

ADDICTION TREATMENT FOR FAMILIES: IS THERE A NEED?

ADDICTION TREATMENT FOR FAMILIES: IS THERE A NEED?

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A Thesis

Submitted to the School of Graduate Studies

In Partial Fulfillment of the Requirements

For the Degree

Master of Social Work

McMaster University

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M.S.W. Thesis – L. DeGasperis

McMaster University School of Social Work

MASTER OF SOCIAL WORK

McMaster University

2014

Hamilton, Ontario

TITLE:

Families and addiction: Is there a need?

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NUMBER OF PAGES:

i-vi, 111

Acknowledgements

Throughout my social work academics there have been people who have been a great influence to me in completing my B.W.S. and Masters of Social Work Degree.

A special thanks to my thesis supervisor, Sheila Sammon who has been a part of my university experience in social work from the beginning. Thank you for your unprecedented dedication to educating us in social work and for always making yourself available when needed. Her support, encouragement and kind approach guided me along my journey. She will always be a mentor who I will admire and respect.

Thank you to Gary Dumbrill for stepping in as my second reader. I had the privilege of working with Gary as a teaching assistant in an undergraduate class, and found his supportive approach to the students exceptional. You are an inspiration and thank you for your being part of this thesis.

A special note of thanks to all those who participated in this study, without your honesty and openness in sharing your experiences - the voice of families would not be heard.

Finally, I would like to thank my family and friends for their understanding and never ending support and encouragement. For the past year they have listened to my ups and downs and given me the space and time for me to fulfill my goals. A special and loving thanks to my mum for her encouragement and many meals that kept me going. I will always be grateful for your support and inspiring words that helped me achieve my academic success.

Abstract

Addiction has been predominantly viewed through the lens of the individual, thereby leaving the family largely out of the scope of treatment or prevention. Csiernik (2002) calls the family the ‘secondary element’ in addiction treatment. The definitions of addiction and research on the prevalence of use are examples of this narrow, individual focus.

This qualitative study sought to widen the lens and explore the family’s experiences of addiction. Families’ voices will be presented and their perspectives captured regarding what would be helpful to them in addiction treatment. This study’s theoretical underpinnings are Family Systems Theory and Social Constructionism. Interviews with the participants were conducted through the use of an open-ended interview process. Interpretive data analysis and phenomenology were used to explore possible themes and meanings to gain a better understanding of the participants’ perspectives regarding addiction.

The main finding of this study, based on the testimony of the participants, was that families perceived there to be a need for more clinical and supportive services to deal with the impact of addictions on the family. This study fills a gap in the literature because, though there is ample research on the consequences of addiction for the family, there is very limited research on the family’s perspective regarding what services they require in order to cope with those consequences. The information supplied by the participants of this study will help social workers and treatment centers provide more holistic, family-centered addiction treatment.

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Chapter One: Introduction

Though addiction has been viewed as a problem located within the individual, the effects on the family, community and society are profound. Substance use has a significant health, economic and social impact in Canada, with annual costs estimated at \$39.8 billion (or \$1,267 for each Canadian) (Rehm, et al., 2006). Research suggests that due to the economic strain on Canadian society there is a need for more preventative treatment (Rehm, et al. 2007). One target of preventative (as well as remedial) treatment is the family because “substance use disorders (SUD) and family relationships are interconnected and therefore impact both the afflicted individual and the larger family structure” (Brewerton & Dennis, 2014, p. 575). Despite the call to include family, many addiction programs, due to limited funding, focus only on the person with the addiction. This narrow focus ignores the fact that addiction in one family member affects the family as a whole.

Like many people, my beliefs about addictions were based on messages from the media and other societal institutions. But, nine years ago, when addictions entered my family, I became an involuntary insider. This influenced me to educate myself about addictions. I completed an Addiction Diploma and then pursued a volunteer position at an addiction agency, where I eventually gained employment. During all these experiences, I found myself continually searching for resources for families. My ongoing desire to both understand and help this population strongly influenced my decision to complete both my BSW and my MSW.

Two things became obvious to me during my work experience: first, families are an important component in the life of people who experience addictions and second, services are severely lacking to support them. I have observed that the roles family members play vary with each situation. In some situations, families may be seen as causing or contributing to an

addiction while in others, families are in a supportive role. I have seen families grow and strengthen as a result of a member's addiction and I have also seen them become troubled and damaged. However it is that families are entwined in a person's addiction, there is an impact on the family and a need for services to support them.

Researchers have explored how the addiction of a family member affects family functioning and relationships (Orford, Velleman, Natera, Templeton, & Copello, 2012; Johnson, 2002). Among these impacts are conflict and “co-dependency issues” (Prest & Protinsky, 1993), poor communication skills, impairment of emotional and physical intimacy, and isolation and depression in all family members (Lander, Howsare & Byrne, 2013). Family roles (Gruber & Taylor, 2006) and rituals (Adelson, 2009) are affected and there are social, economic, legal and health consequences (Orford, et al., 2012; Lander, et al., 2013; DeCivita, Dobkin & Robertson, 2000).

As can be seen from the above, there is a great amount of research regarding families' experiences with addiction, but little has been said about what supports or treatment families require. My own personal experience echoes Csiernik's (2002) statement that families are “a neglected component of the majority of Canadian addiction programs” (p. 79). My hope is that this thesis will shed light on the needs of this heretofore overlooked population.

This thesis will seek to explore the perspective of families who have or are attending counselling for family addictions. It will consider their experiences with family addictions and what supports and services they perceive are needed in family addiction.

Chapter Two: Literature Review

1. Addiction definitions

There are many definitions of addictions. The Centre of Addiction and Mental Health (CAMH) suggests looking for the four “C”s: “cravings, loss of control of the amount or frequency of use, compulsion to use and use despite consequences” (2010, p. 4). The World Health Organization (WHO) provides this, more expansive, definition:

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state (2014, np).

The American Society of Addiction Medicine and the Canadian Society of Addiction Medicine commonly agree on this definition of addiction:

A primary, chronic disease, characterized by impaired control over the use of a psychoactive substance and/or behaviour. Clinically, the manifestations occur along biological, psychological, sociological and spiritual dimensions. Common features are change in mood, relief from negative emotions, provision of pleasure, pre-occupation with the use of substance(s) or ritualistic behaviour(s); and continued use of the substance(s) and/or engagement in behaviour(s) despite adverse physical, psychological and/or social consequences. Like other chronic diseases, it can be progressive, relapsing and fatal (College of Physicians and Surgeons of Alberta, 2008, p.1).

The final classification of addiction is through the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM 5) “the diagnosis of a substance use disorder and identifies ten classifications of substance-related disorders: “alcohol; caffeine; cannabis; hallucinogens (including phencyclidine and other hallucinogens); inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances (2013, p. 483-585).

The elements of a “substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (APA, 2013, p. 483) and is

an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders. The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli (p. 483).

A brief description of the criteria listed in the DSM 5 to determine addiction is found in Appendix N.

2. Prevalence of use

The WHO (2014b) has reported on prevalence of alcohol use in the “Global status report on alcohol and health 2014”. This report indicated that 38.3% of the world’s population actually consumes alcohol and 16% engage in heavy binge drinking (np). The “World Drug Report 2012” reported prevalence rates for the year 2010. The report estimated that between “153 million and 300 million people aged 15-64 (3.4-6.6 per cent of the world’s population in that age group) had used an illicit substance at least once in the previous year” (p.7). In 2010, worldwide prevalence (for the same age group) reported the highest prevalence of use was cannabis between 119-224 million users, followed by amphetamine stimulants (excluding ecstasy) between 14 and 52.2 million users and opioid use between 26 and 36 million users (WHO, 2012).

Since 2008, Canada has conducted a telephone survey, Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) to monitor alcohol and illicit drug use among Canadians aged 15 years and older. The results of the 2012 CADUMS were based on 11,090 participants across 10 provinces. (Health Canada, 2012, p. 1). A summary of the findings for respondents 25 years old and over is located in Appendix O. There may be limitations to this survey due to sampling biases.

Definitions and prevalence rates are beneficial because they can be used by social workers to educate family members and provide norm referencing. What the definitions lack, though, is the family perspective.

3. Historical views of addictions

During the 1800s the moral model was used to understand addictions. Substance use was seen as a sin (White, 1998), or as a result of personality defects and a lack of will power (Parliament of Canada, 2014). Alcohol use was considered disruptive to families and society because it had the capacity to reduce a person's self-control and its use could lead to other addictive behaviours (Levine, 1993).

The North American temperance movement, which was a campaign advocating abstinence from alcohol, first arrived in Canada in 1827 (Dostie & Dupre, 2012). The movement “was a part of a general effort toward the improvement of the worth of the human being through improved morality as well as economic conditions” (Gusfield, 1955, p. 222-223). It used a “mixture of the religious, the equalitarian, and the humanitarian” efforts to help “the underprivileged...to alleviate suffering ...or to reform the habits of the suffering as a way to the improvement of both their character and their material situation”. Treatment was focused on improving the character of people who were from the underclass (Gusfield, 1955, p. 223).

Despite the intentions of the temperance movement, treatment was restricted to those who could afford it. The idea of treatment also came under scrutiny when some programs charged money but could not guarantee a cure. An example, in the late 1880s Dr. Leslie Keeley pronounced that he had found the cure for the disease of alcoholism, drug addiction and tobacco use. He called it the “Double Chloride of Gold Cure” (White, 1998, p.1). The popularity of this ‘cure’ grew between 1880 and 1920 when more than 500,000 people with an addiction received

treatment in private centres. The cure involved attending a voluntary four-week inpatient program, four injections per day of the Keeley remedy, attending lectures and following a set of rules (White, 1998). Despite Keeley's proprietary control, it was eventually revealed that the cure contained a number of addictive and harmful substances including alcohol, strychnine, opium and morphine (White, 1998, p. 7). Criticisms of the Keeley Cure lead to a decline in the public confidence and nearly all of the institutes were closed (White, 1998, p. 14). The 'Keeley Cure' is an example of an addiction treatment based on financial gain, where medical professionals were more concerned about protecting the patents of medications than about protecting their patients (Ati Dion, 1999).

By the early 1900s, addiction was seen more as an illness than a moral deficiency. As such, hospital clinics opened for the treatment of alcoholism. Canada began to consider ways to address addictions by establishing addiction treatment programs, contributing to research and introducing legislation to control drugs (White, 1998). Through the literature on alcoholism grew, victim blaming continued on into the 1920s. People affected by social inequality were perceived as 'different' and this difference became the explanation for social problems including addictions (Weinberg, 2010).

One of the most profound contributions to alcohol treatments was the emergence of Alcoholics Anonymous (AA), a self-help group that was founded by Dr. Bob Smith and Bill Wilson in 1935 (AA, 2014, White, 1998). By 1939, they published a book called Alcoholics Anonymous better known as the 'Big Book' (AA, 2014) to help people quit drinking. Soon after, Marty Mann, "The First Lady of Alcoholics Anonymous" became immersed in the program for her own addiction and devoted her life to "educate an ignorant society and fight the stigma too often associated with alcoholism" (National Council on Alcoholism and Drug Dependence,

NCADD, 2014). Mann's advocacy work led to the formation of the National Committee for Education on Alcoholism (NCADD) in 1944. This committee promoted the ideas that alcoholism was a disease and that treatment was a public responsibility. This committee advocated for education programs and community information centres; they encouraged hospitals to provide detoxification programs; and they fought to establish clinics and "rest centres" or residential programming (White, 1998). The lobbying that groups such as AA and NCADD did helped to establish the view that alcoholism was, in fact, a treatable disease (Parliament of Canada, 2014).

In the mid 1960s to the end of the 1970's, funding for addiction services increased and there was a new focus on specialized services including withdrawal management, outpatient counselling, short and long terms residential programs and aftercare (Parliament of Canada, 2014). Unfortunately, at the same time, there was an increase in drug use (especially heroin) that seemed to re-establish a version of the old moral views of addiction (Mold, 2007). Due to the perceived risk to public health, specialized drug dependence units (DDU) were opened in hospitals for heroin addiction treatment (Mold, 2007). Those patients were segregated to limit the spread of heroin addictions and were prescribed methadone as part of a harm reduction treatment strategy (Mold, 2007).

During the 1980s, diversity and specialization in services continued, recognizing that treatment needed to be customized based on culture, gender, age, mental health and type of addiction (Parliament of Canada, 2014; White, 1998). In the 1980s, with an increase in drug use and the rise of HIV/AIDS, addiction treatment was given more attention (Collins, 2006). For example, the Government of Canada developed Canada's Drug Strategy (CDS) (1987-2003) which implemented two consecutive five-year, \$245 million plans (Collins, 2006). This "gave a means to address substance use with both supply and demand reduction strategies" (Riley, 1998,

np). The first five-year plan distributed funds equally among “enforcement, treatment and prevention programming” (Riley, 1998, np). A survey regarding prevalence and potential harms was also implemented, but its results were limited by the exclusion of high-risk populations, certain drugs and people with concurrent disorders (Collins, 2006).

The second five-year plan reflected the belief that drug use was no longer a serious problem (Riley, 1998, np), other than an economic one. Therefore, the focus of the plan was privatization of services (Street, 2012). The result was “reductions in Health Canada’s budget for drug treatment—but hefty increases in budgets for drug enforcement by police and prosecutors” (Geddes, 2012; Riley, 1998). The shift in allocating funds seemed to indicate that treatment services were no longer valued – what was important now was policing the sale and use of substances (Battle & Torjman, 2013; Street, 2012). Riley (1998) cited:

The problems related to criminalizing drug users, the social and economic costs of this approach, and its failure to reduce drug availability, have still not been addressed. As a result, the costs, both financial and human, of licit drug use remain unnecessarily high while the costs of criminalizing illicit drug use continue to rise, steadily, predictably and avoidably (np).

This new focus led to privatization, decentralization, continued individualization and familialization (Brodie, 1999). Privatization presumes that when services are delivered through the market they are economically beneficial as services are shifted to Canadians. This sets the platform form for decentralization (Brodie, 1999, p. 41), which burdens provincial and municipal governments who were already strained due to lack of federal funding for social programs (Brodie, 1999). Due to this, individualization and familialization (Parliament of Canada, 2014) becomes valued, where the structure of our services “reflects the voice of the institution as opposed to the voice of the client” (Street, 2012, p. 66), and supports the belief that people are consumers with choices (Street, 2012). The problem with this ideology is that program

construction is based on cost savings which may result in shifting the responsibility of treatment onto the family, it may maintain a belief system that blames the individual and it may exclude the voices of people with addictions, the very ones who are in need of the services.

4. Social Constructs of addiction

The way addiction is viewed in society greatly depends on how it is socially constructed. As indicated above, our understanding of addiction is entwined with the socio-economic-historical context. The way people with an addiction have been defined has changed over time - from sinners, to diseased, to people who are at high risk for deviant behaviours (Weinberg, 2010). The language we use to describe those who use addictive substances is equally shaped by cultural context (Lloyd, 2010; Janulis, 2010). For example, when society adopted the view that alcoholism was a genetic problem, stigma was lessened. Whereas the stigma associated with drug use was maintained as it was still seen as sinful (Janulis, 2010).

The language we use to describe addictions is powerful and is a primary way in which our understanding is constructed. Link and Phelan (2001) assert that language is used to label, so words like ‘drug addict’ or ‘alcoholic’ imply that the person is labeled as that ‘thing’, rather than identifying the person as a person first, who has a problem with drugs or alcohol (Lloyd, 2010). The dominant view that addiction is an individual’s problem is promoted through the media, government and health organizations. As Sophie Freud (1999) would suggest, the individual addict is constructed as a deviant while the non-addicted person is ‘normal’.

4.1 Stigma

As one can see, the historical characterization of the nature of addictions and the focus on the individual in treatment, stigma is a problem. Lloyd (2010) stated that stigmatization “stems from the normal way in which people make sense of the world, categorizing and stereotyping

people in order to simplify the great complexity of the social world” (p.7). No doubt, addiction is a complex issue with multiple determining factors and so is vulnerable to such reductionist attempts.

