

OUTCOMES OF INVOLVEMENT AND OVERALL
LIFE SATISFACTION FOR FAMILY MEMBERS WITH A
MEMBER IN TREATMENT AT LUTHER/MIDELFORT'S
NEW JOURNEY OUTPATIENT AODA PROGRAM

By

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ABSTRACT

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<u>Outcomes of Involvement and Overall Life Satisfaction for Family Members with a Member in Treatment at</u>			
<u>Luther/Midelfort's New Journey Outpatient AODA Program (Title)</u>			
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Families with an alcoholic member are characterized by a number of structural dysfunctions, including chaotic or rigid patterns of adaptability and low levels of life satisfaction marked by characteristics of codependency. The subjects of this study are the significant others or spouses of alcoholic members who were involved in the New Journey Family Night Program at Luther/Midelfort Hospital in Eau Claire, Wisconsin. The Luther/Midelfort Family Recovery Scale measured their levels of involvement in recovery and overall life satisfaction. The results indicate that the significant other or spouse's recovery and participation in the New Journey Family Night Program

is related to the completion and depth of involvement of the alcoholic member in treatment.

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CHAPTER 1

Introduction

The costs of addiction; emotional, physical, and economic are vast and complex. A recent United States federal report has found that an estimated 18 million American people, teens and adults, have a serious problem with alcohol abuse (Edwards & Steinglass, 1995). In addition, the Substance Abuse and Mental Health Services Administration (1999) reported that an estimated 4 million American adults and teens met the criteria for dependence upon illicit drugs. As many as four family members are directly and negatively affected by a related family member with a serious alcohol and/or drug problem (O'Farrell, 1989). If approximately 20 million persons are reported to have serious problems with alcohol and/or drugs, then an estimated 80 million family members will be adversely affected. These findings give strong cause to further the research of the potential role of family participation in alcohol and drug treatment.

Of a United States population that exceeds 250 million, approximately 31 percent of the population will be affected by a family member's addiction (Famighetti R., et al., (Eds.), 1999). These effects include devastating occurrences such as divorce, domestic violence, sexual

dysfunction, incest, extramarital affairs, crime, poverty, unemployment, accidents, injury, physical and mental illness, child neglect/abuse, adolescent "at risk" behaviors, and suicide (Rotunda, Scherer, & Imm, 1995). In alcoholic families the incidence of these dysfunctional, traumatic occurrences tend to exceed, sometimes double, what is reported in non-alcoholic populations (Edwards & Steinglass, 1995; Stanton & Todd, 1982; Steinglass, Bennet, Wolin, & Reiss, 1987). Addicts do not live in a vacuum. Their addictive behaviors have an impact on others. Family members are probably the most affected group.

A case study on the effects of alcoholism on children by Chafetz, Blane, and Hill (1971), found that 41 percent of alcoholic families experience divorce as opposed to 11 percent of non-addicted families. In addition, 60 percent of the intact alcoholic families were reported to have poor spousal relationships, compared to 11 percent of the non-alcoholic spouses (Steinglass et al., 1987). Patterns of disturbed marital interactions such as verbal abuse and violence have also been linked to antisocial behavior in the children of alcoholics (Jacob, 1992; O'Farrell, 1992).

In recent years, many studies have been published which support marital and family therapy in the treatment

of alcoholism and drug addiction (O'Farrell, 1989; O'Farrell, 1992; Rotunda et al., 1995). Marital and family therapies are designed to help alcoholic family systems adjust their functioning from coping with active alcoholism to thriving in recovery. Research supports that positive and active family involvement in treatment reduces structural dysfunction in alcoholic families including: divorce, potential "risk factors" for children of alcoholics, and potential risk of relapse of the addict into old using behaviors (Edwards & Steinglass, 1995; Preli, Protinsky, & Cross, 1990; Rotunda et al., 1995).

Statement of the Problem

Traditionally, treatment centers have focused on the recovery of individual addicts. Less consideration is given to their families (Lawson, Peterson, & Lawson, 1983). However, research suggests that without family involvement in the addiction treatment process, addicts are more likely to relapse (Edwards & Steinglass, 1995). The chemical dependency treatment community has gradually increased the inclusion of family in the treatment process. This is due, in part, to research that supports the family contributions to the etiology, course, treatment and prevention of addiction (Edwards & Steinglass, 1995; O'Farrell, 1992; Steinglass et al.,

1987). Nevertheless, most treatment programs do not fully integrate the family into the treatment process.

Addicted persons receive treatment that focuses primarily on their addiction (Steinglass et al., 1987). More research is needed to determine the efficacy of integrated family involvement in the treatment of addiction.

