson et al. (2006) explained that based on their inquiry of parent experiences accessing service, "a sense of shame. . .effectively silenced participants and made it difficult for them to reach out for help" (p. 327). In addition, parents are often excluded from hierarchical and individualistic clinical interventions, treated with condescension, viewed as either not being the client, or not being a source of therapeutic benefit (Sims as cited in Butler & Bould, 2005; Choate, 2011; Madsen, 2009).

In his exploration of parent perceptions of professional adolescent substance use treatment service, Choate (2011) engaged a convenience sample of 31 parents and caregivers. Parents participating in Choate's study described feeling excluded from the professional intervention, uninformed, and denied opportunities to share information. Burdened by shame and guilt, many of the parents described feeling isolated, muted, and unable to reach out to formal and informal supports. Parents felt challenged finding effective help tailored to address not only their teenager's substance use concerns, but also their concerns and emotional struggles as parents. Parents asked for service provision centred on unifying rather than segregating family members. In his discussion, Choate advocated for engaging parents as well as providing support that enhances parent-teen relationships.

Jackson and Mannix (2003) acknowledged that most of the 20 mothers in their exploratory-descriptive study of adolescent substance use felt dissatisfied with formal services available to them. Mothers shared that service was not supportive and felt professionals did not express an adequate degree of empathy with respect to the behavioural and emotional challenges they experienced. Jackson and Mannix heard from participants that they appreciated the opportunity to share their experiences and found the

opportunity to talk during the research study to be therapeutic. The researchers recommended that formal supports offer “space to acknowledge the stress and anxiety associated with mothering, especially with mothering very challenging children, as well as a space for women to tell their stories” (p. 178).

Pearson (as cited in Jackson et al., 2006) recommended that parents be provided with service options in order to attend to high levels of stress and the significant emotional impact of dealing with adolescent substance use. Jackson et al. (2006) suggested services be inclusive of parental involvement and designed to preserve relationships without allocating blame. In addition, Usher et al. (2007) encouraged care providers to more broadly address the pervasive culture of blame and resultant stigma, shame, and isolation. Interventions targeted towards maintaining family cohesion and reducing caregiver distress may preserve the parent-teen relationship, reducing potential harms of ongoing adolescent problematic substance use and dependency (Choate, 2011).

Butler and Bauld (2005) explored parent perceptions of the benefits of accessing professional youth and family substance use support services. By using semi-structured interviews Butler and Bauld (2005) heard parents describe a decreased sense of isolation following the development of a therapeutic relationship. By receiving support parents found they were more able to manage the degree of confrontation and anger in the home, in turn enhancing connection of relationship with their son or daughter. In addition, parents involved in the study described a sense of comfort knowing other caregivers were experiencing similar challenges. Overall, Butler and Bauld suggested that “providing assistance to parents can have benefits for the drug user, including an increased possibility of receiving familial support in the first instance, and improved communication and relations with their family” (p. 43). Working with parents can provide an indirect support for the adolescent actively engaged in substance use (Meyers et al. as cited in Butler & Bauld, 2005).

In 2012, Copello and Templeton reported key findings from their mixed methods study for the United Kingdom Drug Policy Commission (UKDPC), investigating both the nature and scope of support available to family members affected by a relative’s use of substances. They explained that because parents are important sources of support to the adolescent using substances, working with parents of adolescents involved with substances is an indirect intervention. Supporting parents’ capacities to cope with their teen’s behaviour in a manner that is based on relevance and consideration of the unique needs of the family improves outcomes for those involved with alcohol and/or other drugs (Butler & Bauld, 2005; Copello & Templeton, 2012). Further, Copello and Templeton (2012) indicated that supporting parents to contend with their teen’s substance use mitigates parental risks such as marital conflict, job loss, substance use, and emotional distress.

Supporting parent populations is important for the health and wellbeing of youth and parents. However, limited research and literature is available to those in formal helping services to inform practitioners about how they might provide support for parents engaging with adolescent substance use service provision (Copello & Templeton, 2012). Although some resources do exist to support parents, including individual, family, and psycho-educational groups (Jackson & Mannix, 2003), not all forms of support are accessible and not all are acceptable to every parent. There is a lack in youth substance

treatment programming of parent specific supports, particularly supports that dispel the constraining influences of blame, silence, and isolation (Copello & Templeton, 2012).

Collaborative Practice: Plurality of Perspectives in Adolescent Substance Use Programming

“A search for understanding is not to seek the undiscovered but to look at the familiar with scrutiny, with new eyes and ears, to see and hear it differently, to understand it differently, to articulate it differently.”

(Anderson, 2007, p. 34)

“Language does not neutrally reflect a shared reality.”

(Neimeyer, 1998, p. 138).

So far I have taken you on a historical adventure and a theoretical tour. I have ventured to tell a story of how parents are influenced by adolescent substance use and why they may be experiencing adolescent substance use as they are. I have endeavored to pursue an “ideological critique” (Anderson, 2007, p. 8), a process of exploration, curiosity, and questioning of knowledge and taken-for-granted truths. I hope that through such exploration the dichotomies between models of addiction might begin to erode and possibilities for multiple meanings and pluralistic approaches to formal youth substance use treatment emerge. I believe that by questioning what we know about the construct of substance dependence, we (as in the you and I, the practitioner, the parent, system stakeholders), might become more open to the possibility of what is yet to be considered, known, or created (McNamee & Shotter, 2003).

As I wrote, I was aware of two primary considerations. I was aware of my research inquiry and my desire to hear what possibilities parents generate in dialogue. I was also aware of my practice as a counsellor and wondered about what processes and approaches might be used to facilitate the development and articulation of such dialogical possibilities. Therefore, in the following section I offer a conceptual account of collaborative therapy, specifically in relation to group therapy. I explain some of the prominent philosophical and theoretical concepts of collaborative practice and identify how these notions may contribute to an alternative approach to working with and learning from parent’s caregiving a teen actively involved with substances. Further, I explore how a group format in a therapeutic program may foster dialogue, ease disconnection, and serve to be a venue with which to develop an atmosphere conducive to relationally influenced transformative potentials of conversation. My intention is to provide a rationale to consider a unique way of working with parents involved in adolescent substance use treatment. In addition, I wanted to create a backdrop for my research intention of learning about what possibilities may be developed in dialogical conversation in a collaboratively orientated group format.

Dialogue.

“Communication creates the webs of belief and meaning to which human beings become attached, and these webs have far-reaching, recursive consequences.”

As I have so far ventured to articulate, many parents influenced by their adolescent's relationship with substances, find themselves struggling with isolation, disconnection, and loneliness (Jackson et al., 2006). In my own work with parents isolation has sounded like, "I am alone," "no one understands," "I don't want to burden anyone with my problems," "I am embarrassed." What has perhaps been one of the most inspirational aspects of my work as a counsellor is witnessing the grip of isolation being released through the act of engaging with another human being in conversation.

The "living activity" (Anderson, 1997, p. 34) of dialogue, the relational process of conversation may be a way in which to bridge the divide between disconnection and unity (Wheatley, 2009; Gergen, 2009a). Wheatley (2009) said, "The simplest way to begin finding each other again is to start talking about what we care about" (p. 4). When people come together in the dialogical activity of sharing and listening, meaning and understanding evolves and transforms. What we come to see as the possibility of tomorrow is shaped through conversation of today (Lord, 2011).

Starting dialogue can be hard. Out of touch with the conversation, caught in the bounds of disconnection, conditioned to repressing rather than expressing, some people may experience unfamiliarity when engaging in dialogue that elicits meaning, values, and beliefs. Yet, beyond the unfamiliarity of reaching out and engaging in conversation, I believe that through dialogue we can connect and through this connection, individuals, groups, communities, and others can develop a "collective wisdom" (Wheatley, 2009, p. 28). I believe that collective wisdom can offer inclusion, reassurance, and consolation offering hope⁶ and healing for the open emotional sores of loneliness, fear, and confusion associated with parenting an adolescent involved with substances. Further, when we, as practitioners can converse with inclusion, reassurance, and relational opportunities, we can ease the shame, guilt, and blame parents experience.

What I have come to learn about dialogue is that when people engage in the act of conversing, generative and relational processes inherently occur (Anderson, 2007). As we participate in the relational processes of dialogue we begin to nurture and hold together all viewpoints, even those that are opposing, contrasting, and resonating (McCarthy, 2010). In holding possibility, as described by McCarthy (2010), "a sense of inconclusiveness in our lives is embraced" (p. 8). We explore options within prevailing truths of discourse, considering plausibility, curiosity, and potential. From Jim Lord (2011), "Just talking, in an intentional and thoughtful way, fully aware of the power of our words, may be the most revolutionary activity we can pursue" (p. 40).

Collaborative Practice in Therapy.

Collaborative practice may be an additional approach to consider within adolescent substance use treatment. With a lack of agreement across current substance use treatment theories and research findings about traditional programming, other perspectives for approaching youth substance use treatment and parent support are

⁶ On October 24, 2012, I was fortunate to watch a presentation by Harlene Anderson. Harlene explained that collaborative practices inspire dialogue that leaves people with a sense of not being prisoners of their stories, but free and with hope.

needed (Jackson & Mannix, 2003). A dialogical collaborative therapeutic approach may be impactful for parents affected by their adolescent's use of substances—inviting the voices of an important group not traditionally privileged in formal adolescent substance use treatment programming. Fraenkel (2006) and Madsen (2009) indicated that collaborative approaches to therapy are effective and efficient. Seikkula and Olson (2006) reviewed the concept of “Open Dialogue” with patients accessing treatment for acute psychosis. With building evidence for the effectiveness of this dialogically orientated approach, the authors suggested that dialogical and postmodern principles could be utilized to address other difficulties.

The inspiration for collaborative therapy came during the 1950s as a response to prevailing approaches to therapy (MacGregor, Ritchie, Serrano, McDanald, & Goolishian as cited in Anderson, 2009). Collaborative therapy has grown from postmodern ideology including social constructionism and dialogue theories (Anderson, 2009; Gehart, Tarragona, & Bava, 2007). Anderson (2009) explains that postmodern assumptions challenge our inherited, and often taken-for-granted and invisible traditions of knowledge and language and provide a contemporary alternative perspective. The central challenge is to reexamine the inherited traditions of knowledge as fundamental and definitive, the top-down nature of knowledge systems, knowledge as the product of an individual mind, language as descriptive and representational, and the stability of meaning. (p. 3)

Anderson (as cited in Tarragona, 2008) suggests that postmodernism, as a philosophical movement, can be conceptualized as a critique—a questioning of knowledge. The postmodern critique includes the notion that knowledge and language are generative social processes (Anderson, 2009), constructing ideas and experiences of what we consider to be our lived reality.

Using concepts of collaborative therapy, practitioners can step outside of traditional ways of thinking. Theoretically, practitioners become conversational partners facilitating transformative potential and plurality of dialogue in which the participants are inspired to create additional ideas and explanations of lived experience (Anderson as cited in Tarragona, 2008; Anderson, 2009). Through his/her stance, the practitioner demonstrates an embodied way of being that creates openness to alternative ideas and meanings (Anderson, 2009). This “communicates to another that he or she is worth listening to, that we see him or her as a unique person” (Tarragona, 2008, p. 34).

The philosophical stance of collaborative therapy is not structured by a cookie cutter rationale or standardized formula, although specific considerations guide the approach (Anderson, 2009). Harlene Anderson (2007) explains that the collaborative therapy practitioner individualizes interactions and therapeutic supports in order to fit the unique needs and wants of the people accessing services.

Therapist and client construct something new with each other. The something new is not an outcome or a product at the end of the encounter. It continually emerges throughout the duration of the encounter while at the same time informing it and continuing afterwards. That is, each conversation will be a springboard for future ones, inside and outside the therapy room, for client and therapist. . .neither will be in the same place where they left off. (p. 52)

Practitioners and parents develop the capacity to construct additional perspectives of adolescent substance use when each contributes thought, perspective, and knowledge

(Anderson, 2009). Parents should be encouraged to tell their stories, to share their experience and perspectives of the situation or challenge at hand and potentials for outcomes. This exchange of contribution can add to the construction of a picture of broader meaning and potential in terms of how both the practitioner and parent understand and experience adolescent substance use.

Another important theoretical tenet of collaborative therapy pertains to expertise. Within a collaborative practice stance, people accessing services are viewed as experts, not only in regards to their challenges, but also to the mode, depth, and content of therapeutic programming that they desire (Fraenkel, 2006). In his 2006 article, “Engaging Families as Experts: Collaborative Family Program Development,” Peter Fraenkel provided an in-depth description of Collaborative Family Program Development (CFPD), and his application of the concept in research with families transitioning from welfare to work in the state of New York. Fraenkel detailed aspects of CFPD as well as collaborative research-based approaches for creating community programming. He asserted that when programs are facilitated in partnership with people accessing services and when professionals position themselves as “respectful learners” (p. 237), families, particularly those previously oppressed by social programming, may be more actively engaged. Fraenkel highlighted the importance of honouring a family’s definitions of problems, resources, solutions, and resilience. He explained that his work with CFPD has involved acknowledging families as experts while nurturing descriptions of capacity and competency, in turn offering connection, vision, and hope.

Collaborative Practice in Group Therapy: Connection through Conversation.

“Generative ideas emerge from joint thinking, from significant conversations, and from sustained, shared struggles to achieve new insights by partners in thought.”
(John-Steiner as cited in Gergen 2009b, p. 93)

I believe collaborative therapy, within a group context, may be a resource to counter the isolation and disconnection often associated with parenting a teen involved in substance use and to foster coordinated actions (Gergen et al., 2001) of developing dialogue and meaning-making. Group programming interactions promote connection amongst group members providing degrees of belonging, care, confrontation, and challenge (Corey & Corey, 2006). Burlingame, MacKenzie, and Strauss (2004) reviewed 107 individual studies and 14 meta-analyses identifying group treatment as being an effective format for addressing a variety of therapeutic applications. Unique factors of group therapy including emergent opportunities for social and interpersonal learning, universality, altruism, and cohesion (Piper, Ogrodniczuk, Joyce, & Weiderman, 2011; Yalom & Leszcz, 2005) may be beneficial for parenting challenges evoked by adolescent substance use.

Toumbourou and Bamberg (2008) reviewed the Behaviour Exchange Systems Training (BEST) program, a group program developed in Australia in response to concerns of adolescent substance use and limited family support options. In order to determine efficacy of the program Toumbourou and Bamberg (2008) sampled 34 parents who had previously participated in the 8-week group program. Parents voluntarily completed self-report questionnaires in both pre- and post-group participation, scoring

predetermined domains of emotional dependence, activity disruption, stress symptoms, cohesive family behaviour, and youth recovery action. Toumbourou and Bamberg reported that parents identified lower stress post-group. Researchers correlated parents' involvement in group with reduced stress from the emotional impact of youth substance use behaviour.

As I have previously noted, parents' feelings of shame and guilt often prevent them from accessing support from professionals, family, and friends (Choate, 2011). Choate (2011) identified that parents were more comfortable reaching out to people within informal and/or formal networks of support who shared common experience. Parents' participation in shared experience alleviated tensions of stigma and judgment. In their summary of qualitative research over the course of the last 2 decades on the experiences of family members affected by substance use, Orford et al. (2010) noted that parents valued support that nurtured acceptance, particularly from others who had been through similar experiences. Markin and Marmarosh (2010) indicate "group therapy may be used to provide members with a new sense of intimacy in personal relationships and a sense of belongingness" (p. 120).

Levac, McCay, Merka, and Reddon-D'Arcy (2008) studied experiences in a group therapy program for parents affected by their children's behavioural challenges associated with attentional and conduct issues. Authors found that the dominant theme from their inquiry was the overarching sense of support parents experienced from group colleagues and facilitators. With the absence of shame, blame, guilt, and the presence of nonjudgmental, genuine support, parents came to acknowledge the impact of their current parenting experience and generated transformational dialogue describing new and hopeful narratives of how they wanted their parenting involvement and efforts to evolve. Parents were able to express experience, challenges, and hopes as a result of the acceptance and safety of the group climate. In their post research follow-up, the researchers indicated an improved relationship between parent and child.

The Poetics⁷ of Collaborative Practice in Group Therapy

"Strand by strand, actions and ideas are woven into a narrative convincing enough to serve as an alternative to this problem saturated story."

(Madsen, 2009, p. 239)

Group programming may take the form of content focused psycho-education and/or process-orientated therapy. Many group programs within the traditional modernist construction of youth service provision lean towards the structure of standardized psycho-education (Canadian Centre on Substance Abuse, 2011). Conventional psycho-educational parent group programs often involve parent behaviour modification including direct skills training, monitoring, discipline techniques, and context specific problem-solving (Canadian Centre on Substance Abuse, 2011; Yuen & Toumbourou, 2008). Psycho-education programming is organized by hierarchical positions with the practitioner as expert and the participant as learner. In addition, psycho-education

⁷ Described by Hoffman and Olson as cited in Seikkula and Olson (2006), poetics may be used to refer to "the language and communication factors in face to face encounters" (p. 404).

programs include predetermined, standardized content and process, and evaluative methods to measure targeted behaviour change (Corey & Corey, 2006).

Few parent group programs are created through dialogically-based generative and relational practices (Barlow & Stewart-Brown, 2000; Fraenkel, 2006; Foxcroft & Tsertsvadze, 2011). The practices of collaborative group therapy diverge from many conventional approaches (Seikkula & Olson, 2006) to adolescent substance use treatment. From a collaborative practice perspective, parents are not viewed as needing treatment nor are they viewed as being the cause of their adolescent's substance use. Seikkula and Olson (2006) said in regards to their work with "Open Dialogue," people are not seen to be objects to treat or causes of distress but are competent and capable resources for their family member's recovery. Parents are considered to be experts of their lives and partners in dialogical group interchange rather than the equation in the problem to be changed (Fraenkel, 2006; Madigan, 2011). Therefore, in a collaborative group setting, practitioners do not enter the group context with predetermined hypotheses or anticipated outcomes, but an intentional focus on the process of dialogue.

In the group setting, collaborative practitioners recognize parents as resources for their adolescent's wellbeing. Practitioners demonstrate a practice attitude or posture, as described by Madsen (2007), grounded in a "spirit of respect, connection, curiosity, and hope" (p. 1). When practitioners recognize the value and expertise of the parent they contribute to the erosion of existing or presumed dichotomous power positions of us and them, expert and non-expert often demonstrated or insinuated between conventional practitioner and client roles (Anderson, 2007). Collaborating in conversation provides an opportunity to "see together" (W. Miller, personal communication, October 5, 2010), an opportunity to understand parents' experiences from their points of view (Groenewald, 2004).

Parents and practitioners work together in the creation of a group atmosphere conducive to relationship and conversational processes (Anderson as cited in Tarragona, 2008). Therefore, both parties partner in the development of "mutual agenda setting" (St. George & Wulff, 2007, p. 406) and shared inquiry. Shared inquiry as defined by Anderson (as cited in Tarragona, 2008), refers to the "process in which participants are in a fluid mode and is characterized by people talking with each other as they seek understanding and generate meanings; it is an in-there-together, two-way, give-and-take, back-and-forth exchange" (p. 198). Practitioners do not "regurgitate" facts but facilitate dialogue in which parents are supported to express their own knowledge, ideas, meanings, and experiences. Practitioners are ready to meet whatever they are faced with in the moment of group interchange, neither pushing/pulling, nor directing the flow and emergent nature of the dialogue.

As a practitioner, I have encountered many parents who access formal help to find relief from the effects of their teen's relationships with drugs and/or alcohol. However, as I have mentioned before, parents often encounter monological directives and expert-based prescriptions of solution and fix. A collaborative group therapy format may provide the context for providing support in an atmosphere in which parents can potentially generate their own dialogical pathways. Parents participating in a collaborative group process may have the opportunity to partner in processes of co-exploration while "co-developing possibility" (Anderson, 2007, p. 26). Such relationally engaged conversation constructs social reality (Gergen as cited in Seikkula & Olson,

2006), which might mean new ways of seeing, new ways of being, new ways of perceiving the adolescent's relationship with substances and/or the parents' experiences of their adolescent's substance use.

An Opening for Inquiry

The conjecture and information throughout my literature review culminated in an expressed reason for exploring a unique support option. Having immersed myself in literature about the historical, cultural, and social contexts of adolescent substance use, as a clinical practitioner I felt impelled to provide an additional offering of support to parents involved in adolescent substance use treatment programming. However, as a researcher I also became increasingly eager to explore parents' attributed meanings and felt impact of such an offering. At this point, relatively few research efforts have specifically been used to elicit parents' subjective perspectives of parent group programming (Levac et al., 2008; Foxcroft & Tsertsvadze, 2011).

Researchers, academics, and a broader community of helping professionals suggest that parents are pivotal influences in the trajectory of their adolescent's wellbeing, yet within our research efforts we have yet to extend our inquiry to qualitatively explore parent perspectives of adolescent substance use or experience participating in formal group programming (Armstrong, Birnie-Lefcovitch, & Ungar, 2005; Jackson & Mannix, 2003; Usher et al., 2005). Groups have been primarily explored via quantitative means. Quantitative data is used to inform what may be considered to be universal laws, objective facts, without the means to consider the private lived experience of the human participants (Gergen & Gergen, 2010).

In their systematic review of literature on direct and indirect effects of parent support, Yuen and Toumbourou (2008) identified six quantitative studies reporting effects of group programming and three qualitative reports evaluating efficacy of individual, one-to-one, counselling interventions. Yuen and Toumbourou did not identify any qualitative studies reporting parent experiences participating in group interventions. Yuen and Toumbourou (2008) provided recognition of the effectiveness of group programming on parents' wellbeing, however their findings provided little context with which to increase understanding of what was considered influential and/or what meaning interventions had on parents' experiences of their adolescent's substance use. Aspects of what parents found meaningful and influential in their experience of group programming remains to be understood. As a result, I was left to wonder if given the opportunity of constructing a parent group program, would parents create content and/or process that was similar or exceptional.

Within my focused exploration of adolescent substance use literature I was unable to identify a qualitative research inquiry specifically designed to illuminate dialogical conversation generated from a collaborative group process. As noted by Thorne (2008),

That which is worth studying qualitatively is credibly argued when the next logical question in advancing disciplinary knowledge is one for which themes and patterns have not been well documented, for which the subjective or experiential elements of the phenomenon are not yet fully reported, or for which the links between elements and the larger experiential context have not been effectively made. (p. 44)

Inquiries illuminating the narratives of a generally untapped dialogue and perceptions of meaning of such dialogue are needed in order to expand the scope of how we support parents and design and facilitate programs for parents involved in adolescent substance use treatment (Barlow & Stewart-Brown, 2000). Further, in my review efforts, I was unable to identify a collaboratively constructed and facilitated group therapy program for parents of adolescents involved in substance use.

As a practitioner and student observing a gap in practice research exploring collaborative group process and dialogical conversation, I was inspired by ideas for both my clinical practice and research pursuits. I came to wonder, if given the opportunity to privilege parent partnerships in the construction of a group dialogue, what conversation parents might generate. Further, I wanted to understand what such dialogue may mean for their experience of their adolescent's substance use. I hoped to elicit parent narratives in order to construct data to broaden formal understanding of what parents have to say and how these voices might contribute to multivocality within adolescent substance use knowledge and understandings. As described by Gergen and Gergen (2003), "Researchers turn to qualitative methods in the hope of generating richer and more finely nuanced accounts of human action" (para. 7).

Conclusion

Parenting a teenager actively in relationship with alcohol and/or other drugs can be difficult. Parents are affected by the emotional, mental, social, and physical toll of their adolescent's substance use. Yet, parents are underserved and under-recognized with formal adolescent substance use treatment resources. Strong social narratives, attitudes, values, and beliefs influence if and when parents access such resources and how parents are responded to once they do.

Despite significant investments in knowledge acquisition, consensus has yet to be achieved in the intellectual pursuit of understanding addiction. Influential voices of those in privileged positions construct and project theory as the truth, consequently influencing how we view, interpret, experience, and respond to adolescent substance use. Conventional notions involve cause and effect correlations that often implicate parents as powerless over, or to blame for adolescent substance use. Hierarchical, expert-directed systems negate the unique expertise and knowledge of parents, privileging the voice of the professional over the voice of the person accessing service.

However, as I have previously articulated, how we have come to perceive and respond to adolescent substance use has been created through dialogical processes. Dialogue creates our social reality (Gergen, 2009a) including the beliefs and meanings to which we subscribe. With this in mind I have come to wonder what new experience, knowledge, and understanding might be constructed if, as practitioners, we created dialogical resources that encouraged the voices of people to be expressed and heard. McCarthy (2010) describes the process of facilitating dialogue as reaching beyond what she refers to as "dilemmas of a dualistic world view" (p. 6).

Collaborative therapy in a group context may be utilized as a resource for fostering such dialogical opportunities. Unlike a recipe-ordered psycho-education group, or a theory-driven process group (e.g., Alcoholics Anonymous), a collaborative therapy group may be used to engage multiple perspectives and partnered dialogical interchange.

I wondered what understandings, meanings, and possibilities might emerge, might transform, or might develop if parents were engaged in a collaborative group process. Unless this therapeutic venue is provided, these questions may not be explored and the richness from potential responses to these questions may not be known.

Chapter Three: Research Inquiry Design

“Rather than confront situations attempting to find the best solution or path, we turn our attention to the various ways in which participants enter into conversation and how these various ways open multiple possibilities for action.”

(McNamee, 2000).

My purpose in the following chapter is to explain in detail my inquiry process. I describe my intention to explore multivocality in dialogical conversations and relational interchange within a collaborative therapy group process. In addition, I explain my rationale for selecting a specific inquiry design, data collection strategy, and mode of analysis. At the foreground of my writing is my voice as a practitioner and researcher, my awareness of the experience of you, the reader, and my intent of sparking social change for parents influenced by their adolescent’s substance use. As I reflected and wrote about decisional junctures and gestures of inquiry, I attempted to privilege, not only the voice of the parent participant, but also the therapeutic practitioner. I highlighted similarities between the inquiry process and processes of therapy, to suggest that the research processes I am involved in, and what knowledge is created, can be accessible to, and applied by colleagues and fellow practitioners situated within clinical counselling contexts.

Putting on My Research Hat

While writing my literature review I intentionally highlighted impacts of addiction discourse on how parents and practitioners experience adolescent substance use. As I wrote my account of such impacts, I was sensitive to you, the reader. I imagined writing for you, weaving together a story through unfolding narrative, meaning-making, and interpretation. In the pursuit of developing my inquiry process I was acutely more aware of continuing a consistent story. I wanted to develop and relay methods congruent with the ideas I had explicitly shared with you in the previous chapter. This means participating and presenting my inquiry in a manner and mode that reflects a “postmodern, social constructionist perspective” (Gergen as cited in McNamee, 1994). I wanted to venture to build a fluid chapter in the continuation of my research story, building on narrative in the development of a plot in which reality is subjective, knowledge is constructed, and dialogue is generative.

In order to share such a story with you, I realized I had to understand and articulate not just what I wanted to research but also how I wanted to be involved in research. I wanted to inspire curious intrigue while generating increased understanding of parents’ dialogue in the context of a collaborative group. I wanted to offer invitations to consider plurality of viewpoints beyond singular expert-based truth claims. I wanted to engage in a postmodern critique of tensions (Gergen & Gergen, 2003) in research practice, while sharing with you my reflexively situated descriptions of influence and investment as a researcher within my inquiry. I wanted to employ an inquiry process situated in an epistemology based on the constructed nature of knowledge and the potentials of plurality from subjective comparative perspectives and viewpoints.