A person who is stigmatized is usually one who is perceived to have attributes that are deviant from social norms. Unfortunately, that person’s identity now becomes obscured because the focus is only on the undesirable characteristic(s) (Lloyd, 2010; Goffman, 2009). When addiction is seen as a character flaw, as it has been historically, this invites an “ideology to explain his [or her] inferiority and account for the danger he [or she] represents, sometimes rationalizing an animosity based on other differences” (Lay & McGuire, 2008, p. 147).

Hence, stigma becomes a moral account regarding the relationship between a person’s characteristics and the social world (Yang, Kleinman, Link, Phelan, Lee & Good, 2007). This perpetuates “power relations because they have implications for what [are] permissible for different people to do and for how they may treat others” (Burr, 2003, p. 5). A power imbalance is thus established between the person(s) engaging in stigmatization and the person(s) being stigmatized (Lloyd, 2010). This power discrepancy reinforces the perception that individuals are responsible for their addictions, and therefore are also responsible for the stigmatization.

The particular stigma attached to substance use problems involves labeling, stereotyping, social rejection, exclusion, extrusion and discrimination (White, 2009). Corrigan & Watson (2002) cited two descriptions of stigma: public stigma which is “negative beliefs individuals in society have about individuals from stigmatized groups” and “self stigma” which “is internalized devaluation that individuals from stigmatized groups turn against themselves” (Janulis, 2010, p.3). White (2009) concurs with these types of stigma and adds that self-stigma comes “from the internalization of community attitudes by the person being discredited” (White, 2009, p. 7).

White (2009) noted other categories of stigma related to addictions, such as ‘enacted stigma’ which is “direct experience of social ostracism and discrimination”, and social stigma also known as ‘courtesy stigma’ (Goffman, 1963) which is “stigma attached to families, organizations (service providers), neighbourhoods, and communities” (White, 2009, p. 7).

Goffman (1963) notes that ‘courtesy stigma’ can be applied to anyone who is associated or in a relationship with a person or group who is stigmatized (Phillips, Benoit, Hallgrimsdottir & Vallance, 2012). Family members, whether they have relationships with the substance user or not, experience ‘courtesy stigma’ resulting in social isolation (Barton, 1991; Chan 2003), feelings of shame when dealing with the schools, police and the legal system (Barton, 1991) and mental health consequences (Palamar Halkitis, & Kiang, 2013).

Birenbaum (1970) cited that families with children with cognitive disabilities experienced negative social interactions, were blamed for their children’s behaviours and were judged by other families on their ability to parent (Phillips, et al., 2012). Green (2004) reported that families with disabled children experienced so much judgment, social isolation and disconnected from social supports that they chose to institutionalize their children. Courtesy stigma was also present between family members in the family unit, which affected relations and the family’s ability to care for the member in need.

In lack of finding conclusive research on ‘courtesy stigma’ in families facing addiction, the above findings infer the importance of understanding the effects of stigma on the substance user and/or the family unit. Recognizing the impact of stigma on families may lead to the development of support programs that help families cope with stigma and, ideally, reduce it.

Though stigma is often seen in a negative light, some authors wonder whether it can be used as a deterrent to substance use. Bayer (2008) asks “is it morally acceptable to embrace or

foster stigmatization if in so doing we reduce the burdens of disease and premature mortality?” (p. 468). Satel (2007) suggests that the stigma associated with the negative consequences of addictions is a disincentive for people to use substances, but that “‘eliminating stigma’ may backfire by making more addicts comfortable continuing drug use and avoiding treatment” (p.148). Lloyd (2010) asks “whether the image of a drug can be dissociated from the stigma the user of that drug experiences, and, therefore, whether the user’s stigma could be reduced without improving the image of the drug” (p. 57). Palamar, et al., (2013) examined stigma as a preventive measure against illicit drug use and the results indicated that “stigmatization [the personal application of stigma to others] helps to protect individuals from use of various illicit drugs, but [public stigma] the perception of this stigma applied by the public does not appear to protect against use” (p. 523).

Despite the potential benefits noted by these authors, my experience in the field of addictions leads me to conclude that society and public policy have not grasped the concept of separating acceptable stigma and unacceptable stigma. I suspect that the current perception of addiction is so engrained in society that the subtlety of ‘stigma-as-a-deterrent’ will be lost and may only result in justification for the use of stigma, regardless of the outcome.

5. Family and addictions

5.1 How families approach addictions

Families have predominantly been viewed as secondary system in Canadian addiction programs (Csiernik, 2002; Gruber & Taylor, 2006). As a result, families attempt to cope with addiction in the best way they can, but for some, these methods are not positive. Orford, et al. (1998) reported the following three negative coping styles: the family may be ‘engaged’ by attempting to deal with the problem, or to change the substance user’s behaviours; ‘tolerant

coping’ where the family member does not exert consequences and, instead, will make excuses for the behaviours and the family member ‘withdraws’ from the situation altogether. Orford, et al. (1998) suggested that, though families may feel these coping styles are effective, they may, in fact, be causing more stress and reduced well-being.

In a similar vein, Ranganathan (2004) notes that family members will adopt predictable roles while attempting to cope with a member’s addiction: ‘the enabler’ who makes excuses for the family member’s use, ‘the scapegoat’ who is blamed for causing the addiction, and ‘the compensator’ who covers up the substance use by focusing on the family’s positive attributes (p. 402). Aside from the unhelpful roles that family members play at home, the research suggests they also can play a helpful role in addiction treatment. Families assist substance users in participating and maintaining treatment thereby reducing the many harmful effects of substance use (Copello & Orford, 2002). Copello, Templeton and Powell (2010) suggest that the inclusion of family members in treatment is both cost effective and a benefit to the treatment provider.

5.2 Addiction’s negative impact on families

Many studies report that treating the individual without family involvement may limit the effectiveness of treatment, because it ignores the devastating impact of substance use problems on the family system; it leaves family members untreated, and it does not recognize the family as a potential system of support for change (Lander, et al., 2013; Copello & Orford, 2002).

In terms of the impact, Marshal (2003) reviewed sixty studies “that tested the relation between alcohol use and one of three marital functioning domains (satisfaction, interaction, and violence)” (p.1). The results indicated that alcohol use was a major stressor in families that was “associated with dissatisfaction, negative marital interaction patterns, and higher levels of marital violence” (p.1). Other impacts cited in the literature include family conflict, co-dependency

issues (Marshal, 2003; Prest & Protinsky, 1993), changes in family functioning, a decrease in the quality and an increase of stress within family relationships (Lander, et al., 2013; Orford, et al., 2012; Templeton, Zohhadi & Velleman, 2007; Johnson, 2002; Marshal, 2003; Ranganathan, 2004; Csiernick, 2002), poor communication skills, impairment of emotional and physical intimacy, and isolation and depression in all family members (Lander, et al., 2013; Marshal, 2003), and the effect on family roles (Gruber & Taylor, 2006; Ranganathan, 2004; Copello & Orford, 2002), and rituals (Adelson, 2009). Studies have also highlighted that addictions have social, economic, legal and health care consequences for the family (Lander, et al., 2013; Orford, et al., 2012; Copello, Templeton & Powell, 2009; Ray, Mertens, & Weisner, 2009; DeCivita, et al., 1999). Financially, for example, addiction costs family members both directly (e.g., time spent supporting the substance user, taking him/her to appointments and helping with caregiving), and indirectly (e.g., loss of paid working hours) (Copello, et al., 2010). As another example, Weisner, Parthasarathy, Moore and Mertens, (2010) studied the effects of addiction treatment on medical expenditures and found that successful addiction treatment correlates with improved family health and reduced medical and healthcare costs.

5.3 Families included in treatment: positive outcomes for substance user

Because of the reciprocal relationship between the substance user and his or her family, (Orford, et al., 2012; Chan, 2003) the literature suggests that programs should take a holistic view by including families in treatment (Gruber & Taylor, 2006; Chan, 2003; Knauth, 2003). Research has shown that there are many benefits to family inclusion. Meyers, Apodaca, Flicker and Slesnick (2002), for instance, assert that inclusive addiction treatment “may be more successful at engaging, retaining, and improving outcomes than individually focused interventions” (p. 286). A study by Edwards and Steinglass (1995) reported that 73% of

substance users with family involvement entered addiction treatment, compared to 12% of those without family involvement. Other studies have outlined even more benefits, such as improvements in the substance user's motivation and compliance (Sarpavaara, 2014; Gruber & Taylor, 2006; Copello & Orford, 2002), lower risks of relapse (DeCivita, et al., 1999), increased time of abstinence, (Beattie & Longabaugh, 1997), and positive family relations (Ellis, Bernichon, Yu, Roberts & Herrell, 2004).

5.4 Families included in treatment: Positive outcomes for the family

When families participate in treatment there are many benefits, including an increase in family cohesion and a higher quality of family relationships (DeCivita, et al., 1999), maintenance of family homeostasis, stability and equilibrium (Lander, et, al., 2013; Adelson, 2009), and increased “awareness of their family dynamics, their personal values, and their ability to modify their relationship behaviors” (Armstrong, 2004, p. 395; Bowen, 1974). Even without the substance user present, families can still benefit from treatment by exploring strategies to deal with the addiction, becoming a support system for the substance user (Copello, Velleman, & Templeton, 2005), and improving family functioning (Copello & Orford, 2002). Treatment can build confidence to openly discuss family issues, increase awareness about the impact of addictions and offer new coping strategies to reduce the stress and strain on the family. The family can learn to disconnect from the situation and focus on their own needs (Templeton, et al., 2007).

The evidence is clear that engaging family members in treatment, in their own right or alongside their substance-using relative, can be beneficial for all involved (Copello, et al., 2005; Orford, Templeton, Copello, Velleman, Ibang & Binnie, 2009). The literature overwhelmingly concurs that more is required to understand the treatment needs of family members (Copello et

al., 2010; Gruber & Taylor, 2006; Copello & Orford, 2002; Csiernik, 2002; Copello, Orford, Velleman, Templeton & Krishnan, 2000), and that the social networks of substance users involved in addiction treatments should be assessed (Sarpavaara, 2014).

6. Theories about families and addiction

There are a number of theories that help a practitioner understand addiction and occasionally, understand the impact of addiction on families. Most of the theories about addictions ignore families and view it as an individual problem. For example, addiction on an individual level is observed in the disease model that perceives addiction “as a progressive and predictable disease that is characterized by features such as a genetic predisposition and the loss of control over the consumption of alcohol”, and Psychoanalytic theory that views substance use as a “result of a person’s pursuit of sensuous satisfaction, fixation at an early stage of development...and conflict among components of the self” (Chan, 2003, p. 129).

Thomas (1989) noted when families “began to be seen as either being the cause of alcoholism or being involved in its maintenance” (Chan, 2003, p.130), theorists began to perceive the family as an influence on an individual’s addiction. For example, Lawson et al., 1983 noted “sociological theory, which stresses the importance of cultural attitudes, suggesting that alcohol is sometimes used in families as a rite of passage”, Alexander (1990) noted the adaptive theory suggested that family dysfunction, along with other social problems like poverty, unemployment produce stress “and alcoholism is considered an adaptive response that numbs, distracts, and masks this discomfort” (Chan, 2003, p. 130). Still these theories focus on the individual and do not account for family dynamics that may support recovery to an addiction and do not seem to be inclusive of the family in addiction treatment.

For the purposes of this paper, I am choosing to focus on two of theories that help explain addictions in families: family systems theory (FST) and social constructionism. Family systems theory works well with other theories and practice approaches such as Behavioural Marital Therapy and behavioural techniques (Copello & Orford, 2002), Prochaska & DiClemente's Stages of Change Model (Chan, 2003), attachment theory (Lander, et al., 2003), community reinforcement approach and CRAFT (community reinforcement approach and family training) (Meyers, et al., 2002; Velleman, 2006), network therapy (Velleman, 2006), action theory (Graham, Young, Valach & Wood, 2008) and ABCT (Alcohol-focused behaviour couples therapy) (Velleman, 2006), to name few.

6.1 Family Systems Theory

The family systems theory (FST) (Bowen 1978) is a comprehensive, holistic theory about human relationship functioning (Knauth, 2003), and demonstrates ways of understanding the family as a social unit where family members are interdependent and that patterns in the family are non static (Bowen, 1974). Bowen's theory (1978) defines family as a

combination of an emotional system and relationship system. Family environment includes the immediate nuclear family, the extended or multigenerational family, and the broader social systems of which the family is a part. Bowen's theory emphasizes how patterns of relationships are transmitted through the generations and how they can influence behavior (Knauth, 2003, p. 332).

FST suggests that all parts of the family are interrelated and have a variety of functions. This approach asks the practitioner to assess for interactions of the family members and assess how these interactions contribute to or maintain problems in a family (Swanson, 2007; Gruber & Taylor, 2006). In FST "the individual cannot be fully understood or successfully treated without first understanding how that individual functions in his or her family system" (Lander et al., 2003, p. 196). Stanton, Todd & Associates (1982) stated that substance use is a maladaptive

behaviour that influences the functionality of a family system (Prest & Protinsky, 1993).

Authors (Bowen, 1974; Davis, 1980; Lawson et al., 1983) concur that individuals with addictions experience family relationships where individuals who are

emotionally cut off from parents tend to overfunction and may turn to alcohol for relief from isolation and feeling overburdened. On the other hand, individuals who are emotionally fused with a parent and lack a sense of self may also collapse into a life of alcoholism. Bowen used the concept of “stucktogetherness” to describe how alcoholism pulls the family together during times of crisis or tension, and thus serves to maintain homeostasis (Chan, 2003, p. 132).

The concept of “stucktogetherness” also referred to as “undifferentiated ego mass” reflects the connected reactions of family members who are poorly differentiated or emotionally fused (Bowen, 1974). For example, when an addiction is in a family, the family reacts to the addiction by taking responsibility and blame for the substance user’s emotions. Therefore, the family becomes emotionally fused with the substance user and collapses into a life of the substance user that maintains homeostasis.

FST moved practitioners away from the individualistic ideology of addictions by avoiding two concepts: the concept of “why” (why a person has a drinking problem, why is the family dysfunctional) and the concept of “cause and effect” or linear thinking (Bowen, 1974). These concepts perpetuate the perception of blame where the person with the addiction is blamed for their problem, and the person with the addiction blames others for their problem. Instead of blaming others or the self for addiction issues, FST puts an emphasis on circular and multiple causality; this “is less blaming than a linear approach and also provides a broader perspective on intervention” (Smith-Acuna, 2011, p. 10). Smith-Acuna discusses circular distancing in the family, where family members may disengage and this disengagement affects family functioning. (2011). For example, when families are affected by the presence of addictions, they

may not understand what the family member with the addiction is experiencing. From this the family may feel relieved when the family member seeks support from other sources, but the family member may interpret the family's responses as an unwillingness to help or a lack of caring. This causes the person with the addiction to distance from the family. In return the family perceives this withdrawal as behaviour resulting from the addiction reinforcing the family's rationale for distancing from the family member with the addiction.

Bowen (1978) discusses the concept of triangles in families. He suggests that triangles are functional when family relationships are stable, but when one part of the triangle increases the stress and anxiety (Prest & Protinsky, 1993) the family becomes vulnerable. For example, a couple has a functional relationship and they relate well to their son and to each other. When the son's addiction starts to escalate, the couple communicates different tolerance levels for the addiction. This accentuates anxiety and stress between the couple and between the individual parents and their child, negatively affecting their relationships.

6.2 Social Constructionism

Family Systems Theory comes out of a modernist era in its attempt to create an overarching theory to explain family functioning in a social context. In contrast, social constructionism, influenced by postmodernism, attempts to understand how the societal discourse shapes and positions individual families and the problems they experience. In social constructionism there are no fixed truths or realities, these are constructed through language and interactions (Atwood, 1993) and this theory "focuses more on social process and interaction" (Puig, Koro-Ljungberg & Echevarria-Doan, 2008, p. 140). Social constructionism suggests that these interactions between people in particular culture and historical context help to construct a version of knowledge and are "seen as products of that culture and history, and are dependent

upon the particular social and economic arrangements prevailing in that culture at that time” (Burr, 2003, p. 4). Social constructionism considers the meaning people attribute to concepts such as family or addictions. It suggests that knowledge is an “accomplishment of communication that evolves in a historical context, is based on assumptions of those who have access to legitimized forms of discourse, and is influenced by constraints on the availability of alternative perspectives and narrative” (Yerby, 1995, p. 349). Hence, addiction and family are popularly portrayed a certain way in a particular culture and time while other portrayals of addictions and families are minimized or ignored.