Purpose of the Study

The purpose of this study is to determine if a relationship exists between the length and depth of recovery for addicts in treatment at Luther/Midelfort's New Journey Intensive Outpatient AODA Program, and their family members' involvement in treatment. In addition, the study examines family members' increased overall life satisfaction. Data was collected during the summer of 2000 by a mailed survey to the family members of addicts who had received or who were currently in treatment at Luther/Midelfort.

Research Hypothesis

Two hypotheses were addressed in this research. They are:

1. There will be a positive relationship between clients' length of time in treatment/recovery and, their family members' involvement in the treatment process.

2. There will be a positive relationship between clients' depth of the commitment to recovery, and their family members' life satisfaction.

Definition of Terms

For clarity of understanding, the following terms are defined:

Alcoholism - "A primary, chronic disease with genetic psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking" (Morse & Flavin, 1992, p.1013).

Addiction - "Dependence on or commitment to a habit, practice, or habit forming substance to the extent that its cessation causes trauma" (Random House-Webster's College Dictionary, 1992, p.16).

Family Systems Theory - "describes how the family works, the mechanisms or structure that allow it to function as a unit. The theory describes how interactional patterns of relationship and behavior maintain the family's sense of balance . . ." (Brown & Lewis, 1999, p.85).

Limitations

Three limitations are apparent in this research:

1. Clients of the Luther/Midelfort Journey Program may not sign the release of information form attached to the survey and pass it on to family members who attended family night with them while they were in treatment.

2. The family members may not respond honestly to the items on the survey due to the personal nature of the questions.

3. This study by its design and nature can not be generalized to other addiction treatment populations.

CHAPTER TWO

LITERATURE REVIEW

Over the past fifty years, researchers have shown increased interest in the study of the family's role in the etiology, course, treatment and prevention of addiction (Jacob, 1992). Addiction has been determined to have pervasive and negative effects on the family (Edwards & Steinglass, 1995; Preli et al., 1990). High levels of marital problems, mental and physical illness, divorce, unemployment, economic loss, legal conflicts, inadequate parenting, sexual inadequacy, and physical and sexual abuse problems are associated with alcoholism (Edwards & Steinglass al., 1995; O'Farrell et al., 1999; Preli et al., 1990; Rotunda et al., 1995). Throughout the years, research has produced a wide variety of theories on what the probable causation of addiction might be. Specifically, addiction researchers have attempted to determine what factors need to be addressed in the prevention and treatment of addiction.

This review provides a brief overview of the field of family focused addiction research. There is a review of the rise of family focus in the field of addiction, prominent etiology theories from a family-orientated perspective, and prominent family treatment models of

addiction. In conclusion, a summary of family-focused research literature and family focused outcome treatment studies are presented.

Foundation of Family Focused Research

Even though addiction has been determined to affect all levels of social order, it has traditionally been treated as an individual problem (Jacob, 1992; Lawson et al., 1983; Steinglass et al., 1987). It is not surprising to find that the history of family focused literature on alcoholism began with the study of individuals within the alcoholic family system (Jacob, 1992; Lawson et al., 1983; Pearlman, 1988; Seilhamer, 1991; Steinglass et al., 1987). The earliest addiction research from a family perspective focused on the female spouse and the children of male alcoholics (Jacob, 1992). These early perspectives were psychodynamic, and individually oriented conceptions of family and its influence on the addictive process (Jacob, 1992; Seilhamer, 1991).

Female spouses of alcoholics were the first family members to generate interest in the study of the family in addiction research. In the early study of family and addiction, clinicians theorized that the neurotic behaviors of the nonalcoholic female spouses of alcoholics helped to perpetuate their male partner's drinking. These

women were originally described as "disturbed personalities who sought to fulfill their unconscious need to dominate a male whose alcoholic drinking rendered him weak and impotent" (Jacob, 1992, p.320).

As the field of addiction progressed, other theories that were empathetic toward the spouses of alcoholics began to emerge. For example, researchers began to see the female spouse's behavior as a product of living in a stressful environment created by their addicted spouse (Jacob, 1992; Lawson et al., 1983; Steinglass et al., 1987). This became known as the 'stress theory' and it inspired additional research into the communication and coping patterns between alcoholic and non-alcoholic spouses (Jacob, 1992; Lawson et al., 1983). Over the past several decades, new research has developed that has attempted to integrate the disturbed personality, stress, and the coping theories into a model that determines spousal functioning from five sets of variables. The variables are: background characteristic, level of functioning of the alcoholic partner, life changing events, coping responses, and family environment (Jacob, 1992). This research has broadened the perspective of the spouse's role in the alcoholic family. It has allowed for a more multi-dimensional approach to clinical measurements

of the alcoholic's effect on the non-drinking spouse and vice versa (Jacob, 1992).