By exploring how I wanted to be involved in inquiry, my interest in the meaning and intention of my inquiry was sparked. It became important to me to explore the

phenomena of dialogue in the context of a collaborative therapy group beyond benchmarks of effective/not effective, right/wrong, and/or changed/unchanged. My intent was not to prove nor deny aspects of dialogue, parent experience, or therapeutic approach. My intention was to acknowledge *what processes and possibilities might emerge from the group and how this knowledge might inform clinical youth substance use treatment practices*. With this in mind, the overall purpose of my research inquiry is underscored by potentials to contribute to social change and quality of life (Foster & Bochner, 2008) of parents influenced by their adolescents' substance use. In order to provide you, the reader, with increased understanding of how I orientated myself in the meaning and intention of my inquiry process I explore the concepts of multivocality, epistemology, and reflexivity.

Multivocality.

“Postmodern shifts the emphasis on the inside inquirer; focus is centered on learning about the first-person-lived experience and about the uniqueness of it instead of similarities and patterns. Difference is valued.”

(Anderson, 2007, p. 9)

Although I have utilized the concept in my clinical counselling practice, it was not until I read the work of Sheila McNamee (2000) that multivocality became meaningful to my experience as a researcher. For the last 12 years, I have partnered with youth and families in conversations as a clinical counsellor. With a passion to understand peoples' presentations of experience, and what might be transformational aspects in these experiences, I have attended to conversations with constant curiosity and wonder. Merging into a formal academic research project, I initially imagined that I had to decipher between my familiar role as a counsellor and what I perceived to be a less familiar role as a researcher. I imagined having to don specific hats, a distinct hat to pose in as counsellor and as researcher. Unfamiliar with formal research, the researcher hat seemed to be decorated with obscurity, complexity, and disparate ideology. In the words of Thorne (2008), “Despite being drawn to qualitative research because of their enthusiasm for subjective experiential clinical knowledge, many clinicians find the transition into the role of researcher considerably more difficult than they had first imagined” (p. 108).

Rather than making the distinction between wearing the hat of the counsellor and wearing the hat of the researcher, I have come to recognize that by engaging in a process of inquiry I pull from many aspects of who I am including curious listener, attentive interpreter, and compassionate witness (McNamee, 2000). By drawing from the voices of various performances of self, I have been able to translate numerous abilities into my inquiry—obscuring the lines and bounds between counselling practitioner and researcher, interpreter and observer, listener and storyteller.

The notion of multivocality became not only an important tenet of how I orientated my position in the process of this research project, but also in how I constructed my data. I sought to understand all of the involved parent voices and viewpoints inclusive of exception, difference, and plurality (Gergen & Gergen, 2010). Described by McNamee (1989), people make sense of their worlds in varied ways based on diverse interpretations of context and experience. Therefore, I heard multiple

perspectives and highlighted the value of diversity. Acknowledging variance within the information and stories that are provided to me reflects a postmodern recognition of subjectivity in the interpretation of constructed conversation and an invitation to wonder about possibility to be considered.

Epistemology.

“Listening to people who are members of groups that have been underrepresented in conventional research provides rich opportunities to discover what scholarly discourse may have obscured, and to see the limits of prevailing truths.”

(Sprague, 2005, p. 120)

Upon exploring the existing literature related to my topic I came to realize that research on adolescent substance abuse and parent voices/perspectives/experiences has not, to date, been directed towards understanding what dialogue parents create in a collaborative group format. In addition, the current inquiries of parent experiences in therapeutic or psycho-educational groups have been primarily based on objective, quantifiable efficacy. I knew early on in my inquiry endeavor that I was more comfortable lingering in an inductive, exploratory process in order to learn more about dialogue created in a collaborative group. However, prior to actively becoming involved in my inquiry I had to articulate my philosophical relationship with research and what I understand as being the nature of knowledge. This meant exploring my epistemological orientation as a researcher.

An epistemology is a theory about knowledge (Sprague, 2005). A theory about knowledge includes considerations of who can know what knowledge and how knowledge is constructed (Harding as cited in Sprague, 2005). Dian Marie Hoskings, described epistemology as a thought-style, the basic assumptions we make about our world and our relationship to it (personal communication, April 9, 2013). From Bateson (as cited in McNamee, 1989), “Epistemology (personal or collective) provides a frame for a researcher and that frame is the process of seeing difference because epistemology distinguishes foreground from background” (p. 110). For me, this means placing multiplicity and subjectivity in the foreground (Bateson as cited in McNamee, 1989) of my inquiry process—challenging objectivity, generalizability, and control (McNamee, 1989), and inviting exploration, exceptions, and possibility.

The epistemological orientation influencing my inquiry practice is rooted in social constructionism. Foster and Bochner (2008) said,

To think about, theorize, investigate, write, or perform the constitutive qualities of communication is to inhabit the world of social constructionism; to root one’s work in social construction is to plant one’s feet squarely in the world of interactive communication. (p. 86)

With this influencing ideology, I realized if I was to explore conversation on a micro group level, I had to also be open to the possible need of engaging in research on macro levels. As the processes of language and dialogue shift and shape the worlds of those involved, language and dialogue constructed through inquiry too has the potential to influence change, making a difference in the lives of individuals and larger populations.

Reflexivity.

“Subjectivity is distinguishable from, and simultaneously in relation to, the positivistic idea of an objective science. With objectivity comes the idea of truth-conditional or criterion-indexed approaches and/or observations, a belief in the lineality of events, and the notion that the researcher is separate from the process of researching.”

(McNamee, 1989, p. 109)

McNamee (personal communication, June 4, 2013) suggested that the hallmark of a constructionist stance is reflexivity. Critical reflexivity is the “attempt to place one’s premises into question, to suspend the ‘obvious,’ to listen to alternative framings of reality, and to grapple with the comparative outcomes of multiple standpoints” (Gergen, 2009a, p. 12). Rowan (2006), suggests that we not hide behind the role of researcher but include ourselves in the process of research by wondering how what we learn is both influenced by us and applied to us.

Being reflexive in my research process was also very important to me. When involved in my own clinical counselling practice I continually consider what relational contributions I bring to the helping process. I ask myself how gender, age, and culture, for example, contribute to what knowledge and meaning are constructed in the interchange. In so doing, I am being reflexive: actively considering, questioning, and wondering about my relationship to the research process (Hays & Singh, 2012). Upon reading Ellingson (2011), I embarked on a process of wondering through which I utilized provocative questions and a reflective journal to ascertain my contribution to my inquiry process. One question from Ellingson (2011) had particular influence in my process of wondering: “How does my age, gender, ethnicity, nationality, abilities and disabilities, special talents, formative experiences, etc., shape how I understand my participants?” (p. 424).

In order to address this wondering, I decided to share with you a brief story about myself. As I wrote this story I found that words of remembering poured onto the pages of my dissertation alongside questions of intrigue. By telling you more about who I am in relation to my study I have provoked for myself wondering about why I am, and how I am in relation to my study.

When I initially wrote this section I started with a description about my professional practice and a story about how my research process had been influenced by such experience. However, upon review I was struck by how I had neglected to write about aspects of my identity not embodied in my performance as a professional. I was missing an opportunity to be authentic, honest, and willing about certain aspects of self in relation to my research process. What I neglected to explain is one very important influence on how I have come to experience situations and people around me—I am a mom. I am a parent!

In 2007, I became the mom of a beautiful baby boy. My experience being a mom has been a tremendous dance⁸ of love, challenge, pain, and triumph. When my son was 6 months old he was diagnosed with a chronic and life-threatening medical condition. A

⁸ Kenneth Gergen (2009b) suggests that emotions are forms of relational action and that as socially influenced performers we “do” (p. 102) emotions.

diagnosis of severe hemophilia rocked what I had expected my role in motherhood would be and what I expected his role as my son would be. Hemophilia introduced us to fear, unrelenting determination, heartache, and heart-bursting love. I am a parent who loves my child and through this love have felt the pierce of pain and vulnerability inflicted by the sharp edge of fear and worry. However, over the years I have stood up to fear and worry and through what I have come to call courage, hemophilia has been reduced from a towering precipice on the landscape of my parenting experience to a small and surmountable feature.

As I tease at the loose end of an intricately woven story, I unravel a complex narrative of experience. I tug on a knot and loosen the bounds of my experience as an adolescent. I pull apart a remembering of my brother's teen experience with substances and how I observed my own mother's desperate and dejecting struggle to find help. I recall pain and isolation in her futile efforts to find support. I gather threads of my previous experience as a youth worker counselling disenfranchised youth, and I consider my current experience in sessions as a family therapist. I think of what I have come to understand as the meaning of being a woman, of being educated primarily in social work, psychology, and social science. I think of religion, marriage, my culture, my ethnicity. The more I unravel my story I come to think of encounters that have influenced who I am now and the performances I enact in both personal and professional contexts. I do not stand unbiased and neutral behind the role of researcher but stand amongst the many relational influences that have weaved together the story of now.

Upon reading this snippet of my story, you might wonder about what meaning such experiences have in relation to my inquiry with parents. What noticing, intrigue, and perhaps what voices are privileged in order to illuminate the conversation of those parents in my study. Has my interest in the parent voice been inspired by my own insider journey as a parent? Has my desire to support parents and develop resources to continue to support parents been compelled by what I have observed throughout my life encounters? Has my own mother's experience with pain and isolation influenced how I have constructed the pain and suffering of others? Has my attention to the potentiality and possibility of triumph through challenge been provoked by struggles and courage I have known? In what ways have 13 years of youth and family counselling in government and not-for-profit systems fueled my interest in language, multiplicity, and a therapeutic paradigm shift? What have I come to believe, to see, to dismiss, to value, to name, to speak as a result of interactions? Is there any one particular influence, or like my leaning towards multiplicity in therapy and inquiry is my draw towards, and impact, on the research process a result of a confluence of events, experiences, and relational influence? From Gergen et al. (2001), "We participate in multiple relationships—in the community, on the job, at leisure, vicariously with television features—and we carry with us myriad traces of these relationships" (para. 30). Unless I am mindful of such relationships and interconnected interactions I might negate the potentiality of what additional conversations might come to be understood and known in this study.

Rowan (2006) explains that all researchers carry assumptions that are historically, culturally, and socially influenced. My assumptions about clinical practice, societal influence, and youth and family substance use may be acknowledged throughout my inquiry including the pieces selected for my literature review, the questions asked within the research conversation, and the findings constructed and reported. Furthermore,

my connection to social constructionism, collaborative practice, competency-based therapies, and the development of the *Recognizing Resilience* group framework may contribute to what themes I supported in my data collection and examination.

Denzin and Lincoln (2012) suggested that recognizing the interpretive nature of the researcher's involvement in the research process "places the researcher, the topic, and the sense-making process in the interaction" (p. 390). My involvement throughout my research process became an important emergent consideration for both the credibility and trustworthiness (Hays & Singh, 2012) of the process. In order to pay attention to this consideration, I attempted to include reflective awareness throughout the following sections and chapters. Specifically, I tried to bring wonder into what I interpreted and reported by posing to myself questions that allowed me to consider alternative viewpoints and other voices or perspectives. This meant documenting my responses and reactions during data collection, analysis, and interpretation.

Quite similar to what I have encountered as a practitioner within the context of therapy, in my research I was faced with the need to articulate my intentions and decisions at important junctures within the process of inquiry. Increasing the rigour of my research meant active transparency, clearly explaining how I came to particular decisions and ventured down certain paths at particular crossroads within the process. This meant articulating aspects of how I built my methodological design and constructed and transformed data. So that I could capture responses and reactions, critical decision points, as well as emergent and reflective thoughts inspired by my experience during the research process, I kept a *Reflexivity Journal*. My reflexivity journal was a reflective notebook that I referenced in order to better understand my role, reactions, responses, and influence within the research process (Hays & Singh, 2012; Thorne, 2008). As you continue to read Chapter Three, I hope you will see how reflexivity has been considered throughout my data collection and analysis process.

Finding a Methodological/Design Match: Interpretive Description

When developing my inquiry I considered your potential needs as the reader, parents, practitioners, and broader youth substance use treatment system, and became concerned about intentionality and the implications of choosing an inquiry process. My exploration into available methodologies involved critical awareness of constructing an inquiry process that allowed me to represent conversation and experience that empowered the parent participant, and invited thoughtful consideration of how to enhance rather than disconnect relationship amongst parents, practitioners, and youth substance use treatment systems. In regards to research Gergen and Gergen (2003) explained: "What is again required is a more tolerant and mutually reflective orientation to the research process" (para. 31).

Conceptualizing how I wanted to construct research and the philosophical notions that I wanted to reflect in my research were two important aspects of consideration; how I was going to do this and what structure would provide me with the epistemological and ethical ideals to do so, were another matter. As expressed by Sprague (2005), "Methodology works out the implications of a specific epistemology for how to implement a method" (p. 5).

It was not until I encountered the method of interpretive description that I had found my methodological match. Interpretive description was developed by Thorne,

Reimer Kirkham, and O'Flynn-Magee (1997) as a research method to construct and increase knowledge of clinical phenomena in the health care field and other applied disciplines (Thorne, 2008). The method of interpretive description is a non-categorical, non-prescriptive approach to research. This means that researchers have methodological freedom to draw theory and procedures from some of the more established and prominent traditions of qualitative inquiry including phenomenology, grounded theory, and ethnography. Thorne (2008) explained that a researcher drawing from an interpretive description approach extends beyond boundaries of objective truth and abstract theory in order to explore the subjective nature of knowledge and to create practical and applicable clinical understandings.

Interpretive description is a form of qualitative research. Qualitative research involves inductive understanding of phenomena from the subjective point of view of the research participant (Hays & Singh, 2012). Denzin and Lincoln (as cited in Guest, MacQueen, & Namey, 2011) said, "Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that makes the world visible. These practices transform the world" (p. 5).

Having a personal orientation in social constructionist ideas, I chose interpretive description based on the epistemological basis of the method. Epistemologically orientated in social constructionism, interpretive description as a method pertains to a process of illuminating perceptions rather than what may be quantified in other research methods as "facts" (Thorne, 2008). Interpretative researchers acknowledge how and what social reality is constructed and how, and in what ways, such constructions influence and inform the meaning of peoples' representations of experience (Holstein & Gubrium as cited in St. George, 2010). The researcher recognizes relational, historical, cultural, and social contexts, as well as collective experiences, influencing how reality is constructed and meaning is developed (McNamee, 2000; Thorne, 2008). For me, this meant remaining open and cognizant of how parents in the inquiry process constructed group conversation and in what ways this conversation had meaning for each group member.

In order to develop an understanding of the operational definition of interpretive description I became familiar with the distinct connotations of both the terms description and interpretation. Description refers to the researcher's efforts to document what has been observed. Unlike quantitative descriptions, qualitative description relies on knowledge accessible through subjective human experience (Thorne, 2008). It is important to keep in mind as Anderson (personal communication, December 13, 2013) noted, "that as interpretive description suggests, any description is an interpretation." In my inquiry I considered the term description as an exploratory, open process of illuminating and bringing awareness to (Thorne, 2008) dialogical conversation emerging from a collaborative group process.

Interpretation, from the words of Schwandt as cited in St. George (2010), "is the act of clarifying, explicating, or explaining the meaning of some phenomena" (para. 4). Denzin and Lincoln (2012) explained that "all research is interpretive: guided by a set of beliefs and feeling about the world and how it should be understood and studied" (p. 26). Interpretive research involves the construction of understanding through interpretation of the meaning of experience (Kvale, 1996). When observing phenomena, we interpret, or attribute meaning and try to make sense of how we can practically take action and apply knowledge (St. George, 2010). As this relates to my inquiry, I interpreted the meanings

parents created from the conversation generated in group and implications for clinical practice in the field of youth and family substance use treatment.

As interpretive description is an applied research methodology, I was keenly aware of articulating what relevance my inquiry had to clinical practice. Interpretive description, as a method, is “designed to fit the kinds of complex experiential questions that . . . applied health researchers might be inclined to ask” (Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004, p. 2). McNamee (1989) said that “social science, as an area of inquiry like therapy has understanding and improving human condition as its goal” (p. 95). By using an applied research approach to understanding phenomena I not only focused on “what” was to be answered, but also on “so what,” and/or “now what” would be done in response to these new understandings (St. George, 2010; Thorne, 2008; Turabian, 2010). What knowledge comes from research is not enough without progressive social change resulting from such understanding (Sprague, 2005).

Through the method of interpretive description I hope to offer understandings and perspectives that might contribute to disciplinary knowledge (Thorne et al., 2004). Thorne (2008) said, “We. . .inherently work within the world of studying instances and integrating what we learn about them with our reflective clinical reasoning process, searching for underlying meanings that might further illuminate what is happening and develop a deeper appreciation toward what could ultimately be. . .[a] clinical response” (p. 50). Wondering how to enhance and/or alter formal systems approaches of working with parents of teenagers engaged in substance use, I understood that merely describing conversation in a group context would, as Thorne (2008) indicated not have been enough. My assumption was that other parents and formal systems involved with adolescent substance use might find meaning in potential practical applications I derive from parent descriptions of dialogue within the collaborative therapy group context.

My Research Question

After considering characteristics of my research identity and how I wanted to be involved in the research process, I came to feel clearer about what specifically I wanted to call attentional curiosity to in my research inquiry. In order to understand how I might broaden my clinical work with parents I came to frame a grand tour question written in the language (McCaslin & Wilson Scott, 2003) of an interpretive description research tradition. A grand tour question is a question framed in a general form so as not to sway or constrain inquiry (Creswell, 1994). To frame and elaborate on my curiosity of dialogical conversation in a collaborative group, I focused my questions, not on defining a clear outcome of a targeted intervention, but on emergent content in an unconventional context.

- What dialogue do parents of adolescents in relationship substances create when they are involved in a collaborative group process?
- What meaning does the dialogue created in this collaborative group process have in relation to parents’ experiences of their adolescent’s substance use?
- What conditions in a collaborative group process inspired dialogical conversation for parents influenced by their adolescent’s use of substances?

In posing these questions I hoped to increase my understanding of what dialogue parent participants constructed when I facilitated a collaborative therapy group. By highlighting dialogue I intended to share with you the reader, with practitioners, system stakeholders, and parents, what parents expressed and deemed to have importance in conversational interchange and how collaborative therapy influenced such interchange. I believe that this knowledge could have implications in the clinical practice arena by adding to practitioner understanding the applicability and influence of collaborative practices and the potential utility of engaging in shared endeavors to generate dialogical conversation with parents of teens influenced by substance use.

Context of My Inquiry Process

In the following section I describe the *Recognizing Resilience* group process as well as provide a general account of how group facilitators are involved in this specific collaborative group program. As the research participants in my study were drawn directly from the *Recognizing Resilience* program, I wanted to provide these details to help you understand the broader picture and climate of my inquiry process. I offered two cohorts of the *Recognizing Resilience* group and conducted interviews with volunteer parent participants to specifically explore what dialogue was constructed within these two group offerings. After explaining the context of the inquiry I provide for you further details regarding participant recruitment and orientation, what steps I pursued in data collection and analysis, and how I theorized and recontextualized the data.

Recognizing Resilience.

Recognizing Resilience is a 6-week group program for parents affected by their adolescent's involvement with substances. I developed the group 4 years ago as an additional resource to the manualized psycho-educational group programs⁹ that were offered at the time. Over the course of the past 4 years, the group has been facilitated solely out of the Discovery Youth and Family Services office where I work as a counselor. Discovery is a direct service clinical counselling program of the Vancouver Island Health Authority, British Columbia, Canada. The mandate of the agency is to provide both individual and group outpatient counselling for youth aged 13-18 using substances, and their families. Participants of the group program are invited to attend the group by Discovery counsellors or allied services. Referrals are commonly initiated when parents express desires to participate in programming in addition to, or other than, individual therapy, and/or to meet other parents also affected by their adolescent's substance use.

By facilitating the group out of the Discovery office, I was able to access parent participants for my inquiry. As described by Berg (2009), "The decision to use a particular research site is tied closely to obtaining access to an appropriate population of potential subjects" (p. 47). In addition, being involved with Discovery allowed me to partner with a co-facilitator, Griffin Russell, who shares similar involvement with youth

⁹ Triple P: Positive Parenting Program, The STEP Program: Systematic Training for Effective Parenting, Positive Discipline, Connect Parent Group.

and families who come to the agency. For these reasons I felt that it made the most sense to run the group through Discovery.

The group is closed, meaning once the group begins no additional members join. I have found that a closed group process allows for a cohesive development of group connection, safety, and dialogue. The group member capacity is 12, however, over the years the group has run with an average of 8 participants. The group cohorts are structured to run for duration of 6 consecutive weeks, with parents participating in either a fall or spring offering.

For my inquiry, I facilitated two separate groups: one held in the urban community of Nanaimo and the other held in the rural community of Duncan. I chose to facilitate two groups so that I could explore unique and common aspects of two different groups from separate and distinct communities. Before either group began, I and my co-facilitator met individually with parents and explained the group logistics including dates and times. We reviewed informed consent and completed confidentiality agreements. In addition, we asked parents what questions they had regarding the group and what they hoped a group might offer them. All parents indicated that they were looking to hear stories from other parents and were hoping to find a sense of not being alone or the only parent caregiving an adolescent involved with substances.

In total 13 parents caring for 10 teenagers joined the two *Recognizing Resilience* groups (6 in the Nanaimo group and 7 in Duncan). Of the parents in Nanaimo, 2 women were adoptive mothers, 1 was an auntie, 1 was a single biological mother, and 2 were a married biological mother/father couple. Of the parents in Duncan, 3 were single biological mothers, 2 were a married adoptive mother/father couple, and 2 were a married biological mother/father couple. Of the 10 teenagers represented in the group, five were female and five were male. Ages of the teens ranged from 14 to 18. Seven, according to their parents were primarily involved with cannabis, one was actively involved with cocaine, one was primarily involved with prescription medication, and one was mostly involved with dextromethorphan (DXM). Poly-substance use was a norm, meaning that most of the youth represented were also involved with additional substances. All 13 parents were involved in the group because they were concerned about their teen's substance use, however 4 were also concerned about a dually diagnosed mental health condition (anxiety and depression), 1 spoke to concerns about her son's diagnosis of autism, and 2 identified that their teens had a diagnosis of fetal alcohol spectrum disorder (FASD). Three of the teens were living outside of their family homes, two were attending school, one was employed full time, and seven were neither attending school nor working.

In the initial session parent participants began developing the group agenda and becoming privy to one another's stories. During the initial group session we inquired about how parents wanted to spend time together in the group by asking specifically about parents' interests in regards to topics, focus, process, needs, and hopes. From Lord (2011), "If people are going to aspire to something for the good of the whole, it's best if they begin with what they want to contribute" (p. 127).

The group outcomes were initially unknown, and uniquely emerged through relational process and the unique generative dynamic of group interchange and relationship. St. George and Wulff (2007) said, "It is when the outcome of the work together is not known that our collaborative process is measured" (p. 406).

My Role as a Group Facilitator: The Aesthetics of My Practice.

“The art of witness”

(Hoffman, 2007, p. 63)

For the purposes of explaining contextual aspects of my inquiry, I think it is important for me to provide for you a description of how I participated as a group facilitator during the *Recognizing Resilience* group process. I place such importance on my role as a facilitator because I feel that the way I facilitated and how I facilitated framed the collaborative approach practiced within the group. For the purpose of my research inquiry I was involved as a co-facilitator of the *Recognizing Resilience* group alongside a colleague and practitioner, Griffin Russell, with whom I have facilitated parent group programming for 4 years.

During our earlier years facilitating the *Recognizing Resilience* group, Griffin and I spent our initial group session developing specific conversational topics and an ordered agenda of discussion. However, once we became familiar with the ideas of collaborative therapy we decided to facilitate the group in a more generative and partnered process. For my inquiry I differentiate from my previous facilitation experiences and show my current understanding of collaborative therapy. In order to demonstrate a collaborative therapy approach Griffin and I became involved as facilitators in a very particular way.

As I facilitated *Recognizing Resilience* I took a relational stance encompassing a way of being (Anderson, 2007; Hoffman, 2007; Miller & Rollnick, 2002). This way of being meant embodying a willingness to be a partner, a collaborative ally in the development of the group, as well as a guide, learner, and teacher when involved in dialogical activities within the group. According to Madsen (2007), collaborative approaches to working with families draw attention to an “attitude” (p. 9) demonstrated by helping practitioners. As facilitators, we demonstrated empathy, compassion, openness, genuineness, and warmth—characteristics found to contribute to both group process and outcome (Burlingame, McClendon, & Alonso, 2011; McBride as cited in Burlingame & Beecher, 2008). This way of being meant that as co-facilitators we were continually curious (Anderson, 1997) and open to hearing the group members’ stories and conversational exchanges. We remained open and receptive to hearing parents share what they felt was important to discuss.

In terms of clinical practice, our way of being within the group also involved an attentional focus on a postmodern context, social constructionism, relational being, and collaborative ideology. During the process of developing dialogue we intentionally invited and evoked curiosity towards dominant social values and knowledge, as well as exploration of possibility and multiplicity in terms of additional perspectives and understandings (McCarthy, as cited in McCarthy, 2010). McDonough and Koch (2007) said that “to collaborate is to invite multiple perspectives into the conversational partnership and into the process of co-constructing new knowledge” (p. 173).

While working within the group process we strove to represent egalitarian and partnering stances, removing ourselves from hierarchical postures (Anderson, 2007). As group facilitators, we were intentional to not assume a position to “fix” and refrained from offering truth or solution, but opened dialogical processes that aroused coordinated

actions of meaning-making. We sat with unpredictability and not knowing, and attuned to interactions and dialogue within the moment, accurately and attentively listening and hearing (Anderson, 2007).

Stemming from David Cooperrider's Appreciative Inquiry concepts, as co-facilitators we joined with parents fostering "appreciative language" (Cooperrider as cited in Pearce, 2009, p. 16). We asked parents questions about what was going well, competence, and capacity, as opposed to questions about what was not working, incompetence, and incapacity. Gergen et al. (2001) explained:

The practice of appreciative inquiry provides an excellent means by which people can move toward the generation of new realities. By sharing stories of value, commonalities are located. And using the sense of shared value, visions are fostered. Dialogue is then employed to fill out the landscape of the vision, to create a sense of a new reality, which, in turn lays the groundwork for alternative forms of action. (para. 38)

Beyond descriptions of problem manifestation, we reflected process-orientated narratives describing how parents might respond to the situation in a manner that would serve themselves and their families' wellness, improving existing challenges (Pearce, 2009). As practitioners we participated as open and non-judgmental, supporting parents to talk about what they felt was important.

Throughout the group process we were cognizant of and interested in tapping into parent insider knowledge. We intentionally elicited parents' perspectives and reflected parents' senses of knowing. We recognized the expertise of parents participating in the generative group dynamics. This focus on parental expertise and knowledge was an attempt to make the professional content, expertise, and knowledge less significant (Anderson, 2007). We were mindful of offering professional knowledge once participant knowledge had been heard and expanded upon. Only with explicit requests for permission within a spirit of collaboration and partnership was our knowledge offered (Miller & Rollnick, 2002).