When working with families that are experiencing addiction issues it is necessary to understand that

Social constructionist inquiry is principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live. It attempts to articulate common forms of understanding as they now exist, as they have existed in prior historical periods, and as they might exist should creative attention be so directed (Gergen, 1985, p. 266.)

Not only do families face the societal messages about addictions and how families should be, each family member filters the societal messages through their own perceptions and experiences. Hence, any and all family members may have their own interpretation of, and give meaning to the experience of addiction. Practitioners may also have their own interpretation of addiction. A benefit of using social constructionism in family treatment for addiction is to break down the myths about addictions, to challenge taken for granted knowledge, to “subvert the more damaging or oppressive aspects of mainstream psychology... [and to] change our own constructions of the world and thereby to create new possibilities for our own action” (Burr, 2003, p. 20).

7. Models of addiction

7.1 Moral Model

The moral model, that previously dominated dialogue about addictions, sees substance use as an intentional action to be morally evaluated (Morse, 2004), as a sin (White, 1998). Blame was imposed on substance users for the act of using a substance that they were addicted to, for having the status or condition of being addicted and the resulting risky behaviors in which they were likely to be involved (Husak, 2004). Addiction was viewed as resulting from a lack of will power, stemming from personality defects (Parliament of Canada, 2014). Morse (2004) summarizes the moral model this way:

[A] theory of responsibility that makes an agent's general capacity for rationality and the absence of unjustified compulsion or coercion the touchstones of responsibility. In turn, if the agent's general capacity for rationality was compromised or the agent acted under compulsion, excuse and non-responsibility may be warranted (p. 443).

The moral model holds that people have a choice to use substances, therefore have a choice to stop using substances (Husak, 2004). With the advent of competing models of addictions, the moral model has been disputed. The medical model, for example, does not blame the person with the addiction because addiction is seen as an involuntary act. We will turn our attention now to the medical model.

7.2 Medical model

There seems to be two medical models that are sometimes mistakenly viewed as one. The first is the genetic model (usually referred to as the disease model) and the second is the brain disease model (BDM) (Bell, et al., 2014; Vaillant, 2005). This paper will refer to the genetic model and the BDM together as 'the medical model' but first I will give a short definition of each model for clarification purposes.

The genetic model, supported by neurobiology research, sees addiction not as an individual responsibility, but as a medical condition. Though the genetic model of addiction has been around for many years, interest in it has grown recently for three reasons (Vaillant, 2005). First, “there is a large body of research showing that animal behavior is influenced by heredity”. Second, “the methodologically sound twin studies conducted since the 1980s have consistently found that genes contribute to the development of complex human disorders, such as addiction”, and third “there is now widespread recognition that genes and the environment *jointly* determine human behavior-particularly addictive behavior (Vaillant, 2005, p. 34, emphasis in original).

A definition of the brain disease model (BDM) has been articulated by the National Institute on Drug Abuse (NIDA), which metaphorically explains addiction as a ‘brain hijacking’:

The initial decision to take drugs is mostly voluntary. However, when drug abuse takes over, a person’s ability to exert self control can become seriously impaired. Brain imaging studies from drug-addicted individuals show physical changes in areas of the brain that are critical to judgment, decision-making, learning and memory, and behavioral control. Scientists believe these changes alter the way the brain works, and may help explain the compulsive and destructive behaviors of addiction (NIDA, 2007, p.7).

As cited by McLellan, Lewis, O’Brien and H.D. Kleber (2000) and Dackis and O’Brien (2005) the genetic model and BDM have helped addictions to be publically accepted as a medical condition. As a result, it is suggested that medical treatments will become more available, criminal sanctions will be reduced and stigmatization of those with addictions will decrease (Bell, et al., 2014). On the other hand, many critics (Cunningham and McCambridge, 2012; Satel, 2001; Satel, 1999; Davies, 1998; Herrman, 2001; Phelan, 2002 and Kessler, Nelson, McGonagle, Edlund, Frank and Leaf, 1996) argue that the BDM implies that a person has a disease that is not curable, which essentially exonerates him or her from any responsibility for managing the addictive behaviour (Bell, et al., 2014). A study conducted by Bell et al. (2014)

concludes that “while most saw some value in neuroscience research on addiction, many were concerned about the potential adverse impacts of the BDM on addicted individuals’ motivation to enter treatment and recovery” (p. 25).

Thombs and Osborn (2013) state that medical model (genetic model and BDM) shape treatment options and advocate for abstinence-based programs. One can see this philosophy, for example, in residential programs where substance use disorders are viewed as “a chronic condition” and abstinence is the only acceptable treatment goal (Thombs & Osborn, 2013, p. 30). Abstinence is also prescribed in self-help groups such as Alcohol Anonymous (AA), Narcotics Anonymous (NA) or Cocaine Anonymous (CA). Though members of these groups do not directly claim that addiction is a disease, they embrace the concept metaphorically, that is “they describe their alcohol problems as being ‘like’ a disease” (Vaillant, 2005, p. 32). Kurtz (2002) explored the ‘disease model’ in relation to AA and concluded that “Alcoholics Anonymous neither originated nor promulgated the disease concept of alcoholism” (p. 5). Kurtz (2014) cited one of the co-founders, William GriffithWilson, who stated at the National Catholic Clergy Conference on Alcoholism in 1961:

We have never called alcoholism a disease because, technically speaking, it is not a disease entity. For example, there is no such thing as heart disease. Instead there are many separate heart ailments, or combinations of them. It is something like that with alcoholism. Therefore we did not wish to get in wrong with the medical profession by pronouncing alcoholism a disease entity. Therefore we always called it an illness, or a malady -- a far safer term for us to use (p. 3).

There seems to be a variation in how the founders of AA (NA, CA) have conceptualized addiction and how the members of these groups have perpetuated confusion through interpreting the meaning of ‘illness or malady’ as a ‘disease’.

Advocates of the medical model argue that its non-blaming stance on addiction is preferable to the punitive moral model, and reduces the guilt for substance users and increases the possibility of substance users seeking help (Morse, 2004; White 2001). The medical model

provides an organizing construct through which the addicted client, his or her care providers, and those in the wider family and social environment can understand the nature of his or her problem (disease), the manifestations of that problem (symptoms), the potential causes of that problem (etiology), the natural evolution of that problem (course), interventions that are available to diminish or eliminate this problem (treatment options), and the likely outcome of such interventions (prognosis) (White, 2001, p. 3).

Critics of the medical model have noted that the model's premises fall apart when people believe that "seeking and using behavior is distinguishable from most signs of disease because it is intentional action, rather than simply the state or movement of a body... that the addict might be able to exert some degree of intentional control over the aberrant behavior and that encouraging the agent to take responsibility" (Morse, 2004, p. 442). Caouette and Boutland (2013) also add that the medical model ascribes the negative effects of addiction to the disease and not to the people with the addiction. White (2001) reported the medical model,

fails to provide an adequate framework for prevention, strips the alcoholic/addict of freedom and responsibility, and is misapplied to types of alcohol/drug problems for which it is ill-suited. Labeling alcohol/drug problems as incurable diseases is stigmatizing and dissuades many heavy drinkers from seeking help. By restricting its definition of vulnerability for alcohol problems to a small group of alcoholic drinkers, the disease concept has allowed the alcohol/drug industries to escape culpability for their product and promotional practices (p.3).

My analysis of the moral and medical models would not be complete without addressing the issue of crime. Because the moral model promotes the idea that people with addictions are responsible and have control of their behaviours, naturally there will be a focus on the development of "laws and regulations, which have significant consequences for many people on a daily basis" (Melberg, Henden & Gjelsvik, 2013, p. 562). The medical model, on the other

hand, sees addiction as an illness or a disease. Even though the legal system may appreciate the concept of addiction-as-disease, it cannot fully embrace it because doing so would contradict the laws relating to substance use (Morse, 2013). The legal model is based on criminal responsibility which means that a person's action is viewed morally even if a disease or medical condition is involved (Morse, 2013). Satel and Goodwin (1998) cited that "even if addiction is properly characterized as an illness, addicts may nonetheless be capable of being guided by good reasons, including the incentives law can provide" (Morse, 2013, p. 497). The legal model seems more aligned with the moral model because of its view that the law is the law and people should be held accountable for their actions.

7.3 Cognitive Behavioural model

Moving beyond the medical and disease models, we come to cognitive behaviour therapy (CBT). According to Dobson and Dozois, cognitive behaviour therapy (CBT) suggests "cognitive activity affects behavior; cognitive activity may be monitored and altered; desired behavior change may be effected through cognitive change" (Dobson, 2010, p.4). Kazdin (1978) and Mahoney (1974) noted that cognitive-behaviour modification holds the same principles as cognitive behavioural therapy, but differs in that it "seeks overt behavior change as an end result" and CBT "focuses' their treatment effects on cognition per se, in the belief that behavior change will follow" (Dobson, 2010, p. 4). Mahoney and Arnkoff (1978) note that there are three foci of CBT: first, cognitive restructuring which "assumes that emotional distress is the consequence of maladaptive thoughts. Thus, the goal of these clinical interventions is to examine and challenge maladaptive thought patterns and to establish more adaptive thought patterns". Second, coping skills training that "focus on the development of a repertoire of skills designed to assist the client in coping with a variety of stressful situations". Third, problem-solving therapies

that “emphasize the development of general strategies for dealing with a broad range of personal problems, and stress the importance of an active collaboration between client and therapist in the planning of the treatment program” (Dobson, 2010, p. 11). While these are only a few of the interventions of CBT, all strategies are predicated on

how learning processes are involved in the development and maintenance of maladaptive thought processes, emotional reactions, and behavioral responses. These learning processes are the foundation for interventions aimed at the reduction, replacement, or cessation of problematic behaviors (Vaughn & Perron, 2013, p.101).

Vaughn and Perron (2013) suggest that CBT is an effective intervention because it meets the complex needs of people with addictions by focusing on present-day behaviours in sessions that are “structured, directive, solution-focused, and time-limited” (p. 115). Another advantage of CBT is that it can be used with other treatment to enhance outcomes.

Some criticisms of CBT include that it does not address the whole person and that treatment focuses on the addiction and not the underlying reasons for the addiction, which leaves the person vulnerable to substituting the addiction with another dysfunctional behaviour. CBT is too structured and this affects the formation of the therapeutic rapport (Vaughn & Perron, 2013). With respect to the last criticism, some have argued that CBT’s structure actually “builds confidence in clients...a necessary condition for therapeutic alliance (Vaughn & Perron, 2013, p. 116).

7.4 Transtheoretical model- Changing Behaviours

The transtheoretical model is one of the most current influential models and it challenges practitioners to understand how people make changes in their addictive behaviours. The transtheoretical model is more commonly known as ‘the stages of change.’ The model suggests that we should understand behaviour change as a “phenomenon of intentional changes as

opposed to societal, developmental, or imposed change” (Prochaska, DiClemente & Norcross, 1992, p. 1102). The model states that change evolves over time through five linear stages, precontemplation, contemplation, preparation, action and maintenance (Norcross, Krebs & Prochaska, 2011; DiClemente, Schlundt & Gemmell, 2004; Prochaska, et al., 1992). A person with an addiction may have the intention to change, but progression through the stages depends on the degree of readiness or motivation that person has (DiClemente, et al., 2004). Though the progression is seen as linear, there is a chance of relapse at any stage.

Readiness is a concept that “typically indicates a willingness or openness to engage in a particular process or to adopt a particular behavior and represents a more pragmatic and focused view of motivation as preparedness” (DiClemente, et al., 2004, p. 104). Motivation is an important part of the process of change as explained by DiClemente, et al. (2004):

Movement back and forth, as well as recycling through the stages, represents a successive learning process whereby the individual continues to redo the tasks of various stages in order to achieve a level of completion that would support movement toward sustained change of the addictive behavior (p. 104).

In the early stages (precontemplation and contemplation) the process of change is “associated with the experiential, cognitive, and psychoanalytic persuasions” (Norcross, et al., 2011, p. 144). During these stages, the goal is to build awareness regarding the benefits of changing behaviours, the consequences of remaining with the addictive behaviours and the possibility of improving one’s thoughts and feelings due to behaviour changes (Norcross, et al., 2011). The preparation stage indicates that the person with the addiction has made small changes and intends to move into the action stage (Norcross, et al., 2011; DiClemente, et al., 2004; Prochaska, et al., 1992). In the latter stages (the action and maintenance) change is “associated with the existential and behavioral traditions” (Norcross, et al., 2011, p. 144). During these stages, the purpose is to replace addictive behaviours with healthier ones, which include

classic reciprocal inhibition methods: assertion to counter passivity, relaxation to replace anxiety, cognitive substitutions instead of negative thinking, and exposure to counter avoidance. Reinforcement management can also be used to help patients establish self-reward schedules to support attainment of their goals (Norcross, et al., 2011, p. 144).

Some of the benefits (to mention a few) of using the stages of change in addiction treatment is in predicting treatment outcome measures, it is uncomplicated to administer, and is important in treatment and therapy progress (Norcross, et al., 2011), it is effective in matching intervention of treatment to the person with the addictions characteristics and is successful in addictions (Prochaska, et al., 1992; DiClemente et al., 2004), and the stages of change can be used simultaneously with multiple addiction issues (DiClemente et al., 2004). Some of the concerns about using the stages of change include that it is possible to mismatch the stage to the person's readiness and motivation for change (Norcross, et al., 2011; DiClemente et al., 2004), that there are occasions when the person with the addiction underestimates or overestimates either the problem or the motivation to change and that there may be pressure to enter treatment programs may unhelpfully influence a person's self-evaluation (DiClemente et al., 2004).

What about a model for families?

All of the models we have just discussed focus on the individual. But, what about the family? How would family members interpret these models? I was unable to find research that specifically addresses families' responses to or interpretations of the models, so what follows are my own thoughts based on my experience in the field.

The moral model, as we know, emphasizes that people are responsible for their own decisions, and places blame on people for any action that is not socially acceptable. Unfortunately, the family may internalize this view and take responsibility for the addiction (e.g., finding fault, justifiably or not, in their upbringing of the individual).

Similarly, the medical model, which suggests that addiction is rooted in genetics or brain functioning, can lead biological parents to feel guilty for conceiving a child and ‘passing on’ an addiction.

The cognitive-behavioural model highlights that people learn distorted thoughts and, consequently, react emotionally and behaviourally to those thoughts. Families may feel they were a contributing factor to that learning process, and wonder what messages they have been giving to the family member with the addiction. Parents may feel, for example, that they have been bad examples to their children. This may lead to decreased confidence in parenting and engaging in endless ‘what if’ discussions. Ultimately, they may internalize the responsibility for the addiction.

The transtheoretical model discusses change of behaviours based on a person’s readiness and motivation to change. In addictions, the focus of change is usually on the individual. The family may not realize that changing one part of the family will affect the whole. Each member of the family may also be at different levels of readiness to change compared with the individual who is addicted, leading to confusion and frustration. Also using the stages of change seems to focus on how the individual with a substance use problems changes his/her behaviours, but does not seem to encompass the change process for family members. Therefore, the stages of change may only be a tool for the family to understand the process of change for the substance use. This analysis reinforced my interest in my research topic and moved me to talk to individuals who have experienced a family member with an addiction.

Chapter Three: Methodology

Theoretical and Methodological Framework

1. Inductive qualitative research

Qualitative research as cited by Van Maanen (1979: p. 520) is “an umbrella term covering an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world” (Merriam, 2009, p. 13). Qualitative research “assumes that reality is socially constructed, that is, there is no single, observable reality. Rather, there are multiple realities, or interpretations, of a single event” (Merriam, 2009, p. 8). Qualitative research seeks to understand people’s perceptions and the meanings they ascribe to their lived experiences (Merriam, 2009; Fellow & Liu, 2008).