Another area of interest in the early research of alcoholic family members is the study of children of alcoholics (Jacob, 1992; O'Farrell, 1992). This research has suggested the children of alcoholics often exhibit emotional and interpersonal difficulties. Researchers characterized these children as being at high risk for alcoholism and psychological disturbances (Emery, 1982; Grych & Fincham, 1990; Jacob, 1992). Despite all of the assertions regarding the long-term chronic problems exhibited by the children of addicts, there is little substantial empirical evidence to back these claims. The research has been undermined by inconsistencies in the findings, research methods, and concepts (Jacob, 1992; O'Farrell, 1992). However, there continues to be popular literature that addresses important issues faced by children of alcoholics (Black, 1981; Copans, 1989).

Contributions to the early study of the family influence in the etiology and course of addiction, whether negative or positive, helped create continued interest into the field of family focused treatment. Today, family and addiction research strives to place the emphasis on the entire family rather than individuals or dyads within

a family system (Brown & Lewis, 1999; Jacob, 1992; Lawson et al., 1983; O'Farrell, 1992; Steinglass et al., 1987).

Family Related Etiology Theories

The family's role in the etiology of addiction has drawn support from many theories. This review will examine family influences from three prominent addiction theories: physiological, sociological, and psychological (Jacob, 1992; Lawson et al., 1983).

Physiological Theories. Literature supports the fact that children with alcoholic parents have more problems with addiction than do children of non-alcoholic parents (Jacob, 1992; O'Farrell & Feehan, 1999). Physiological researchers study the genetic patterns found in families of alcoholics. Genetic control studies done on twins and adopted siblings have shown that there is a significantly increased risk of drug abuse in the samples with one alcoholic parent (Cadoret, 1992; Cadoret, Yates, Troughton, O'Gorman, & Heywood, 1986; Pickens, et al. 1991).

Genetic studies are also often used to determine premorbid vulnerability factors that serve as identification for children who may be at risk for substance abuse/dependence. Research suggests that family aggregation of psychiatric disorders and/or criminal

behaviors are strongly correlated with the subsequent development of substance abuse and dependence (Merikangas & Avenevoli, 2000). These studies help to identify genetic risk factors involved in the development of substance use problems to further the progress intervention and treatment of families at risk.

Merikangas and Avenevoli (2000) carried out a controlled family study on the relationship between the comorbidity of psychiatric disorders and substance abuse. A sample of 223 probands with substance use and/or anxiety disorders and community controls, 1218 first-degree relatives and spouses and 203 offspring, were followed for 8 years. The results of the study revealed that family risk factors are more strongly associated with substance dependence than abuse, with an attribute risk of 55%. They also found that premorbid psychiatric disorders such as social phobia, bipolar affective disorder in adults, and depression, anxiety, conduct and oppositional defiant disorders in children were strongly associated with the subsequent development of substance dependence with an attribute risk ranging from 44 to 86%. The study gives cause for further genetic research into family risk factors and for family based interventions in the treatment of substance abuse.

Another type of family-focused genetic research is the study of genes that may be responsible for the development of alcoholism. Blume et al., (1990) identified the Dopamine D2 receptor as a possible candidate for the gene transmission theory of alcoholism. They studied the brains of both deceased alcoholics and non-alcoholics and found that the receptor was present in 24 (69%) of the alcoholics and was absent in 28 (80%) of the non-alcoholics.

Psychological Theories. The second group of addiction etiology theories concerns the psychological aspects of addiction. Psychodynamic theorists commonly explain addiction as being a result of crucial unconscious needs left unmet in early development. Psychological studies on personality traits of alcoholics support the fact that alcoholics have distinct personality types. "Characteristics such as dependency, denial, depression, superficial sociability, emotional instability, suspiciousness, low tolerance for frustration, impulsivity, self-devaluation, and chronic anxiety occur in high frequency among alcoholics" (Lawson et al., 1983, pp. 78-79).

Psychodynamic researchers have also examined the primary role parents play in an individual's psychological

development. Lawson et al. (1983) surveyed 1,000 alcoholics and with the exception of one, each identified themselves as having at least one parent that was an alcoholic, a teetotaler, overdemanding, or overprotective.

A second family related psychological theory is the transactional theory of alcoholism. Steiner (1969) proposes that alcoholism is not a disease but rather a product of dysfunctional communication patterns between family members. He labeled these communication styles as 'games' and 'scripts.' He paints a highly negative picture of alcoholic families where they are portrayed as infantile, egocentric, and manipulative.