Reflexivity Journal

March 1, 2013

Looking at the Story Ball

Harlene Anderson (2007) uses a metaphor to describe how she engages with others in dialogue. She explains that each person (client) accessing services comes into counselling conversations with a story ball. Traditionally orientated within expert positions, those holding the seat of the therapist or practitioner have been inclined to take the ball from the person, touch it, turn it, identify problems, provide meaning, and subsequently give feedback on strategies and methods for attending to such interpretations. However, Harlene offers a unique approach to encountering the story ball. In an attempt to create what she calls shared or mutual inquiry, the practitioner does not take the story ball from the person but with permission holds the ball with the person. Together the person accessing service and the practitioner look at and become curious about what has been shown. The practitioner asks questions informed by the client's talk, demonstrating openness to learn and be informed by the expert insider. As a result, a back and forth dynamic develops and all parties become engaged in a shared curiosity and exploration. Harlene suggests that new understandings and meanings emerge from the interactive nature of the exchange generating possibility and potential.

This week I had the privilege to be curious about the story balls presented and created in two unique group dialogues. With much anticipation and excitement I

facilitated the initial session of two separate cohorts of the Recognizing Resilience parent group. I started both groups with an invitation to participants to share what they felt others needed to know. With few additional prompts the group dialogue ensued. Both groupings of parent participants became immersed in rich descriptions of their experience parenting a teen involved in substance use. I heard stories of fear, loss, sadness, and frustration. Glimmers of hope and perseverance subtly lined the heartache and anger that most of the parents identified. As each parent told his/her story, the others in the room witnessed, reassured, and wondered. I found myself actually quite struck by the intimacy of the conversation and how quickly parents moved into positions of support and compassion for each other. "If I could come around the table and hug you right now I would," said one parent; "follow your gut instinct, you are a good mom," said another. Gestures of interest, care, and kindness were generously offered amongst the parents in the room.

I had to be quite intentional during these two evenings of initial group discussion. As a practitioner looking at and exploring the metaphorical story ball growing in the room I was mindful of trying to not catch the pass of the bouncing ball, nor position the ball to be focused on what I felt it should be showing. To be truthful, at times I felt this effort to be difficult. At times I wanted to provide what I thought might be an "answer" or a potential "solution." Despite being so aware of the dominant expert position, I noticed a deeply engrained reflex to provide. As a result, I had to practice in the moment my ability to gaze at what was being said, to invite curiosity by exploring questions and meanings, and to highlight process rather than pull in particular directions. By batting the ball back and forth, holding on together, taking time, and really intently paying attention, I feel like both sessions generated a lively atmosphere of inquiry, acceptance, and openness.

At the end of the first session one parent closed by suggesting that she looked forward to telling the others more about her story. In the second of the two groups, one of the participants shared that he actually did not initially want to come to the group at all, but now that he had had an opportunity to talk, he said he felt better and was looking forward to seeing everyone again next week. When I heard these two pieces of feedback what stood out for me was that these statements were directed not to me as a professional, but to the other parents in the room, to each other. I blended in to the dynamic, not taking the attention, not leading the way, or driving to the destination, but was a facilitator of conversation that was truly inspired by the story ball of the group. So intrigued by the story ball, I have created a visual demonstration of the words I noticed during the conversations within both group sessions.



Excerpt from Stephanie’s Reflexivity Journal (February 28, 2013)

Description of My Inquiry Process

Throughout my inquiry I provided an intentional focus on what processes I navigated in order to engage in research conversations (McCaslin & Wilson-Scott, 2003) with parent participants. Specifically I paid particular attention to developing processes for how I entered, elicited, and exited the research conversation. In the following section I provide for you a description of what aspects of process I considered as I designed and conducted my inquiry. I detail my process seeking ethical approval. I introduce you to the research participants and then I share with you a description of how I constructed and conceptualized my research data. I follow this with a description of how I participated in analysis. I conclude this section by explaining how I began to make meaning of the data. Each of these pieces cumulatively contribute to my overall inquiry process (see Figure 2).

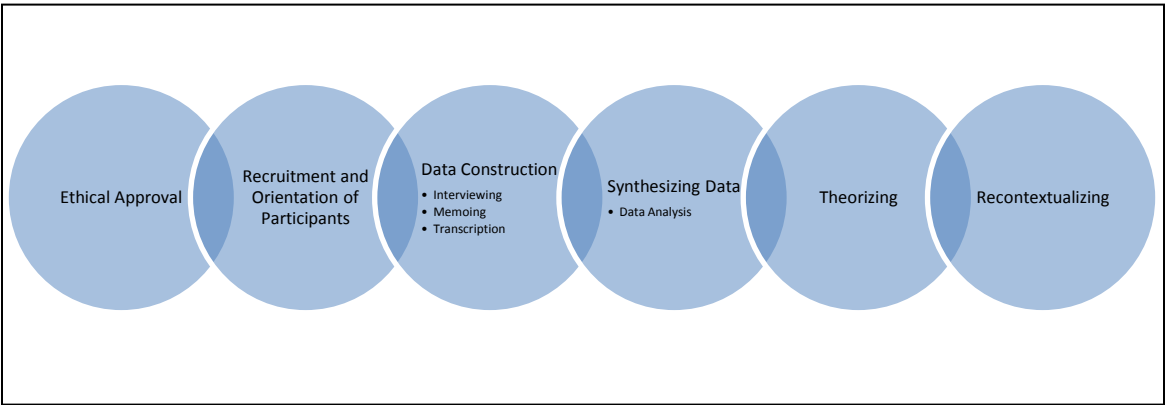


Figure 2 . The steps of my research inquiry.

Ethics.

One of my initial steps of inquiry involved an application to seek and obtain external ethical approval. As a clinical counsellor the idea of ethical practice is not unfamiliar to me. My efforts involved in conversation with people accessing service are guided by both explicit and implicit ethical considerations. Beneficence, to promote the wellbeing of others, and non-maleficence, do no harm, are two terms heavily weighted in my clinical counselling code of conduct. Seeing similarity within the relational interactions and processes of counselling and research, I have applied my ethical understanding to both contexts. In my counselling and research practice, ethical conduct means proactively upholding the rights, dignity, choice, wellbeing, and privacy of participants (British Columbia Association of Clinical Counsellors, 2008). This proactive intention underscored interactions with parents in the clinical context of the *Recognizing Resilience* group as well as the individual research interviews with parent participants, and in constructing and reporting the knowledge generated through the research process.

To begin my research procedures I sought ethical approval from the Vancouver Island Health Authority (VIHA), Health Ethics Review Board (HREB). It was important and necessary for me to receive the Board's ethical approval in order to appeal to rigors of ethical conduct as outlined by VIHA, to receive permission to conduct my inquiry, and to ensure that I was proactively situating participant welfare at the forefront of my research process. Specifically, I requested the board to give approval for me to run two cohorts of the collaborative therapy group, *Recognizing Resilience*, for parents of teenagers actively involved in substance use. I asked to recruit a minimum of 6 parent group participants in order to conduct a qualitative interpretive description inquiry. I asked to audio record and transcribe 60-90 minute interviews designed to elicit information about what dialogue parents generated within the group, the meaning of this dialogue, and the atmosphere that contributed to the dialogue.

When initially applying for approval I expected I would be navigating a straightforward and standard procedural process, but I later came to be surprised by the depth of challenge and learning from this procedural process. Perhaps a reflection of my naivety as a new researcher, and/or system unfamiliarity with a postmodern research process, the hurdles of the ethics approval process were numerous. After revising and re-submitting my application a total of five times, I received ethical approval.

Upon submitting my application, I quickly came to recognize that my social science research process was met with unfamiliarity by, what I would consider to be, a medically-orientated health care system. The ethics panel members met my application with uncertainty and posed questions indicating hesitation about social constructionism, interpretive description, and qualitative methods. Perhaps one of the most contentious issues addressed within my ethics application was the HREB's concern about what they referred to as blurring of roles. The panel members were concerned about the ethics of me being involved with research participants in both a therapeutic capacity and as a researcher. However, as Trahar (2009) spoke to in regards to her narrative inquiry of intercultural research, I was not entering the field to gather a specific object called data

but was already positioned as a practitioner in the field of study, situated within the landscape of practice and in relationship with the people with whom I was studying.

Given the traditionalist assumption that researchers are experts (McNamee, 1994) and in a position of power, the ethics review board insisted on strategies to mitigate the perceived power differential and dual relationship between myself and the parents in the group. I was challenged by the panel to come up with safeguards to reduce impacts of power-over and blurred boundaries. I was given permission to recruit parent participants based upon whether I was able to demonstrate distance from the recruiting process. In order to do this, I agreed that I would not be present during the recruiting process, and turned this piece over to my co-facilitator, Griffin. On the sixth of six sessions I exited the group room and Griffin introduced the research process. He followed a scripted narrative (see Appendix A) providing details of the research purpose, risks, and benefits, and instructions on how parents could become involved. Parents who wanted to be a part of the research process were asked to call Discovery and were subsequently offered a time to complete the inquiry interview.

In addition to *how* I recruited parent participants, the HREB recommended that I develop additional safeguards for those parents who eventually came to be involved in the research interviews. Prior to commencing interviews I explained to parents the concepts of informed consent and voluntary participation (see Appendix B) and checked in with them to ensure understanding. I also talked with parents about the dual relationship of me being both a facilitator and researcher and explained that during the interview sessions emotional support for parents would be provided by a separate, available, on-site counsellor. I explained to the volunteer parents that if they required emotional support during the interview session, I would have to stop the session and connect them to this separate counsellor who would be waiting and available in another office in the agency. The panel had identified these aforementioned efforts as being best practices in ethical conduct.

The Research Participants: Recruitment and Orientation.

I began the process of recruiting parent participants for my research inquiry once the two cohorts of *Recognizing Resilience* concluded. In order to understand the dialogue generated within the group context, I had to specifically draw from a purposive sample of the 13 parents who had participated in either one of the group offerings. Purposive sampling pertains to the selection of research participants based on the researcher's knowledge of a group population (Berg, 2009). Parents who had participated in one of the two groups would be able to speak to the questions of my research inquiry. For the purposes of my research inquiry, parent participants were required to meet the following inclusion criteria:

- They had personal experience caregiving a teenage son or daughter actively involved with alcohol and/or other drugs.
- They had participated in the 6-week *Recognizing Resilience* parent group.
- They were willing to participate in the research process and provided informed consent understanding the purposes, requirements, risks of being involved, as well as issues of confidentiality and privacy.

Qualitative research requires volunteer participants to contribute both time and energy (Sprague, 2005). For this reason, I considered what amount of time and what

degree of involvement I would ask parent participants to provide. Parents involved in a son or daughter's substance use usually have numerous demands on their time and limited time to dedicate to pursuits that do not have an immediate impact on either their own or their family's needs. Although therapeutic research can positively affect involved participants, inviting parents to become involved in erroneous efforts beyond a brief time limited interview, felt ethically inappropriate. With this consideration in mind, I chose to structure interviews to be for a short period of time, between 60 and 90 minutes, and to be conducted either in person in their own communities (Nanaimo or Duncan), or over the phone.

As I have previously mentioned, based on recommendations from the Health Ethics Review Board (HREB), my pursuit to recruit research participants was quite specific. At the end of the sixth of six group sessions I explained to both group cohorts that I was actively involved in post-secondary pursuits and was in the process of developing an inquiry to explore conversation created in a group setting. I explained that I was seeking volunteers to be involved in the exploration however was mindful of not putting any undue pressure on parents to sign up. In order to ease pressure, I said that I would excuse myself from the room and ask my colleague, Griffin, to provide a few more details. Once I exited the room, Griffin followed a somewhat structured script (see Appendix A), offering a description of the research purpose and some of the logistics of the research process. Griffin handed each participant an informed consent document (see Appendix B), and invited them to contact the Discovery agency should they wish to participate. I then re-entered the room and graciously thanked the group participants for their time spent hearing about my project and to Griffin for sharing the details and expressing the invitation.

After a period of 3-weeks post group I had received confirmation from 6 parent participants who were both interested and able to be involved in the research process. I was grateful to have as many as 6 parents and satisfied that I did not need any more or fewer respondents. Interpretive description as a method often involves small numbers of participants (Thorne et al., 2004).

Three parent participants came from each region. I scheduled sessions to be conducted in the most comfortable and convenient locale as requested by the parent participants. Interviews were set in parents' home communities, some in their homes, and others in the local Discovery office. Although each parent was provided the option of doing the interview over the phone, each participant wanted to sit down in-person face-to-face. Interviews were scheduled for up to 90 minutes but most interviews concluded after approximately 60 minutes. Prior to starting each interview conversation, I reviewed informed consent with each parent participant. All of the 6 parent participants (4 women and 2 men) voluntarily signed the informed consent document.

Three of the parents were adoptive parents, 3 were concerned about a concurrent mental health issue and 1 identified a comorbid fetal alcohol spectrum disorder (FASD) diagnosis. One of the parents was a single parent and 2 of the parents were a couple set who interviewed separately. This group represented five teenagers. Since the beginning of the first *Recognizing Resilience* group, up until the time of the interviews, four of the five teens had reduced use, and one continued to maintain active involvement. The parents recruited for my inquiry were particularly concerned about their son or daughter's involvement with marijuana, alcohol, cocaine, and ecstasy.

Constructing and Conceptualizing

Counselling and research alike, from my experience, are processes of shared inquiry (McDonough & Koch, 2007). Counsellors and clients join together to explore concerns in an effort to develop additional perspectives and understandings to potentially inform change. Through research inquiry the researcher and research participant examine phenomena in order to generate knowledge and inform practice. The counselling process evolves through phases characterized by distinct skills and tasks. Similarly, the process of inquiry also involves a sequential movement through distinct phases and tasks. Although the contexts in which the actors join are distinct, the processes for how they generate understanding and knowledge are similar.

As I have previously noted, when I began my efforts to pursue research I was concerned about entering into what I thought would be distant and inaccessible language and unfamiliar processes. However, when I read the work of Morse (as cited in Thorne, 2008) I found that I was able to conceptualize the process of inquiry as being similar to the activities I pursue in my counselling practice. Morse (as cited in Thorne, 2008), postulates on four sequential processes of research inquiry. She suggested that the first process is to comprehend or learn whatever the researcher can about, for example, the research participants, their experience, the setting. She then says that the researcher synthesizes, or sifts and sorts significant from insignificant patterns, common features, and other potential groupings. Once this has begun, the researcher starts to theorize, developing ideas, guesses, and potential explanations for the phenomena of interest. Morse explains that the final part of this process can be identified as re-contextualizing, in which theory transforms into practice and new understandings are applied to particular settings and contexts.

Having reviewed Morse's work, I found I could embark on the research process in a way that was reflective of what I have become so familiar with in my clinical counselling practice. For example, I could translate my understanding of Harlene Anderson's (2007) story ball metaphor and imagine myself as a researcher being privy to the research participant's experience—touching, turning, viewing, curiously questioning, shifting, shaping, and transforming. Morse's (as cited in Thorne, 2008) conceptualization in conjunction with Anderson's (2007) metaphor has allowed me to draw on my existing skill sets and apply my counselling experience to my research inquiry. In my data construction and analysis section I offer you a clear description of how I came to collect, describe, transform, and understand my data. I structure the following sections using Morse's taxonomy as a guide to identify and explain what sequential processes I pursued.

Eliciting Understanding: Data Construction

An interpretive description involves constructing understanding of what data is and how data will be explained (Thorne, 2008). As described by Thorne (2008),
When we use the term “construction” in relation to the data collection process, we are explicitly drawing attention to the active role that the researcher is playing in deciding what of the universe of possibilities makes it into the data basket and what becomes part of the later analytic considerations. (p. 124)

The purpose of data construction, as noted in Morse's aforementioned taxonomy of cognitive processes of data analysis is to aid in the understanding, or comprehending of participant perceptions (Thorne, 2008).

Interviewing.

I chose interviewing as the means to elicit participant perspectives (Thorne, 2008). I considered interviewing as being a process of "inter-viewing," what Miller and Rollnick (2002), described as a dialogical interaction involving a face-to-face partnered seeing together. Interviewing was a "meaning making occasion" (Holstein & Gubrium, as cited in Berg, 2009, p. 104) to mutually explore the phenomena of interest.

In order to gather descriptions of parents' dialogue and the meanings they derived from the group dialogue, I conducted post-group, semi-structured interviews (Moustakas, 1994). The process of interviewing allowed me to enter into the descriptions of study participants, creating an opportunity for parents to tell their personal perspectives. In total I asked 10 interview questions with five sub-questions (see Figure 2). When I was actually engaged in the interview process, I noticed many of the parents would naturally answer the questions throughout the conversation. I had to do little to elicit participant responses as all of the parents seemed quite engaged and ready to share their stories and feedback.

Interview Questions

- What is the story of how you came to participate in the *Recognizing Resilience* group?
- Can you tell me about what conversation you participated in during your experience in the parent group?
- What do you recall as being the main conversational topics in the group?
- What conversation in group had the greatest impact on you?
- What knowledge or understanding was created out of the conversation you participated in?
 - What have you come to understand about your adolescent's substance use from the group conversation?
 - What have you come to understand about yourself through the conversation in the group.
 - What value, if any, has this group conversation had on you, on your adolescent?
- How has what you talked about in the group evolved over time?
- What was it about the group that created the atmosphere for conversation
 - What contributed to the conversation in the group?
- What happened beyond the words in the group?
- Please describe your overall experience in the *Recognizing Resilience* parent group.
 - What value, if any, has been derived from this group effort? (Groenewald, 2004).
- Are there questions that you would like me to ask that I have not?

Figure 3. Interview questions.

Dialogue is dynamic, shaping and forming, developing meaning and importance through encounters and experience during and outside of the conversational event in which it was created. I framed questions in such a manner that parent participants would

be asked to reflectively explore the whole of the group conversation and/or aspects that they recalled as being significant and particularly meaningful. McNamee (personal communication, April 9, 2013) explained for the research participant, “questions are an invitation to reflect on their stories and the meanings they make.” Beyond concise descriptions of what was being said in group, I felt reflective conversations would capture more of what stood out in addition to verbatim descriptions of what was said.

I began my interview conversations by first asking parent participants to share with me the story of how they had come to the *Recognizing Resilience* group. Thorne (2008) suggested that background information within an interpretive description can contribute to analytical understanding when making sense of data. In addition, starting with the contextual question seemed to ease parent participants into the process of interviewing and allay some of the initial descriptions of “nervousness” coming into the dynamic. I then followed this question by asking parent participants to share with me what they experienced in group, what conversation stood out, how this impacted them, and what conditions influenced the conversation.

During the course of the interviews I became aware that parents had a difficult time identifying the specific topics or themes that were discussed in the group. Every parent indicated that he/she had an opportunity to tell his/her story, and that the conversation emerged from the familiar aspects of what these stories entailed. I shifted my language from conversational “topics” and used the word “story” to elicit the content of what participants talked about.

Throughout the interviews I demonstrated curiosity by providing verbal and non-verbal prompts. Thorne (2008) explained that generating quality data comes from a practice approach and researcher communication style that involves a stance of curiosity—eliciting and inviting exploration with the research participant. As I participated in the research dialogue I remained open to each possibility and potential the parent participants offered. Similar to counselling, taking a not-knowing position (Anderson, 2007) in my research inquiry, allowed me to explore the “newness” of what each individual parent had to share and how I might learn from what they had to say.

After I had completed all of the parent participant interviews I found myself quite struck by the overall interview experience. I was so deeply grateful to have parents share their time to participate in the project. Most suggested that they were keen to be involved in the hopes of enhancing the future efforts of youth and family substance use services. I was moved by this generosity and the parents’ consideration of youth and families accessing services down the road. I was also taken by the tone of the parent interviews and the sense of closure that they seemed to offer. Meeting with the parents individually seemed to provide a stage on which parents could spend time reflecting on their experience—what they have come to know and value, how they have shifted and moved through their teen’s relationship with substances. I wondered how the follow-up interview reinforced or validated these reflections.

I also noticed how easily I, and the parents, moved into the inquiry interview. I recalled the HREB panel’s initial hesitation about the researcher/therapist dual relationship and felt relieved that this dual relationship did not seem to confuse or hinder the process. At no point did a participant ask for emotional support, request a therapeutic appointment, or identify an emergent worry or concern. It seemed that we were able to move through the questions in a comfortable manner with no pull to draw out specifics,

no need to take emotional reprieve, and with freedom to acknowledge and pay attention to what parents wanted to recognize and offer to the future of parents and practitioners engaged in adolescent substance use programming.

Transcription.

With explicit informed consent, interviews sessions were audio-taped for my review. The audio device was subtly positioned so as not to detract from the intimacy of the conversation. Once I had completed all of the parent interviews I ventured to review and transcribe each piece of audio data. Content from post-group inquiry was transformed into textual transcripts. I typed each interview verbatim in order ensure the integrity of the data. I strove to keep transcripts both comprehensive and congruent with what I had collected from the research interviews (Hays & Singh, 2012). Transcribing the research conversations allowed me to hear not only the words framing parents' responses to my questions, but also the nuances, tones, sighs, laughter, and other sounds infused in the dialogue. I was very mindful of including nuances as I wanted to be sure that these important non-verbal pieces of data were included in the constructed findings.

I carefully listened to each audio recording and heard for the second time the research participant's responses to my questions. Hearing the interviews a second time allowed me to pick up on pieces that I had originally not acknowledged or missed. Slowly typing while I listened I feel like I developed a connection with each word. I took my time to record, rewind, replay, and reflect on each one of the individual interviews. In total I spent almost 25 hours transcribing the audio data and ended up with almost 100 pages of transcribed text. I formatted the transcribed text into a word document table with columns to note reactions, descriptions, and interpretations. Once I had transcribed all of the audio data and arranged the text into table format I started to wade through a process of analyzing, reviewing, organizing, and describing the data.

Memoing.

I used the process of memoing to capture emergent data that I saw, heard, and witnessed through the course of the parent participant interviews. An interpretive description study involves concurrent data collection and analysis requiring, as described by Thorne (2008) "ongoing engagement with data strategically employed to confirm, test, explore, and expand on the conceptualizations that begin to form as soon as you enter the field" (p. 99). Following each parent interview I maintained ongoing observational notes capturing my interpretations of emergent process, dialogue, and interactions of each individual interview session. These interpretations provided aspects for consideration and allowed me to be cognizant of my own influence and assumptions following each session. This was an important process for understanding how I could be potentially influencing premature categorization and bias (Groenewald, 2004).

When I started to make sense of all of my transcribed data I reviewed my interview memos. I reflected on what I had written down as some key thoughts that had stuck out from the interviews. I had written quite a bit about some of the explicit pieces of the conversations such as the use of the metaphor of the rollercoaster, the emotions of grief, shame, guilt, anger, and some of the descriptors of the group atmosphere (acceptance, non-judgment, empathy). I had also written notes (see Figure 4) about what I

started to notice as being a shift in perspective in the absence of answers. I had begun to notice that these shifts were not so much about how to fix adolescent substance use, but were more about ways of conceptualizing the parent in relation to the experience. When I reviewed my transcribed text I used my memo notes to recall the initial poignancy of what I had heard in the face-to-face interview.

*Interview Memo: Apr.23/13
P1
I was struck when this parent said "I found my voice." She explained that by providing support to other parents, she realized that she had wisdom to offer and important knowledge to share. She said this allowed her to see herself as having something meaningful to contribute which added to her own confidence parenting her daughter.
I wonder what conditions contributed to this experience of having a "voice?"*

Figure 4. Example of one of Stephanie's notes following a parent interview.

Synthesizing Data: Sifting, Sorting, and Sense-Making

After completing the interviews I found myself faced with a wealth of data. In an effort to recognize patterns and pieces of significance within the data, I engaged in a lengthy and iterative process of synthesizing, sifting, sorting, and sense-making. With six separate complete parent interviews I ventured to identify common features, similarities, and exceptions in order to begin developing broader conceptual understandings. Morse (as cited by Thorne, 2008) suggested that the actions of synthesizing data involve "selecting, revising, and discarding possibilities" (p. 166).

Interpretive description, as method of inquiry, is relatively new and there are very few resources for explaining ways to analyze or make sense of the data. As a result, I relied heavily on Sally Thorne's (2008) text *Interpretive Description*. I spent many months highlighting, bending, earmarking, reading, and re-reading this resource.

Despite appreciating uncertainty and not-knowing in my clinical counselling work, I entered into my data analysis experience with a desire for a plan (see Figure 5). I referred to my data analysis plan as a guide and anchor when I found myself floundering within the enormity of the data and possibilities for organizing, describing, and interpreting the parent responses.

Comprehending

1. Collect Data:
 - a. Conduct individual semi-structured interviews.
2. Memo and Summarize:

<ul style="list-style-type: none"> a. Following each interview identifying initial reactions to data, themes, and emergent questions. <ul style="list-style-type: none"> 3. Transcribe individual interviews. 4. Review transcripts and memo notes several times in their entirety. 5. Document reactions, attention grabbers, and responses to transcribed data and memo notes. 6. Construct a holistic sense of the whole (important part of Interpretive Description). <ul style="list-style-type: none"> i. Explore: What is present here? How might these pieces be related to each other? <p>Synthesizing: Sifting and Sorting Group Signifiers</p> <ul style="list-style-type: none"> 7. Organize Text: <ul style="list-style-type: none"> a. Develop into broad based themes —Descriptions of dialogue, meaning of dialogue, context of dialogue. <ul style="list-style-type: none"> i. Describe: What does a theme look like? b. Sort data into sub-themes. <ul style="list-style-type: none"> i. Data will be reviewed for similarities and differences, patterns, and themes, and organized into additional subcategories. c. Within thematic groupings allow for wide inclusionary descriptors of meaning and relationships. d. Continue to sort and organize groupings. e. Move from individual groups of patterns and themes to understanding relationships amongst the groupings in order to identify themes in the overall data. <p>Theorizing: Consider Relationships Between Pieces</p> <ul style="list-style-type: none"> 8. Interpretation: <ul style="list-style-type: none"> a. Consider what data means individually and in relation to one another. b. Identify relationships amongst phenomena and meaning of such relationships. 9. Wondering: <ul style="list-style-type: none"> a. Pose questions and Consider <ul style="list-style-type: none"> i. Explore what is taking shape in relation to the research question. ii. How does what is being formed fit within the context of the larger picture of the study? iii. Explore parts of what is being understood in relation to whole. iv. What might have been found if others who were not involved in the research interviews had been? <p>Re-contextualizing: Transforming Data</p> <ul style="list-style-type: none"> 10. Identify patterns and relationships amongst descriptions of phenomena in order to create new interpretations of understanding and knowledge in which to inform professional practice.

Figure 5. Data analysis plan.

To begin analyzing the data, I read the transcribed interviews several times in their entirety. Reading and re-reading all transcribed data as well as specific sections allowed me to develop a sense of the whole as well as to preliminarily identify themes for outlining the analysis. Recalling Morse’s cognitive processes, I sought to synthesize data by sifting and sorting, grouping similar events and noting unique instances. Writing marginal memos throughout the pages of transcribed text allowed me to begin noting themes and what stood out for me as being points of interest and intrigue (see Figure 6). For example, I was intrigued by the use of similar language in regards to parents’ initial descriptions of what they talked about in group. All of the parents used the up and down metaphor of a roller coaster in order to explain their experience of their adolescent’s substance use. I also noticed that parent participants attributed this shared metaphor to the development of commonality and group relationship.