One of the earliest qualitative studies on addictions was cited in “De Quincey’s (1822) *Confessions of an English Opium Eater*” (Rhodes & Moore, 2001, p. 280). There is consensus, though, in research by Brooks, 1994; Feldman and Aldrich, 1990; Koester, 1996; Lambert, Ashery & Needle, 1995; Wiebel, 1996; Boulton, 1994; and Singer 1999 that the use of the qualitative methods in addictions research was not popularized until the advent of HIV/AIDS (Rhodes & Moore, 2001). This was due to the rise of HIV in injection drug users which hoisted a risk to public health (Rhodes & Moore, 2001). The results of that research helped to form new social policy in addictions (Neale, Allen, & Coombes, 2005).

There are many advantages to using the qualitative research method in the field of addictions. These include that it produces constructive interpretations of how people perceive their world and it enables the researcher to understand addictions from the individual’s perspective. It also allows us to identify trends in alcohol and drug use and it offers the

opportunity to counteract myths by disseminating accurate information about the daily lives of people living with addictions (Neale, et al., 2005). As Rhodes (2000, 1995) has argued,

qualitative addiction research seeks both to describe the social meanings that participants attach to drug use and the social processes by which such meanings are created, reinforced and reproduced. In particular, qualitative research focuses on exploring the details of people's lived experiences and on appreciating why drug-using [and alcohol] behaviours occur and how they are understood in different contexts among different social groups (Neale, et al., 2005, p. 1584).

In addition, qualitative research may be more appropriate when working with families on ontological questions because there is more emphasis on textual data that considers the meaning of human action than there is on number analysis (Carter & Little, 2007). It also allows for layers of analysis using both the emic and the etic approaches. The “emic approach looks at things through the eyes of members of the culture [the family] being studied. What is valid or true is what members of the culture agree on” (Willis, 2007, np). The etic approach allows the researcher to reflect on her role in interpreting the information given by the study participants as “scientists doing the study are the judges of what is true because they are the ones who select the external standards or structures that will be used” (Willis, 2007, np).

2. Interpretive Phenomenology: Interpretive social sciences (ISS)

Qualitative research supports an Interpretive Social Science (ISS) approach. ISS focuses on subjective meaning people ascribe to social action and their interactions with each other. Essentially, social reality is based on people's interpretations (Neuman, 1997). ISS aligns with the principles of social constructionism in “that people create and associate their own subjective and intersubjective meanings as they interact with the world around them. Interpretive researchers thus attempt to understand phenomena through accessing the meanings participants assign to them” (Orlikowski and Baroudi 1991, p. 1-8), and to describe, understand and interpret those multiple realities (Merriam, 2009, p. 11). Gall et al., (1996. p. 19) writes this about the

need to research multiple social realities and the suitability of the qualitative method for doing so:

An opposing epistemological position to positivism is based on the assumption that social reality is constructed by the individuals who participate in it. ... This view of social reality is consistent with the constructivist movement in cognitive psychology, which posits that individuals gradually build their own understanding of the world through experience and maturation. ... Educational researchers who subscribe to this constructivist position believe that scientific inquiry must focus on the study of multiple social realities, that is, the different realities created by different individuals as they interact in a social environment. They also believe that these realities cannot be studied by the analytic methods of positivist research (Willis, 2007, np).

The challenge issued to ISS researchers is that their research is not grounded in a scientific method and, therefore, how can the results be valid? In response, Willis (2007) stated that interpretivists suggest that

all research is influenced and shaped by the preexisting theories and world views of the researchers. The terms, procedures, and data of research have meaning because a group of scholars has agreed on that meaning. Research is thus a socially constructed activity, and the “reality” it tells us about therefore is also socially constructed (np).

Therefore, interpretivists do not ignore “rules of the scientific method; they simply accept that whatever standards are used are subjective, and therefore potentially fallible, rather than objective and universal” (Willis, 2007, np).

ISS research is designed specifically to examine the individual’s perspective and it is valuable to social work because it respects the participant’s voice (especially those of vulnerable and marginalized people) and it bridges “the gap between policy and the lived realities of practice” (Becker, Bryman, & Ferguson, 2012, p. 112). Using the ISS approach with families and addictions is appropriate because it accounts for many variables: the differences in the substance use, the family dynamics, how families and addictions are socially constructed and the participants’ diverse experiences with, and perceptions of, addictions.

3. Ethical considerations

The main concern in this study was that I hold both insider and outsider positions. I have personally experienced addictions in my family and I am a provider of addiction treatment through my employment. Great care was given to ensure transparency regarding this. Due to my experiences, I chose to use ISS in order for the participants to have a voice and for me to practice distancing from the interview using bracketing (a concept I will discuss later).

Transparency about my professional involvement with addictions was maintained in the recruitment and screening of participants (appendix J), in the letter of information and consent (appendix A), and in the introductions in the interview process. I decided to withhold disclosing my personal involvement with addictions until the end of interview so as not to influence or intimidate the participant in any way. In reflection this decision was an assumption on my part that the participant may respond differently because he/she would be aware of my family experiences with addiction. Hepworth, Rooney, Rooney and Strom-Gottfriend (2013) states that self-disclosure is all about timing and intensity because early self-disclosure may “undermine the confidence of client”...and “conclude that the social worker prefers to focus on his or her own problems” (p. 114). He also goes on to say that self-disclosure is best done when the social worker has built a rapport and trust with the person and the social worker can “relate with increased openness and spontaneity...that are relevant to the clients’ needs and do not shift the focus from the client” (p. 115). I found my personal self-disclosure well-timed because it allowed the participants to speak freely about their perceptions of addiction without any thoughts about my personal experiences. I also found that disclosing after the interview seemed to build a comfortable rapport between the participant and myself and the participant seem to understand that I also had personal experiences from which to draw.

Prior to the commencement of the interviews I reiterated that I was a social worker in the addictions field, and that this would not influence or affect the availability of treatment options for the participant or family members. Although this may have shaped their responses, I was hoping that it might be perceived as useful. Due to the nature of the conversations, individuals may have experienced discomfort or emotional stress. To mitigate this, I had a list of resources/counselling services in the Hamilton/Burlington/Brantford area was provided to each participant (appendix E, F, G).

4. Phenomenology

As I have already argued, there is minimal research on the family's perception of addiction. However, my experience in the field is that the family's insight is of paramount importance if one wants a holistic view of addiction.

The use of phenomenology in this research appealed to me because it stressed the importance of the participant's (family members) lived experience from their perspectives. Shinebourne and Smith (2009) believe that interpretative phenomenological analysis (IPA) "can make a valuable contribution to psychological understanding of the experience of addiction as it provides an opportunity to build up a rich picture of the subjective-felt experience" (p. 153).

Phenomenology takes an idiographic approach which focuses on the individual and understands the distinctiveness of each participant (Shinebourne & Smith, 2009). Phenomenology is "powerful for understanding subjective experience, gaining insights into people's motivations and action, and cutting the clutter of taken-for-granted assumptions and conventional wisdom" (Lester, 1999, p. 1). It investigates "themes and underlying meaning structures in order to arrive at a synthesis or integrated statement of the whole" (McCormick,

2010, p. 73). Phenomenology research is cited by Patton, (2002, p. 106, emphasis in original) as based on

The assumption that *there is an essence or essences to shared experiences*. These essences are the core meanings mutually understood through a phenomenon commonly experienced. The experiences of different people are bracketed, analyzed, and compared to identify the essences of the phenomenon (Merriam, 2009, p. 25).

When using phenomenology, research participants are “not replaceable or interchangeable; their individuality – the differences that characterize each participant– are sought and preserved” (McCormick, 2010, p. 71). This “implies that the fact that people are capable of thought, self-reflection and language necessitates an alternative framework that ascribes priority to the actor’s perspective” (Becker, et al., 2012, p. 126). Smith (2004) notes IPA enables the participant to have a voice. It analyzes the lived experience of the participants and how they understand their experiences (Shinebourne & Smith, 2009; Lester, 1999).

Epistemologically, phenomenological approaches allow for participants’ lived experiences to emerge and for the researcher to immerse herself in their life narratives (McCormick, 2010; Lester, 1999; Findlay, 2014). Moustakas (1994) explains,

A phenomenological interview is the primary method of data collection. Prior to interviewing those who have had direct experience with the phenomenon, the researcher usually explores his or her own experiences, in part to examine dimensions of the experience and in part to become aware of personal prejudices, viewpoints and assumptions. This process is called *epoche*, “a Greek word meaning to refrain from judgments...In the Epoché, the everyday understandings, judgments, and knowings are set aside, and the phenomena are revisited (Merriam, 2009, p. 25).

Phenomenology also assists the researcher by promoting the idea of bracketing (Findlay, 2014; Becker, et al., 2012; Houston & Mullan-Jensen, 2011). In data collection, the researcher adopts a non-judgmental, open-minded and curious stance towards participants’ meanings while, at the same time, disconnecting (bracketing) from his or her professional and personal

knowledge (McCormick, 2010). Bracketing allowed me distance from my personal and professional experiences with addiction so that I could accomplish my goal of understanding the family's experiences and treatment needs. I will discuss this further in the section to follow.

The task in phenomenological data collection and analysis is to describe rather than explain (Lester, 1999) the phenomenon so that “other researchers can read the description from the perspective of that researcher and understand-not necessarily agree with – the essence of the phenomenon as it has been illuminated through the research” (McCormick, 2010, p.73). Lester (1999) discussed the importance of summary findings, in that they should be, transparent, authentic to the participants and open about the researcher's biases or any ethical issues.

4.1 Bracketing

Interpretative phenomenology requires the researcher to become absorbed into the participant's perceptions of the phenomenon being studied. “A researcher's ability to hear previously silenced voices and shifting centers of oppression relies on the ability to silence, for a time, his or her own voice and give precedence to the voice of the participant” (Tufford & Newman, 2010, p. 93). As noted previously, bracketing may be used to engage in this difficult process (Finlay, 2014). van Manen (2011) explains the challenge of bracketing:

One needs to reflect on one's own pre-understandings, frameworks, and biases regarding the (psychological, political, and ideological) motivation and the nature of the question, in search for genuine openness in one's conversational relation with the phenomenon. In the reduction one needs to overcome one's subjective or private feelings, preferences, inclinations, or expectations that may seduce or tempt one to come to premature, wishful, or one-sided understandings of the experience and that would prevent one from coming to terms with a phenomenon as it is lived through (np).

Bracketing is used to build the researcher's self-awareness about personal/societal ideologies and social location and to gain an understanding of power differences between the researcher and the participant. It helps maintain focus on the research agenda and compartmentalize and protect the

researcher from exposure to participants' emotions. (Tufford & Newman, 2010; Houston & Mullan-Jensen, 2011).

There are several effective ways a researcher can engage in bracketing, including having a journal throughout the research process, making notes about thoughts and reactions during the interview, and discussing possible biases and preconceptions about the research topic with outside sources (Tufford & Newman, 2010). There is debate, though, on when bracketing should begin and whether the participant should be part of the process (Tufford & Newman, 2010).

Due to this I felt that engaging in 'bracketing' before I started the process of this study would be beneficial. I wrote out a journal of my experiences and then summarized them (appendix P) so I could read them over before the interviews and before I started the coding and writing up the findings. I felt this reflective experience of 'bracketing' helped me to put my experiences and perceptions into perspective. It also helped me to be in the moment with the participant attempting to limit influences of my experiences, and help me to continually ask myself during the data analysis whether I had unduly influenced the results. Bracketing also helped me during the interviews, because one of the participant's stories reflected much the same as my family experience. Bracketing helped me to realize what I was feeling during this interview and to remain focused on the participant's story. As I was aware of the similarities of our experiences, I was particularly conscious in checking that the interpretation of this participant's story was based on his/her perceptions and that my experiences did not interfere with my interpretations.

In reflection after the interviews I realized that four out of the five participants questioned about the process of using quotes in the study. I feel that 'bracketing' helped me to express that

through the interviews themes may exist and that the quotes, which is their voice regarding those themes would be the support for families perceptions about those themes.

5. Challenges and Drawbacks of Phenomenology

There are a number of drawbacks to the using a phenomenological research approach. First, there is a danger of “misrepresenting, distorting or deleting findings which have been provided in good faith by participants (Lester, 2014, p. 3). Bracketing (Tufford & Newman, 2010) may compensate for any such skewing of the data. Another concern is small sample sizes. However, in phenomenology research, one participant is viewed as being valid (Lester, 2014). A third challenge is the misuse of bracketing by limiting it to “assumptions, theory and concepts from outside sources” (Finlay, 2014, p. 124). The researcher must also eliminate her biases and understandings of the phenomenon studied (Finlay, 2014). Fourth, phenomenology generally requires that the researcher and participant build a close rapport. Due to the time constraints of this particular study, contact was limited to one session. Despite this, I did get a sense that a connection was formed and that the participants were as strongly committed to the subject of this study as I was. Finally, some may worry that my insider and outsider roles would present challenges. Though this may be true, I attempted to compensate for it in the recruitment process, the data analysis as well as through regular reflection on my social location and role within this study.

Chapter Four: Methods

Methods will give details regarding recruitment, participants, data collection, data analysis and ethical considerations. After the findings were complete, I assessed evaluations from 10 random psycho-educational groups that were provided by co-facilitated community agencies that provide services for addiction. There were 94 evaluations regarding participant's satisfaction of the group, what was useful to them after completing the group and what specific skills they found most useful and what they felt they would most likely use after leaving the group. I used this information strictly as a comparative analysis to the findings of this study.

1. Recruitment

In recruiting participants for this study I discovered that most agencies dealing with addictions provide a family psycho-educational group. This seemed a natural starting point for recruitment. The agencies that I approached were asked to disseminate information about the study by handing out the letter of information and the brochure (appendix A and I), as well as displaying the recruitment poster (appendix H) at the agency. Participants voluntarily engaged in the study and were instructed to contact the researcher directly to ensure confidentiality.

To my dismay, out of 30 group members, there were no respondents. Many variables may have attributed to their lack of uptake but two possibilities might be that the families attending the psycho-educational group were at the beginning of their learning process and felt unsure about publically discussing their family story, and they may have obtained what they needed from the group and, therefore, did not see the value in being involved in the study. I was forced to alter my recruitment process allowing for a larger recruitment locality in the agencies.

The McMaster University Research and Ethics Board identified that recruiting at my place of employment, Alcohol, Drug and Gambling Services (ADGS) may be a conflict of

interest if any of the participants or their family member with addictions are, were or might be a service user of the agency. I addressed this concern by being transparent in all the information given to, and conversations with, the participants, that I work for ADGS. I also developing a recruitment screening process to ensure there was no conflict of interest between the participant and any current involvement with ADGS. I ensured all participants that my involvement with ADGS would in no way affect their treatment at the agency. Lastly, I informed the participants that I would not be the counsellor for any family member should anyone access ADGS services after the interview was completed, and should this happen accidentally, the client would be transferred to another ADGS counsellor.

2. Participants

There were five participants in this study who had all attended some type of counselling for addictions. The participants attended a single one-on-one interview conducted at an agreed-upon setting where confidentiality could be maintained and comfortable for the participant. Of the participants, 4 identified as female and one as male; two females were in the age group of 45-54, one female was in the age group of 55-64, the male was in the age group of 65-74 and the fourth female was over the age of 75. The age cohorts were varied, but, for the sake of inclusivity, there could have been more diversity with gender, race, and socio-economical status. In terms of the addiction, 3 families involved alcohol, 2 involved drugs and one involved both alcohol and drugs. In terms of the length of experience with addiction, three participants reported 40 years, 1 reported 20 years and one reported 2 years. Three participants had multiple family members dealing with addiction while two participants cited only one.

When the interview was completed, participants were compensated with a twenty dollar gift certificate from a café and a thank you card.

3. Data Collection

In order to minimize my insider role, before I started the data collection I reviewed the bracketing reflections I did before I started the study (appendix P). I also evaluated each research question (appendix C), and reflected on its rationale (i.e., how it was applicable to the research topic and whether it would allow the participant to be openly share about without interference from me).