Sociocultural Theories. The third of the three etiology theories on addiction are the sociocultural theories of addiction. These theories examine social and cultural attitudes toward alcohol and drug use. In terms of the family, researchers examine the ways addiction may result from a family's social and cultural orientation. According to Graves, Hanson, & Jessor, as cited by Lawson et al. (1983):

The role of the family as socializer can be seen as primary and pervasive. The family is, after all, the most proximal social system to which patterned exposure occurs; it generally guarantees a continuance exposure extending back to the earliest consciousness of social meanings; and it is the single milieu that encompasses at pre-adolescence,

the widest range of experience and involvements for the child. Analysis of socialization as it occurs within the family should reveal a significant amount of information about the influence exerted by the culture on the developing child (p. 12).

There are many sociocultural theories that attempt to explain varying rates of alcoholism among different cultures and sects of people. Vaillant and Milofksy (1982) collected data that suggests that ethnicity and the number of alcoholic relatives may account for the most variance in adult alcoholism. Myerson (1940) cites social ambivalence as the main sociocultural reason for problem drinking. He contends that societal ambivalence creates unstable attitudes toward drinking that are not exhibited in certain other cultures (as cited in Lawson et al., 1983).

O'Connor (1975) identified eight sociocultural characteristics that correlate with a low incidence of alcoholism within a family system. They are: children are exposed to alcohol at an early age through religious practice and family ritual, moderate drinking is practiced by family members, low alcohol content in alcohol beverages consumed by family members, alcohol is usually served with food, moral importance is not associated with drinking alcohol, drinking is not seen as a right of passage, abstinence, not intoxication, is considered

socially appropriate, and most group members agree on the conduct of drinking behaviors (as cited in Lawson et al., 1983).

Wolin, Bennett, and Noonan (1979) studied family rituals in families in which one parent was an alcoholic. They found that alcoholic families that maintained the integrity and order of family rituals did not readily transmit alcoholism to their children. Their investigation suggests regular daily rituals structure family life, create less alienation, and increase family identity. Additionally, they found that alcoholic families that maintain larger socially practiced family life rituals like birthdays, holidays, weddings and funerals were less likely to transmit alcoholism to their children.

Family Focused Treatment Models

Although there are many family therapy models, only three prominent models used in addiction treatment are reviewed. The models include the family systems model, the behavioral and marital therapy model, and the social network model (Jacob, 1992; Steinglass, 1999). This section briefly explains each of these treatment models.

Family Systems Therapy Model. The concepts behind the family systems model and the alcoholic family systems

model are derived from the general systems theory published in 1928 by an early twentieth century Australian biologist named Ludwig Von Bertalanffy. The family systems concept applied Bertalanffy's belief that the whole organizational system is greater than its additive parts (as cited in Steinglass et al., 1987). Family systems proponents believe that all members are continually interacting with one another, and one member can not be clearly defined outside the context of his/her family system (Lawson et al., 1983; Lipps, 1999; Steinglass et al., 1987; Steinglass, 1999).

In systems-oriented theory, families are constantly trying to change and grow while at the same time maintaining balance or homeostasis. Healthy family systems are capable of creating balance between growth and stabilization. Unhealthy families become threatened by change. These family systems often exhibit pathology because they frantically attempt to maintain rigid homeostasis when change is indicated (Brown & Lewis, 1999; Lawson et al., 1983; Lipps, 1999; Steinglass, 1987).

Alcoholic family systems clinicians incorporate core principles of family systems concepts, however they use these principles to uniquely define the alcoholic family system. In family systems theory of addiction, the

alcoholic members can not be treated adequately without family involvement. The family has become an alcoholic system and all members require treatment. Treatment involves the restructuring of the family functioning so as to eliminate the symptom, alcoholism. (Brown & Lewis, 1999; Lawson et al., 1983; Lipps, 1999; Steinglass et al., 1987; Edwards & Steinglass, 1995).

Behavioral and Marital Family Therapy Model. The second model used in the field of family therapy in the treatment of addiction is behavioral marital and couples therapy or BMT. Of the three family models discussed in this review, BMT has the most empirical research to support its basic premises (Lipps, 1999; O'Farrell, 1992). BMT is derived from reinforcement theories of addiction. The behavioral approach to family therapy assumes that alcoholism, and its associated behaviors, result from the influence of reinforcements (Azrin, 1976; Budney, Higgins, Delany, Bickel, 1991; Edwards & Steinglass, 1995). Reinforcement for addictive behavior can be the result of the drug acting as a stimulant or as a depressant. Moderate drug use can relax or excite the central nervous system. This pleasant effect can also act as a lubricant in social settings and allow individuals to loosen their inhibitions. The drug's pleasurable effect and its ability

to increase social interaction acts as reinforcement that promotes continued use (Azrin, 1976; Hunt & Azrin, 1972).