Date: April 25/13
Participant: P3
Interviewer: S (Stephanie McCune)

<i>Recognizing Resilience Interview</i>	
Data	Memos
S Q1 The first question is what is the story of how you came to the RR group, the 6-week parent group in Nanaimo?	
P3 Short version, I got your name from a counsellor we had been accessing through Duncan and actually that was the second time I had heard about it and the first time I didn't think I was comfortable opening up in a group. The second time I just was, I needed it and I don't think it mattered and so that is why I answered it and attended it.	Referred through a clinical counsellor "needed" the group
S And is there anything that drew you to following this suggestion about going into a group?	
P3 I think you get to a point where you're somewhat isolated when it is just you and maybe you and your spouse and your one friend that you talk to about everything and you have your counsellor although that was for my daughter and you begin to feel isolated and at some point you begin to open up and think that it might be helpful. You try all kinds of things on this journey and I guess I was ready. And I made my mind up that I was coming whether my husband was or not, I wasn't sure at that point, so maybe I was just there. It was kind of a rocky 6 months I think I...	Get to a point of needing to come out of isolation— Ready to try something new Hopeful For self
S So there was an appeal to do something for yourself and you were ready to do that.	
P3 I think I just needed to talk and after speaking with Griffin and getting a bit more of an idea that a person could sit and listen if they wanted, which is where I was, I didn't know what to expect so I didn't want to say no I wanted to explore what it could offer for me because there isn't a lot of support for parents, at least I don't think there is and it is hard, you are always taking appointments at work and maybe fitting into a one-on-one with somebody, but this was outside of work and it seemed like a logical step for me at that point.	Flexibility with how to participate Outside work hours
S It fit your schedule, your time frame, and your sense of readiness about being able to do it.	
P3 and as it turned out, I couldn't make the local one, so Nanaimo for me it was even more anonymous for me which was more in my comfort zone. I think it is easier when you don't know anybody. You just want to talk. So ...	Anonymity was important to ease the discomfort of being in group
S It is easier when you don't know anyone. What is it about having strangers in a room and being able to talk?	
P3 I think sometimes we worry that people we know will judge us. We are always trying to protect our kids, so keeping things behind closed doors is an avenue we tend to follow. So if you are out there talking to others maybe that doesn't happen so well. Sometimes it is easier to talk to people you don't know. It just is, I don't know why, I think you get to that point, especially if they are sharing similar stuff, you almost build an instant camaraderie, you know that they are going through exactly what you are going through, same stuff different pile, it's the same stuff. Once you have been there for a couple of meetings you know them anyway. But you still are only someone you meet once a week for a few weeks. But it does solidify that you are not alone, you know all those things you think maybe, you did this wrong, this has happened because you have done this because you didn't do this right, or this has happened because you should have done it this way or you realize by talking to other parents that we are all thinking the same. So I think that the fact that we are total strangers is better for me.	Worried about judgment— judgment contributes to isolation Connection through commonality (camaraderie-similar stuff) Validate- not alone Alleviate blame and guilt
S You speak to this other element of coming into a room where people aren't familiar and the other element was the familiarity of their stories, they are strangers but they are familiar because of their experiences.	
P3 Yah, the first night didn't everybody say rollercoaster. It is just exactly what it feels	Rollercoaster

like, up down, up down, up down.	
S What stood out for you in terms of what people were talking about?	
P3 Just the major ups and downs. For me I was stunned that my husband came and spoke out more than anything that blew me away, I did not expect that. But it was the uncertainty and the ups and downs. Everyone was careful to not get excited when you got an up because you were afraid you were headed for a down. It didn't matter, every one of our circumstances were different, yet the experiences were the same. The pitfalls of addiction were the same.	Uncertainty, ups and downs, the experience of coming to group and doing something different Pitfalls of addiction
S What are some of those experiences that were the same?	
P3 Certainly the loss, the sadness, the grief, the fear, helplessness. We all seemed to try to control, "you need to stop this, I am going to make you do this," we all tried that, we were all similar, some people were earlier on in their situations than we were, but we seemed to experience the same thing and seemed to have hit those walls, and then you realize and have gone through those steps and then there is hopelessness and small measures of getting better and getting hope and coming to realize you had to take those little pieces that were encouraging and go with them and you had to learn to take care of yourself or you can't take care of them. I guess what stood out was the similarities and learning to cope. I have said it to my (named counsellor) over the weeks, hope and cope. If you lose hope you are sunk. You always have to keep hope, I think we are all a little guarded after going through this you keep everything... you are never foot loose and fancy free again, maybe in time yes, but I think you are always going to live with kids that have life addictions, they can be under control, but they are always there. We have the addiction too, not really an addiction but a symptom of it.	Mixed group of people with different experiences, at different points, yet similar stories of loss, sadness, fear Hitting walls Learning to cope and maintaining hope Life changing experience

Figure 6. Excerpt from an interview transcript with memoed notes.

Thorne (2008) suggested that “the initial phases of data analysis are very much a time of allowing ourselves to react to the initial pieces of data that seem to take on a life of their own and ‘attract our attention’” (p. 143). While I spent time reviewing the transcribed data, I also reflected on the memoed notes I had developed following each individual interview session.

After reviewing the transcripts several times, I started to relay my marginal memos and highlighted notes into a thematic framework. I began to recognize what pieces of data would be useful at the foreground of my inquiry and which were more contextual. Thorne (2008) says “the overarching intellectual task driving your data analysis journey in an interpretive description study is making sense of which ideas are core to the phenomenon you are studying and which are more usefully understood as context” (p. 158). I used my research questions to guide what data would be at the foreground of my analysis. For example, I had gathered a lot of information about parent experiences prior to coming into the group process. Contextual information about why parents came to the group was important in terms of providing a rationale for why I had offered the group, however these pieces did not specifically address the topic of my inquiry about group dialogue. Rather than developing thematic categories for these particular aspects, I placed processes that occurred within the group at the foreground of my attention and context of experience in the background of my attention.

In order to begin the process of illuminating pertinent phenomena, I started to get colourful and highlight the transcripts (see Figure 7). I used one colour to identify context (yellow), one to identify the dialogue within the group (green), one to identify the meaning of this dialogue (orange/red), and one to identify the group conditions (pink).

Date: April 25/13	
Participant: P3 Interviewer: S (Stephanie McCune)	
<i>Recognizing Resilience Interview</i>	
Data	Memos
S Q1 The first question is what is the story of how you came to the RR group, the 6-week parent group in Nanaimo?	
P3 Short version, I got your name from a counsellor we had been accessing through Duncan and actually that was the second time I had heard about it and the first time I didn't think I was comfortable opening up in a group. The second time I just was, I needed it and I don't think it mattered and so that is why I answered it and attended it.	Referred through a clinical counsellor
S And is there anything that drew you to following this suggestion about going into a group?	
P3 I think you get to a point where you're somewhat isolated when it is just you and maybe you and your spouse and your one friend that you talk to about everything and you have your counsellor although that was for my daughter and you begin to feel isolated and at some point you begin to open up and think that it might be helpful. You try all kinds of things on this journey and I guess I was ready. And I made my mind up that I was coming whether my husband was or not, I wasn't sure at that point, so maybe I was just there. It was kind of a rocky 6 months I think I...	Get to a point of needing to come out of isolation— Ready to try something new Hopeful For self
S So there was an appeal to do something for yourself and you were ready to do that.	
P3 I think I just needed to talk and after speaking with Griffin and getting a bit more of an idea that a person could sit and listen if they wanted, which is where I was, I didn't know what to expect so I didn't want to say no I wanted to explore what it could offer for me because there isn't a lot of support for parents, at least I don't think there is and it is hard, you are always taking appointments at work and maybe fitting into a one-on-one with somebody, but this was outside of work and it seemed like a logical step for me at that point.	Flexibility with how to participate Outside work hours
S It fit your schedule, your time frame, and your sense of readiness about being able to do it.	
P3 and as it turned out, I couldn't make the local one, so Nanaimo for me it was even more anonymous for me which was more in my comfort zone. I think it is easier when you don't know anybody. You just want to talk. So ...	Anonymity was important to ease the discomfort of being in group
S It is easier when you don't know anyone. What is it about having strangers in a room and being able to talk?	
P3 I think sometimes we worry that people we know will judge us. We are always trying to protect our kids, so keeping things behind closed doors is an avenue we tend to follow. So if you are out there talking to others maybe that doesn't happen so well. Sometimes it is easier to talk to people you don't know. It just is, I don't know why, I think you get to that point, especially if they are sharing similar stuff, you almost build an instant camaraderie, you know that they are going through exactly what you are going through, same stuff different pile, it's the same stuff. Once you have been there for a couple of meetings you know them anyway. But you still are only someone you meet once a week for a few weeks. But it does solidify that you are not alone, you	Worried about judgment— judgment contributes to isolation Connection through commonality (camaraderie-

know all those things you think maybe, you did this wrong, this has happened because you have done this because you didn't do this right, or this has happened because you should have done it this way or you realize by talking to other parents that we are all thinking the same. So I think that the fact that we are total strangers is better for me.	similar stuff) Validate- not alone Alleviate blame and guilt
S You speak to this other element of coming into a room where people aren't familiar and the other element was the familiarity of their stories, they are strangers but they are familiar because of their experiences.	
P3 Yah, the first night didn't everybody say rollercoaster. It is just exactly what it feels like, up down, up down, up down	Rollercoaster
S What stood out for you in terms of what people were talking about?	
P3 Just the major ups and downs. For me I was stunned that my husband came and spoke out more than anything that blew me away, I did not expect that. But it was the uncertainty and the ups and downs. Everyone was careful to not get excited when you got an up because you were afraid you were headed for a down. It didn't matter, every one of our circumstances were different, yet the experiences were the same. The pitfalls of addiction were the same.	Uncertainty, ups and downs, the experience of coming to group and doing something different Pitfalls of addiction
S What are some of those experiences that were the same	
P3 Certainly the loss, the sadness, the grief, the fear, helplessness. We all seemed to try to control, "you need to stop this, I am going to make you do this," we all tried that, we were all similar, some people were earlier on in their situations than we were, but we seemed to experience the same thing and seemed to have hit those walls, and then you realize and have gone through those steps and then there is hopelessness and small measures of getting better and getting hope and coming to realize you had to take those little pieces that were encouraging and go with them and you had to learn to take care of yourself or you can't take care of them. I guess what stood out was the similarities and learning to cope. I have said it to Tasha over the weeks, hope and cope. If you lose hope you are sunk. You always have to keep hope, I think we are all a little guarded after going through this you keep everything... you are never foot loose and fancy free again, maybe in time yes, but I think you are always going to live with kids that have life addictions, they can be under control, but they are always there. We have the addiction too, not really an addiction but a symptom of it.	Mixed group of people with different experiences, at different points, yet similar stories of loss, sadness, fear Hitting walls Learning to cope and maintaining hope Life changing experience

Figure 7. Excerpt from an interview transcript with colour coded scheme.

Using my colour coded scheme, I developed word document tables and began to conceptualize an initial arrangement of the data by sorting and organizing highlighted notes and marginal memos (Thorne, 2008). I developed broad-based categories based on specific group signifiers and language referencing devices (Thorne, 2008) conveying the similar elements of the described conversation, conditions of conversation, and what meaning parents attributed to conversation. My intention within this first round of sorting was to develop the broad-based categories in order to create wide groupings of data that were thematically related (see Figure 8)—group signifiers with like elements (Thorne, 2008). I was able work through the data and sort first accounts of themes, patterns, and meaning units. Thomas (2003) explained that “the primary mode of analysis is the

development of categories from the raw data into a model or framework that captures key themes and processes judged to be important by the researcher” (p. 3).

Atmosphere Conditions	
Category	Participant Statement
Empathy	It felt good because I really felt like they understood what I was going through (p1) Until you have walked in those shoes you can't, you really can't empathize a 100% (p3) As soon as you see those other parents you know darn well how they are feeling (p3)
Genuineness	Their involvement felt real (p1)
Altruism	Everyone was important—no one was left behind (p1) There was always genuine concern when someone was missing (p1)
Importance	There was no “Well that’s nothing, let’s move on (p1) We all worked hard (p1) Everyone took it serious (p1) I was ready (p3) Everybody there wanted to be there (p6) I was ready to have those kind of conversations (p6) No one was left out (p5)
Commonality	We were all in the same boat (same reason) (p1) (p3) I could relate to everyone equally (p1) All there for our kids (p2) Going through the same stuff—instant camaraderie (p3) Everyone had commonality among all the parents and all the craziness they went through (p4) A group of people going through the same thing—everyone is going through this and is willing to be open (p4)
Relationship Community Belonging	It made you want to go back; I looked forward to the groups because I always felt like there was a real sense of understanding and a deep concern about each individual’s situation (p1) The more we met the easier it was to get caught up—we could get deeper into things (p2) Once you meet a couple times you feel like you know the other parents (p3) Everyone was included—no one left out (p5) They were all such nice people and I felt such a connection to them (p4) You almost build an instant camaraderie, you know that they are going through exactly what you are going through, same stuff different pile, it’s the same stuff (p3)
Understanding	Don’t assume (p1) You strike up a conversation that a person with a child with an addiction would understand (p3) People understood re: having a teen beyond normal behaviour involved in SU (p5) It is hard to explain to someone who hasn’t been through it (p5) You don’t have to defend a position
Openness	Opened space (vs. narrowing space with criticism and judgment) (p1) Open up and listen to others (p3) The freedom to speak without being dismissed (p5) Freedom to speak without being judged (p4)

Acceptance	Acceptance of where people were at (p1) Supporting people in the ups and downs (p1) Having ideas accepted and heard (p2) A person could sit and listen if they wanted (p6)
Exchange—back and forth	Willingness to “put it out there” with an willingness to take it or leave it (p1) There was always something you could be there and try to put your two bits in and help, even just to listen (p2) Everybody participated in the listening and sharing (p2) —helping and receiving To be with others and support them as well (p5) Taking perspective, sharing perspective (p6)
Diversity (multiplicity of voices) of perspective	It was nice to have the variety, some older, some younger, the couple, the one fellow (p1) Good mix of people (p1) Anonymous (p4) There was no sense of right or wrong (p3)
Invitation to Speak	Immediate invitation to share story (p1) “I have been in lots of groups and I don’t normally say nothing so that is the first time I found myself yapping way too much but that is because I normally don’t” (p1) “Everybody’s voice was important” (p1)
Facilitators	Easy (p1) Comfortable (p1) Kept dialogue going—listened more than talked (p1) Helped to stay out of “ruts” (p2) Facilitators created the atmosphere of acceptance—setting the parameters right away—inviting people who had experiences with their teens’ SU(p5) Like-experienced people (p5) Gentleness in our approach—good tone for the room (p5) No one was cut off (p5)
Trust	You get a feeling you can trust people—they are there for the same reasons and it is their lives—if anyone is at the point of going to the group they are invested—they are taking this seriously (p3)
Care	Felt cared for (p1)
Structure	No mandate (p2) After work hours (p3) Relaxed, food (p6) Small group, cozy, food No format—it was our group—that was important (p5)
Safety	No one was going to judge what you were thinking or saying (p2)
Conversation	You don’t wallow with people—you walk the line of belly aching with people (p3) Stay out of the ruts (p2) Light-hearted moments humour in the conversation (p4)

Figure 8. Example of some initial broad-based categories of group conditions.

Once I had gone through an initial thematic sort and grouped the data into broad-based categories I pursued an iterative process of reflection and reasoning. I drew large scale mind maps (see Figure 9) and entered energetic brainstorming sessions with my colleague, Griffin. I scribbled notes and questions to record what I believed to be understanding and what I continued to wonder about. I continued to pour over the

transcripts and made ongoing revisions and refinement of what categories and themes I had developed (Thorne, 2008).



Figure 9. Example of two large-scale mind maps from one brainstorming session.

As I continued to question aspects of the data, I was mindful of my own influence on the data analysis. My analysis was constructed in order to be reflective of the objective of the research inquiry and what was construed from the data was influenced by my own subjective assumptions and interpretations. In working through the sifting and sorting of the data set I recognized that my assumptions were

- That parents had been influenced in some way by their adolescent’s relationship with substances.
- That parents experienced some additional and/or perhaps alternative thoughts, ideas, perhaps shifting of perspective as a result of dialogue generated through group conversation.
- Conversation had some meaning on parents’ experiences of their adolescent’s substance use.
- There was a relationship between what was talked about and parents’ experiences of their teen’s substance use.

I recognized that these assumptions could be possibilities and also tried to not let these assumptions categorize what I would construct for the whole.

After my initial data sorts into broad-based categories and meaning units, I began to look at the thematic groupings and notice similarities, patterns, and relationships. I recognized that some of the broad-based categories could be broken into sub-groups and other categories could be understood as being similar. For example, when I reviewed what parents identified as conversation within the group context I recognized descriptions of anger, guilt, worry, and fear. These descriptions were originally acknowledged separately but upon further reflection I could see how they related to one another and could be similarly named as part of a familiar story of the rollercoaster of adolescent

substance use. I started to conceptualize how groupings were unique and also related to each other. Through these recognitions I began to paint more of a picture of how I wanted to conceptualize the data as a coherent compilation within my thematic summary. I started to understand how I was viewing themes within the unique aspects of my inquiry, specifically in regards to the three distinct research questions, and how these themes related to the overall whole.

Theorizing: Questioning Best Guesses and Meaning-Making

After I had sorted and organized the data I began to wonder what links could be identified amongst the significant themes and patterns. I began to wonder about how I might order and organize (Thorne, 2008) the phenomena so as to develop meaning pertaining to the conceptual whole. Within the process of theorizing and meaning-making I began, as Miles and Huberman (as cited in Thorne, 2008) described, “making sense of what relationships various groupings have one to another, and inductively building some sort of coherent whole out of an iterative reasoning process as to the implications of understanding them in various ways” (p. 149).

I had the most fun working through creative iterations of the theorizing process. In order to conceptualize the common elements amongst the themes I had begun to describe, I mapped out images of the identified phenomena (see Figures 10 and 11).

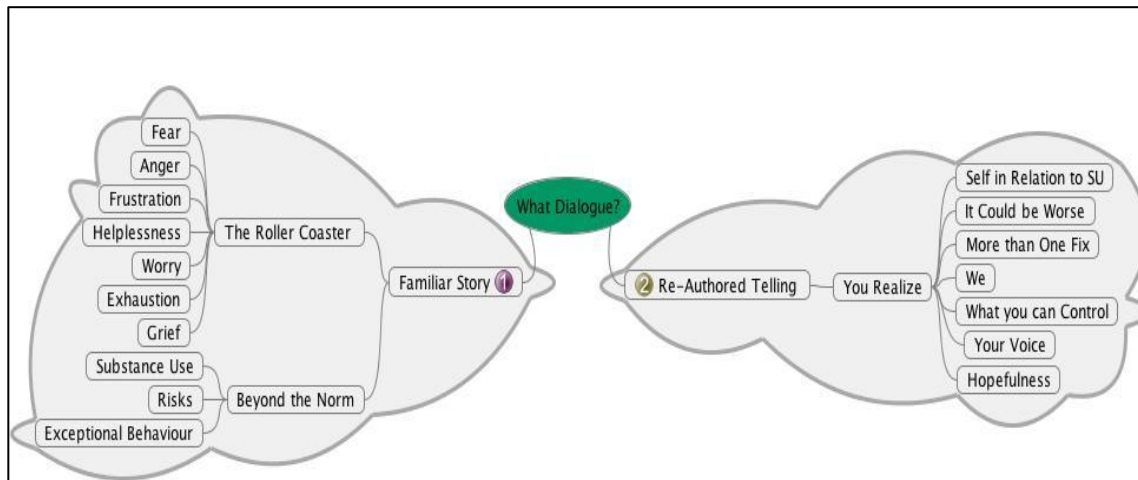


Figure 10. Example mind map of what dialogue parents constructed in the collaborative therapy group.

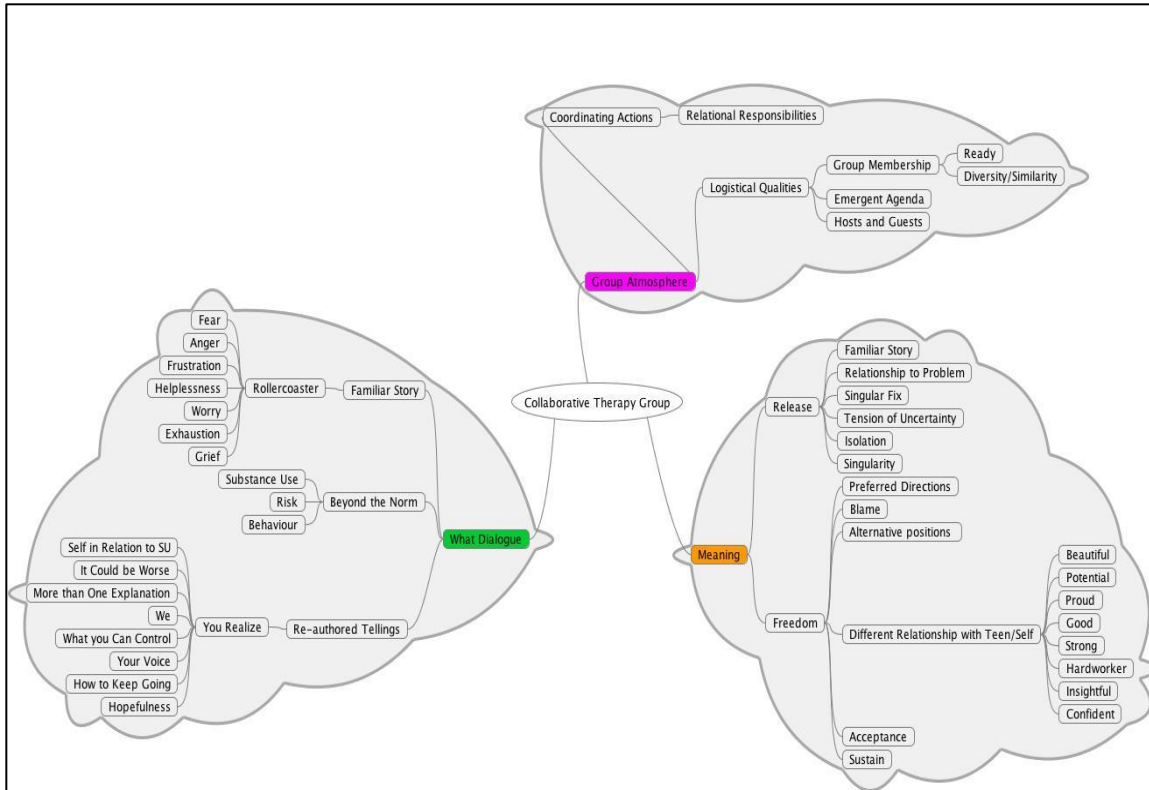


Figure 11. Example mind map.

As I viewed these mind maps I imagined what would happen if I ordered them in particular ways, how each aspect influenced the other, and what other considerations might have been missing in any observable empty spots (S. St. George, personal communication, June 4, 2013). Through this process I began to shift my view of the data as being comprised of individual groups and patterns, towards an understanding of relationships and thematic linkages amongst the groupings (see Figure 12).

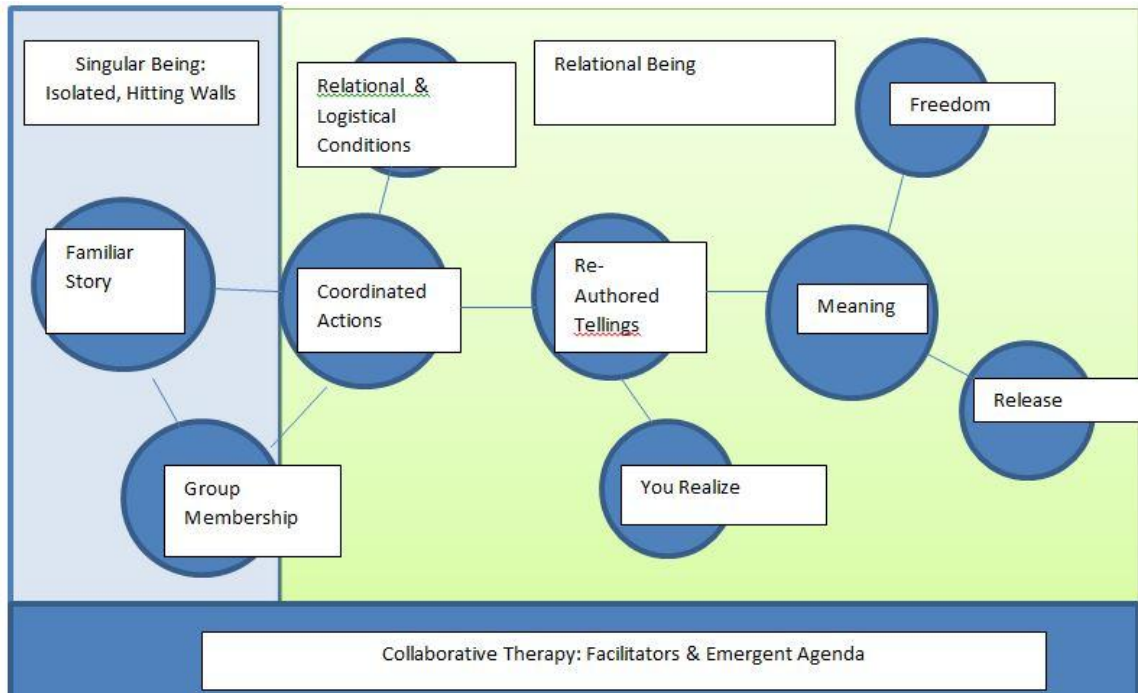


Figure 12. Example mind map of thematic linkages.

Through this process of mapping I wondered, “How do individual parts of what is being understood fit in relation to the whole?” By revisiting the individual transcripts and shifting my attention again to the whole, I moved back and forth amongst my numerous iterations of word tables, mind maps, and consultation notes and considered and reconsidered how I could develop the whole. I realized that the familiar story of the parent participants sparked the coordinated actions of being in relationship with one another—how parent participants engaged with one another influenced new perspectives and realizations. I realized that these new perspectives and realizations were transformative and the impetus to what meaning parent participants ascribed to their group experience. I realized as well that group membership was an important condition to both the experience of the common and familiar story and also in how parents engaged with one another in the group context.

By laying out my data in this manner I was able to see that I would not be able to report my findings by sequentially going through my research questions but would have to speak more specifically to the process of how dialogue developed, evolved, and transformed. Thorne (2008) recommended that in order to develop rich descriptions of relationships amongst the groupings and patterns, that the researcher “engage in various operations designed to shift attention sequentially from individual cases to the whole data set, from groups of similarity within certain cases to various manifestations of difference within other cases” (p. 49).

Recontextualizing: Theory Meets Applied Practice

Coming to generate a finding in interpretive description involved an interpretive process of meaning-making. Wolcott (as cited in Thorne, 2008) suggested that the

researcher pursues description in order to share with the reader what the researcher has come to see. However, through the researcher's interpretations, the reader is shown what the researcher has come to believe to understand and how this understanding might inform practical applications within various contexts. In order to share my interpretive understanding, I looked beyond the explanations of pattern and theme and endeavored to construct interconnected relationships amongst the various phenomena in order to illuminate what might not have otherwise been considered in clinical practice. Thorne (2008) suggests that interpretive description is a "meaning-making activity, directed at a particular kind of audience (such as clinicians) toward the purpose of rendering a new, enriched, or expanded way of making sense of some problem or issue" (p. 175).

As I conceptualized the findings to report, I also began to articulate applicability to clinical practice. The maneuver of interpreting meaning to applied practice was one of the most enticing aspects that originally drew me to utilize the method of interpretive description. I was inspired by Thorne's (2008) descriptions of interpretive description as "a research report that makes visible and accessible the clinical wisdom of a passionate and thoughtful expert practitioner. . .acquired through extensive pattern recognition and reflective practice observations. . .the ultimate purpose is not theorizing but rather illuminating insight" (p. 169).