Data collection was conducted using a semi-structured, open-ended, one-on-one interview with each participant. The interviews lasted for one hour. The interviews began with a review of the Letter of Information and signing of two copies of the consent form (appendix A). One copy was given to the participant and I kept the other. Through bracketing, I was already aware that I have many preconceptions about families and addictions, so I purposefully allowed the interview to be directed by the participant. At the beginning of the interview I explained to the participant that my goal was for the participant to voice his/her perceptions, and to discuss only what was comfortable to discuss. I did have an interview guide (appendix C) with possible discussion topics. As the researcher, I was mindful of respecting the enormity of what the participant was offering me: intimate and private stories regarding addiction in the family.

The interviews were audio taped with participant's permission, and then were transcribed by an independent transcriber who signed a Confidentiality Oath (appendix B).

4. Data Analysis

Before starting the data analysis I, again, reviewed my insider preconceptions regarding families and addictions (appendix P). This review helped to ensure that I remained focused on the participant's perspective and that I allowed for themes to emerge from the data. Even though

I was very aware of my insider role, I acknowledge that it is still possible that my experiences filtered into the data analysis (including findings and discussions).

The interviews were transcribed verbatim yielding anywhere between 12-20 pages per interview. To ensure accuracy, I listened to the audio recording while matching the transcription. I reread the transcriptions to eliminate any identifying information and replaced this information with a pseudonym for the participant. Any names used were changed to reflect the person's relationship to the participant. Company names were changed to reflect the type of agency or service that the participant referred. Names of cities or places of residence were generalized. Once this was completed, the transcripts were analyzed for meanings without referencing themes, and then the relevant key quotes were identified. These quotes were then grouped for meanings in order to allow for themes to emerge.

After the data analysis was complete and the findings were written up, the review of the evaluations from the psycho-educational groups from the community family addiction programs began. This review looked for themes and assessed for similarities or dissimilarities from other families that have experienced addictions in their families.

5. Ethical considerations

I submitted an application to McMaster University Research Ethics Board (MREB) for approval. After minor revisions, the application was approved (appendix P). As noted above, I applied for two revisions due to the lack of participant contact; both of these were also approved (appendix Q and R). Transparency was a key consideration in this research due to my insider and outsider roles. My employment at ADGS as an addiction counselor was clearly indicated on the letter of information/consent form (appendix A), and was verbally discussed with the participants before interviews began. Confidentiality of the participants was ensured. The recruitment

process (as described above) accounted for any involvement with ADGS of the participants and their family members. Transcripts were modified to eliminate any identifying information and pseudonyms used for each participant. A list of resources was made available to the participants should support after the interview be required.

Chapter Five: Findings

The interviews were conducted using an interpretive approach that enabled the participants' to explore and recognize their social realities and reveal their meanings and values (Neuman, 1997). Due to my experiences in addiction, I consciously tried to not influence the participants' perceptions in any way. I asked questions only as a means of maintaining a sense of direction in the conversation.

I found the participants to be forthright in the interview and comfortable talking to me about their experiences. All the participants express gratitude for the opportunity to express their perspectives on family addictions and there was a consensus that there is a need for more education and treatment options.

Several themes emerged including family disconnection of addictions, family reactions to stigma; families have a voice-lived experience with addictions, and benefits of counselling. These themes represent my understanding of the participants' experiences with addictions and their perspectives regarding family addiction treatment.

FAMILY DISCONNECTION OF ADDICTIONS

The theme of family disconnection emerged at the beginning of each interview. The participants seemed to start the interview by telling their family story and the effects of addiction on their family. When the participants talked about feeling disconnected, they seemed particularly emotionally affected, something I observed from their non-verbal communication (expressions of sadness, tears, poor eye contact, determined voice). In using this term, I mean “social disconnectedness, marked by a lack of social relationships and low levels of participation in social activities and perceived isolation, defined by loneliness and a perceived lack of social support” (York Cornwell & Waite, 2009, p. 32). Two types of family disconnection were noted

by the participants: disconnection from the substance user and disconnection from communication.

1. Disconnection from the substance user

All of the participants perceived disconnection from the substance user which ultimately influenced the dynamics of the family. Participant One's comments were particularly meaningful as this participant spoke of the long-term effects on the family. In this situation the family member had been diagnosed with a life threatening disease:

It took my husband out of the home, so it was very clear over the years that smoking pot to him was more important to him than spending time with us... The problem is that there's really no emotional connection. You know, he can do what he wants but it takes a toll on our relationship and we are no longer close. When somebody chooses to abuse drugs and alcohol it can definitely ruin a marriage. Yeah, you know, and I mean I don't, I just see that my husband made some poor decisions and that his use of pot and alcohol changed who he was, made him unavailable to his family, affected his mood and ultimately affected his health. And now he's going to die and my children are losing their father and I remember years ago saying you have to think about your children not just yourself as you make these decisions. But he always acted like, you know, it was no big deal nothing serious was going to happen and get off his case and now my kids are starting to have to face losing their father...And I'm going to be left having to deal with that myself so it's kind of interesting that theme continues. You know I pretty much had to raise the children by myself 'cause he was unavailable...I often felt alone, felt isolated, I felt it was all on my shoulders and now he's going to die and again I'm going to have the mess to clean up.

Throughout the participants' stories about the disconnection from a substance user there was an underlying sense of the loss in the family, which Participant Two and Five, respectively described:

I love him for who he is, but the dynamics of what a relationship should be was lost...It destroys so much. It destroys so much.

So, it has a way of tearing people, who are really close completely apart

The participants talked about disconnection from the substance user mainly in reference to the breakdown in relationships and a lack of togetherness.

2. Disconnection in communication

Many of the participants remarked on communication problems in the family, leading to family disconnection. For example, verbal abuse was referred to in several interviews, usually in the context of the substance user acting out impulsively instead of calmly discussing family issues.

Participant Four remarked, "...he was absolutely rotten. He was a miserable bastard. Verbally abusive, not physically, verbally abusive. He tried to put me down every chance he got but he didn't succeed". Participant Three noted that when his son was living with his mother and grandmother he witnessed his son "verbally abusing her [the mother] with vulgar language. And his grandmother who lived there". Participant Two stated that she experienced verbal abuse, but now says to her partner "don't look at me or talk to me after your third drink. Because he becomes very abusive".

Verbal abuse may be viewed as a way for the substance user to disconnect from communicating with the family. In response, the family may attempt to buffer the damage by shifting roles to maintain homeostasis. Participant One stated that she became the "peacekeeper in the family. It was like walking on eggshells ... don't say anything; don't do anything that would upset Daddy. So of course, that was a hard place to be". Participant Five compared the experiences of dealing with an addiction in the family to riding a rollercoaster, where emotions were up and down. In order to avoid any outbursts she said:

During our son's active addiction, I was scared to rock the boat, ask him to do something, wake him up, get him up, and talk with sternness. Not that he was ever violent or mean to me, just that I didn't want to start anything. He wanted to be left alone, and so I left him alone.

What is reflected in all these statements is that the participants seem to adjust their lives to accommodate the person with the substance use in order to avoid more emotional upset in the family. This pattern is in accord with the research concerning the negative impact on families from addictions (Lander, et al., 2013; Orford, et al., 2012; Copello, et al., 2010; Weisner, Parthasarathy, Moore & Mertens, 2010; Copello, Templeton & Powell, 2009; Ray, Mertens, & Weisner, 2009; Adelson, 2009; Templeton, et al., 2007; Gruber & Taylor, 2006; Ranganathan, 2004; Marshal, 2003; Csiernick, 2002; Johnson, 2002; Copello & Orford, 2002; DeCivita, et al., 1999; Prest & Protinsky, 1993).

FAMILY REACTIONS TO STIGMA

There is no disputing that families are impacted by addictions. The concern is, as Laslett et al. 2010 cited, that family addictions have “often been hidden by methodological individualism” (Berends, Ferris & Laslett, 2012, p. 300). As addiction treatment is typically based in this individualist ideology, the “circumstances and needs of family members are not fully assessed” (Orford, Templeton, Velleman & Copello, 2010, p. 76).

As previously described, stigmatization occurs when a person has attributes that is perceived to be unacceptable. This focus on the undesirable characteristics obscures a person’s identity (Lloyd, 2010; Goffman, 2009). As a reminder, there are four different types of stigma: public stigma (society’s negative beliefs about stigmatized people or groups); self stigma (when people of stigmatized groups adopt negative beliefs about themselves); enacted stigma (which is when people or groups experience social ostracism and discrimination) and courtesy stigma (stigma that is attached to families, organizations, neighbourhoods, and communities) (Janulis, 2010; White, 2009; Phillips, et al., 2012).

1. Family reactions to stigma

To begin, Participant Two talked about the stigma associated to having an addiction in the family; she stated “the stigma is there, you’re labeled...because people look at me the same way”. This might be categorized as ‘courtesy stigma’. Participant Four noticed ‘courtesy stigma’ when she attended an AA meeting with her family member. Specifically, her family member remarked, “this can’t be the right place” when he saw the nice cars in the AA parking lot (thereby revealing his assumption that people with addictions would not drive nice cars).

Participant Five gave an example of ‘enacted stigma’ when she talked about a hospital experience. Participant Five was at the hospital supporting her son who was admitted for a drug-related health concern. While at the hospital, Participant Five encountered a friend who was there to support her daughter, who had had a difficult birth experience. Participant Five recalls the following about how their friends reacted differently:

... everyone was like chipping in to help [friend’s name] and her daughter and I said here we are all by ourselves. They care outside there but they would not think to say would you guys like for us to bring you food while you sit and wait for your son to come back to life. I said ‘but if he was here because he'd had a brain operation or a tumour they'd be here’.

Participant Five took her son another time to the hospital because he was having problems breathing and was lethargic due to substance use. About this she said:

I was so angry with this man because he kept him and his wife, kept walking by and looking with this like disgust. And I said I don't understand why people just don't get it. I said, loudly, and my husband walked away. You know I used to have a little boy, I used to have a beautiful little boy, just like that man's little boy. And I was screaming it and she [the nurse] said it's OK. I said no it's not OK because he should not be staring at my son because one day it may be his son lying here with a problem.

She also discussed how ‘enacted stigma’, likely generated by public stigma, is experienced through how communities react to a family that is dealing with addictions. She once had a

conversation with a woman about their similar experiences of having ambulances come to their houses, and how this woman was shunned by her neighbourhood:

...twice we had ambulances come to our house and I remember going to coffee with this woman who was going through similar thing. Exactly similar in that she had police come and smash in her front door 'cause they found out her son was dealing. And she said how horrible her neighbours treated her after. How it was like they ganged up on her and almost wanted her to move out of the neighbourhood... We don't want drug dealers in our neighbourhood.

Public stigma is perpetuated by the language of addiction and what are particularly noticeable in how there are different stigmas associated with different substances. (Lloyd, 2010; Janulis, 2010). Participant Five explains it this way:

I think addiction scares people. Because addiction is drug addiction is a bad word. If someone's an alcoholic, it's very different because alcohol is legal. But for some reason people think drug addiction is well you're a criminal, you must be a criminal; you must be because you are a drug addict.

The narratives in the interviews demonstrated self stigma, where the participants blamed themselves for the addiction in the family. Participant Two stated, “How could I have been so stupid to not recognize the signs? And why am I still with them? And what is keeping me with him”? Participant Five reminisced about the “shoulda, coulda and wouldas” regarding her parenting:

I felt that I had focused too much on me when he was a little boy and maybe not enough on him... I felt that well you work too hard... but I worked so hard... to give him the things I wanted to provide him in his life. Well you should have had a second child so he would have had a sibling, that's why he's an addict. So you failed because you only had one child. You failed because you were busy... instead of you should have been home with him 24/7. And so it was more in that moment. I know now I didn't fail him, and that it had nothing to do with me but when you're in that abyss it is all your fault and that's just how you feel.

Participant Five identifies ‘self stigma’ by explaining the emotional investment a person may have in dealing with a family member with an addiction:

... I'm as much of an addict as he is except I am addicted to his addiction... it took a long time [and]...I realized that holy shit, if he's good I have the best day but the minute he falls I am right back...Everything I did revolved around our son...He was up, I was up. He was down, spiraling and so was I. I had only one focus and I had no idea that is what was happening...

2. Secrecy

Secrecy is a way to hide addiction to protect the substance user and family from experiencing stigma (Palamar, 2012). Smart and Wegner (2003) state that people with a substance use problem that keeps their use “a secret may limit social interactions with non-users because preoccupation with nondisclosure can be a burden as they must remain cognizant of their secrets” (Palamar, 2012, p. 573). Families maintain secrets to conceal information that is perceived as shameful and are stigmatized or condemned by the family and/or others (Vangelisti & Caughlin, 1997).

Secrecy as a theme emerged in the majority of the participant interviews. Some of the participants stated that they had been oblivious, at first, to the presence of addiction mainly because the substance user was so skillful at hiding his or her use. Interestingly, after the shock of discovery, once the participants became aware of the addiction, the knowledge actually gave them a sense of understanding regarding the behaviours of the substance user and their impact on the family

Participant Four describes the experience of a concealed addiction this way:

How could I not have known what was going on? I thought he was ill...which of course he was. I had had no experience with alcoholism previously so was not aware of the signs.

...what he was doing was stopping off and buying a mickey on the way home from work and then putting it in his kit to go out the next morning to

get rid of the empty bottle. So of course I didn't, there was no...No evidence and I couldn't smell. But nobody knew. Nobody knew, not even the kids.

Likewise, Participant One stated “I had no idea and it was something that he was hiding from me because he knew, he knew enough about me that he knew that I would not like that”. Participant One’s family member kept his substance use a secret because, years before, he had assured her that he would cease using substances and that it would not be an issue. Participant One said: “I know it's hard to believe that I could be in the dark for that long but when we were married about 25 years I found out that he was still smoking pot and had never quit. He completely hid it from me. And then it all made sense to me and that's why he was away from home so much...”

Families also use secrecy to hide the family addiction from friends because they cannot be assured of their understanding and support. Participant Five explains:

I didn't want to share what was happening with our son...because I always had hope that this was going to get better. Because I knew that inside he was a really special person and I didn't want anyone to think less of him for that so I didn't want to tell my friends because I was scared that when he gets better they're not going to understand and they're not going to forgive him...So I just thought it's best if I just don't...

Because secrecy is so prevalent in addictions, it all the more substantiates why we need to be open about it in society. When addictions are viewed as the result of an individual’s deviant behaviour, then stigmatization of both the individual and the family occurs. In this context, families will naturally respond with a ‘sweep it under the carpet’ mentality, which only serves to reinforce the secrecy.

3. Social isolation

An addiction influences the social aspects of family life and often leads to a social isolation, whether it is the family members isolating themselves from their social network or vice versa. Social isolation is “the distancing of an individual, psychologically, physically, or both,

from his or her network of desired or needed relationships with other persons” (Lubkin & Larsen, 2013, p. 97). Social isolation has certain characteristics: “negativity, involuntary or other imposed solitude and declining quality and numbers within the isolate’s social networks” (Lubkin & Larsen, 2013, p. 114).

Participant One explained her use of secrecy and how it led to social isolation because she

... wasn't willing to let people know what happened in my life. It is not what I thought it was going to be at all. Marriage did not turn out to be what I wanted it to be. And so for many, many years I just didn't tell anyone what was going on... From the outside everything looked great. Nobody knew that we had problems. I didn't tell anyone. Nobody knew about how difficult our marriage was and how lonely I was and how sad I was about our relationship. And so that was isolation.

Participant One also noted that “when I started to have some really close relationships and started to have the courage to tell my real story. And then the isolation dropped away”.

Families may experience stressful and uncomfortable situations due to the substance user’s behaviour, so avoiding social situations may be a way of minimizing the impact.

Participant One described social interactions as being anxious and stressful:

I was always worried when we would go out that he was going to drink too much and he was going to make a fool of himself and that it was going to be embarrassing. So going out with friends wasn't a whole lot of fun because I worried about what was going to happen. You know there were a lot of events... that were wrecked because he drank too much and he made a fool of himself.

Participant Five avoided social interactions by withdrawing from friends:

I wanted to be in my cocoon then I wanted to be by myself where (my husband) and I are social with our friends and we go out often and we have a healthy social life. I didn't want anybody. I didn't want to go out for dinner at friends' houses and hear about their perfect children all the time when I was dealing with chaos in my own home.