Bandura's (1977) concept of reciprocal factors contends that personal, environmental, and behavioral factors are all interdependent. For example, an alcoholic behaves and people in the environment respond. The alcoholic then uses personal factors to evaluate the response and acts out a new behavior. If the drinker feels that the response is rewarding, such as social attention, then the behavior will be repeated according to the reinforcement theory of alcoholism (Lawson et al., 1983; Longabaugh, Beattie, Noel, Stout, & Malloy, 1993).

BMT therapists involve family members to help them learn how to change the family environment so as to eliminate old family behaviors that have reinforced the alcoholic's drinking patterns. Family members are taught to reinforce sober behaviors and to practice negative reinforcement for old drinking behaviors (Hunt & Arzin, 1973; Azrin, 1976; Higgins, Delany, Budney, Bickel, et al., 1991).

Social Network Therapy Model. The Social Network therapy model is cited by Steinglass (1999) as a popular family model of treatment for addiction. The Social Network Model is derived from the Social Systems Model.

The Social Systems Model and the Social Network Model are based on the theory that substance addiction and recovery are as a result of interactions between individuals and their social environments (Dodd, 1997; Galanter, 1993). Social Network therapy utilizes the substance abuser's family and peers to act as the motivation for change. Members are considered part of the client's social environment and are thus used to provide ongoing support and attitude change for the client in and out of treatment (Steinglass, 1999; Galanter & Brook, 2001).

Network researchers have determined that addicts are characterized as often having great difficulty developing attachments with family members and with parents of origin (Galanter & Brook, 2001). They have also found that the more support addicts have the more likely they are to maintain their abstinence and experience substantial changes in character needed for long term recovery (Galanter & Brook, 2001)

The goals of the Social Network Model of therapy are established by developing family therapy groups that coincide with the addicts treatment groups. The family groups may or may not include the addicted member. Members of the network should not have chemical issues themselves. The focus of the multi-family group therapy sessions is on

addressing difficulties that the non-alcoholic members may face during the recovery period. Network therapy groups help members learn to identify and avoid enabling relapse situations with the client, to understand and address denial in themselves and the client, and help to learn to support one another and the client effectively (Steinglass, 1999; Galanter & Brook, 2001).

Family Based Research Studies

Alcoholic family systems therapists work to alter the family system so that the alcohol no longer acts as the central organizing force. Existence of a reciprocal relationship between non-alcoholic family members and the alcoholic has been established in studies on family violence (Lipps, 1999; O'Farrell, 1992; Rotunda et al., 1995). Also, greater levels of family dysfunction are associated with alcoholic families (Jacob, 1992; Lipps, 1999; Rotunda et al., 1995). Marital discord is also associated with renewed drinking behavior of abstinent or dry alcoholics (Lipps, 1999; Rotunda et al., 1995).

Steinglass is an important contributor to the field of family systems research. His research of alcoholic families began in the 1960's. His early research was a series of experimental studies of observations of alcoholics during active drinking phase and then during a

withdrawal period (Jacob, 1992; Steinglass et al., 1987). His early studies lead to two essential conclusions. Abusive drinking can be an indicator that a relationship within the subsystem of a family is undergoing significant stress. Reciprocally, it can signal that drinking has become a centralizing-force in a family with long term, ongoing drinking problems (Steinglass, Weiner & Mendelson, 1971). His early studies established that intoxication does have a significant effect on the interaction and behaviors of family members. His observations helped to confirm the relevance of reciprocal effects involving alcohol and the interpersonal exchanges between family members (Jacob, 1992).

Steinglass's observations of interactions during intoxicated verses sober periods also served to stimulate a small number of important studies aimed at testing his early observations (Billings, Kessler, Gomberg, & Weiner, 1979; Frankenstein, Hay & Nathan, 1985). Although these studies have been criticized for methodological weaknesses, they have provided some of the most important information to date on variations in behavior among alcoholic members and their families during sober and intoxicated phases (Jacob, 1992; Rotunda et al., 1995; Steinglass et al., 1987). The studies also indicated that

alcoholic-spouse interactions were more negative and disturbed than those of the depressed or non-distressed couples used in the studies. The data gathered during the drinking sessions revealed also that the alcoholic often engaged in a 'responsibility avoiding' style of communication. It was found that spouses of alcoholics often accepted the rationale that the alcohol, not the alcoholic, was to blame. In doing so, the alcoholics could become less inhibited and more negative than if they were sober and/or held accountable. Another finding was that non-alcoholic spouses reported less stress and more marital satisfaction with an alcoholic spouse whose drinking habits are steady than did non-alcoholic spouses whose partner drinks episodically (Jacob, 1992).