While I wondered about naming the "so what" of my conceptualized findings, I found myself generating many questions. Thorne (2008) posed three specific questions to aide in the process of determining the meaning of illuminated phenomena to applied practice. She suggested that the researcher ask of themselves in regards to their conceptualizations,

- "What are the main messages?"
- "What is it that I know now, having done this study, that I did not know before?"
- "Or, that I did not know in the same way?" (p. 195).

In order to explore my questions more fully I relied heavily on the voices of my colleagues in clinical practice, the parents involved in my research, and other practitioners in various roles within the field. I shared my analytical renderings with my colleagues and asked for feedback and ideas regarding what insight they believed could be illuminated. For those parents with whom I was maintaining communication I asked their perceptions on what they believed practitioners might interpret from the dialogical and group phenomena. I also presented the understandings I had generated from the data to a large group of managers and clinical supervisors on a provincial mental health and substance use committee and asked what they had heard from the data and how they believed the understandings could inform clinical practice. I embraced an opportunity to ask questions and to listen carefully to unique interpretations and perceptions. I carefully considered multiple voices and became clearer on how I wanted to articulate the implications of what knowledge I had developed through my research inquiry.

As I closed this particular chapter I heard the imagined beat of a mounting drum roll and recognized a felt sensation of nervous anticipation. Moving into Chapter Four I imagined you preparing to engage with me in a journey through those understandings I drew from the voices of the parent participants. As the artist lifts the canvas off of the sculpture, the chef removes the lid from the platter, I place the final period on Chapter

Three and without further ado share with you the conceptualizations sparked from my research curiosity.

Chapter Four: Thematic Depictions

My intention in Chapter Four is to share with you what I have come to understand about dialogue generated within the *Recognizing Resilience* collaborative group process. I have transformed pieces of individual data into an assemblage of a collective story. Within this chapter I share descriptions of each aspect of my research question including the dialogue that was generated within the collaborative group process, the conditions that contributed to this dialogue, and the meaning of the dialogue in regards to parents' experiences of their son or daughter's substance use.

An important aspect of using interpretive description pertains to how I decided to organize, compile, and write my findings. While I prepared to write my initial realizations, I recognized that I would not fully demonstrate the meaning of the dialogical process if I reported my findings in a linear way. As I mentioned in Chapter Three, if I were to simply report all of the dialogue that parents had described from the group, I would have a fairly simple telling of what topics of conversation were created. My findings might have sounded like a generic or even static depiction of "the parents talked about A, B, and C." This depiction would have provided you with a response to what parents might discuss within a collaborative group context, however you would not be provided with what I believe is a much more telling and interesting generative dialogical process.

In order to demonstrate the unfolding movement of the group dialogue and the ensuing meaning of this dialogue I have organized this chapter in a specific way. I decided to tell a story about how the participants came together in conversation, what this initial conversation sparked, how this spark generated further dialogue, and what has come to be some of the meaning associated with the actions of the dialogical process. Although I am sharing one telling of a story, many stories have joined to construct the interpretation of the story that I would like to tell. I acknowledge that there could be multiple tellings of this particular story rather than a singular truth or a right/wrong version.

Description of Findings: The Point Beyond the Walls

My research inquiry was initially piqued by my interest to understand what dialogue parents would generate within a relationally engaged, collaborative group context. Having run parent groups for a number of years and participated in the delivery of predominantly content driven psycho-education programming, I wanted to explore what would happen if the parent voice was elicited in a paradigmatically unique therapeutic opportunity. From facilitating two parent group cohorts, I heard much conversation, a variety of topics, and an exchange of insider knowledge that I interpreted as both profound and pivotal. When the groups came to a close I was keen to hear parent participants recount the conversation and eager to write these accounts for the larger substance use helping system to consider.

When parent participants shared with me the stories of coming to the *Recognizing Resilience* group, they said that they were open to trying anything that they could to help their son or daughter. Some parent participants said they joined the group because they were "floundering" and felt helpless in terms of controlling their teen's behaviours. Parent participants also indicated that they had experienced judgment and exclusion from

the services involved in treatment efforts with their teens. I was fairly stunned to hear how each parent had felt that he/she had been “*hitting walls*” or “*banging their head against walls*” when trying to access support. One parent shared “*it is like banging your head against the wall because the resources are just not there.*”

With the toll of isolation, shame, and stigma wearing so heavily on the parents, all participants indicated that they had “*gotten to a point*” where they needed to access an option that would allow them to talk and receive support for themselves. One parent explained this by saying, “*there is only so much you can do and you are tearing your hair out, at some point you need to have something for yourself and talking about it from your perspective and commiserating with other parents, that helps.*” The parent participants described how much of their efforts had been concentrated on supporting their teens and that few, prior to accessing group, had acknowledged this need for themselves.

I found it interesting to note that all of the parent participants said they were “*ready*” to engage in dialogue. One parent explained: “*You begin to feel isolated and at some point you begin to open up and think that it might be helpful. You try all kinds of things on this journey and I was ready.*”

In many cases, parent participants used words to describe the ways in which they were impacted by initially engaging in the group process. Parents used words like “*release*” from isolation and silence, “*validation*” in terms of being understood, and “*connection*” with other people who could relate. It seemed that the first contacts of the group experience had made an important impression on the participants. Juxtaposed with the contextual descriptions of what brought the parent participants to the group process, I could see how parent participants were impacted by the actual experience of coming out of isolation, judgment, helplessness, and uncertainty.

Dialogue Constructed in the Group Process

What dialogue do parents of adolescents in relationship with substances create when they are involved in a collaborative group process?

After I had explored what sounded to be an impactful experience for the parent participants coming out of the binding constraints of isolation, I wondered about how this experience transformed into what conversation was created. I noticed two distinct descriptions of conversation. The first descriptions referred to what parent participants recalled about the initial group conversation and the second descriptions referred to the dialogue they identified beyond this initial telling. The first descriptions, or initial tellings, were reflective of the individual parent participants’ narratives and sounded like tellings of a story born out of the parents’ experiences prior to the group encounter. The second form of conversation was what I interpreted as being transformative dialogue, or what I will call re-authored tellings of the initial group narrative. In this chapter I separated these aspects for you and provided descriptions of both in a way that demonstrates the movement of the group dialogue, the generative, emergent, and fluid nature of what was being said and how it was being formed into something meaningful for each parent participant. I first describe what I have come to understand as the initial, familiar story and describe the emergent, re-authored story at another point in the chapter.

A Familiar Story: The Parent’s Relationship with the Problem.

As I noted in Chapter Three, parent participants had a difficult time recalling specifics about what topics¹⁰ of conversation they were a part of in the group. Instead parents talked about the opportunity to tell their stories. Parents indicated that the conversation emerged from the familiar aspects of what these stories entailed. Parents found that the process of telling each other stories of how they had been experiencing their son or daughter’s substance use was memorable. I deciphered this as meaning that the dialogue developed within a process of exchange rather than from singularly identifiable topics.

Most parent participants recalled the stories of the others as having both unique and familiar components. They were drawn to speak when they listened to familiar aspects of another person’s experience. One parent participant explained that although each story had differences, each story had familiarity or what she called “*common threads*.” I could see from iterations of data analysis that some of the common threads appeared to be a part of a familiar story. In the following section I will share a more detailed description of what I understood from parent responses as being the familiar story.

The Rollercoaster Ride: Ups and Downs.

As I sorted through the 100 pages of transcribed data, I noticed a few explicit common phrases. Within minutes of each research interview, every parent participant recalled conversation about what they called the “*rollercoaster ride*” of parenting a teen in relationship with substances. Parent participants from both group cohorts used this metaphorical depiction to describe their experience as a parent and to describe what they had heard about the experiences of the other parents. One parent explained:

“I think over and over we heard what kind of a rollercoaster we live with our kids in their struggles in life. Sometimes it is up and sometimes it is down, it is all over the place. We are up and we are down as parents—it takes a toll on us too.”

Another parent shared that

“the first night everybody said rollercoaster, and it is just exactly what it feels like, up and down, up and down. Everyone was careful to not get excited when you got an up because you were afraid you were headed for a down.”

The ups and downs of the “rollercoaster ride” had come, for all of the parent participants, at some cost. One parent described “*the pitfalls of addiction*,” or the consequences of the ride. Parent participants described the effects of the rollercoaster using words like “*loss*,” “*sadness*,” “*grief*,” “*fear*,” “*anger*,” “*helplessness*,” “*hopelessness*,” “*exhaustion*,” “*worry*,” and “*heartache*.” In the telling of their stories, some parent participants spoke more specifically about, for example, guilt, others spoke of grief, while others spoke more about anger. All of the parent participants identified that they were able to engage in group dialogue about how they had been impacted by

¹⁰ To me, this is indicative of parent participant’s experience in a collaborative therapy group. Facilitators in a collaborative therapy group open dialogical space for participants to share what they want to talk about. In a psycho-educational structure facilitators would often pre-determine topics and content focused conversation.

their teen's active relationships with substances. In her recollection of the group conversation, one parent said, *"I felt guilty, like what did I do, what wrong turn did I take? How did I let him down that he is at this point? I was feeling bad about myself."*

Another mother reflected on the conversation and said,

"Grief stands out for me. There is loss, there is no doubt loss. You see your kids lose their innocence and we as parents are knocked down a couple notches because we want to be in control, you want your kids to grow up and be outgoing, productive, and out of the home. Suddenly you have this kid who was your right hand friend, and that is severed, whack. I was mad lots of the times, mad and sad. It is not normal separation, it wasn't the transition you were hoping for, it was just whack. Grief stood out for me."

Another parent explained that helplessness had taken a toll, *"the bottom line was that everybody was floundering, trying to seek resources, trying to seek support and help"* she said.

Beyond the "Norm."

I noticed another familiar storyline that had stood out in most parent participants' description of the initial group conversation. All of the parent participants said what they talked about was *"beyond the normal teen behaviour."* They explained that they were not discussing what they called typical adolescence or normative rebelling teens, but were talking about something above and beyond. They talked about having a teenager involved with drugs and/or alcohol, the risks, behaviours, and exceptional considerations they and their families experienced, and what additional measures and actions they had taken in response to the substance use. Parents talked about wanting to find solutions and trying to find ways to fix the problem.

One participant explained that in the group he was able to talk about *"some of the stuff that seemed to be missing versus your normal teen. . .we were dealing with other stuff, it was an elevated aggravating behaviour."* Having come out of what she called *"secrecy"* in regards to her son's relationship with substances, one parent said that she talked about *"what was really happening inside our family with him. . .and how I really felt about it."*

Impact of a Familiar Story

When I reviewed the transcribed data and explored the notion of commonality, I came to recognize that commonality seemed to be associated with the parent participants' experience of feeling understood. Parents said, *"we were all in the same boat," "I could relate to everyone,"* and *"we were going through the same stuff."* Having entered into the group from the isolating, shaming, exclusionary constraints of what many referred to as *"the walls"* and participating in the telling of their personal stories, parent participants seemed to experience a paradoxically unique encounter. Not only did parents indicate that the familiar story allowed them to feel understood, but also through the first encounters of sharing, parent participants identified that they felt belonging. They heard their own grief in each other's accounts, they witnessed their own suffering through the individual telling, and they saw their own experiences within the individual descriptions. Parent participants identified that hearing others allowed them to feel that their own

stories were important, that the others' stories were important, that they were sharing within the lives, the ups, downs, pitfalls, and experiences of another human being. One parent described this by saying,

“Right away you get to share who you are and why you are there, this is important because you get a quick overview of each other right away. . .you realize that this is serious, we are all here for the same reason, we have serious issues in life and we need to listen and pay attention.”

When I asked her if what the other group members talked about was important she responded quickly and with firmness, *“Very important! It is my life, it is very important! The fight we have takes 99% of our lives, so it is critically important. . .our struggles with our children.”*

Another significant aspect of commonality was the recognition for parent participants that they were not alone. One father said that there were no words to describe the feeling he got when he realized that he was not the only one. During the research interview he took a deep exhaling breath and physically demonstrated the sense of release of which he spoke. All of the parent participants had said that before they heard the stories of the others, they had been in a private experience and had felt very alone. Commonality seemed to bridge the divide between isolation and what became the development of relationship. Not feeling alone was a major impact of coming into the group process and I will talk more about this impact throughout Chapter Four.

Commonality, understanding, and a sense of importance seemed to spark a new sense of relating. I use the word sparked in order to capture the quality of an action and, hopefully, to inspire a magnificent visual of something new and profound—something that had not existed prior to the moment of the action. One mother explained this by saying,

“It was amazing to see how much we all had in common. In a way it was a relief, not that you wish it on someone else, but just to be able to be open and connect with someone who knows what you are going through.”

Other parent participants also shared this sentiment of how striking it was to hear familiarity in what had previously been an isolating experience.

Through my analysis of the familiar story I have come to make some interpretations. I see the initial group story as being based on the individual telling of what had been an isolating and exclusionary experience of parenting a teen in relationship with substances. Parent participants entered into the collaborative group as singular selves—individual participants with separate experiences. However, through a collaborative approach, parent participants were invited to share their stories and as a result seemed to begin identifying with the other group members. The shared stories had common elements that inspired for parent participants a sense of being in connection, of belonging, and of being important. Gergen et al. (2001) said that “by sharing stories of value, commonalities are located” (para. 24). I believe that the collaborative therapeutic approach to group allowed for initial offerings of space for parents to express those stories they wanted to share and to be heard. Speaking to what they felt they needed to share and experiencing commonality with others sparked what I will later describe as coordinated actions of relational responsibility (Gergen et al., 2001) and transformative dialogue. In the next section I will continue to describe the evolution of this dialogical process.

Breaking Down Walls: Sparking the Conditions of Dialogue

What conditions in a collaborative group process inspired dialogical conversation for parents influenced by their adolescent's use of substances?

“The words the speaker chooses invoke the ways of being that the participants take themselves to be involved in.”

(Davies & Harré, n.d.).

In my efforts to write the following section, I found myself reflecting on my earlier experience of formulating my research questions. As most researchers and practitioners can attest, coming up with well-formed, comprehensible, and meaningful questions is an important and sometimes difficult task. Thinking back, I am struck by the amount of time I spent specifically considering my questions about *what* dialogue was constructed and the *meaning* of the dialogue. In all honesty the question about what *conditions* contributed to the dialogue was somewhat of an afterthought. I thought I should include it in order to generate a thicker description of how my material might be applied to clinical practice. What I did not realize at the time was that the question about what conditions contributed to the generation of dialogue would be one of the most important aspects of my research inquiry and of my learning about social constructionism.

It was not until I began to wonder about the interconnectedness and interrelationships amongst my data that I noticed the significance of what conditions contributed to the dialogue. As I have described within the previous chapters of my dissertation, what we perceive to be real and true is born within the coordinated actions of relationship (Gergen, 2009b). I learned from parent participants that by participating in a collaborative group process, by being provided opportunity to share their stories and to talk about what they felt was important, parents began to move from singular beings into a coordinated relationally engaged collective. I believe that coming into relationship became the platform (Gergen et al., 2001) for what dialogue and what meaning-making ensued. Davies and Harré (n.d.) spoke to the joint action of conversation: “A conversation unfolds through the joint action of all the participants as they make their own and each other's actions socially determinate. . . what has been said evolves and changes as the conversation develops.” In the following section I explain for you the conditions of relational being, voice, and safety that contributed to the construction of dialogue and meaning in the collaborative group process. I also highlight logistical conditions of group membership, agenda, and facilitation that parents identified as having significance in terms of how they experienced the group process.

Relational Conditions—What we Take Up in Relationship (dialogue creates our social reality)

Meaning making is a form of coordinated action. Thus if we are to generate meaning together, we must develop smooth and reiterative patterns of interchange—a dance in which we move harmoniously together.”

(Gergen et al., 2001, para. 24).

Prior to entering the group, parent participants had encountered isolation, helplessness, grief, shame, and judgment. Parents had occupied the positions of caregiving as influenced by a larger narrative of what it means to be a parent of a teen actively involved in alcohol and other drugs. However, upon entering into an opportunity to tell their stories as well as hear the stories of the others, parent participants entered into relationship with one another. A parent participant explained this by saying, *“I think as you start hearing stories and they are so much like your own, you strike up a camaraderie that a person without a child with addictions would not understand.”*

The action of the parent participants and facilitators coming into relationship with one another contributed to dialogical conditions of the collaborative therapy group. Parent participants identified specific considerations for how they came together in relationship and what actions and practices maintained this relationship and the development of continued conversation and meaning-making. These relational conditions were pivotal in terms of fostering dialogue beyond the singular being and the perpetuation of the familiar story.

The Condition of Relational Being: Beyond the Singular Self.

Parent participants explained that once they had heard the stories of the others, they began to notice the others not as separate and distinct from themselves, but as connected and important to themselves. “As participants move toward common purpose, so do they redefine the other, and lay the groundwork for a conception of us” (Gergen et al., 2001, para. 29). Parent participants talked about what it felt like to witness the pain of another and how they felt having people empathize for them. One parent said,

“Until you have walked in those shoes you can’t empathize a hundred percent. It is really devastating when it is your child because you just see them, they are just starting out and your heart is ripped out, and as soon as you see those other parents you know darn well how they are feeling.”

Parent participants said that the effect of having their emotions noticed and affirmed by people in a group was significant. In reflecting on her “worst week” with her teen, one mother shared,

“To me I am always on auto-pilot, I don’t have a lot of emotion tapped in at times [speaks about her teen’s suicide attempt], I felt that the way I was saying it probably didn’t come across as like a huge ordeal for me, even though it was. The support I got from everybody, the feeling I got from everybody was. . . it was a big impact. I really felt their empathy. It was genuine—it felt real. . .when I left that night I thought about that.”

The development of care for one another instigated the relational responsibility of wanting to help one another. A parent participant said, *“I believe you so want to help those people not feel as crappy as you did, you want to help them.”* By coming into the relational context of the collaborative group experience, parents developed a concern for the others. The familiar stories and the sharing of experiences inspired a desire to help each other—to alleviate the distress experienced by other group members. Many of the parent participants noted that they felt that they had moved into a relationship of having regard for one another very quickly. For example, one parent said, *“Everyone was important, no one was left behind. When someone was missing there was genuine*

concern that they were doing okay and we were glad to see them when they came.” One father, who had a particularly hard time recalling the specifics of what the group talked about said, “It just seemed like we were all there to assure everybody else that you are not the only one going through what you are going through. I was there to offer support to anyone else who was there.” This was from another parent:

“It was nice to be able to share what I have come to know and understand even though our situations were different, we are still coping with our teenagers and their struggles and there is always something that someone says or shares that could be very helpful, so I didn’t want to hold back anything that I had. . .if there was anything possible that I could do because of my experience to help. . .you definitely want to get it out and share it because you know if it could help me, maybe it could help someone else.”

Parent participants said that by helping one another, offering insight and perspective, they felt good about themselves and confident. They felt that they had done something to contribute to the wellness of others, and that they had been validated as having something helpful to share. Moving beyond the singular self and practicing the relational practices of care and concern fostered the dialogical condition of “us/we” in the collaborative therapy group.

The Condition of Being Heard: Acceptance of Voice.

Gergen et al. (2001) said, “If dialogue is to proceed successfully, it is critical that one’s voice be heard” (para. 19). Parent participants identified that conversation within the collaborative therapy group was a result of coordinated actions occurring within the relational context of acceptance and affirmation. The specific word, *acceptance*, was used many times within most of the individual parent group interviews. Acceptance pertained to the relational responsibility of how parents engaged with and attended to the others in the group process. Acceptance, from what I deciphered, meant that parents received the group members, their stories, and their involvement in the group in a way that was affirming, non-judgmental, inclusive, and free of an intention to argue or change the other. Parents talked about accepting each other where the other was “at,” supporting them through the ups and downs or with whatever came with them to the group conversation. One dad emphasized how he valued being able to sit and listen if he wanted, or share and provide if he chose. He said people could take his input or leave it, but never was there any dispute or disagreement, just openness to listen, openness to allow another to speak. Another parent said that she felt people were really listening to her.

The relational condition of being heard also involved an aspect of inclusion. A mother from one of the groups said,

“I felt that everyone had equal opportunity, when someone wasn’t ready we would come back to them, never forget them. When they wanted to go first that was fine, when someone wanted to talk more because their situation was more difficult then they were given that with no hesitation or attitude from others.”

Parents also talked about their experiences of being heard by the others. I recall the feeling of surprise when I heard one parent say that she felt that she had found her voice in the group. She shared that she had felt heard, appreciated, and that she felt permission and “*freedom to speak without being dismissed.*” I recall the feeling of awe

when I heard a second and a third parent express this similar sentiment of “*freedom to speak*.” “*Everyone’s voice was important*,” said one parent, regardless of what needed to be said, how it was shared, and when it came up. Another parent said she felt

“the freedom to be there without having to defend my position or argue that this is not normal, my son is struggling, he is not himself, and not have someone say, oh it is just normal. What stood out was the ability to be free to talk about what is going on, what is uncomfortable and speak to the fears and concerns, to talk about the petty things, and how I ache.”

Parent participants were able to experience the full significance of what they and others were saying through the actions of hearing, affirming, accepting, and appreciating. They were able to talk about what was important to them without contest or challenge. One parent said that within the group, parents were able to let down their “*guards, telling all sides of their stories, admitting things and thinking, ‘dare I say this’ and people admitting they feel the same things and you realize that it is an environment that is non-judgmental and it is a good place to be.*” Parent participants were free to navigate with each other ideas and possibilities without judgment or connotations of right or wrong, good parenting, bad parenting. “*There was no sense of right or wrong,*” said one parent.

The Relational Condition of Safety.

Safety, particularly coming into a group of strangers, is an important aspect of therapy. Some parent participants indicated that they had initially been concerned about coming into the group environment and having, what they called “*secrets*” being shared with total strangers. Upon reviewing the transcripts, I could see that participants identified the notion of safety as being an important facet of what contributed to the conditions of dialogue within their group experience. In terms of my data analysis, safety pertained to the relational practices of maintaining privileged information and witnessing confidential and sacred experience. Parent participants explained that because they were engaged in such similar stories, they quickly developed an implicit trust with each other and who they were, what they said, and how they were influenced by teen substance use would be strictly protected. As a result of feeling so safe with each other, parent participants said they became very open and willing to share. A parent explained this by saying,

“I was surprised, there is no guarantee that people aren’t going home and saying ‘this happened to this person’ and ‘this person said this.’ I think you do just get a gut feeling that that is just not why people are there. I know for myself that wouldn’t be what I would do. You just get a feeling that you can trust people and really what does anyone have to gain, you just want to help your kids get healthy.”

Another explained that he trusted the group members because they too were in the “*same boat*” and that he was less worried about the risk of being vulnerable with people as he was about getting help for himself and his family. The responsibility of safety developed from the opportunity to share stories and from the commonalities located within the stories. Many traditional group therapy programs begin group dialogue by outlining the concept or structure of safety—developing group guidelines and rules (Corey & Corey, 2006). However, what the parent participants from the collaborative therapy group

explained was that safety was emergent, occurring as a result of moving beyond singular entities sparked by the action of sharing and the development of relationship.

Logistical Conditions

Parent participants identified specific qualities of the group logistics that contributed to the dialogical conditions in the collaborative therapy group. As I have mentioned previously, a collaborative approach to group therapy is different from psycho-educational approaches. Within a collaborative approach parents are encouraged to talk about what they feel is important for them to talk about and facilitators participate in a relationally engaged dialogical process of meaning-making. Parent participants identified some additional characteristics of the group process that they attributed to the development of the dialogue that was generated in the group.

The Condition of Group Membership.

It may seem quite obvious that who was in the group influenced the group dialogical conditions. I questioned if I should include this particular description, but realized who was in the group had tremendous impact on what the group became. In order to nurture a cohesive, common connection, group membership was intentionally considered as part of the group design. Those parents who participated in the research inquiry reflected the importance of needing to relate to who was in the group and felt that this design element impacted what was talked about and how it was talked about. All of the parents who participated in the group were actively caring for a son or daughter who was involved in a relationship with alcohol and/or other drugs. One parent participant was caring for a teen influenced by what the parent called an addiction to self-injury and consequences of a mental health challenge. This parent participant explained that the familiar story of the rollercoaster and the pitfalls of the roller coaster were so similar that she could relate to the experiences of the other parents in the group.

Although there were many similarities amongst the group members, parent participants placed importance on the diversity amongst the membership. Several parents said that they appreciated seeing and hearing from parents who had been involved in a process of dealing with adolescent substance use for many years, while other parent participants noted the value of meeting parents who were just encountering adolescent substance use. Stories of hopefulness, issuances of support, exchanges of advice and perspective were inspired by the diversity of the people, places, and processes of those involved in the group dialogue. Parent participants indicated that they did not need to be talking about similar drugs, behaviours, ages of teens, even communities for the dialogue to be meaningful. One of the fathers said that he felt that regardless of the group cohort, the people, the experiences, and situations, that the process of the group dialogue would be similar because of the one specific unifying element of participation, “*you are all there for your kids.*”

Over and over again I heard parent participants explain that they had all “*gotten to a point*” where they either needed support for themselves or did not know what else to do. Parent participants said that they decided to participate in the group experience because they wanted to. They all felt it was important to be there (for themselves and/or for their teens), and they were “*ready*” to engage in conversation with other parents.

When I asked one parent in particular what she thought were the conditions that contributed to the group conversation she said strongly, *“Desperation! Everyone was at a point. By the time you get to a group like that you have been through a lot.”* By being ready to come, parent participants were invested in the process of sharing, support, and exchange, willing to be vulnerable, willing to provide reassurance to others, and able to be as present as possible. There was a sense of joint responsibility for the group and the group interchange; *“Everybody nurtured the conversation along,”* explained one parent. Many parent participants reflected on the openness of others and said that *“everyone was open”* to participate, whether that be through sharing, listening, and/or supporting. *“Everybody who came was wanting to be there and ready to be in that situation,”* explained one of the participants. Who was in the group and how they were willing or able to be present in the group contributed to the engagement in coordinated actions of “us” throughout the group process.

The Condition of Emergence: Agenda and Conversation.

Parent participants explained that the group process was different week to week and was primarily based on what they wanted to talk about. Parent participants acknowledged an overall appreciation for the emergent nature of the group and valued the uncertainty of what dialogue was going to unfold. Parent participants said that how they responded to one another depended on what each parent was experiencing. There was no formalized agenda and parent participants identified that the conversation was inspired each week by the group members. One parent said that the dialogue was initiated by *“whoever had the bigger thing on their mind that week.”* Not having a predetermined agenda allowed the parents and facilitators to be responsive to the emergent needs of the group members. One of the fathers in the group said, *“There was no mandate, no need to get somewhere, it freed it up so people could get things off their mind, off their chest, and just float.”*

The emergent nature of the conversation gave room for parent participants to speak to aspects of their story that were most pressing, or pieces of experience that were most related to the exchange of others. Parent participants said that the dialogue had a back and forth quality that allowed parents to both hear the other and share with the other. Parent participants identified that regardless of what the other parents in the group were going through, there was value for the other members to witness or support each other. As one parent explained,

“You know each week was different for all of us and so getting that out there and really enjoying somebody else’s good week or good period was equally as good as supporting them when they had a bad week. . .never really knowing what the day was going to be like or the week.”