Participant Two identified that she had to assume the role of a caregiver, but in doing so she lost her own social network. She explains: “You don't have a life. You don't experience the joys of

life. Like I love to sing and I used to belong to the [name of choir] Singers. I travelled across Canada. But now, it's [the addiction] made me stay home...I become the caregiver..."

Another form of social isolation involves the family being excluded from social events because of the substance user's behaviours. The participants had an interesting point of view on this: they expressed no malice, only understanding (and possibly relief) about this reaction from family and friends. Participant One expressed her feelings this way:

It really hurts me when my brothers go off with their wives and we're not included. And they're kind, you know, it's not like they're mean to us but I totally get it. I totally get it that they don't want to be with us and have my husband drinking too much and making things awkward or just, you know, he just doesn't really have good social skills. And so it's not really a feeling of being judged or not liked, but it's just I guess left out because of his behaviour and that has hurt...because my family means a lot to me.

Later in the discussion Participant One stated that she resolved the issue of by having separate vacations, some with her partner and others with friends and family.

Participant Five expressed her feelings regarding exclusion from family functions in this way:

I don't fit the mould and it makes for very, very lonely, lonely life, especially with my [sibling]. Like they went away on their family vacation, which we were always family, but they picked a week that they knew that I wouldn't be able to come.

Participant One noted that her exclusion was made more painful because her partner's friends would defend his substance use:

I thought, he has this whole life aside from me, apart from me that everyone else knows about and they know don't tell, don't tell his wife because she doesn't accept it. And so...it was dishonesty...disloyal...that one group of friends knew that there are just certain things that they had to keep from me.

Families do their best in handling family addictions and the stigma attached to addiction. Families manage addictions by keeping secrets, which implies that they are blaming themselves for what is happening in the family. Social isolation becomes a way of evading the stigma and

judgment they experience or fear experiencing. But many of these strategies, while perhaps effective in the short-term, often end up being destructive and causing unhealthy relationships as well as exacerbated loneliness, depression and chronic health conditions (Orford, Copello, Velleman, & Templeton, 2010; Hawthorne, 2008).

BENEFITS OF COUNSELLING

As is obvious from what I have said thus far, family members' voices are often subdued when dealing with addictions. This is due, in part, to the stigma attached to addiction by society and the reactions families have to the stigma associated with addictions. However, in the interviews, all the participants stated that attending some type of counseling. Three of the five participants indicated they attended addiction counselling for families through an agency that specialized in addiction counselling. The other two participants stated they attended counselling services that did not specialize in addictions, but that family addiction was addressed in the counselling. All participants stated that counselling was beneficial and was a place where they were not judged and it was safe to tell their stories. The participants learned knowledge regarding change for the substance user and the family as a whole, the importance of boundaries and the importance of communication and support. They were encouraged to have a voice and they gained a different perspective on dealing with addictions in the family.

1. Elements of change

The participant's narrative showed that their experiences led them to a better understanding of what is involved in the change process. Participant One stated, "you can't make a person go for help, you can't make a person change, but I do think you can offer help to the family members". The participants all strongly believed that they could not change someone else, that one can only change oneself. All participants concurred that change, whether it be

behavioural or thought patterns, had to be involve all family members, not just from the substance user.

2. Boundaries

Four out of five of the participants indicated that the most significant change that the family had to make was with respect to boundaries.

Participant Three recounts the following story about when he first established boundaries:

I said OK that's it; there are no drugs in here, that's the way it is. If you don't like those rules you have to go out. And I let him go a couple of times and finally laid the law down and said that's it you have to go somewhere. I don't care where you go, you have to go somewhere.

Participant One stated:

you can't force anybody to change. It doesn't matter how hard you try, and in fact I think, what happened is when I stepped away from my husband, that's when he kind of stepped up to the plate and stated to look at his own pot use and drinking.

Participant Five stated:

... don't be afraid to set boundaries and stick to them because we were wishy washy. I was wishy washy on boundaries and I think once I got super tough and (my son) has even acknowledged that it's when I got super tough about boundaries was when he realized that this wasn't going to work.

When boundaries were established, this seemed to be a turning point for the substance user. Participant One noted that boundaries are set in the family when members are “able to say what's OK, what's not OK and to put a plan together for themselves.” Only then is the substance user informed about what are acceptable and unacceptable behaviours in the family..

3. Communication and being supportive

All the participants acknowledged that one of the changes required in families with addictions is to change the way that they communicate. Participant Five said that dealing with the addiction in the family has helped the family to learn to communicate with each other and

that we actually now operate in our house like three adults living in a house and we actually have more conversations. We're more open. I think before it was everyone trying to be the perfect family. Now we are who we are and we're closer. We're more open.

Participant Three talked about how having open and supportive communication with his family member helped him to “[keep] in touch with him. We go for coffees or out for lunch or whatever and we would talk about drugs and it seemed to help him...Now we have grown closer”. Even though the participants did not directly state what constructive communication entailed, one of the elements was that communication is more about listening than about getting your point of view across. It seemed, from the participants’ stories, that the experience of addiction may have actually been a catalyst to addressing communication issues that were already present. Once those issues were addressed, the family relationships were closer and stronger.

4. Finding your voice

When the participants talked about finding their voices in counselling, they meant three things: feeling confident to tell their story, being comfortable enough to discuss the family addiction and not feeling judged. All of the participants were advocates for counselling.

Participant Two talked about not believing that she could voice her opinions, but that she gained confidence through attending counselling and is now able to speak out:

I appreciate being able to say that because I could never speak out like that. I could never speak. If you ever asked if I could do this [speak out] five years ago I would have said ‘no’ I couldn't say things.

Participant One noted,

I just felt really safe with her and felt like I could just completely tell my story and found that that was a very, very freeing thing to do. And it really wasn't making me look bad, it was the story of everything that had happened and how the choices of my husband really impacted me and my children. So I think opening up was really the number one way of coping, to be honest in a really safe relationship.

Participant Five discussed how counselling helped the family and she now attends a support group that runs twice a month for family members that are dealing with family substance use.

...there's a lot of family members that don't have their own counsellor. They want their addict to get a counsellor, but they don't. And so I'm an advocate for get your own counsellor and then educate yourself, take care of yourself.

5. Find a different perspective

Through counselling the participants gained support and new perspectives. Participant Five said “I depended on my counsellor...I listened to him, I learned from him, I got strength and hope from him” and participant One stated that “having someone to talk to and get support from is really important. I see things completely different now, seeing a counsellor to talk about the difficulties was really, really helpful”. Participant One also remarked that “...one of the most important things was that she just, she [the counsellor] really helped me to understand how complicated my situation was and how much grief and loss I have experienced over the years”. Participant Three said he “learned an awful lot about life thanks to [the counselor’ name]. I think she's a miracle worker. What I was learning about my life I could relate to their [the family members who use substances] life”.

Participant Five discussed how counselling changed her way of thinking and the way she approaches her life. She stated:

It has just changed who I am and how I view life and I never would be the person I am today if I hadn't gone through it...I find I'm not judgmental... I am very much learning to be more present in the moment and I am slower and more methodical in the things I do.

The biggest thing for me that changed ...is my compassion towards people with less, people struggling with addiction, people struggling with homelessness and with mental illness.

You know we learned a lot about, through the journey we learned so much about each other. You always think you know people and then something

happens and then you really get to know that person.

Counsellors offered a sense of positivity and they assisted participants to gain a different perspective on family involvement with addictions. All of the participants believed, as participant Two stated: “you have to live for yourself before you can begin to enjoy life”, and participant Five stated that families need to “focus on ourselves and our healing... We have a life, we need to live it”.

6. Is there a need?

When discussing treatment initiatives in addictions, the participants had strong views. All participants agreed that there is a need for further treatment and support options for families and substance users. The participants talked about increasing awareness and education, which they felt would reduce the stigma attached to addictions. As Participant Five stated that “people need to start talking more about addiction so that it's not seen as something horrible, it's seen as a sickness”. Participant Three remarked, “...we have to get more help for families and problems. Mothers and fathers get so frustrated that they could just go crazy because there's just nowhere to turn”.

Participant One suggested that programs should

somehow reach out, get the news out, get the information out to family members who are being affected to just give them information to make them aware of how do you deal with this stuff? So maybe rather than concentration so much on trying to get him to change, you know, if I was taught years and years ago about setting boundaries and taking steps you know to protect myself and the children and I think that maybe that's the way to be helpful is to have support services for the family members who are impacted.

Participant Five's suggestion for a family program was,

I wish there was a way that we could implement a family program, you know it was four days long, it was funded through OHIP and you would go and you would learn all this stuff. Because even though you're not going to implement

all of it or take all of it away, the important things you learn will stick and maybe six months down the road you'll start to realize oh maybe I could. I just think families are lost out there and so alone.

About the need for awareness and education, Participant Five stated, “I wish society knew more about addiction” and Participant Two said “everything is always been behind closed doors”.

Participants all agreed about the need for increased funding. Participant Four said:

Programs for both the addicts and the families can actually save society money by preventing family breakups.....and forcing many families to depend on financial support by the taxpayers. Money is going to be spent either way. Better to put those resources into the more positive option.

Participant Five stated that her family paid for private residential programming but noted that most families do have this option:

...we could get him right in to (private residential program name) because if you can pay you can get anything you want right. And so many people that's not an option for them and their kids or their spouses, their loved ones, and you have to be able to do it when the opportunity's there. It can't be well there'll be a bed in six weeks. 'Cause you, your child could be dead in six weeks right, or, so I think the government has to do more for families.

Through the journey of addictions, all the participants experienced ups and downs, frustration and surprising benefits. They became informed and educated through counselling; they developed new perspectives on addiction and on life and they learned healthier ways of coping. They all concur that there is a need for more addiction services.

Finally, the similarities of the themes in this study and in the evaluations of the community family addiction programs psycho-educational groups show that there is a continued need family addiction programs. The evaluations from the 94 people who attended the psycho-educational groups stated that the families perceived that their understanding of substance use and the resources and supports available for families increased by at least 50% after they

attended the group information. There were 97.7% of the families who stated they would use the coping strategies learned in the group, particularly setting boundaries (38.6%) and communication skills (35.2%). The families from these groups seem to have the same sentiments as the participants in this study; hence, there is a need.

Chapter Six: Discussion

In addictions research, families are viewed as a secondary system (Csiernik, 2002). Consequently, treatment is predominately focused on the individual. This study explored an alternative point of view, that of the family. It asked whether there was a need for family addiction treatment. My personal and professional opinion is that families' views are under-represented in addiction research and, consequently, their treatment needs are under-served. The purpose of this study, as described to the five participants, was "to understand the family experiences when a family member has an addiction. I am hoping to find out your family's experiences when addiction issues are within the family and your opinions and perceptions about what, if anything would be helpful to your family" (appendix A).

The participants were clear that there is a need for addiction programs for family members who are coping with an individual member's substance use. Though the participants were aware that there are some services for families, they all agreed that the current services are insufficient. Three themes emerged from the interviews: family disconnections of addiction, family reactions to stigma and benefits of counselling.

The first theme, family disconnections of addiction spoke to disconnection from the substance user and disconnection in communication within the family. This theme is echoed throughout the literature on the impact of addictions on families (i.e., how it alters family functioning, family relationships, communication patterns and how it leads to conflict and isolation) (Marshall, 2003; Prest & Protinsky, 1993; Lander, et al., 2013; Orford, et al., 2012; Templeton, et al., 2007; Johnson, 2002; Ranganathan, 2004; Csiernick, 2002). What I observed in the interviews connects well with Orford, et al.'s (1998) coping styles framework. Specifically, these authors talk about 'engaged', 'tolerant' and 'withdraw' styles of coping. In

this first theme, the ‘engaged’ coping style seems to reflect the disconnection in communication spoken of by the participants (i.e., trying to change the substance use behaviour). The ‘withdraw’ coping style seems to be equivalent to disconnection from the substance user, where there is a distance between the substance user and the family members. The ‘tolerant’ coping style seems to parallel to more towards the next theme, family reactions to stigma, where secrecy and social isolation is used to excused or covered the substance user’s behaviours.

In the second theme, family reactions to stigma, the participants discussed ways of dealing with the addiction in their families. One way of coping was through secrecy whereby the individual with the addiction so skillfully hid the substance use that the family was oblivious to it. The family also engaged in secrecy, though. The reality of the addiction would be hidden from friends and other family members in order to avoid stigma. The literature on stigma in relation to addictions has been widely researched, but there is minimal exploration of how the family perceives the effects of stigma. Stigma in addictions is mainly associated with the people who are using the substances, where stigma characterizes people with addictions (Yang, et al., 2007) as engaging in behaviours that deviate from societal norms (Lloyd, 2010; Goffman, 2009). When you broaden the scope, the stigma that is attached to people with a substance use problem may be transferred to other people who are associated with the substance user, including the family. Therefore, it is easy to understand why families use secrecy as a coping mechanism to evade the social stigma (Goffman, 1963; White, 2009) that is connected to them.

Another way that family members reacted to stigma was through social isolation through avoiding people, places and social activities. The participants in this study remarked that this way of coping was mainly to avoid the stigma and judgments associated with addiction. This strategy may work well for the substance user who is avoiding triggers, but not for the family

members whose distance from social supports was is often destructive and a catalyst for other family issues (Orford, et al., 2010).

The third theme was the benefits of counselling where the participants clearly stated they gained awareness about the change process, specifically that you can only change yourself and not another person and that change is required by everyone in the family, not just the substance user. The participants also developed knowledge on setting boundaries and building productive and supportive communication skills. The families developed new perspectives and regained their voices.

It is worth noting that a fourth theme emerged in the transcripts that was beyond the scope of the study but, in the interests of respecting the participants' voices, seems important to acknowledge it here. The participants wished to theorize on why addictions occur. First, there was a strong reference to genetics as the cause of addictions. Four of the five participants indicated that addictions were present in other family members and throughout generations. Each of these participants had been dealing with addictions for over 20 years, some for 40 years. The one participant who did not refer to genetics was a participant who was dealing with addiction for less than 5 years. The other contributing factor that the participants mentioned was that addiction was a learned behaviour acquired over several generations. Participant Three stated "I'm sure because of some of the problems that I went through I'm sure that part of my problem rubbed off on my son... and rubbed off on the kids [referring to his son's children]".

Finally, the groups that were co-facilitated community by family addiction programs showed that the 94 participants seem to correspond with some of the themes in this study. Overall, 97% of the participants in these groups stated that this psycho-educational group was helpful, which corresponds with the study's findings that counselling was helpful. The group

members most valued help with setting boundaries and communication skills (DeGasperis, 2014). This paralleled with the perceptions of the participants of this study. This information indicates that families find addiction services helpful in building their awareness about dealing with addictions in the family.

The themes in this study are best understood using Family Systems Theory (FST). FST understands the family as a unit that is interdependent (Bowen, 1974). To be successful in treating individuals or families, one must understand how each individual functions in the family system and how the family members interact (Lander et al., 2013). The findings in this study conform to the overwhelming literature that promotes holistic addiction treatment.

The participants in this study experienced the benefits of counselling, which concurs with the literature on that subject. Specifically, the research tells us that counsellors help families by teaching them about family dynamics, raising their awareness about their personal values and needs, improving family relationships and functioning, coaching them on how to support each other; offering them a safe space to voice their concerns; suggesting different perspectives and giving them skills to maintain homeostasis (DeCivita, et al., 1999; Lander, et al., 2013; Adelson, 2009; Copello, et al., 2005; Copello & Orford, 2002; Armstrong, 2004; Bowen, 1974; Copello, et al., 2005; Templeton, et al., 2007). A number of studies consistently indicate that including families in addiction treatment leads to improvements such as increased motivation, engagement and compliance in the substance user; maintenance of changes; lower relapse rates; increased time of abstinence; and improved family relations over the long-term (Meyers, et al., 2002; Steinglass, 2009; Sarpavaara, 2014; Gruber & Taylor, 2006; Copello & Orford, 2002; DeCivita, et al., 1999; Beattie & Longabaugh, 1997; Ellis, et al., 2004).