Family Focused Treatment Outcome Studies

A family systems study done by Zweben, Pearlman, and Li (1988) developed a study to explore some questions raised by Steinglass et al., (1987) in their descriptive study of alcoholic families (Edwards & Steinglass, 1995). They used couple treatment (CT) to examine the adaptive functioning and the role alcohol might play in the day to day patterns of the families involved in the study. Eight conjoint sessions were used to help the therapist assess the couples' interactional patterns, the possible links

between problem drinking, and the disturbed interactional patterns of each couple. The therapist then made suggestions to help the couples' to problem solve and communicate more effectively (Edwards & Steinglass, 1995).

The control group, attended by an alcoholic and his/her spouse, received a single session of advice counseling. In the session, the therapist assessed the couples problems related to the drinking. The therapist then gave recommendations for improving the problems areas and helped the couples develop relapse prevention strategies (Edwards & Steinglass, 1995).

At a six-month follow-up, subjects in both groups reported increased percentages for abstinent days compared to pretreatment levels. They also reported less-heavy drinking days compared to pretreatment levels. However, no significant results were reported between the two treatment groups (Edwards & Steinglass, 1995).

An early behavioral model by Cheek, Franks, & Burtle (1971) attempted to teach wives of alcoholics how to reduce the consequences of their male partner's drinking, and to become less upset by situations with their alcoholic partners that commonly produced stress. The study did not have a control group and had a low participation rate however it produced a small change in

the wives communication and coping behaviors. The outcome was measured by the spouses' self-reports (McGrady, 1990).

Another more recent study carried out by O'Farell, Cutter, & Floyd (1985) called Counseling for Alcoholics' Marriages (CALM) Project, involved couples whose husbands had just completed a primary Veterans Administration inpatient treatment program (McCrary, 1990; O'Farell, 1992; Rotunda et al., 1995). The subjects were 36 male alcoholics and their wives. The subjects were randomly assigned to interactional couples' group therapy, behavioral marital therapy, or a non-spouse involved control group. Overall, the results of this project show that male alcoholics involved in BMT group reported had better marital adjustment scores during and one year following the treatment, then did the to other groups used in the study (McCrary, 1990; O'Farell, 1992; Rotunda et al., 1995).

Program for Alcoholic's Couples Treatment (PACT) study carried out by McCrary et al., (1986) randomly assigned alcoholics and their spouses to three outpatient behavioral therapy groups. One group had minimal spouse involvement, the second had spouse training to cope with drinking situations, and a third had the spouse fully involved in the treatment of their alcoholic partner. A

six month follow-up study found that all three groups reported decreased drinking, however the third group reported higher levels of marital satisfaction, better follow through with homework assignments, less drinking days while in treatment, and slower post-treatment drinking increases (Lipps, 1999; McCrady, 1990; O'Farrel, 1992; Rotunda et al., 1995). Behavioral Marital Therapy (BMT) has yielded outcome study results that are promising and suggest that behavioral models may be more effective long-term than the interactional or systems models in the treatment of addiction (Lipps, 1999; McCrady, 1990).

Galanter (1993) reviewed the treatment of 60 patients being treated for addiction to chemical substances, including alcohol, cocaine, and heroine. 92% of the patients were involved in network therapy. The networks included significant others, friends, and to a lesser extent parents, siblings, and children. This review by Galanter found that 77% of the patients achieved full recovery. Network therapy was found to work better with those patients classified with mild or moderate drug dependence than those with severe or chronic dependence (Galanter & Brook, 2001). Also, disulfiram (Antabuse) was offered to patients whose primary drug was alcohol, and the acceptance of the disulfiram by the patient was

observed by a network member. 14 out of the 16 patients that participated experienced abstinence throughout the treatment process with full acceptance of the disulfiram (Galanter & Brook, 2001).