Another said, *“You never really knew where it was going to lead. . .there was always something that you could be there for and try to put your two bits in and help, even just to listen and find out something for yourself.”* The structure of the collaborative therapy group, the emergent nature of the agenda, and resulting dialogical interchange created the context for parents to explore, to be curious, and to generate perspective from the multiple pathways and directions through which the conversation ensued.

The Condition of Facilitation: Hosts and Guests.

The *Recognizing Resilience* group was a facilitated process designed to host participants in a specific manner. Facilitation was identified by parent participants as having an influence over the group atmosphere and parent experience. Harlene Anderson (2007) spoke to a host and guest metaphor in her descriptions of partnered and collaborative therapeutic practices. Anderson (2007) said that the therapist is “a host who meets and greets the client as a guest and simultaneously acts as a guest in the client’s life” (p. 45).

Parent participants expressed they appreciated that the facilitators introduced them to the other group members immediately and that they were invited to share, within their own limits of comfort, what they felt the others should understand. Parent participants also identified that they were provided with facilitated opportunities to look beyond the familiar story. One parent explained this by saying that the facilitators opened conversation that allowed participants to explore beyond the narratives of “*problem*” or “*ruts*” and supported exploration of additional narratives. Another parent participant said that exploring beyond the problem allowed her to move away from “*wallowing*” and she said as well that parents were provided with opportunities to have “*their bitch sessions*,” but through the dialogue, realized that it was no longer productive and that she needed to be a part of generating other conversations about her teen’s involvement with substances.

Parent participants identified that facilitators elicited multiplicity in terms of how people were involved in the group (listening, sharing, witnessing, advising), what directions conversation ensued, and what meanings participants constructed. In her reference to the facilitated process one mother said, “*You let us know that there was no right or wrong, there was no ‘format,’ that the group was our group, that was important.*” Parent participants said that facilitators did not defer to providing answers or fix-it advice, but honoured the knowledge of the parents in the room and the process of parents sharing and providing for each other.

In the absence of agenda, directives, or being talked at, parent participants described becoming conversational partners. No one member was constructed as the expert and answers and solutions were reserved for individual interpretation rather than universal generalization. A parent participant captured this by saying,

“I was surprised when I got to the group and it wasn’t more formal and structured, I didn’t know what to expect. I thought we were going to a class and we were going to cover topics and someone was going to give me a million dollar answer to fix it [laughing]. In hindsight you realize it can’t run like that.”

Facilitators also demonstrated the position of being guests in the narratives of the parent participants. Parent participants suggested that facilitators valued each group member, never left anyone behind, or out of the dialogue, and placed importance on each participant. “*You don’t cut people off*,” said one parent; each voice was important and what people had to say was acknowledged. Parent participants said they were supported as partners in the dialogical processes; “*Everybody nurtured the conversation along*,” explained one father. The facilitated atmosphere was described as being gentle, relaxed, and informal.

Several parent participants reflected on the ambiance or “*tone*” of the facilitated process. Parent participants recalled the comfort that was felt by sitting around a table—

the provision of food, coffee, and tea. The setting was described as not intimidating but as having “*coziness*.” A parent said that it was the “*simple things*” in the space, like the food, beverages, seating arrangements that created a feeling of community, intimacy, and connection. Further, parent participants acknowledged the accessibility of the group and appreciated that the time of the group was in the evenings in order to accommodate the parent schedule, as opposed to having the parent accommodate the professional schedule.

Meaning of the Dialogical Conditions

Exploring the conditions that contributed to the dialogue in the collaborative group process was paramount to understanding how the dialogue was initially shared, constructed, and transformed. The relational context of the group process inspired the conditions of moving beyond singularity into generative actions of construction and relational responsibility. Some of the research participants referred to the relational ways of being in the collaborative group context as opening conversational space. One parent said that conditions of being judged, blamed, dismissed, and/or directed tend to close space, or feel exhausting, or defeating. Gergen et al. (2001) said, “Discourse of individual blame is divisive. In finding fault with another, we begin to eject a wall between us.” Words like “*freedom*,” “*open*,” and even “*float*,” were used to describe the feeling of being in this particular kind of dialogical atmosphere.

By not having to defend a position to make others listen, or to suppress ideas or perspectives at risk of being judged, the parents’ voices were elicited and given the freedom to resound in all aspects of the developing dialogue. Parents in turn felt validated, important, understood, and included. In regards to hearing her voice in the group context one parent said, “*The more you vocalize things, the more you stand up for things.*” Parents identified that being accepted, listened to, supported, and cared for contributed to a sense of confidence to continue the dialogue in the group and also to carry forth into dialogue outside of the group. “*That’s a big deal,*” said one mom, “*because it is exhausting trying to reach out for support when people don’t hear you.*” Parent participants attributed relationship to their responsibilities to maintain involvement in the group process. Parents developed an allegiance to the group and a desire to remain connected with the group members. One parent said, “*It made me want to go back. I looked forward to the groups because I always felt like there was a real sense of understanding and a deep concern about each individual’s situation.*”

The logistical conditions of the collaborative therapy group were also influential in the dialogue parent participants generated. Facilitators connected with parents as conversational partners free to explore what was emergent without the constraints of a psycho-educational structure or preconceived agenda. As a result, the parent voice resounded and the parent participants felt free to bring up what they felt they needed to talk about. The gentleness, comfort, and informal tone of the conversational atmosphere contributed to a sense of ease engaging in dialogue with others. As I reviewed the data I read descriptions of parents feeling valued, more confident, and liberated from deficit-based directives. Shifts began to occur as parents felt validated, respected, understood, and supported. I recognized the word relief being used on many occasions in order to describe the impact of such an atmosphere of affirmation and acceptance.

Having articulated my findings about the group conditions, I began to postulate...I believe that the relational and logistical conditions of the collaborative

therapy group were mutually influential to the dialogical process of the parent participants. Moving into an exchange of story, commonality, and relational responsibility allowed the parent voice to be heard, insider knowledge to prevail, acceptance to grow, and safety to develop. Coming together in conversation, and how participants attended to one another sparked the coordinated construction of conversation and meaning. From Gergen et al. (2001),

By sharing stories of value, commonalities are located. And using the sense of shared value, visions are fostered. Dialogue is then employed to fill out the landscape of the vision, to create a sense of a new reality, which, in turn, lays the groundwork for alternative forms of action. (para. 34)

In the following section I share for you descriptions of what dialogue grew from the group conditions.

Re-Authoring the Familiar Story: What “You Realize”

The relational context and logistical qualities of the collaborative therapy group inspired the transformative potentials of dialogue and the process of re-authoring the experience or story of parenting and adolescent substance use. The coordinated actions and relational opportunities to hear and witness, and to share and tell, allowed for perspectives, ideas, and meanings to change. One parent said in regards to the development of her own understandings, *“You don’t tie it together until someone else says it aloud, and you think, I hadn’t really thought about it like that.”* In the following section I share descriptions of the new narratives generated within the group process. I explain some of these new narratives generally and also explore unique narratives of the individual parent participants. Although there were some common themes regarding some of the dialogical shifts experienced by the group, there were also some distinct differences regarding what stories were authored by each person.

You Realize...

Throughout the process of analyzing my data I consulted with my advisor Sally St. George. Sally always demonstrates enthusiasm and she often bolstered me up with ideas of data analysis being the “fun” part of my inquiry. Although I had been exhilarated by the experience of conducting research interviews, I noticed my sense of “fun” begin to wane with transcription and fizzle with the overwhelming task of sorting and organizing a lot of transcribed text. Sally recommended that I slow down and “play” with the data. She advised that I read the transcripts from different vantage points in order to see what I would potentially notice.

Based on her advice, I read my transcripts from the lens of a couple of different readers. During one particular reading I tried to imagine a parent with whom I had been working. She had not been in any of the group cohorts and had newly accessed substance use services. She was very concerned about her son and feeling, as other parents had described in my inquiry, helpless, sad, angry, and desperate to find resolution. I decided to go through the transcripts and read them from her vantage point. As I read the transcripts from her position I began to notice something quite explicit. First off, I noticed the term *“you realize/I realized”* preceding statements that I had come to recognize as the original “familiar story” coming *into* the group and preceding statements about what

dialogue parents generated *within* the group. I began to make a connection between the initial telling, the relational and logistical conditions, and the development of transformative dialogue. It was through this lens of viewing that I had made the distinction between the familiar story and the re-authored story—re-authored stories became a compilation of different narratives about parent perspectives and experiences of their son or daughter’s substance use. Imagining that I was this particular mom reading through transcripts ripe with familiar stories, I started to get really curious about what these new narratives were. Imagining her struggles on what she too has called a rollercoaster ride, I found thick descriptions of insider knowledge that seemed to offer, what one parent called, “*light at the end of the tunnel.*”

You Realize Self in Relation to Adolescent Substance Use.

When parent participants first shared accounts of the dialogue generated in group, they referred to familiar stories, or common threads. Amongst these common threads was an intricately woven implied narrative of secrecy. Shame, judgment, and guilt had sewed shut pathways for conversational exchange creating what were called “*walls*” of isolation and exclusion. This dominant narrative became how parent participants came to know their positions in the societal telling of parenting a teen involved with alcohol and/or other drugs. When the walls of isolation came down, parents profoundly realized that they were not alone. This tale of isolation and the practices of secrecy shifted and changed to a telling of connection and an opening to share. By participating in such a relationally engaged dialogical process parent participants were able to consider themselves in relation to the people around the room and realize that adolescent substance use could happen to other parents and teens, and because it could happen to others, parents were not the sole cause of the “*problem*” and that the position of “*bad parent*” or “*all your fault*” could be abandoned and a different way of conceptualizing self could be constructed.

This re-authoring was shared by a number of parents. A parent explained:
“It was nice to share with someone and realize that maybe it wasn’t all our fault. There are some things you have to take responsibility for, there are some things we could have done different but we didn’t have control over it and when you hear that reinforced by others it is comforting.”

Another parent shared her telling of what she realized upon connecting with others:
“You come to realize that we are all just doing the best we can and it is pointless to feel guilty. When I met the other parents I realized ‘wow’ these are really good people trying to do their best and it is nothing we did wrong as parents, it is just the way things are going and we are trying our best.”

Parent participants were able to realize different descriptions of self in relation to their teen’s involvement with substances. One of the fathers described that he had been very angry about his teen’s substance use until he realized after hearing from others in the group, that as a parent he had been blaming himself and taking the substance use personally. He said that he realized by talking with other parents that he was not alone, he was not to blame and that he did not need to take sole personal responsibility for what came to be constructed as the “*problem.*” His re-authoring narrative shifted from one that sounded like “*I am angry I failed as a parent*” to “*I am not going to take it so personally anymore.*” When anger no longer had the upper hand in his relationship with his son, he

said that he was able to shift from having the problem as the foreground of his interactions;

“I am not talking with my son as though he is a screw up. I have had a couple of conversations about his situation, what he is doing, what he is not doing, what he can do instead of the normal stuff. So what, you are not doing the normal stuff, but don’t throw this time away.”

You Realize It Could be Worse.

Witnessing the experiences of others had transformative influence on how parent participants perceived themselves and their own experiences. By engaging in conversation with others, parents realized new descriptions of how they saw themselves and their situation. One parent said, *“When you see someone suffering more than you, you can go away feeling thankful. I felt guilty thinking phew, at least I am not there, I can get through this, we are not that bad.”*

As I sorted through the data I was quite struck by this particular experience of witnessing. Every parent participant spoke to the generative shifts that came as a result of hearing another person’s story. Despite having common themes with the group stories, there were unique contexts, experiences, and situations that allowed the group members to see themselves as similar or distinct in relation to the other. For example one parent said, *“I felt that the other person’s situation was way worse.”* During the interviews parent participants seemed to apologize for witnessing and interpreting the experience of others, explaining how they felt guilty for comparing; *“I felt guilty thinking phew at least I am not there.”* All of the parents countered these positions of guilt with descriptions of relief and comfort; the same parent continued by saying, *“That was a relief, I can go on, we can get through this, we are not that bad yet.”*

Witnessing additional perspectives and experiences seemed to spark an ability to externalize experience and generate unique perceptions and accounts; *“It made me think ‘okay’ we haven’t got it as bad as it can get.”* A parent explained this phenomenon by saying, *“I think it is because you are always consumed in your own fight of whatever you are dealing with and by being exposed to another person’s fight, our own fight can be placed in relation to another human being.”* The intensity of the pitfalls, the walls, and the rollercoaster could be measured outside of isolation and within a context of human experience.

You Realize More than One Explanation.

I consider multiplicity as pertaining to how we conceptualize substance use, how we understand the causes of substance use, how we believe substance use is experienced, what we consider to be treatment interventions, and also what processes we think people may navigate as they experience relationships with substances over time. Hearing similarity and unique descriptions of substance use experiences, witnessing a diversity of people and perspectives within the group environment, and exploring possibility during group interchange evoked a few realizations related to the notion of multiplicity. In the absence of truth claims about cause or fix, parent participants were able to abandon the problem-saturated positions of guilty, wrong, and/or blame.

Several of the parents spoke to a realization that there was no “*easy answer*” or magic “*fix*.” In regards to the group dialogue one mother said,

“It made me realize that there is no absolute answer. This point is strong for me because I see that in the group everyone has done everything they could. There is just no answer and I think I got to the point where, at first when this happens you are looking to go to fix it and put a stop to it, but I realize that that is not the case, that is not possible. You can do everything you can do to try to help and support [her teen] to come through this okay but there is no absolute one thing that you can do to make this go away. So it just made me realize that well if I had the answer of what I could do or the formula to make this different I would do it.”

When liberated from the notion of fix or the singular idea of an answer, parents were free to exist in the vastness of possibility. One of the fathers said that hearing multiple perspectives regarding how parents would respond to their teens “*broadened the horizons*” in terms of how he considered responding to his own teen. The group narrative shifted from a problem-saturated story of adolescent substance use and parenting and a destination or benchmark of success or failure, to an ongoing and experiential journey of learning and growth.

You Realize “We.”

Engaging in the life experiences of others transformed singular stories and individual realities into interconnected relations. The story of being alone in suffering changed into a story of together in suffering. I was struck by what three parents described as their experiences with empathy outside of the group experience. Having come into relational being within the group context, and participated in the relational conditions amongst the group members, parents described a recognition of the suffering of those outside of the group. They said that when they became witness to the suffering of others they realized that suffering is not an isolated event but a human condition any person can experience. Relational being, transformed suffering from just “*my problem*” or “*your problem*” into “*our problem*”—interconnectedness. This is described by one mother who said,

“The group thing makes you way more empathetic for other people out there. We often meet people in our day-to-day life who are grumpy and miserable or off or whatever and we assume that they are miserable people but after you have been to a group and you realize that you could be sitting next to a person on the bus or a clerk who could be going through exactly what we are or the others in the room, it does make you think. Sometimes we forget sight of what other people are going through and it teaches us to be a little more intuitive, or not to jump to conclusions that people are miserable, because they might have their own bucket of troubles like we did.”

You Realize What You Can Control.

As the dialogue sparked realizations about possibility, parent participants described new tellings of how they might respond to their teen’s relationship with substances. The familiar story had included descriptions of powerlessness and

helplessness, however, what parent participants voiced as re-authored stories were quite contrary. One of the parents shifted her original telling of helplessness and explained:

“I felt bad before, I knew he was suffering and going through a lot so I would tip toe, but I thought “no” I am going to say what I mean and not feel bad about it, I am going to say it like it is. In the past I would worry if I say something it would hurt his feelings, but I am able to still be supportive and be able to confront him and not feel bad about saying this is not working, I don’t like what is going on. I was trepidatious before, unsure of how to handle him, like if I say the wrong thing to set him off. I am still not sure the right thing to say but I am going to be guilty about not liking it [marijuana] and wanting it [marijuana] in my space anymore and saying how I feel about it.”

Many of the parent participants talked about control and acceptance. The narratives shifted from an exhausting pursuit of fix-it interventions to relinquishing control of “making it better.” Parents talked about wanting to be helpful and supportive of their teens, and at the same time, parents talked about not having control over making their teens want or receive such support. Shifting from a position of blame or guilt, liberated the parent from expectations of “should” and “have to” in terms of taking responsibility for resolving adolescent substance use. One parent said, *“I realize I can’t force [her teen] to go [to counselling] and I realize I can’t dwell on those things.”*

Another parent said,

“I have just realized that I can’t do it for him. I used to think I could force him to do this or do that or force him to go there and I realize that doesn’t work. I can set restrictions and boundaries for myself, about what I can tolerate or put up with but I can’t force him to want to make that change. He has to come to realizations on his own. We have pulled out all the stops to make sure every kind of services and counsellor is available to him.”

She continued on in the interview by saying in regards to her thinking about her son and his relationship with cocaine, *“This is the place where I am right now.”* I asked her what this place was called and she replied, *“Acceptance.”*

One parent talked about her reframed response as a parent:

“When he changed the rules by changing his personality, his friends, his ability to get anything accomplished, when that stuff changed, I went ‘yikes’ I can’t let him live like this, this is crazy. I lost the ability to pass the information [to him]. So I reflected on my own experiences [as a teenager] and thought ‘okay’ that must have looked horrific, but I survived and the values my parents taught me are still intact. I have come to understand that I can’t control it and it is up to him, which I think I already knew, but it was sort of reaffirmed that I can’t really duct tape him down and stop him from the behaviour.”

She continues by saying that she realized, *“You can accept that they are not going to stop but you can set a firm line around what you expect in your home.”*

You Realize Your Voice.

Whether the parents were asserting boundaries, speaking out to others, or advocating for their families, parent participants came to realize the power of their voices. A mother said that she realized that she was her child’s best advocate and that she needed to be vocal with systems involved in her teen’s life. She expressed confidence in

knowing what she had to say and realized the ability to bring the words out. In regards to her experience in the group, one mother shared a moving account of finding strength in her voice:

“I thought I was shy by nature, more of a listener. I didn’t really have a lot of input over my years. I have been in lots of groups and I don’t normally say nothing so that is the first time I found myself yapping way too much [laughing] but that is because I normally don’t. That made sense to me because I had good things to share—insightful things.”

Some parents described realizing that they could trust their voices, or what some referred to as instincts.

You Realize What You Have Been Through and How to Keep Going.

For many of the parent participants, the group experience had been the first and only time that they had met with other people to talk specifically about what it was like for them riding the “rollercoaster” of adolescent substance use. Prior to the group, conversations had often been framed specifically around the adolescent and had not included accounts of the parents in relation to adolescent substance use. Parent participants explained that they had been resolved to find help for their sons or daughters and had not had an opportunity to think about what they had been going through and what that had been like for them specifically as mothers, fathers, men and women, and human beings.

In speaking with other parents, parent participants said they were able to reflect on how much they had been through and develop a sense of perseverance. By offering support, advice, and ideas for one another, the parents felt validated regarding how much they had learned and come to know as a result of their journey. What had been originally thought of as a stuck situation became reframed into a developing experience of learning and growth. Further, in being able to talk about what they had personally been through, several parent participants were able to acknowledge the toll of such a journey and how they had been impacted. One of the parents said of the group dialogue, *“It made me realize I am human and of course I am going to react after a while, it doesn’t mean I don’t love him, but of course this is hard to take.”*

When looking at the re-authoring examples within the data, I noticed a lot of description about sustaining self and persevering. One theme that highlights the point of sustaining was the theme of being present. Parents talked about embracing the moment and in particular realizing the value of hanging on to the “good moments.” A parent said, *“I realize that there are just no absolutes here, we have to take the good moments for what they are.”* Having come to recognize the rollercoaster up and down of adolescent substance use, the parents talked about the sustaining action of reveling in the moments of calm, the moments of hope, the moments of connection, and other sustaining moments. They talked about these moments as being fleeting, but said that they realized that because they could be fleeting that they had to focus on them rather than the downward dips of the ride. This act of being in the moment was described, by some parents, as a gesture of self-protection, protecting themselves from the “wallowing” in the “pitfalls” of adolescent substance use.

In regards to sustaining and persevering, parent participants unanimously talked about the notion of self-care. Parents identified that unless they took measures to attend

to their own wellbeing, that they would not have energy to maintain. Parents realized how important they are in regards to their teen and families, and also in regards to their own lives. Parents talked about standing up to feelings of guilt or blame by taking time, for example, to go to an exercise class, or even to come to the parent group.

Another realization came specifically from the process of what it was like to engage in dialogue with others. All of the parents talked about how much it impacted them to be heard, accepted, and validated. As a result of such a dialogical encounter, parents identified that it helped to talk because there was benefit to letting it out. The familiar story of secrecy and isolation shifted. Parent participants identified that there were people whom they could talk to and that what they and others had to say was important, it had value, and that they could participate in a back and forth exchange or support and possibility with another human being. One parent said of her experience in the dialogical process, *“It has made me realize that even when you go and talk to someone that they can’t fix anything, it is just helpful to go and let it out and talk to someone who is not judging you.”*

You Realize Hopefulness.

Transformation was possible without “solving” the “problem.” Despite the absence of an “answer,” parent participants described a new narrative of hopefulness. What was interesting was that hope was not described as a far-reaching destination of their kids being “better” or “fixed” but a process of making meaning of circumstances. Several parents suggested that their experience was not over, that parenting a teen in relationship with substances was not *“finished,”* however this story of an ongoing *“journey”* was told not in the language of helplessness or hopelessness but told with possibility. One parent shared about his teen:

“They are not out of the thick of it yet. We are all in a process, we are all being shaped as we go, I know it is not I got to that point I am done, I am fixed now. There will be good days and bad days and hopefully there will be more good days.”

The construct of hope might generate ideas of a preconceived destination, however, hopefulness, or what Weingarten (2010) calls reasonable hope, sparked ideas of making sense of what exists in the present and embracing uncertainty within the journey. One mother explained this notion when she said, *“Some days there is hope and then some days you see disaster in the future.”* She continued to explain how she realized that *“it is just accepting that it is going to be what it is going to be.”*

The familiar story of hopelessness was initially constructed as a black and white concept with a far-reaching ideal of *“better”* and *“fixed.”* The re-authoring of hopefulness allowed for the co-existence of uncertainty and despair (Weingarten, 2010), and small measures of action rather than grand leaps of the ideal. Weingarten explained: *“reasonable hope is a humble hope. It allows reasonable goals to trump ideal ones”* (p.10). One parent described her re-authored telling of hopefulness:

“You realize there [are times of] hopelessness and small measures of getting better and getting hope and coming to realize you had to take those little pieces that were encouraging and go with them.”

In response to what it was like participating in the dialogue of the group, one father said, *“It opened up that there is a light at the end of the tunnel and it is not another train*

[laughing].” Coming together in commonality within the context of a collaborative therapy group, parents realized hopefulness. When situations might have seemed most dire, most bleak, some glimmers ignited and transformed into shifts that shed a new light on the telling of parenting a teen in relationship with substances.

Deconstructing Walls and Building Walkways: Creating Meaning

What meaning does the dialogue created in this collaborative group process have in relation to parents’ experiences of their adolescent’s substance use?

So far I have discussed what I have come to understand from parent participants in regards to what dialogue was constructed in a collaborative therapy group and how the dialogue was constructed. In the following section I describe what I have learned in regards to the overall meaning of the group interchange in relation to parent participants’ experiences of their son or daughter’s involvement with substances. I explain how the new narratives of parent participants changed how parents experienced their son or daughter’s substance use.

As I read and re-read the data, I interpreted the meaning of the group interchange as having an influence on parent experience that contrasted with the initial problem-saturated story parents had initially encountered. In terms of the influence of the generative dialogue, I learned that parent participants still experienced the changing landscape of the rollercoaster ride but they were no longer passengers hanging on and desperate to find an exit at a destination of “fixed.” Instead, parents described willingness, even strength, in being able to be in the moment of the situation. The re-authored narratives of the transformative dialogue meant that parents had, according to one mother, a “*shift in thinking*.” When considering the meaning of the dialogical process I interpreted this shift in thinking as having two qualities in terms of how parents experienced their son or daughter’s involvement with substances. One quality was what I would call a “release” and the second was a quality of “freedom.” I interpreted the quality of release to mean what they removed, or let go of, in terms of their experience with their teen’s substance use. I then interpreted the term freedom to mean what became available to them, or what was introduced in how they experienced their teen’s substance use.

I came to understand that through the group dialogical process parents were able to release themselves from positions within the problem-saturated narrative of the familiar story. The onus of individual responsibility was released. When these bounds of personal ownership were broken, parents became free to experience themselves in different ways. The re-authored stories of “this could happen to anyone” sparked freedom from blame and freedom to see themselves and their teens in different ways. When problem identity no longer absorbed parents in the pitfalls of pain and suffering, parents became free to navigate alternative positions of self in relation to adolescent substance use. They moved from seeing themselves as being the cause of adolescent substance use to resources of strength. One parent said,

“You are your child’s best advocate and you need to be vocal ‘cause [you] know your kid. You also have to accept the fact that your kid is doing something they shouldn’t do and that professionals know stuff but you do have to draw that line between I understand all of that and I am listening but you have to listen to me and I am telling you. . .you have to find your voice.”

Parents were able to release their relationship to the problem to the background of attention and bring to the foreground relationship with themselves, their teens, and other important people in their lives. One father talked about working to move past the original focus on the negative (the influence of marijuana on his son's life) and talked about freedom to have different kinds of conversations with his teen. The conversation was not about the gaping divide that marijuana had constructed but the common goals of the family. Noticing the shift in the focus on the problem, I went back to the transcripts and read new, or perhaps renewed, ways of viewing their children. In the transcripts I found parents describing their teens with words like, "*beautiful*," "*potential*," "*talented*," "*good*," and "*proud*." I also reviewed the transcripts and found words parents used to describe themselves, "*strong*," "*hard worker*," "*insightful*," "*confident*," "*good*," "*calm*," and "*important*."

Parents released themselves from the promises of a singular fix. Parents embraced a freedom to explore and become acquainted with numerous pathways and trajectories of change. Black and white ideals of singular solutions and benchmarks of "better" were replaced with descriptions of an experiential journey, or an "ongoing process of learning" and growth. Parents had shifted their gaze from the ruts of bleak pitfalls, to the momentary brilliance of small glimmers. One parent said,

"[I take] one day at a time, because you don't know. I have my good days and I enjoy them. That is the thing, take the good times, take the moments and don't try to wonder about what is going to fail tonight or this week. If you have a good weekend relish in it, don't look down the road. . .enjoy the good moments. Hug her, praise her, hug myself, praise myself, go to sleep early, enjoy the moments."

As a result, parent participants released the tensions provoked by negative descriptions of uncertainty and not-knowing and, by practicing acceptance and re-authoring hopefulness, parents became free to experience uncertainty of the ups and downs as an experiential process. Uncertainty had at one point meant powerlessness and hopelessness, and through the group interchange uncertainty had evolved and had become an invitation to embrace and revel in the present moment. Uncertainty was no longer something to be feared but something to be expected. Uncertainty became more familiar than the false promises of knowing. What parents had been subjected to in terms of dominant truths of knowing had led them down a path of defeat and pain; not-knowing raised the parent onto a platform of openness and fluid adaptation. One parent explained:

"We let go of the fact of how successful he will be, that depends on him, we can support him, but if he mucks up, and he likely will, that is okay, he has to go through the growing pains. I can continue to support him, but I don't need to hold on so tightly."

Having come to trust their instinct and the wisdom of their voices, parents released the notion of the expert outsider and embraced the direction of their own insider knowledge.