Limitations of the study

Because of the recruitment difficulties I explained previously, there were time constraints on this study that led to certain limitations. First, there was a smaller sample that was not inclusive of gender, age, or socioeconomic status. The participants of this study were all white Anglo-Saxon and socioeconomically stable. The study was limited by not taking into account cultural and race diversity and how those differences may have influenced the family's perceptions on addictions. The study also did not include marginalized populations (e.g., those experiencing homelessness or poverty).

Another limitation in the study is that all the participants were knowledgeable about family addictions services and reported attending counselling with positive outcomes. This means that the study does not include those who have not attended addiction counselling or who have had a negative experience of counselling.

The final limitation in this study is my own professional and personal experiences of addiction. Even though I was mindful of this limitation and precautions were in place to minimize it, there is still the fact that I am an insider and the lens through which I approached this study is informed by my personal and professional experiences.

Implications to research and practice

While this study sample was limited, the results may peak interest to continue this research with a larger sample. I would suggest that further research be inclusive of gender, socioeconomic status, social and cultural contexts. There is an abundance of research on family addictions but the family's voice needs to be considered, especially in researching the content of family programs. It would be interesting to consult with family members in proposing a plan for addiction family services and compare that plan to what is currently being provided.

FST tells us that family members should be seen together (Bowen, 1966), but this is not always an option in addiction treatment due to family distancing or disconnection. Even if the family member is not in the counselling room, it behooves us to remember that there is a reciprocal influence between family members and family members are influenced and react to the person with the addiction and vice versa even if they are not in direct contact. It is important to gain knowledge about the family dynamics and its influence on the person with the substance use problem. The more advantageous approach to addiction treatment is to be more holistic and taking into account multiple frames of reference (individual, family, social, cultural and/or political). The evidence is clear that engaging family members in treatment, in their own right or alongside their substance using relative, can be beneficial to all involved (Copello, et al., 2005; Orford, et al., 2009). The literature regarding addiction treatment for families overwhelmingly concurs that there is a need for understanding addiction research and family treatment (Copello et al., 2010; Gruber & Taylor, 2006; Copello & Orford, 2002; Csiernik, 2002; Copello, et al., 2000), and that the social networks of those involved in addiction treatments should also be assessed in family treatments (Sarpavaara, 2014).

Family services are available in the addiction field predominately through psycho-educational groups and self-help groups. In evaluating the 10 psycho-educational (DeGasperis, 2014) groups it seemed that families find addiction services useful. This paralleled with the findings of this study that supported that educational groups are useful, but that addiction education needs to be more widely distributed if we hope to break down the misconceptions that have been socially constructed over time in our society. For families to be included in addiction treatment, we need a change in social policy and an increase in funding for family addiction

treatment. If addiction programs were to listen to the voices in this study, it would be a good beginning.

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[Puc_BnEdN&sig=yP9ggeImh0XbZ5W1phmknKY7vZ0#v=onepage&q=definition%20o](http://books.google.ca/books?hl=en&lr=&id=rTVuAAAAQBAJ&oi=fnd&pg=PA97&dq)

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Appendix A



Inspiring Innovation and Discovery

LETTER OF INFORMATION / CONSENT

A Study about: Addiction treatment for families: Is there a need?

Investigators:**Principal/Student Investigator:**

Laurie DeGasperis, B.S.W., R.S.W.
M.S.W. Candidate in Social Work
Department of Social Work
McMaster University
Hamilton, Ontario, Canada
E-mail: degaspli@mcmaster.ca

Faculty Supervisor:

Sheila Sammon, M.S.W., R.S.W.
Department of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 23780
E-mail: sammon@mcmaster.ca

Purpose of the Study

You are invited to participate in this study because you have been dealing with addictions in your family. You have a family member has or had an addiction problem. The purpose of the study is to understand the family experiences when a family member has an addiction. I am hoping to find out your family's experiences when addiction issues are within the family and your opinions and perceptions about what, if anything would be helpful to your family. I am seeking to explore the needs of addiction services for families.

The research is a requirement of my Masters of Social Work degree. The findings will be presented to a number of addiction services to help with programming.

Procedures involved in the Research - What will happen during the study?

If you agree to participate, you will be participating in an interview:

- This will be a face to face interview that will take approximately 1 to 2 hours, with a break if desired.
- The interview will take place at an agreed upon location that is private and ensures your confidentiality.
- The only people attending this interview will be you and me.
- With your permission, the interview will be recorded and later transcribed (typed out on paper).
- With your permission, I will be taking handwritten notes during the interview.
- With your permission, I would like to be able to contact you after the interview to clarify any points that might come up as I go through the data.

During the interview:

You will be asked to complete a very brief demographic/background questionnaire and we will have a conversation about:

- your experiences with addictions as a family
- about your experiences with a family member with an addiction
- Your perceptions of what services would be helpful to you and your family.

Potential Harms, Risks or Discomforts in doing this study?

It is not likely that there will be any harm caused by your being in the study.

Some of the questions may raise issues that have caused you worry and stress. You do not need to answer questions that you would prefer to skip and are free to end the interview at any time.

You may also worry about how others might react to what you say if they knew. I described below the steps I am taking to protect your privacy.

Potential Benefits

The research will not benefit you directly. However, your participation will lead to a better understanding of families' experiences with addiction and possibly to improvements in addiction services for families.

Compensation

Each participant will receive a \$20 Tim Horton's gift certificate.

Confidentiality

Every effort will be made to protect your confidentiality and privacy. I will not use your name or any information that would allow you to be identified. However, we are often identifiable in the stories we tell and references we make. Please keep this in mind through the interview.

All study-related documents will be kept in a locked desk/cabinet where only I will have access to them or on a password-protected computer. The only people who will have access to the data are me and my research supervisor, Sheila Sammon.

Since I am employed as an addiction social worker, there is a chance that if your family member contacts Alcohol, Drug and Gambling Services in Hamilton, he/she will be assigned to me. If this happens, I will maintain your confidentiality and ask that your family member be seen by someone else.

What if I change my mind about being in the study?

It is your choice to be part of the study or not. If you do not want to answer some of the questions you do not have to, but you can still be in the study. If you decide to be part of the study, you can stop the interview for whatever reason, even after signing the consent. If, after the interview is completed, you decide you would like to withdraw from the study, you may contact me and I will destroy all information related to you and your family. This will be possible only for two weeks after the interview. After that point I will have started my analysis and will not be able to remove your data. If you decide to withdraw, there will be no consequences to you.

Information about the Study Results

I expect to have this study completed by approximately September 2014. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study

If you have questions or need more information about the study itself, please contact me at: degaspli@mcmaster.ca

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat

Telephone: (905) 525-9140 ext. 23142

c/o Research Office for Administrative Development and Support

E-mail: ethicsoffice@mcmaster.ca

This letter of information was discussed on _____.

As agreed your scheduled appointment to discuss your experiences on family and addictions will be on:

Date: _____ Time: _____ Location: _____

CONSENT

- I have read the information presented in the information letter about a study being conducted by Laurie DeGasperis, a Master of Social Work student of McMaster University.
- I understand that all information collected in the interview will be destroyed 6 months after researcher’s graduation.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study up to one (1) week after the interview.
- I have been given a copy of this form.
- I agree to participate in the study.

_____	_____	_____
Signature of Participant	Name of Participant (Printed)	Date

_____	Laurie DeGasperis,	_____
Signature of Study Investigator/ Witness to consent	McMaster University Student Name of Study Investigator/ Witness to consent	Date

1. I agree that the interview can be audio recorded. Yes No
2. I agree that note taking can be taken during the interview. Yes No
3. I would like to receive a summary of the study’s results. Yes No

Please send them to this email address _____

Or to this mailing address: _____

7. I agree to be contacted about any follow-up clarification about the interview information, and understand that I can always decline the request. Yes No

Please contact me at: _____

Appendix B



Oath of Confidentiality

(Check the following that apply)

I understand that as:

an interpreter

transcriber

audio assistant

video assistant

research assistant

other (*Please specify*)

for a study being conducted by Laurie DeGasperis, B.S.W., R.S.W. of the Department of Social Work, McMaster University, under the supervision of Professor Sheila Sammon, M.S.W., confidential information will be made known to me.

I agree to keep all information collected during this study confidential and will not reveal by speaking, communicating or transmitting this information in written, electronic (disks, tapes, transcripts, email) or in any other way to anyone outside the research team.

Name: _____
(Please Print)

Signature: _____

Date: _____

Witness Name: _____

Witness Signature: _____

Appendix C

Interview Guide (Questions)

Addiction treatment for families: Is there a need?

Laurie DeGasperis, B.S.W., R.S.W., Master of Social Work student
Department of Social Work at McMaster University

These questions will be used in a one-to-one semi-structured interview. The exact wording of the questions may change, and other short questions may be used to explore information and/or clarify information.

Questions:

These questions are transitional questions from the demographic questionnaire into the face-to-face interview, and to clarify information on the questionnaire, if needed.

1. What was the reason for seeking help?
 - a. Prompts: knowledge, help, education, how to deal with addictions
2. What was your experience like?
 - a. Prompts: educational, knowledge, enlightening, useful/not useful,
 - b. Probes: How did you feel in the group?
3. In your opinion, was there any subject you would have liked covered in the group or counseling that was not? If so, what are they?
 - a. Prompts: Communication, relationship building, strategies,
 - b. Probes: changes in life after the group? In what way did it change?

Interview discussion

4. How has it been dealing with addiction in your family? How has it affected your life?
 - a. Prompts: Understanding addiction, family values, individual beliefs, stressful, disruptive, disconnected
 - b. Probes: impact on stigma, impact on judgments
5. What is your response to the addiction? How have you coped with family addictions? What strategies have you used?
 - a. Prompts: enabler, supporter, contributor, positive, negative, relationships
 - b. Probes: the part (you played) in the family when working with addictions
 - c. Probes: How does an addiction influence your family relationships?

6. Have there been any significant changes in the family experiences? If so, what would they be?
 - a. Prompts: family/social interactions, relationships, trust, understanding, knowledge, strategies to cope
 - b. Probes: How did the dynamics of the family change? What change had the most impact on the family?
7. How are things in your family now? What are your major concerns, and why?
 - a. Prompts: Needs, wants, family improvement, family concerns
 - b. Probes: what would help your family now?
8. Have you had any experiences of working with a professional in the field of addictions?
 - a. Prompts: individual counseling, group work, support groups
 - b. Probes: Were there any barriers to getting help?
9. Do you think any additional professional help would be useful? Why or why not?
 - a. Prompts: family needs, additional help
 - b. Probes: What are the next steps for the family?
10. From your experiences, what might you propose for addiction services treatment? What would have been helpful for your family?
 - a. Prompts: family needs, help for family

Appendix D

Background Questionnaire

Addiction treatment for families: Is there a need?

Laurie DeGasperis, B.S.W., R.S.W., Master of Social Work student
Department of Social Work at McMaster University

This information will be used to summarize themes and statistics. It will be collectively gathered into past evaluations of psycho-educational groups.

Please do not put your name on this form

Thank you

1. I am Male Female

2. What is your age?
18-23 years old
23-34 years old
35-44 years old
45-54 years old
55-64 years old
65-74 years old
75 years or older

3. Would private addiction counseling be an option for your family? Yes No

4. How many people are in your family? _____

5. What is your relationship to the family member with the addiction?

6. How old is the family member with the addiction? _____

7. How long have you been dealing with the addiction? _____

8. Have you attended any groups or counseling for family addictions?

9. If yes, was the group or counseling helpful to you?

Not helpful somewhat helpful helpful very helpful

10. How much did you know about addictions before seeking help?

None Little Somewhat /a little quite a bit lots

Thank you



Appendix E

Supportive Services for Families in Hamilton

Alcohol, Drugs, and Gambling Services (ADGS)

21 Hunter St. E, 3rd floor, Hamilton, Ontario 905-546-3606

www.hamilton.ca/adgs

Hamilton Family Health Team

Individual consultation. Individual counselling in some doctors' offices. 905-667-4848

Catholic Family Services

447 Main Street East, Unit 201,

Hamilton, Ontario 905-527-3823

intake@cfshw.com

(fee for service)

Centre for Addictions and Mental Health

www.camh.net

Al-Anon/Alateen

Hamilton & Burlington area

www.alanonhamiltonburlington.ca

905-522-1733

Drugs and Alcohol Helpline - Ontario

www.drugandalcoholhelpline.ca

1-800-565-8603 anytime

Provides information about treatment services in local community and Ontario

For family member with addiction

Alcohol, Drugs, and Gambling Services (ADGS)

21 Hunter St. E, 3rd floor, Hamilton, Ontario 905-546-3606

www.hamilton.ca/adgs

Suntrac

Partners in Recovery – drop-in supportive group for family members - Thursdays 6:30-8:30

<http://www.mission-services.com/programs-and-services/mens-services/addictionservices/suntrac-wellness-centre/index.html>

196 Wentworth St. North, Hamilton, Ontario 905-528-0389

Women for Sobriety

A self-help program based on positive thinking, meditation, group dynamics, and the pursuit of health through nutrition. The group is peer led by a certified moderator.

www.womenforsobriety.org

Wednesdays, 7-8:30 p.m., Salvation Army, 151 York Blvd., Unit D1. Hamilton 905-628-0421

Men for Sobriety

Self-help group. Promotes a lifestyle change by developing a positive attitude.

Wednesdays, 7 to 8 p.m., Hamilton General Hospital, 5th floor teaching room. 905-573-6473

AA (Alcoholics Anonymous)

24 Hour Helpline: 905-522-8392

www.aahamilton.org - local AA meetings, literature

www.aa-intergroup.org -Online AA meetings –chat, e-mail, literature

www.e-aa.org -Online AA meetings -chat, e-mail, discussion forums, phone, literature

NA (Narcotics Anonymous)

www.nahamilton.org – local meetings 1-888-811-3887

CA (Cocaine Anonymous)

www.ca-on.org – local meetings 1-888-622-4636 – info only

Moderate Drinking Resources On-line and Book

www.moderation.org

www.moderatedrinking.com

www.alcoholhelpcentre.net

“DrinkWise: How to Quit Drinking or Cut Down” by Martha Sanchez-Craig. Self-help book. Available at www.camh.net or Chapters/Indigo on-line.

Drugs and Alcohol Helpline - Ontario

www.drugandalcoholhelpline.ca

1-800-565-8603 anytime

Provides information about treatment services in local community and Ontario

Appendix F

Supportive Services for Families in Burlington

ADAPT

700 Dorval Drive, Suite 501, Oakville, ON (administrative services)
905-639-6537 Ext. 0
[**adapt@haltonadapt.org**](mailto:adapt@haltonadapt.org)

Halton Family Services

720 Guelph Line, Suite 306, Burlington, ON 905-845-3811
www.haltonfamilyservices.org

Centre for Addictions and Mental Health

www.camh.net

Al-Anon/Alateen

Hamilton & Burlington area
www.alanonhamiltonburlington.ca
905-522-1733

Drugs and Alcohol Helpline - Ontario

www.drugandalcoholhelpline.ca
1-800-565-8603 anytime
Provides information about treatment services in local community and Ontario

For family member with addiction

ADAPT

700 Dorval Drive, Suite 501, Oakville, ON (administrative services)
905-639-6537 Ext. 0
[**adapt@haltonadapt.org**](mailto:adapt@haltonadapt.org)

AA (Alcoholics Anonymous)

District 19 Area 86, 3017 St. Clair Avenue, Suite 283, Burlington, ON
24 Hour Helpline: 905-631-8784
www.d19area86.ca - local AA meetings, literature
www.aa-intergroup.org -Online AA meetings –chat, e-mail, literature
www.e-aa.org -Online AA meetings -chat, e-mail, discussion forums, phone, literature

NA (Narcotics Anonymous)

www.naburlington.org – local meetings 1-888-811-3887

CA (Cocaine Anonymous)

www.ca-on.org – local meetings 1-888-622-4636 – info only

Moderate Drinking Resources On-line and Book

www.moderation.org

www.moderatedrinking.com

www.alcoholhelpcentre.net

“DrinkWise: How to Quit Drinking or Cut Down” by Martha Sanchez-Craig. Self-help book. Available at www.camh.net or Chapters/Indigo on-line.