The results of the trial treatment using network therapy were so successful that the National Institute of Drug Abuse supported an extensive study on the use of network therapy in the treatment of addiction. Galanter, Keller, & Dermatis (1997) carried out the study. Participates were individuals addicted to cocaine. The patients were given 15.4 weeks of treatment, and participated in an average of 9.5 network therapy sessions and 11.3 individual sessions. 262 urinalyses of the participants were observed during this study. 67% of those tested had three consecutive weekly urine samples returned negative for cocaine and 42% had their last three urine samples returned free of cocaine prior to terminating treatment. Comparative studies were reviewed on the outcomes of outpatient treatment for cocaine addiction (Galanter & Brook, 2001). The network approach proved to perform as well as or better than other techniques used in the treatment of cocaine addiction (Caroll et al., 1994; Higgins et al., 1993)

Summary

The literature in support of family involvement in the treatment of alcoholism is still maturing. However, the efforts of researchers over the past five decades point to great potential for family involvement in the treatment of alcoholism. This review summarized the development of a professional field of therapeutic practice for family based treatment of addiction, and then traced the advancement of family focused research, treatment approaches and outcomes in the field of substance addiction. However, there is still a great need for more research in family focused treatments for addiction. It was clear from this review and from the results of the study designed and executed for this research project, which closely resembled the social network model, that family research is difficult to collect, to analyze, and to interpret. In closing, more rigorous experimental methodology and greater attention to reliability and validity of outcome measures are needed in each of the areas reviewed in this chapter.

CHAPTER THREE

Methodology

Introduction

This chapter describes the subjects selected for inclusion in this study. Additionally, the instrument that was used to collect the data is described. Information on data collection and analysis procedures will follow. The chapter will conclude with an enumeration of the identified methodological limitations.

Description of the Subjects

All of the subjects for this study were family members of present and former clients in Luther/Midelfort Hospital's Alcohol and Drug Intensive Outpatient Treatment Program. Only those clients that had a spouse, significant other, and/or family members attend Luther/Midelfort's New Journey Family Night Program were eligible to participate. In this group, every family member had an equal opportunity to participate.

Sample Selection

A questionnaire was mailed out to 187 present and former clients using the Luther/Midelfort Alcohol and Drug Treatment mailing list. The clients were given a general description of the purpose of this study, asked to sign a release of consent form, and then were asked to give the

survey to a family member who attended the treatment program's family night. The family members were also given a description of the purpose of the study and what their participation would entail. Subjects were guaranteed that their participation was voluntary and confidential.

Instrumentation

The survey was specifically designed to gather information pertaining to family members' perceptions of the length time and depth of involvement of their addicted spouse, significant other, and/or family member's participation in the Luther/Midelfort New Journey treatment program. Also, information was collected on the family members' perceptions of their own depth of involvement in the treatment process, and overall life satisfaction since treatment commenced. Additional questions were asked about how family members would rate Luther/Midelfort's family night for purposes of making beneficial program changes. The survey did not collect very much demographic information. Subjects were asked to indicate their gender and relationship to the client that received or was currently receiving treatment for addiction. Furthermore, information was collected on participation in self-help groups, such as Alanon/ACOA/Alateen and Alcoholics Anonymous. The family

members were also asked to rate their overall life satisfaction in a number of areas, and to rate their overall satisfaction with Luther/Midelfort's family night program. This researcher's thesis advisor, research professor, and The UW-Stout Human Rights Advisory Board established that the survey had face validity. Because this instrument was designed specifically for the family members who attended Luther/Midelfort's family night treatment program, no other measures of validity or reliability were available.

Data Collection

A mailing list of all present and former clients of the Luther/Midelfort New Journey Intensive Outpatient Alcohol and Drug Treatment Program was obtained. From this list, the staff crossed off those persons who were inappropriate for the study (i.e, they did not have a family member attend the family night program with them while in treatment). All other subjects were given opportunity to participate in the study. The survey, consent letter, release of information forms and letter of attention to clients were mailed in an official Luther/Midelfort envelope with a self-addressed stamped envelope enclosed. The clients who received the forms were instructed to sign the release of information form,

and pass the survey to their family member who attended the family night program with them. They were instructed to disregard the survey if they did not attend family night with a spouse, significant other, and/or family member. Family members were reminded that their participation was voluntary and confidential. Additionally, they were asked to complete the entire survey, and return it along with the filled out and signed release of information form in the enclosed stamped, self-addressed envelope.

Some of the surveys were passed out to clients and their family members on family night. They were asked to complete the surveys and return them to one of the three on staff alcohol/drug counselors or follow the mailing procedure detailed to them in the letter of consent. A second mailing was conducted in an effort to increase the number of responses.

Data Analysis

Originally, the Pearson Correlation Coefficient was intended to be used on the data collected for the study. Due to the low number of surveys returned, it was not used. Instead, the frequencies are reported, and non-statistical inferences are made from these frequencies.

Limitations

Six limitations were apparent in this methodology and/or procedure:

1. The use of a survey that had to be returned by mail and the indirect approach adapted in order to reach family members created a low return.

2. The subjects may not choose to complete the survey due to the personal nature of the subject.

3. The Subjects may not answer honestly if they perceive positive responses are desired by this researcher or are more desirable to them.