By entering into the context of the collaborative therapy group and the coordinated actions of relational being and meaning-making, parents experienced a release from isolation and the bounds of silence constrained by the impositions of the "walls." Parents felt a freedom to belong, to be heard, and to speak. Parents described not having to argue for their stories to be heard—they had been released from their solitary fight to be recognized. Freedom to be recognized, known, and validated flourished into feelings of importance and strength of voice. From their experience in the group parents

experienced a new energy to continue their efforts to sustain, to hang on, and not give up on their lives. “[I] can keep going,” said one parent, and “Don’t ever give up,” said another.

Summary: A Meaning-Making Occasion

“The kind of conceptual claim that you are striving toward is unlikely to be highly abstract, original, or metaphoric, but is one that will powerfully capture the important elements within the clinical phenomenon in a manner that can be grasped, appreciated, and remembered in the applied context.”

(Thorne, 2008, p. 169).

We live within a dominant narrative that promotes the destination rather than the process of the journey. We regularly encounter the notions of black or white, right and wrong ways of viewing problems and potentials. These narratives contribute to the positions we assume when we are encountering such problems and potentials. Further, when we have incongruent ideas of what the destination is, should be, or has to be, and when we view ideals from different lenses, our ideals become fortified walls constructed out of values, beliefs, and theoretical musings. As we strive for the various perspectives of “better,” “success,” and/or “fixed” we can, at times, find ourselves venturing the journey alone.

Within my inquiry I came to recognize and illuminate a dominant discourse of the parent experience of caregiving a teenager influenced by a relationship with alcohol and/or other drugs. Through the relational process of a collaborative therapy group, parents were able to construct new narratives and experiences of being a parent in this particular position. Dialogue constructed within a collaborative group offering was based on how parents came together within such an intentional context. Parents had gotten to a point where they were ready and able to join with others outside of the walls of isolated suffering. By sharing stories and hearing commonality amongst the group members, parent participants recognized themselves and their stories as having importance. The commonality of the shared story sparked relational conditions and coordinated actions of meaning-making as parent participants moved beyond singular selves and began to locate themselves in others as “us/we.” Additional perspectives began to ripple throughout the interchange serving as catalysts for what came to grow into re-authored tellings of each parent’s experience of adolescent substance use. As a result of the re-authored tellings, parents released taken-for-granted narratives and a familiar relationship with the problem-saturated story and developed new narratives about relationship with self, others, and their teens. Parents gave up the struggle to compete with ideals and mold to socially constructed expectations. Parents were able to realize life with acceptance and find comfort in the guarantee of the moment. Parents found that strength, relief, release, and hopefulness could occur within the absence of a solution and possibility and grow within a landscape of uncertainty. Accepting self and others helped draw hopefulness into reach and dissolved benchmarks of “better” and “fixed.”

When people have an opportunity to be heard and feel validated they feel more able to persevere in their lives, and not only persevere but flourish. I would suggest that this is certainly not earth shattering new theory or a radically unique postulation. However, by not trying to make problems go away or push to correct, we may help

parents to find meaning in their lives in more dialogical ways. By supporting parents to share what they want to talk about rather than directing content or structuring topics, parents might have opportunities to experience affirmation, importance, and belonging. When we expand substance use discourses and include multiple perspectives, helping systems might broaden the scope of ideas and practices within a parent's experience of adolescent substance use. When systems engage parents in collaborative, relational processes, and dialogical practices we invite parents to generate new realizations and make meaning—broadening the scope of possibility for how they were in the moment of their teen's substance use and imagining the future of how they saw themselves around substance use.

A significant aspect of an interpretive description inquiry is for the researcher to bridge findings to applied practice. It is my task to relay how collaborative therapy, dialogical practices, and relational processes might be used to inform helping services. As (Thorne, 2008) explained, it is not enough to engage in research and explain what understandings have been derived from the phenomena of interest. The research must endeavor to articulate how the “what” can be incorporated to clinical practice and the “so what” in regards to the importance of doing so. In the following chapter I share with you more about what I have come to illuminate about parents' dialogues within the collaborative group context and what this might mean for applied practice within formal youth and family substance use treatment systems.

Chapter Five: Interpretations and Discussion

As I considered how I wanted to bring life to this final section of my dissertation, I reflected on what I have included so far. Up to this point I have tried to express to you an understanding of how parents are influenced by adolescent substance use and dominant addiction narratives. I have shared what dialogue can be constructed through a collaborative group process. Further, I have explained my basis for exploring this particular topic and my philosophical leanings as a practitioner and researcher. Through each aspect of my dissertation, I have asked you to come along on a journey with me to learn, to critique, and to explore. I am now asking you to carry on with me and embark on a journey to imagine. In Chapter Five I draw together my literature review and research findings in an attempt to imagine what possibilities might be generated. I articulate for you the importance of acknowledging the parent voice and options for influencing systems involved with parents and teens.

As I began to write the final chapter of this story called my dissertation I felt a weighted responsibility. I recalled the many hours parents graciously offered to sit with me through research interviews and the rich texts of personal experience and intimate reflection. I pictured the faces of the parent participants and thought about how I could translate the importance of their voices and the messages of their words. At the conclusion of each parent interview, the parent participants expressed wishes for their words to matter—hope for their participation to have meaning for others. I write this chapter to continue to author the re-authored tellings of how clinical practice can be influenced and existing structures changed. Just as parents had shared with me the narratives of “you realize,” I wrote Chapter Five to share with you concepts that *I* realized.

My Inquiry in Relation to Existing Literature

Through the process of developing my dissertation, I have come to recognize the impact of the mixed messages and dissonant dichotomies of adolescent substance use conjecture. I have witnessed what dialogue develops when parents enter into a collaborative therapy group and how parents are influenced by this. I have learned how to bring utility to social constructionist philosophy within relational processes that coordinate actions and opportunities for meaning-making.

Ungar (as cited in Sanders & Munford, 2008), suggested that social constructionist ideas can be utilized to contribute to additional understandings of youth substance use. Through my studies of social constructionist literature I have come to understand knowledge as being made within social, cultural, and historical contexts. As a result, I demonstrated a clinical practice that embodied a relational perspective and perseverated on what people can do together and what realizations and meaning this can spark. Relational processes create the conditions for transformation amidst adversity. Through my research I have been privileged to witness the generative potentials of connection and conversation.

Logical Positivism.

When I initially entered into my research inquiry, I was specifically interested in what dialogue parents would generate without the bounds of a psycho-educationally orientated script or pre-determined agenda. I wanted to hear parent voices and understand what those voices together might create. As I described in Chapter One and Chapter Two, the parent voice is often silenced by blame, societal stigmas (Jackson & Mannix, 2003), and expert-based directives of fix and solution. Parents are not consistently engaged as conversational partners and collaborators in substance use services (Copello & Templeton, 2012).

As I started to write this section a colleague came into my office. He smiled as he handed me a book he had found at a garage sale. I scanned the front page and noticed the smiling face of a parenting “expert” and words such as “solutions” and “answers” dotting the title. With almost 700 pages, the book offered “steps,” “strategies,” “answers,” “styles,” and “solutions” for “every” childhood challenge a parent could encounter. I read through the book and marveled at the many pages of advice and endless monologues of solution. I skipped to the last pages in the book; I typically like to read the last pages first, looking to find the section titled “What if?” “What if” the advice does not help, “what if” the solutions are not relevant, “what if” the issue or challenge is not written about? I starred flatly at the last chapter realizing that it was a continuation of advice and directive for the final alphabetized list of childhood challenges. There was no chapter to account for “what ifs” or “what else.”

Although I believe conventional literature has offered significant insight and provocative perspectives regarding parenting and adolescence, the narratives claiming truth and expert knowing perpetuate problem positions in the face of “what ifs.” Instead of proposing “options,” parents are often given “solutions.” Unfortunately the implicit message in having an answer or a solution is the notion of right or wrong ways of addressing a concern as well as successful attempts and failed attempts to broach such concerns.

Logical positivism, as described by Ken Gergen (personal communication, April 8, 2013) or rational empiricism is inherited through exposures, education, and accumulated truths constructed by the progressions of science. As I described in my literature review, parents are exposed to taken-for-granted understandings and discourses of how we have come to generally know adolescent substance use. Medical discourses purport substance dependence as being an illness of the individual (Hart & Ksir, 2011; Maté, 2009; Morse, 2004), moral perspectives attribute addiction to bad choices (Bickel & Potenza, 2006), and social theories correlate behaviour with family, environmental, community, and other social contexts (Di Clemente, 2006). Traditionally dominant ideas have cause and effects correlates and related practices for intervention and treatment. Jackson and Mannix (2003) identified constraining impacts of strong societal messages of how to explain and respond to adolescent substance use. What I had heard from parents in their descriptions of “hitting a wall” and in the “familiar story,” brought to my attention that logical positivism and claims of cause and effect contribute to the silencing accounts of bad parent, at fault, and problem-focused scripts.

Dominant understandings of adolescent substance use impact parents who seek formal resources. When I constructed my findings I was struck by parent descriptions of difficulty and challenge accessing adolescent substance use services. In his research to understand parent experiences of formal service programs, Choate (2011) also identified the phenomena of what I came to call “hitting a wall.” He too explained that parents felt excluded from formal services and muted from the process of sharing and exchanging information. As a result parents felt isolated and burdened by shame and guilt. I also heard that the parent voice had been silenced by such constraints.

The descriptions I had heard about hitting the wall represented depictions of what I interpreted as therapeutic violence (Tomm, 2010). As described by Karl Tomm (2010), therapeutic violence closes dialogical space by asserting judgments and assumptions that the person accessing services is incapable, wrong, and mistaken. Therapeutic violence has a constraining effect experienced by the acts of exclusion, shaming, and blame—blockades assaulting access to dialogue. I learned from my research inquiry that collaborative group practices bridge commonality and inspire relational practices that allow people to free their voices by breaking down walls of isolation and truth claims. The language used to describe the group experience was what Tomm (2010) refers to as therapeutic love—opening space through empowerment and liberation of restricting elements.

The Familiar Story and The Re-Authored Telling.

As I described in Chapter Four, when I asked parents to share conversation they participated in during the 6-week group process, I heard examples of what I came to call the “familiar story.” When I referred back to my literature review I noted that the “familiar story” is not unfamiliar in the existing literature. The initial tellings of the ups and downs and the pitfalls encountering adolescent substance use were congruent with a number of current research studies (Butler & Bauld, 2005; Copello & Templeton, 2012; Jackson & Mannix, 2003; Orford et al., 2010; Usher et al., 2005; Usher et al., 2007). The descriptions of isolation, guilt, helplessness, anger had been previously reported (Butler & Bauld, 2005). The toll of these experiences had been identified by Usher et al. (2007) who found that parents get to a “point” where they needed to reach out for their own self-sustaining support. Orford et al. (2010) described isolation, worry, fear, and uncertainty in their summary of nine studies from Italy, Mexico, England, and Australia.

My research offers unique insight into how collaborative clinical practices might facilitate the development of narratives beyond the “familiar story.” Harlene Anderson (2012a) described language and knowledge as being social, relational, and inherently generative processes. By coming into the relational context of a group process, out of the isolation of powerlessness, helplessness, and guilt for example, parents began to generate different narratives for how to view and respond to adolescent substance use. These narratives were counter-stories to the familiar dominant narratives and released the parent from the notions of “fix-it,” and silencing constraints of blame. Parents were able to free themselves from the uncertainty of the rollercoaster while embracing the hopefulness of small glimmers offered in a moment. Parents were able to move away from cause and effect, and identify with multiplicity and possibility. As a result, parents experienced a freedom to voice their own perspectives, ideals, and selves in relation to substance use.

My study offers an important understanding of what dialogue parents construct and what meaning this dialogue has on their experience of their adolescent's involvement with substances. Descriptions of the re-authored tellings of that which parents realized and the meaning of release and freedom of such realizations offer the substance use treatment field examples of what narratives might be generated within the context of collaboration, relationship, and through the opportunity to be heard. Despite the availability of a vast array of literature offering promises of cause, effect, answers and solution, if given an opportunity, I learned that parents can and will create their own answers.

Group Therapy.

Parents are recently being recognized as important contributors to the outcome of adolescent substance use treatment (Copello & Templeton, 2012; Liddle as cited in Usher et al., 2007). Despite this acknowledgment, limited information is available to describe how adolescent substance use services might engage and support parents and caregivers (Jackson et al., 2006). Through my inquiry I have come to learn about possible means to address this lack. I learned from parent participants that collaborative group programming can be a resource for therapeutic support.

Forsyth (2000) explains that "although individualism is the hallmark of Western thought, group-centred approaches have suggested that members' sense of self and identity changes when they become members of groups" (p. 4). When identity is challenged by dominant discourses alluding to deficit, blame, and individually-focused problem-saturated perspectives, interpersonal relations within a group context and coordinated actions of group members foster alternative descriptions of the self, the family, the adolescent, and so on.

Practices that serve to create relationships are important, specifically in response to the isolation identified in the parent experience. Choate (2011) indicated that parents feel more comfortable connecting with people who share common experiences. Orford et al. (2010) also found that parents valued support from others who had been through similar experiences. The parent participants in my inquiry spoke strongly of the influence of commonality and acceptance, particularly in relation to developing transformative narratives and what I came to understand as release and freedom. My research supports findings by Burlingame et al. (2004), and Piper et al. (2011), who also came to report that cohesion, commonality, and belonging draw people from individual distress into relational connection. Similar to the aforementioned studies, my research supports the utility of group therapy in terms of being a practice for developing conditions for therapeutic process. As a result of my learning, I believe that a collaborative approach to group therapy can contribute to dialogical and relational conditions that alleviate the experience of shame and stigma of parenting a teen in relationship with substances.

Through my inquiry I came to recognize that conditions contributing to transformative dialogue are developed through shared experiences and collaborative and relational practices. My findings were very similar to findings reported by Levac et al. (2008) who also identified that a group atmosphere that nurtures acceptance, empathy, and safety, provides the conditions for developing dialogue and generating change. By experiencing such conditions, parents developed unique narratives for their experiences

of their teen's substance use. Emerging from the binds of isolation and the exhausting pursuit to circumnavigate the "wall" and the "pitfalls" of the rollercoaster, my study brings to the academic and professional community dialogue that parents co-created in the face of such experience, and the meaning of release and freedom associated with such re-authored tellings.

Primarily, group processes within the adolescent substance use field have quantitatively examined structured, psycho-educational and recovery based self-help group approaches. I offer you a unique account of an in-depth qualitative study and elucidate experience in a collaborative group process. I show that without a predetermined agenda, dominant theory driven directives, or specific measurable outcomes, parents describe therapeutic benefit and transformational change. I show that a group dialogical process can contribute to what parents develop as answers, ideas, and realizations in regards to their experience of their son or daughter's substance use. I identify that parents and practitioners can work together in partnership to foster interchange and meaning-making opportunities. My study is the first study to qualitatively explore a dialogical, collaborative therapeutic group process with a specific population of people traditionally underserved and underrepresented within the substance use profession.

In regards to current literature and conventional understandings, my inquiry was not so much about distinguishing like and unlike in terms of group processes and technique. The dialogue constructed in the group process is not a reflection of a generic process. My research was not about operationalizing a technique but expressing a value about a particular population. I identified how collaborative group practices offer a possibility in terms of how the youth substance use field might work with parents accessing services. I demonstrated how relational practices can be used to contribute to the generative transformation of potentials in what has been scripted in the dominant narrative to be an isolating and exclusionary experience. I do not offer a universal script, but an opportunity to shine a light on an isolated population—illuminating glimmers within a dynamic process. I believe that this unique way of working with parents and the constructed dialogue is contextual. Although I heard some very similar themes as noted in previously identified research efforts, I believe that the possibilities for dialogue and unique accounts of re-authored narratives are limitless. I think there is much to learn about the uniqueness of each parent and parent conversation. From Harlene Anderson (n.d.) "the invitation is to learn about the distinctiveness of others and their lives directly from them and see the familiar or what we take for granted in an unfamiliar or fresh way" (p. 4).

Clinical Application: How Can we Create a Relational Discourse in Youth and Family Services?

"Lives are built, so we had best become good craftspersons with the other worldly actants in the story."

(Haraway as cited in Frank, 2012, p. 145).

An important aspect of offering an interpretive description inquiry is to translate what knowledge has been constructed to clinical application. To identify phenomena of

interest without interpreting relevance limits the potential of bringing utility to what has come to be learned. Interconnected with my interest in social constructionism is my interest in social change. “We are curious about what sorts of worlds can be made possible through particular forms of interaction, particular ways of talking and acting” (McNamee, 1994, p. 3). In the following section I have allowed my interest in research, my commitment to practice, and my desire for social change to merge. I offer you recommendations and visions for the broader adolescent substance use system and the youth and family substance use practitioner.

Responsive Systems.

As a result of my experience with the *Recognizing Resilience*¹¹ process, I have learned that in order to support parents of teens involved in substance use, the broader system of care must be responsive. Responsiveness requires a shifting from an individualized perspective in which one adjusts to the system, to a consideration of how the broader substance use treatment system adjusts (Ungar, 2011) in response to the parent. Ungar (2011) suggested that systems demonstrate responsiveness by being both available and accessible to client populations.

Availability.

Availability is an important aspect of a responsive adolescent substance use system. Available support would include support for parents who have a teen that either is, or is not, actively involved in existing system support. At any point on the “rollercoaster” parents should be able to access a menu of service options that include information, education, counselling, and individual, group, and/or family therapy.

Perhaps one of the most concerning aspects of what I heard from parent participants was the degree of isolation and powerlessness associated with their experiences of adolescent substance use. Formal resources can be constructed in a way that invites relational being by intentionally facilitating relationships with and amongst parents and caregivers. Offering collaborative therapy group options can counteract one of the most significant barriers that the parent population encounters while allowing for familiar stories to be exchanged and acknowledged as important and valid. Coming into relationship, either within a group or an individual counselling dynamic, pulls apart the brick wall of systemically influenced isolation and stigma.

¹¹ While writing my research inquiry I came to consider more carefully the title of the collaborative group program, *Recognizing Resilience*. Michael Ungar speaks to the construct of resilience and offers an alternative telling to a static and individualist tale. Instead, Ungar (2011) described the concept of resilience as being contextually influenced by the social ecology of community. This lens for which to consider resilience moves focus from a traditional individualized perception of health to a broader social and relationally influenced conception. The title of *Recognizing Resilience* is reflective of coordinated responses amongst system, practitioner, and parent in efforts to enhance resilience by developing more sustaining social processes.

Availability can also be enhanced by eliciting parent feedback in regards to program delivery and efficacy. Further, by developing programming that is contextually relevant, systems may be more available to mitigate harmful social aspects of adolescent substance use and caregiver distress including, community stigma, discrimination, and exclusion (specifically in school, justice, and health settings).

Accessibility.

Responsiveness can also be reflected in the degree of accessibility of formal service systems. During my research interviews, all of the parent participants had indicated that they wanted, and were ready, to receive support. However, the parents explained that until they had encountered the *Recognizing Resilience* group they had not been able to find support for themselves. Many had to navigate a number of complex pathways in order to find a resource in their community. Some parents described having previously accessed individual counselling resources, however they found difficulty being able to regularly attend due to a conflict with service office hours and their work schedule. By incorporating options for accommodating the parent work schedule and advertising programming in readily available community resource materials and venues, systems may broaden their reach to the parent audience.

In order to increase accessibility, system stakeholders might question, “What gets in the way of dialogue?” Exploring such a question might require broader systems to consider the aesthetics of practice, or the way in which people are or are not accessing services. Everything we do or say is an invitation to the other and creates meaning within the coordinated actions of performances. Gestures of accessibility and availability implicitly suggest a regard of importance for this particular parent population. In addition, such gestures offer a counter-narrative that stands up to secrecy, isolation, and blame.

A System Way of Being.

System responsiveness also includes an important aspect beyond the “what to do” in terms of increasing accessibility and availability. The parent experience of “hitting the wall” can be influenced by “how to do” what to do—an overall system way of being. This requires broader systems to consider how dominant theories inform taken-for-granted practices with youth and families, while questioning how such taken-for-granted practices build walls of isolation or create paths for inclusion.

Part of the challenge, however, is that dominant practices of systems, practitioners, and client populations are largely structured as a hierarchical composition built with system stakeholders at the top, client populations at the bottom, and dominant substance use constructs as scaffolding framework. Operating from a set structure with rigid frameworks can be relationally and fiscally constraining, limiting collaboration, polyvocality, multiplicity, and meaning-making. Moving from individualized practices means developing egalitarian relational practices in which all parts of the structure are recognized as interconnected and influenced by and contributing to the other—a conception of “us” (Gergen et al., 2001, para. 32). Leadership, government, and academic communities can collaborate with parents as teachers and allies, versus adversaries, while

supporting practitioners to engage as learners and partners. The parent voice can be privileged by opening dialogical space for parents to share what is important to them and encouraging parents to be active participants in the development of re-authored tellings and meaning. In addition, including parents as contributors in the development of programming and therapeutic resources would allow for the construction of relevant knowledge and understanding. This requires such communities of practice to become gentle, not because parents are delicate but to nurture the space required for the parent voices to be heard.

Ken Gergen (personal communication, April 8, 2013), suggested that drawing from multiple discourses prevents dominant discourses from being crystallized. As I noted in my literature review, evidence does not exist concluding that one theory of addiction is superior to another. As a result, systems have an opportunity to move from positions of certainty and develop tolerance for holding multiple narratives. Considering multiplicity in terms of substance use knowledge, theory, and treatment efforts expands applicability and relevance to accommodate the diversity and unique contexts of client populations, while expanding the current scope of ideas and practices within conventional traditions.

If we are to shift the familiar story of the parent, we also need to shift the dominant or familiar story of the helping profession. Systems can become appreciative allies reflecting insider knowledge. The walls of powerlessness and helplessness can be toppled by engaging and working with parents as resources as opposed to the problem to be fixed or the cause to be constrained. Further, as I have previously shared, words create worlds. The broader community of helping professionals and leaders need to pay attention to the words currently used within dominant lexicon of substance use practice and wonder about the implications of these words on the youth and families accessing services. As innovators of substance use practice it behooves us to contribute to discourse in ways that build new narratives constructing parents as competent partners.

Responsive Practitioners.

I think in many ways it is difficult to witness the pain and suffering of the parent. The story of the rollercoaster and descriptions of pitfalls might challenge helping professionals. When we hear these stories we often want to fix. When I am working with a parent who is expressing hurt and pain, I want to take it away. I want to offer a sure fire best fit strategy that will alleviate the “problem” and that will allow me and the other to feel better. However, I realize that one approach does not work for everyone, and approaches that are designed to alleviate my sense of discomfort and responsibility are likely to contribute to stigma and shame, and perpetuate problem narratives. I have come to learn that sometimes attempts to take away the pain of others can contribute to the bounds of silence.

As I was facilitating a recent cohort of the *Recognizing Resilience* group I noticed that I had a reflex. When I would hear someone describe pain or discomfort, physical or emotional, I would immediately begin to form a response to offer. Sometimes these responses were simple reflections, sometimes questions to elicit more detail or to shift the thinking, sometimes I would offer a statement of empathy or even an idea to soothe. I realized that upon offering such gestures I was left with an empty uncertainty and a

disquieted void. Thinking carefully about this reflex, I realized that these responses, although well-intentioned, were empty promises of a fix—superficial offerings of I wish I could make this better. When I felt the tug of “I wish I could” I was mindful to not impart but to bear witness—to be “with” as opposed to be “for.” By being with and listening, parents in the group context began to hear themselves and others in different ways. Uncertainty transformed into a catalyst for strength and perspective—a rich dialogical space for the growth of meaning and possibility.

When I talk about my experience with “wish I could,” or in regards to eliciting the parent voice, I am not suggesting that the practitioner withhold responses of empathy or abandon knowledge (Gergen & Gergen, 2010) that might be of use for parents. I am suggesting that the practitioner be aware of his/her intentions and acknowledge whether responses are based on one’s own agendas and engrained discourses of fix and solve, or are based on developing dialogical possibilities and collaborative conversations. How system stakeholders and practitioners position themselves in relation to parents either opens or closes (Tomm, 2010) dialogical space. Karl Tomm (2010) suggested practitioners can more intentionally consider their involvement in helping relationships when they are aware of taken-for-granted practices and approaches to service provision.

Not only do I believe that it is important for practitioners to recognize their own responses in relation to parents but I also feel it necessary to recognize the parent response in relation to adolescent substance use. In the research interviews, experiences of loss, grief, anger, and shame had significantly shaped the stories of the parent participants. However, many of the parents had been so focused on their own teen’s experiences or felt consumed by the shadows of secrecy and guilt that they had not yet spoken about their own experiences. Practitioners can mitigate the bounds of isolation, singularity, and silence surrounding the parent experience by inviting dialogue with the parent. Practitioners can draw out the parent voice by privileging “local knowledge” (Anderson, 2012b, p. 11), the wisdom, expertise, and knowledge of parents accessing services. Practitioners can spend time hearing the parent story, validating, and recognizing their experiences of adolescent substance use. As Gergen et al. (2001) suggested, “self-expression is vital” (para. 19) and “because meaning is born in relationship an individual’s expression doesn’t acquire full significance until supplemented” (para. 21).

The landscape of service tends to place youth at the foreground and parents at the background of therapeutic treatment interventions. I think that when parents are stuck in the experience of having to argue with others for validation and recognition, the perception of “problem” becomes bigger—the problem becomes as large as the fight is to be heard. By engaging in a dialogue that allows for the uninterrupted telling of experience, the fight to be heard disappears and the ability to listen and re-conceptualize grows. I believe as practitioners if we begin to look through a lens of parent experience we might magnify the distant viewing of parent and bring to the foreground the importance of engaging parents. When I started to look through this lens I began to see the parent experience of isolation and the toll of the familiar story. Looking through this lens piqued curiosity about parent experience and an awareness of responding to parents if and when they get to a point of requesting service for themselves.

Looking through such a lens will not, for some practitioners, mean that they can or will engage parents in youth service delivery. However, by gazing through such a lens, the practitioner will be provided with an alternative perspective regarding his/her own values, beliefs, and ideas about parent and family systems. Ken Gergen (personal communication, April 8, 2013) said, “Don’t let any story be dominant.” He explained that when we look through a different lens we yield different results which may be useful.

Collaborative Practice: A Practice Stance.

Collaborative practices can be utilized to open space and generate dialogical shifts with parents accessing formal adolescent substance use programming. Throughout my dissertation I have spoken to the philosophical and practical descriptions of collaborative practices. Collaborative practices ignite partnered interchange, in turn constructing mutually engaged back and forth dialogue. Dialogue becomes the vehicle for authoring new ways in which to view and make meaning of adolescent substance use. The back and forth dynamic of dialogical processes promote opportunities for participants to both voice and to hear.

As practitioners we can engage parents as “active participants in constructing their worlds” (Anderson, 2007, p. 13). Through generative and emergent dialogue and collaborative two-way exchanges, practitioners and parents can shift the onus of fix and weight of responsibility from the individual person, to what emerges from the dialogical processes. Madsen (2007) explains that interactions between practitioners and parents “can inadvertently invite the enactment of pathologizing and constraining life stories and can also invite the enactment of liberating and empowering life stories” (p. 7).

Collaborative practitioners demonstrate a willingness to hear. While attending a workshop, I heard Sheila McNamee used the term “generous listening” (personal communication, June 3, 2013). So often as practitioners we enter into sessions with explicit and implicit agendas detailing how, and in what ways, we will attend to distress. When a practitioner generously listens, the practitioner tries to understand the other without asserting an agenda to reach a benchmark or ideal destination of fix or solution. I have come to realize from the freedom of being heard, appreciated, and accepted, parents create their own pathways or destinations of resolve. I now understand that there is no one particular way to explain an experience. As practitioners we can engage in different kinds of conversations with parents accessing formal resources. We are all different story tellers and tell our stories in unique and different ways. In practice the collaborative practitioner might try to suspend assumptions and ask, “How can I be curious about the experience of others?”