Women for Sobriety

A self-help program based on positive thinking, meditation, group dynamics, and the pursuit of health through nutrition. The group is peer led by a certified moderator.

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Drugs and Alcohol Helpline - Ontario

www.drugandalcoholhelpline.ca

1-800-565-8603 anytime

Provides information about treatment services in local community and Ontario

Appendix G

Supportive Services for Families in Brantford

St. Leonard's Community Services

133 Elgin Street, Brantford, ON
519-759-8830 or 519-759-7188 or 1-866-811-7188
Website: <http://www.st-leonards.com/AMH.html>
<http://www.st-leonards.com/Home.html>

Family Counselling Centre of Brant

54 Brant Avenue, Brantford, ON 519-753-4173
Email: office@fccb.ca
Website: <http://www.st-leonards.com/Home.html>

Centre for Addictions and Mental Health

www.camh.net

Al-Anon/Alateen

Brantford
<http://al-anon.alateen.on.ca/meetings/pdf/11Brantford.pdf>
<http://al-anon.alateen.on.ca/meetings/html/11Brantford.html>

Drugs and Alcohol Helpline - Ontario

www.drugandalcoholhelpline.ca
1-800-565-8603 anytime
Provides information about treatment services in local community and Ontario

For family member with addiction

St. Leonard's Community Services

133 Elgin Street, Brantford, ON
519-759-8830 or 519-759-7188 or 1-866-811-7188
Website: <http://www.st-leonards.com/AMH.html>
<http://www.st-leonards.com/Home.html>

AA (Alcoholics Anonymous)

Brant Erie District AA, PO box 26010, Brantford, ON
24 Hour Helpline: 519-752-5981
<http://www.branterieaa.org/en/>
<http://aa-meetings.com/aa-meetings/aa-canada/Ontario/Brantford.html>
www.aa-intergroup.org -Online AA meetings –chat, e-mail, literature
www.e-aa.org -Online AA meetings -chat, e-mail, discussion forums, phone, literature

NA (Narcotics Anonymous)

http://www.orscna.org/english/city_meetings.php?id=Brantford&id2
local meetings 519-756-9408

CA (Cocaine Anonymous)

www.ca-on.org – local meetings 1-888-622-4636 – info only

Moderate Drinking Resources On-line and Book

www.moderation.org

www.moderatedrinking.com

www.alcoholhelpcentre.net

“Drink Wise: How to Quit Drinking or Cut Down” by Martha Sanchez-Craig. Self-help book. Available at www.camh.net or Chapters/Indigo on-line.

Women for Sobriety

A self-help program based on positive thinking, meditation, group dynamics, and the pursuit of health through nutrition. The group is peer led by a certified moderator.

www.womenforsobriety.org

Wednesdays, 7-8:30 p.m., Salvation Army, 151 York Blvd., Unit D1. Hamilton 905-628-0421

Men for Sobriety

Self-help group. Promotes a lifestyle change by developing a positive attitude.

Wednesdays, 7 to 8 p.m., Hamilton General Hospital, 5th floor teaching room. 905-573-6473

Drugs and Alcohol Helpline - Ontario

www.drugandalcoholhelpline.ca

1-800-565-8603 anytime

Provides information about treatment services in local community and Ontario

Appendix H



Recruitment Poster

***PARTICIPANTS NEEDED FOR RESEARCH IN
FAMILIES AND ADDICTION***

We are looking for volunteers to take part in a study about

**Addiction treatment for families:
Is there a need?**

You would be asked to:

- Complete an anonymous questionnaire
- Attend one interview that will take 1-2 hours to discuss your family experiences with addictions

For more information about this study, or to volunteer for this study,
please contact:

Laurie DeGasperis
Student completing Master's degree
Social Work Department

Email:
degaspli@mcmaster.ca

In appreciation for your time, you will receive a gift certificate

**This study has been reviewed by, and received ethics clearance
by the McMaster Research Ethics Board.**

Laurie DeGasperis

Email:

degaspli@mcmater.c
a

Laurie DeGasperis

Email:

degaspli@mcmaster.
ca

Appendix I

Brochure

About the Researcher

I have worked in the addiction field for the past 7 years and have a great interest in family treatment with addictions. I am hoping this study will extend my learning about addiction treatment and be a tool to enhance family treatment in addictions.

I have a degree in Social Work and returned to McMaster University to complete my Masters of Social Work.

Contact Information

If you have any questions about this study or would like to participate, please contact Laurie DeGasperis at my email at:

degaspli@mcmaster.ca

A review of this study will be available upon request. You can contact the researcher by email if you would like to receive a copy.

This study has been reviewed and cleared by the McMaster Research Ethics Board.

If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact the McMaster Research Ethics Board Secretariat.

Phone :(905) 525-9140 Ext.23142

Email: ethicsoffice@mcmaster.ca

Mail :

c/o Research Office for
Administrative Development and
Support
McMaster University
1280 Main St West
Hamilton, ON L8S 4L8

My faculty supervisor, Sheila Sammon, can be reached at (905)525-9140 ext 23780 or sammon@mcmaster.ca

McMaster University

McMaster University

Addiction
treatment
for families:
Is there a need?



Research Investigator
Laurie DeGasperis

Master Student
Department of Social Work
McMaster University
Hamilton, ON

Appendix I cont

About this Project

This project is being conducted for my thesis for a Master degree in Social Work at McMaster University.

I have the pleasure to work in the addictions field and I am interested in the experiences of families when they have a family member with an addiction.

This is a onetime interview process to gather information about addictions and families from the family's point of view. The information will be summarized to identify common themes and needs in family addiction treatment.

My intent is that this information will enhance the knowledge in addiction services to help develop programs that will assist families dealing with addictions.

Participant's Role

Individuals are invited to tell me about their experiences with addiction in their family. Participants will be asked to speak about how their life has been affected by addictions and their perceptions of addictions.

Individual interviews will be conducted. Interviews will follow a general theme, but will be open to follow discussion topics as they arise during the interview. Interviews will be approximately 1 to 2 hour in length, depending on the availability of the participant.

Our interview will take place in a mutually agreed upon quiet and comfortable location. With the permission of the participant, I will use a small digital voice recorder to tape the interview.



Confidentiality

All records of my observations, tapes of individual interviews and conversations will be kept private and will only be available to my supervisor and the supervisory committee. Records and basic demographic information of the participant will be used only for research purposes and will be kept in secure storage. I will use pseudonyms (a code) in all publications, and no one will be identified by name in this study.

If at any time you feel uncomfortable in the interview or with me taking notes in the interview, we can end the interview. If there are any questions that you feel uncomfortable answering or that you would prefer not to answer you may skip over that section or stop the interview. If an interview is stopped, all information will be erased or destroyed to ensure your confidentiality.

Participation in this research is completely voluntary and the participant can decide to withdraw from this study up to two weeks after your interview.

Appendix J

Recruitment screening questions at initial contact with participant

Addiction treatment for families: Is there a need?

Laurie DeGasperis, B.S.W., R.S.W., Master of Social Work student
Department of Social Work at McMaster University

These questions will be asked at initial contact with the participant to reduce the potential risk of any therapist/client relationship between the family member with the addiction and the researcher.

-
1. Do you have a family member involved with addictions that is 23 years of age or older?
 2. Does this family member live in the Hamilton area?
 3. Does this family member attend or ever attend services at ADGS?

If an appointment for the interview is scheduled, ask if the participant wants a reminder letter of the appointment.

Do you want a reminder letter for the interview? Yes No

Address to send letter: _____

or _____

E-mail _____

Appendix K

Reminder letter of interview



Date: _____

To: _____

RE: Our discussion on Family and Addiction treatment
one hour interview

Dear Ms. Mr. _____

This is a friendly reminder that we are going to meet to discuss your experiences about addictions and families.

Our time together is scheduled for _____ at _____.

I will meet you at this time at the agreed location of _____.

If there are any changes and you are unable to make it, please send me an email at degaspli@mcmaster.ca. I look forward to meeting with you.

Laurie DeGasperis
Student of Masters of Social Work
McMaster University

Appendix L

Thank
You
For
Being
Part Of
The Study
On
Families
And
Addictions

I would like to express my sincere thanks for being part of this study. I have a passion working with people who experience addictions, and helping families is an important part of addiction treatment. Your openness and honesty about how you experience addictions was appreciated and was paramount in finding information about the needs for family in addiction.

I will continue to help families in addiction and will make sure that agencies have a summary of this study, in hope to improve program development in addiction treatment for families.

Thank you for participating in this study and giving your voice to family addiction needs.

Study of

**Addiction treatment for families:
Is there a need?**

Research Investigator
Laurie DeGasperis
Master Student
Department of Social Work
McMaster University
Hamilton, ON

Any data pertaining to you as an individual participant will be kept confidential. If you have any questions about this study or would like a copy of a review of this study, please contact Laurie DeGasperis at my email at:

degaspli@mcmaster.ca

As with all McMaster University projects involving human participants, this project was reviewed by, and received ethics clearance through a McMaster University Research Ethics Committee. Should you have any comments or concerns resulting from your participation in this study, please contact the Office of Research Ethics, at 905-525-9140 Ext. 23142.



Inspiring Innovation and Discovery

Appendix M
Compensation Log

Date of Interview: _____

Participant pseudonym: _____

Thank you for participating in this study
and in appreciation,
please accept this \$20.00 gift certificate for Tim Horton's.

Laurie DeGasperis

Participant for receipt of compensation



Appendix N

Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM 5)Impaired Control (Criteria 1-4)

1. The individual may take the substance in larger amounts or over a longer period than was originally intended.
2. The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use.
3. The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects.
4. Craving ... is manifested by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used. Craving has also been shown to involve classical conditioning and is associated with activation of specific reward structures in the brain.

Social impairment (Criteria 5-7)

5. Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home.
6. The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
7. Important social, occupational, or recreational activities may be given up or reduced because of substance use.

Risky (Criteria 8-9)

8. This may take the form of recurrent substance use in situations in which it is physically hazardous.

9. The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Pharmacological (Criteria 10-11)

10. Tolerance ... is signaled by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed.
11. Withdrawal ... is a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance. After developing withdrawal symptoms, the individual is likely to consume the substance to relieve the symptoms. Withdrawal symptoms vary greatly across the classes of substances, and separate criteria sets for withdrawal are provided for the drug classes.

Appendix O

Canadian Statistics

The following summarizes the outcomes that were reported in the CADUMS for life time use, past year use and use of respondents 25 years of age and older for cannabis, illicit drugs, psychoactive pharmaceutical drugs and alcohol (Health Canada, 2014; Health Canada 2014a, Table 1-10).

Substance	Overall, Life time use in Canada 2012 N=11,090	Overall, Life time use in Canada 2011 N=10,076	Overall, Life time use in Ontario 2012	Last year use in Canada 2012 N=11,090	Past year use in Canada 2011 N=10,076	Life time use in Canada of respondents age 25 +	Past year use in Canada of respondents age 25 + 2011
Cannabis	41.5%	39.4%	39.4%	10.2%	9.1%	42.8%	8.4%
*Illicit drugs	15.4%	n/a	14.7%	2.0%	1.7%	16.0%	1.2%
**Psychoactive Pharmaceutical drugs				24.1%	22.9%		23.9%
**Psychoactive Pharmaceutical drugs-For use to get high				0.9%	0.3%		0.4%
**Psychoactive Pharmaceutical drugs-Abuse of drugs For use to get high				1.5%	0.7%		0.9%
Alcohol	91.0%	89.7%	90.1%	78.4%	78.0%	93.1%	79.3% (2011) 80.0% (2012)

Legend

* Illicit drugs include cocaine or crack, speed, ecstasy, hallucinogens (excluding salvia) or heroin
 ** opioid pain relievers, (such as Percodan®, Demerol®, and OxyContin®; stimulants, (such as Ritalin®, Concerta®, Adderall®, and Dexedrine®); and tranquilizers and sedatives, (such as Valium®, Ativan® and Xanax®). While these drugs are prescribed for therapeutic purposes, they have the potential to be abused due to their psychoactive properties (Health Canada, 2012a, p.4).
 n/a (or blank areas) the information was not available or not reported.

Appendix P

Bracketing – Reflection of the researcher's inside role

This topic is of great personal interest for me and I hope this will help others. I hope that addiction agencies will take heed to the findings and maybe include the family's perspective into programming.

My perceptions of addictions in families are from two views:

First was the time before I gained knowledge and awareness of addictions and I was just engulfed in the affects the addiction had on the family. This was a frustrating time; it was the fear of not knowing what to do, no supports, no education. It was thinking the worst possible scenarios. It was thinking I had no control; the family dynamics were changing, relationships were changing and that drugs and alcohol had the control and 'it was winning'.

The second view began with a three hour education group; unfortunately this accentuated my fears and I felt I had no next steps. It did set me on a course of gaining knowledge. I attended counseling that gave me understanding and perspective on responsibility and how to let go of the situation. But still I needed more, so I attended the addiction diploma at McMaster. Most people would not take this route, but I gained what I needed, insight on addictions and this changed my approach to the family situation. This also changed my career choice, set me on a different course that was so different than my past career. I realized through the process of family addiction, that there were some benefits.

It is important to remember for this study---I may understand the insider role in addictions but...

My experiences personally and professionally are ONLY mine

They do not transfer to others

We all have our own journey

Appendix Q Psycho-educational group evaluations (page 1 of 2)

	<u>Not</u> <u>Satisfied</u>		<u>Satisfied</u>		<u>Very</u> <u>Satisfied</u>
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
Feb 19, 2010 (11), N =11 Old Evaluation					
What is your overall rating of this group			4	3	4
How satisfied were you with the information			4	3	4
How satisfied were you with the format			4	3	4
	<u>Disagree</u>		<u>Unsure</u>		<u>Agree</u>
My knowledge & understanding about substance use increased			1		10
After group, I feel I will try some coping strategies					11
My knowledge & understanding of information about resources to support families has increased			1		10

NEW EVALUATIONS N=94

	<u>Not</u> <u>Satisfied</u>		<u>Satisfied</u>		<u>Very</u> <u>Satisfied</u>
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
Overall how helpful was this group to you		1 (0.01%)	16 (17.0%)	25 (26.7%)	52 (55.3%)
How helpful was the information provided			17 (18.1%)	28 (29.8%)	49 (52.1%)
How satisfied were you with how the group was run			14 (14.9%)	20 (21.3%)	60 (63.8%)

	<u>Poor</u> <u>1</u>	<u>Fair</u> <u>2</u>	<u>Good</u> <u>3</u>	<u>Very</u> <u>Good</u> <u>4</u>	<u>Excellent</u> <u>5</u>
How would you rate your understanding of Substance Use before the group	1 (0.01%)	22 (23.4%)	35 (37.2%)	25 (26.7%)	11 (11.7%)
How would you rate your understanding of substance use now		1 (0.01%)	21 (22.3%)	51 (54.3%)	21 (22.3%)
How would you rate your understanding of Substance Use resources available to support families facing substance use problems before the support group	15 (15.9%)	22 (23.4%)	23 (24.5%)	16 (17.0%)	18 (19.2%)
and now	1 (0.01%)	3 (0.03%)	21 (22.3%)	50 (53.2%)	19 (20.2%)
Do you plan to use the coping strategies	yes	84 (97.7%)	no	1	maybe 1
To what extent do you think participation in the session will help you cope with the ongoing stress of being involved with a person with substance use problems		2 (0.02%)	26 (30.0%)	28 (31.8%)	32 (36.4%)
<u>Strategies that people would use or found useful that you learned in group</u>					
Boundaries	34 of 88	38.60%			
DESC Model	17 of 88	19.30%			
Self time/Self care	15 of 88	17.10%			
Communication	14 of 88	15.90%			
Stress Management	3 of 88	0.03%			
Open discussion	3 of 88	0.03%			
Breaking problem down	2 of 88	0.02%			
April 30, 2010 (6), June 25, 2010 (6)	10	94			
Oct 22, 2010 (16), Nov 11, 2012 (11)	groups	People			
no date(12), no date (9), no date (8)					
no date (11), Oct 18, 2013 (9), Feb 7, 2014 (6)					