Collaborative practices involve a way of being translatable to both group and individual contexts. Through my research I recognized the influence of collaborative therapy and the shift from singular being into relationally engaged participation. Relational practices stood out in my inquiry as important and influential qualities of the collaborative dialogical process. Parents referred to such practices as a way of being amongst the facilitators and others in the group without the pull to change, convince, or persuade, but really to appreciate and honour the other. Whether in group or individual programming, the practitioner and broader system can also offer the collaborative

relational practices by being with and non-judgmentally witnessing and hearing¹² the parent experience.

Harlene Anderson (n.d.) provided additional descriptions of how practitioners might also demonstrate a collaborative way of being. She suggested that practitioners can take a learning position giving clients a choice to tell their story while listening and responding to what the persons are saying and not what the practitioner thinks they should be saying. She recommended that practitioners embrace insider knowledge, trust uncertainty, and take a not-knowing position in order to privilege local knowledge and wisdom. She highlighted the importance of manners, humility, flexibility, and authenticity. St. George and Wulff (as cited in Anderson, 2012b) said, “The beauty of collaborating is that there is no set roles; there is flexibility and fluidity that allows for leading and following to be in motion” (p. 14). When practitioners demonstrate a collaborative way of being that sparks curiosity, relational practices, back and forth interchange, and generous listening, parents have an opportunity to participate in the partnered construction of new dialogical realities.

Menu of Options.

I do not believe that collaborative therapy will be a best fit for all, nor do I think that group programming is essential for all parents encountering adolescent substance use. I do not propose to have *the* answer and I do not feel that any one institution of knowledge has *the* answer either. I do not think that cookie-cutter and standardized techniques will be of therapeutic benefit to everyone at all times. I think that when systems promote singular ways of practice, investing time, money, and personnel, that there is a risk that not every person will experience the same measurable outcome or achieve an idealized benchmark of change. As a result, I believe systems become overburdened as needs are unmet and people remain in programming for longer, drop out, and/or frequently re-access with increased frustration.

I have come to think that when systems collaborate with people accessing services to develop multiple ways of practice, or a menu of service options, that clients and practitioners can more effectively develop relevant approaches, methods, and outcomes. Although this might sound like more work to facilitate on the front end of service delivery, I think that by spending time listening to clients at the outset of services that system strains will be reduced over the long term. Further, I think when systems loosen their grip on claims of Truth in helping practices that services may more readily adopt a plurality of perspectives therefore becoming more available to facilitate alternative possibilities and potentials for youth and families.

¹² As I wrote this I recalled a conversation I had with a parent after one of my research interviews. As she shared some advice for practitioners and substance use systems, she explained that, for her, the most important resource that she could be offered was the resource of being heard.

Conclusion.

Through my inquiry, I studied a collaborative group program that demonstrated transformative potentials of relational practices and processes. The philosophical influences that inspired the conditions for collaboration, multiplicity, and acceptance, are not born out of technique but out of a way of being. I believe that it is important to make meaning of this inquiry beyond a recipe-ordered technique for “how to” and “when to” work with parents. I believe that the helping professionals including those individuals who constitute the larger body of social services have what Sheila McNamee (personal communication, June 3, 2013) calls conversational resources. Like I said, I do not think we need to start instituting or standardizing group methods but accessing what already exists that allows the community of helping professionals to be with people in a way that co-ordinates multiplicity, that emphasizes willingness to hear, and that precludes isolating practices.

Limitations and Future Inquiry

I am closing my dissertation with a lot of useful insight and understanding that has, and will continue, to impact my work with parents, youth, and practitioners. However, with this additional insight and understanding have come many, many questions, new ideas, and a lot of curiosity. As I think about what knowledge I have articulated in my research findings I am aware of two specific limitations. One, I drew a small sample of parent group participants from a limited number of group cohorts. Therefore I am curious what additional information might have been constructed had I interviewed parents from more than two cohorts of the *Recognizing Resilience* group. What additional dialogue would be constructed within the unique relationships from additional cohorts? In what ways might these be similar and distinct and how might additional knowledge be used to inform practice? Second, because I was a facilitator for both cohorts and an active member of the dialogical process, I wonder what conversation and meaning might have been generated with different collaborative practitioners.

Recognizing such limitations, I would like to continue the research inquiry I started with the *Recognizing Resilience* participants. Specifically, I am interested in revisiting the parents from my research inquiry and continuing a conversation. As dialogue continues to shift and evolve, ever changing and transforming, I am curious about how the re-authored stories continued to take shape as parents left the context of the group and continued to navigate the experience of parenting. I wonder about how the re-authored narratives have influenced the familiar story of the family and the experience of the adolescent. I am also very interested in continuing to elicit responses from future participants of the *Recognizing Resilience* group. I would like to explore how the dialogue shifts and changes based on who, when, where, and why people enter into the dialogical opportunity. I am also very interested in understanding what dialogue is created in a collaborative group with parents influenced by other problem-determined contexts such as adolescent mental health, chronic disease, and disability. I am interested in exploring collaborative group programming with caregivers of adults in relationship with substances. In addition, I hope to continue to elicit conversation with parents and

caregivers involved in helping systems. I would also like to engage in dialogue with practitioners about their work with parents and their experiences of the “wall” and pathways to increasing inclusion in community and formal services.

When I thought about future research I also considered a broader global picture. I would like to explore what narratives might be developed from group processes outside of the Western cultural contexts. I would like to inquire about the relationship between a society’s cultural framing of the “problem” and what narratives are constructed in dialogical processes.

Mutual Transformation

I have been influenced by my research inquiry and the learning processes that have surrounded the construction of my dissertation. Had I neglected to acknowledge this influence, I would have grossly neglected the mutually transformative process I have been privy to. Harlene Anderson (2012b) said,

Therapy is a mutually transforming process for all members. Each person is under the influence of the other(s); hence, each is at-risk for change. The process is not a one-sided, unilateral therapist-driven activity, nor is a therapist merely passive and receptive. A therapist is actively involved in a complex interactive process of continuous response with a client, as well as with his or her own inner talk and experience. As conversational partners we continually coordinate our actions as we respond with and thus affect each other. (p. 20)

As a result of my PhD journey, I have come to look at the world in a very different way. I have learned that realities are shaped and influenced by our interactions with others and that communal interchange influences how we come to view and experience our worlds. I have come to question existing knowledge and institutions of understanding, and have begun to imagine how additional possibilities might be constructed. At times this ongoing critique can be overwhelming and seemingly futile, yet I have also experienced this as both liberating and hopeful. In the following section I share reflections of what professional and personal transformations have been inspired as a result of my learning.

Provoking Dialogue with Practitioners and Other System Stakeholders.

My understandings of social constructionism, dialogical processes, collaborative therapy, and of the method of interpretive description have sparked a perception of self as an agent for social change. Instead of positioning myself as a passive recipient to the bounds of reality, I have positioned myself as an active participant in the construction of reality. I have questioned taken-for-granted knowledge and practices, and become much more open to hearing and learning about additional ways of knowing and understanding. I have become willing to hear perspectives and able to be curious about those situated in a stance of hard and fast truth. My openness and concomitant critique have particularly influenced how I conceptualize myself as influencing change in my professional practice.

As a result of my learning, I have come to realize that my focus on developing conversation with parent groups should not preclude developing dialogical processes with practitioners and system stakeholders. I understand that as a collaborative practitioner I can translate my philosophical assumptions to therapeutic, social, education, and

community systems. For me, this has meant participating in communal dialogical processes co-creating knowledge. In order to do this I have started to explore questions with my colleagues and peers and have begun advocating for multiplicity and collaborative practices in service design and delivery.

When broaching system stakeholders I have also begun to consider how I respond as an ally versus adversary in social change. I loved this quote from (Ellingson, 2011): “To reach practitioners, policy makers, social commentators, and other stakeholders, we must engage in meaningful dialogue—a process that requires us to listen as much (or more than) we speak” (p. 435). From this quote I was reminded of what I have worked so hard to embody with parent populations and how I can translate this way of practicing to my work with practitioners and system stakeholders. Being tentative, polite, able to share and willing to listen are all qualities I will strive to demonstrate within my ongoing practice. I have learned that I do not wish to stand from a position purporting truth and knowledge claim, but want to demonstrate a way of being that elucidates curiosity and inspires resources that directly influence people.

Although I have specific ideas and understandings to offer, I also have numerous questions to evoke mutually inclusive creative ventures. Questions create worlds, according to Jim Lord (2011), and I have many questions that, when posed, might generate additional ideas and possibilities within youth and family substance use programming. Some of the questions I have come to consider are,

- How can we create collaborative practices in youth and family substance use treatment?
- If we were to suspend individualist beliefs in counselling and research practices how might we move in our work?
- Within substance use treatment systems are there ways of focusing on processes that create relationship and the construction of additional possibility?
- Can we take what might be thought of as negative and transform this into a different perspective? How can deficit discourse as a language become optional?
- How can we create/craft more generative conversations in clinical practice?
- How can systems privilege the voices of parents—evoke the parent story?
- How can systems privilege the voices of practitioners as researchers?
- What story is influencing our narratives about how we understand clinical practice and research concepts?
- How can we blur the boundaries of positions in clinical practice and inquiry?
- If systems were open to collaborative clinical and research practices, what might it be possible to create?

I hope to continue to generate questions with which to start dialogue with systems, practitioners, and students. I feel a responsibility to ask questions in order to open the dialogical space to carry the voice of the parent and importance of the parent story.

Engaging the Practitioner as Researcher.

When I entered into the initial development of my dissertation, I recognize that I wrote from the position of practitioner. To imagine myself as a researcher seemed

unfamiliar and far-reaching. Research seemed to be guided by complex structures that were privileged to only those belonging to a certain community of knowledge and know-how. However, when I interpreted the philosophical notions of social constructionism to my work as practitioner and researcher I began to see that the boundaries between the two could be blurred and that the two positions were not exclusive. I used my skill as a practitioner to better inform my role as a researcher and I used my learning of research to enhance my curiosity as a practitioner. I have come to recognize the importance of inquiry in clinical practice and the insight that can be derived from the front-line position of the practitioner.

At one point in my inquiry process I felt that my voice as a practitioner was constrained. During my ethics review process, I philosophically disagreed with the ethics panel's understanding of practitioner and researcher as operating from distinct and separate roles. I have come to experience counselling practice as a process of curiosity just as I have witnessed research as therapeutic. Further, I am inclined toward a stance that the separation of researcher from practitioner objectifies the research subject as being sources of information—limiting the research process to a method for gathering knowledge without the possibility of impacting research participants in a therapeutically meaningful way. The objectification of the research participant creates a distinct dichotomy between the researcher, and for example, parents as objectified researched subjects (Sprague, 2005). I believe this dichotomy contributes to the continued construction of helping professionals and researchers as having expert knowledge and in turn power over vulnerable populations. Upon considering the relational interaction and influence of research participant and researcher I have come to see the two as connected, not distinct. As described by McNamee (1994), “Both the researcher and researched contribute to the realities that are constructed, and consequently intervene in each other's lives” (para. 21).

I have come to believe that the broader discipline of youth and family substance use service can be enhanced by privileging practitioners to participate in practice-based research endeavors. By demonstrating interest in response to practice questions, practitioners can utilize qualities of curiosity and wonder in order to inform formal resources. Conventional research practices are structured similar to the structure of hierarchical social service organizations. Academia, stakeholders, researchers are positioned above the practitioner and person accessing service and knowledge is disseminated down the line, touted as best practice and evidence-based knowledge. Just as I suggest that we paradigmatically unite with people accessing services as allies, learners, teachers, and partners in care, I also suggest that we unite with practitioners as resources for informing and enhancing system knowledge. I do not think research practices should be viewed as a distant activity but as an activity that can be incorporated as a regular practice by those privileged to work directly with client populations (McNamee, 2000).

Stephanie McCune.

As I wrote this section I thought of what I had learned from Mary Gergen (personal communication, April 8, 2013) about the concept of the multi-being. Mary drew a butterfly image and explained that one of the wings was made up of many

relational encounters over the span of one's life. The other wing was made up of the other, another person who also had been formed by relational encounters and processes. The body of the butterfly was the relational process of the two coming together and the capacities constructed through the interaction. Each relational encounter impacted the self, influencing, affecting, changing, growing, and developing into the multi-being—a coming together of our relational processes.

When I think of my interactions with the parent group participants I imagine the many ways that I have been influenced by the interaction. I feel tremendously honoured to have shared in the parents' private experiences and to be witness to the unfolding narratives in the group process. From the wisdom of the re-authored tellings I have also realized my own voice, the concept of "we," and hopefulness. I think of myself as a mother and what these tellings have meant for my own experiences with my son. I imagine how these realizations have influenced my ability to be with others. I think about how I have come to be a bit kinder, a bit more patient, and bit more compassionate in everyday, ordinary situations. I see myself as connected to, rather than separate from, the people and places I encounter.

Instead of viewing my surroundings and encounters from a lens in which knowledge is stagnant and fixed, I have come to recognize my world as fluid, ever changing, and constantly shifting. This idea came to light during an experience taking my son to see a fireworks show. The sky was alive with colourful explosions and gut-felt bangs. As the show came to an end I noticed curls of dark smoke drifting along the horizon—empty shadows of momentary brilliance. "The show is over" I thought, as I started to think of packing up and getting away from the crowds. However, when I looked down I saw my son. His eyes were turned up to the sky still holding the full glory of the display—mesmerized by the now empty sky. The finale never came as in that moment, watching my child, the brilliance of the show continued on. I have let go of finales and come to view experiences as ever-forming and ever-changing, evolving and transforming from one moment to the next.

In Closing

Closing my dissertation is a strange experience. For 2 years I have immersed myself in learning. I have been profoundly moved by social constructionist philosophy and have challenged myself to understand my world in a way that is much different from anything I have ever learned before. I have had intense moments of excitement and also moments of vulnerability and uncertainty. In one breath I have been passionately drawn to system change, and in another have doubted myself. I have developed an identity as a student and wrestled with a wondering of what I will do beyond this position.

One day while watching me grapple with my studies and an unrelenting personal and professional question of "what's next," my friend and mentor shared with me a parable (see Appendix C). The parable is titled *The Fear of Transformation* by Fran McKendree (n.d.). As I listened to the story, I began to imagine my journey through my studies, my learning, my ups and downs, and my realizations.

I see another trapeze bar swinging toward me. It's empty, and I know, in that place that knows, that this new trapeze bar has my name on it. It is my next step, my growth, my aliveness going to get me. In my heart-of-hearts I know that for

me to grow, I must release my grip on the present, well known bar to move to the new one.

Each time it happens to me, I hope (no, I pray) that I won't have to grab the new one. But in my knowing place I know that I must totally release my grasp on my old bar, and for some moment in time hurtle across space before I can grab onto the new bar. Each time I am filled with terror. It doesn't matter that in all my previous hurtles across the void of unknowing, I have always made it. Each time I am afraid I will miss, that I will be crushed on the unseen rocks in the bottomless chasm between the bars. But I do it anyway. . . And so for an eternity that can last a microsecond or a thousand lifetimes, I soar across the dark void of "the past is gone, the future is not yet here." It's called transition. I have come to believe that it is the only place that real change occurs. I mean real change, not the pseudo-change that only lasts until the next time my old buttons get punched. . . I have a sneaking suspicion that the transition zone is the only real thing, and the bars are illusions we dream up to avoid, where the real change, the real growth occurs for us. Whether or not my hunch is true, it remains that the transition zones in our lives are incredibly rich places. They should be honored, even savored. Yes, with all the pain and fear and feelings of being out-of-control that can (but not necessarily) accompany transitions, they are still the most alive, most growth-filled, passionate, expansive moments in our lives.

And so, transformation of fear may have nothing to do with making fear go away, but rather with giving ourselves permission to "hang-out" in the transition between trapeze bars. Transforming our need to grab that new bar, any bar, is allowing ourselves to dwell in the only place where change really happens. It can be terrifying. It can also be enlightening, in the true sense of the word. Hurling through the void, we just may learn how to fly.

Had I encountered this parable on day one of my studies, it would have had meaning. However, the meaning on that particular day would have been different than the meaning I make today. The meaning I make today will be different when I revisit the story at another juncture in my life. Today this story sums up my journey through my schooling, the thrill, the uncertainty, and at times, the steadiness. It tells the tale of what I learned from parents—dwelling in transition and learning how to fly within the transformational space of the void. In my heart of hearts, I knew that for me to grow I had to do this project, I had to take the leap and grasp the bar of the swinging trapeze. Now as I dangle in the space of transition I allow my mind to wander to "what is next" but I also revel in the weightlessness of just hanging and the strength I have grown to hold onto the moment of now. Although this metaphorical account may be too gray or abstract for you the reader to fully grasp, I realize that this story of my dissertation is written by your interpretation and what meaning this sparks for the audience. I have interpreted my own meaning for me and now swing the trapeze bar to you.

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Appendix A

Introductory Script Letter

Stephanie McCune is conducting a research study of parents' perspectives of their experiences of conversation created within the Recognizing Resilience group. The Recognizing Resilience group does not start with an agenda of what to talk about during each session. What is talked about comes from the parents in the group. Stephanie would like to hear from your perspective what you recall as being topics that you talked about. She would also like to understand from you how what you talked about within the Recognizing Resilience group has influenced your experience of your son or daughter's substance use.

Stephanie's research is separate from the Recognizing Resilience group in that she is not looking to discuss the private stories shared amongst you and your group peers. Stephanie sees the research as being separate from the group in that the stories shared by others, the people in the group, and the details of group members' experiences with their son or daughters substance use will remain confidential and not discussed in the research interview. Stephanie's involvement in the Recognizing Resilience group and ongoing counselling sessions with parent clients will be separate and distinct from this research process.

In this research project, Stephanie McCune is participating in a dual role as both the facilitator of the Recognizing Resilience group and the principal researcher. This means that during the research recruitment and interview process Stephanie will create distance between her role as a counsellor and her role as a researcher. In order to ensure that you can consider this opportunity on a completely volunteer basis I am providing the initial introduction of the research project to you, the Recognizing Resilience group participants. So that you are not unduly influenced to participate in this project I am explaining the research process and then will outline how you can, if you choose, initiate involvement. In addition, during all research interview sessions I will be available at the Discovery Youth and Family Services location in order to offer any support should you request or experience the need for emotional support during the research interview. I will also be available during these times in the event that you would like to withdraw from the research interview, so that I can support you with your decisions, once again so that you do not feel pressure to continue on.

Stephanie is currently in the process of working on her doctorate degree in Social Sciences. Stephanie will be using the findings of this research process for her dissertation. In addition, Stephanie would potentially like to publish the anonymous findings in a research article. Stephanie hopes to inform practitioners working within the field of youth and family substance use treatment what

conversation parents place importance on speaking to in group process and how this influences parents' experiences with their son or daughter's substance use.

*I would like to give you a document called the **Information and Consent Form** in order to provide you with a further description of what some of the risks and benefits of this project are, details about confidentiality, and how the research will be used. If you are interested in being involved in this project please call the contact number on the document within the next four weeks in order to schedule an interview time.*

Should you decide that you do not wish to participate I would like to assure you that your continued clinical care with Discovery will not be linked to this research project.



Information and Consent Form Conversations in a Collaborative Group

You are invited to participate in a research study that is being conducted by Stephanie McCune. This study is to explore conversation created in a group process and the influence of this conversation on parents'/caregivers' experiences of their son or daughter's substance use.

Stephanie is currently pursuing her PhD with the Taos-Tilburg PhD program under the supervision of Dr. Sally St. George. Stephanie is also a clinical counsellor with the Vancouver Island Health Authority. You may contact her if you have further questions by email: stephanie.mccune@viha.ca or you may contact her supervisor at sstgeor@ucalgary.ca.

This research is being supported by Discovery Youth and Family Services, a community agency of the Vancouver Island Health Authority.

Purpose and Objectives

The purpose of this research is to learn what conversation is created during participation in a collaborative group process for parents/caregivers influenced by their adolescent's use of alcohol and/or other drugs. Further, Stephanie will be exploring what meaning this conversation has on the ways in which parents are experiencing their son or daughter's substance use.

Importance of this Research

Research of this type is important because it informs service agencies and larger youth substance treatment systems about providing relevant and meaningful programming to parents/caregivers of youth engaged in substance use.

Participant Recruitment

You are being asked to participate in this study because you have participated in *Recognizing Resilience*, a unique six-week collaborative group therapy process for parents/caregivers of adolescents engaged with alcohol and/or other drugs. Participants who have participated in this six-week program are being invited to reflect on conversation from this group process.

In this research project, Stephanie McCune is participating in a dual role as both the facilitator of the *Recognizing Resilience* group and the principal researcher. This means that during the research recruitment and interview process Stephanie will create distance between her role as a counsellor and her role as a researcher.

In order to prevent undue influence to participate in this project and to create space between these dual roles, on the sixth of six sessions of the *Recognizing Resilience* group, co-facilitator Griffin Russell provided the initial introduction of the research project to the *Recognizing Resilience* group participants. In addition, Griffin will be available at the Discovery Youth and Family Services location at the time of each interview in order to offer any counselling support should you request or experience the need for emotional support during the research interview. Stephanie's involvement in the Recognizing Resilience group and ongoing counselling sessions with parents will be separate and distinct from this research process. Should you have any concerns or questions about Stephanie's dual roles and the influence of these roles please do not hesitate to contact any of the provided contacts included at the end of this document.

During the sixth session of the Recognizing Resilience group, Griffin Russell, the group co-facilitator provided you and the other parents participating in the group with a verbal introduction of the research purpose and process. Those parents who expressed an interest to participate were given this informed consent document. You are invited to take the document and further consider the points identified within. Parents who wish to participate in the research are asked to contact Discovery Youth and Family Substance Use services at **250-739-5790** in order to schedule a 60 to 90 minute research interview session within four weeks of receiving this document. At the time of the interview session Stephanie will review this document with you to acknowledge your full understanding of the research process by signing the document.

What is Involved

With your consent, your participation will involve one individual 60 to 90 minute interview. Interviews will be conducted by the researcher, Stephanie McCune at the Nanaimo Discovery Youth and Family Service office. Stephanie will ask questions of the research participants and will provide a summary of what she heard at the end of the session. Stephanie will ask you to advise whether her summary accurately captures what you shared. If you have any disagreement with what Stephanie summarizes, she will revise her summary accordingly.

Interviews will be digitally recorded. Audio recordings of the interview sessions will be available to be heard by Stephanie and her supervisor, Dr. Sally St. George. Recordings of all of the interviews will be transcribed by Stephanie and reviewed several times in order to determine and examine themes. All research data and documents will be kept securely in the Discovery Youth and Family Services central file room.

Inconvenience

Participation in this study may cause some inconvenience to you, including the dedication of 60 to 90 minutes in one interview session.

Risks

Risks to you are minimal, meaning they are not thought to be greater than other risks you experience every day.

Sharing your experiences of conversation regarding your son or daughter's substance use may initiate some emotional discomfort. If this happens, Stephanie McCune will pause the interview session and have Griffin Russell made available to support you. Griffin will ask you if you would like to end the interview at this time and, if so, will let Stephanie know of your decision. Your decision to participate in this research project will not in any way influence your clinical care with Discovery Youth and Family Substance Use Services. Your involvement receiving group or individual counselling will be separate and not related to this research project.

Benefits

The benefits of your participation in this research include the potential of influencing programming and practice of how Discovery Youth and Family Services offers services for parents/caregivers, as well as how larger youth and family substance use systems engage in collaborative practices to support parents/caregivers of adolescents involved with alcohol and/or other drugs. Participation may also deepen understanding of your experience participating in conversation created from a collaborative group process.

Voluntary Participation

Your participation in this research is completely voluntary. If you decide to participate, you may withdraw at any time without any consequences or without need of any explanation. Should you wish to withdraw from the study prior to the completion of the study report, your transcribed responses will be either returned to you or destroyed. Once data analysis has begun however, your responses will be anonymously included in the study. All identifying links will be destroyed. Once your responses have been transcribed from recordings to text they will be grouped and organized by themes. These themes will come from the responses of all the research participants. Once your responses have been organized into themes it will not be possible for Stephanie to remove them from the larger grouping of responses. Your responses will be anonymously merged into a larger body of data.

Anonymity

In terms of protecting your anonymity, your name and other linking identifying features will be excluded from research records. With the exception of the consent form, your real name and other potentially identifying information (your teen's name) will not be used. Instead, a numerical generic identifier, such as P1 for participant one, will be used throughout the study and in the final text.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected by removing any identifying elements from the research records. All data will be stored in a

Appendix C

Sometimes I feel that my life is a series of trapeze swings. I'm either hanging on to a trapeze bar swinging along or, for a few moments in my life, I'm hurtling across space in between trapeze bars.

Most of the time, I spend my life hanging on for dear life to my trapeze-bar-of-the-moment. It carries me along a certain steady rate of swing and I have the feeling that I'm in control of my life. I know most of the right questions and even some of the right answers. But once in a while, as I'm merrily (or not so merrily) swinging along, I look ahead of me into the distance, and what do I see? I see another trapeze bar swinging toward me. It's empty, and I know, in that place that knows, that this new trapeze bar has my name on it. It is my next step, my growth, my aliveness going to get me. In my heart-of-hearts I know that for me to grow, I must release my grip on the present, well known bar to move to the new one.

Each time it happens to me, I hope (no, I pray) that I won't have to grab the new one. But in my knowing place I know that I must totally release my grasp on my old bar, and for some moment in time hurtle across space before I can grab onto the new bar. Each time I am filled with terror. It doesn't matter that in all my previous hurtles across the void of unknowing, I have always made it. Each time I am afraid I will miss, that I will be crushed on the unseen rocks in the bottomless chasm between the bars. But I do it anyway. Perhaps this is the essence of what the mystics call the faith experience. No guarantees, no net, no insurance policy, but you do it anyway because somehow, to keep hanging onto that old bar is no longer on the list of alternatives. And so for an eternity that can last a microsecond or a thousand lifetimes, I soar across the dark void of "the past is gone, the future is not yet here." It's called transition. I have come to believe that it is the only place that real change occurs. I mean real change, not the pseudo-change that only lasts until the next time my old buttons get punched.

I have noticed that, in our culture, this transition zone is looked upon as a "no-thing", a no-place between places. Sure the old trapeze-bar was real, and that new one coming towards me, I hope that's real too. But the void in between? That's just a scary, confusing, disorienting "nowhere" that must be gotten through as fast as unconsciously as possible. What a waste! I have a sneaking suspicion that the transition zone is the only real thing, and the bars are illusions we dream up to avoid, where the real change, the real growth occurs for us. Whether or not my hunch is true, it remains that the transition zones in our lives are incredibly rich places. They should be honored, even savored. Yes, with all the pain and fear and feelings of being out-of-control that can (but not necessarily) accompany transitions, they are still the most alive, most growth-filled, passionate, expansive moments in our lives.

And so, transformation of fear may have nothing to do with making fear go away, but rather with giving ourselves permission to "hang- out" in the transition between trapeze bars. Transforming our need to grab that new bar, any bar, is allowing ourselves to dwell in the only place where change really happens. It can be terrifying. It can also be

enlightening, in the true sense of the word. Hurling through the void, we just may learn how to fly.