4. The sampling method employed a sampling of convenience in terms of surveying only one treatment program. Therefore, the results are not generalizable to a larger population.

CHAPTER FOUR

Results

This chapter presents the results from a survey that was designed to determine if a positive relationship exists between the length of time clients have been in AODA treatment/recovery and their family members' increased involvement in the treatment program. In addition, the study attempted to determine if a positive relationship exists between the clients' commitment to recovery and their family members' increased life satisfaction.

The family members that participated in this research consisted of wives, husbands, siblings, parents, friends, and significant others. All voluntary participants were drawn from the Luther-Midelfort Outpatient Chemical Dependency Journey Program. The data was collected from May-August 2000. 187 surveys were sent out initially with a return of 11 surveys. A second mailing of 30 surveys added a return of 6 more for a total of 17 completed surveys.

Effect of Family Involvement on Treatment Outcome

Originally, the Pearson Coefficient was intended to be used on the data collected from the research study. Due to the low number of surveys returned, statistical

analysis was not a viable option. Instead, frequencies are reported, and non-statistical inferences are made from these frequencies.

Participant Profile

The sample for this survey consisted of 29.4% (N=5) males and 70.6% (N=12) females. The respondents relationship to the clients consisted of 35.3% (N=6) wives, 29.4% (N=5) spouses, 11.8% (N=2) husbands, and 23.8% (N=4) consisted of a mother, a best friend, a girlfriend, and a brother. All of the respondents had a family member who had received or was currently receiving treatment at the Luther/Midelfort New Journey AODA Program. Demographic information was kept to a minimum to protect the respondents confidentiality/privacy.

Hypothesis 1

Hypothesis one states that there will be a relationship between the length of time in treatment of the Luther/Midelfort clients and their family's increased involvement in the treatment program. In the survey, questions 1, 4, 6, 9, 10, 12, and 13 addressed hypothesis one. Question number one asked how many times the family member attended the New Journey Family Night Program. 5.9% (N=1) respondents indicated they had attended one time, 5.9% (N=1) attended two times, 47.1% (N=8) attended

four times, 5.9% (N=1) attended five times, and 35.3% (N=6) indicated they attended six or more times. Family members are invited to attend the family night program indefinitely. However, the client's primary treatment and aftercare run approximately twelve weeks altogether. Question four asked respondents to indicate what phase of treatment their family member in the program completed. 35.3% (N=6) respondents indicated that their family member had completed the first five weeks of primary treatment. 53.0% (N=9) respondents indicated that their family member had completed both primary treatment and aftercare, and 11.8% (N=2) indicated that their family member had not completed either of the programs.

In question six, family members were asked if they had been "encouraged" or "discouraged" to attend the Journey Family Night program. 82.4% (N=14) of the respondents indicated that they had been "encouraged" by the client to attend, while 17.6% (N=3) indicated they were not "encouraged or discouraged" to attend. Question nine asked family members to indicate if they had spent more quality time with their family member since they had been involved in treatment. 88.2% (N=15) respondents indicated "yes" while 5.9% (N=1) indicated "no." For question twelve, family members were asked to indicate

whether the Journey family night program had helped connect them with community family support groups. 58.2% (N=10) of the respondents indicated "yes", while 29.4% (N=5) indicated "no." In question thirteen participants were asked how often they attend a self-help support group. 5.9% (N=1) of the respondents indicated regular attendance, 17.6% (N=3) indicated sometimes, 17.6% (N=3) indicated rarely, 5.9% (N=1) rarely, and 47.1% (N=8) indicated never.

Question ten asks if the family members' involvement in treatment has helped improve specific areas of their life. The frequencies of the family members' responses for question ten are reported in table 1. The majority of the family members indicated that their lives had stayed the same, improved some, or greatly improved. Only one member answered has gotten worse on any of the questions. Interestingly, the majority of family members indicated their family life, communication, and overall satisfaction of life had greatly improved whereas, the majority of the family members answered questions directed toward self-improvement of work life, spiritual life, and self-esteem as stayed the same or improved some.

Table 1

Frequencies reported by study participants on their
quality of life

Quality of Life	Greatly Improved	Improved Some	Stayed the Same	Gotten Worse	Much Worse
My family life has	58.8%	29.4%	5.9%	0.0%	0.0%
My work has	11.8%	41.2%	35.3%	0.0%	0.0%
My communication with the family has	52.9%	41.2%	0.0%	0.0%	0.0%
My spiritual life has	11.8%	47.1%	35.3%	0.0%	0.0%
My self worth has	5.9%	47.1%	35.3%	5.9%	0.0%
My overall quality of life has	29.4%	52.9%	11.8%	0.0%	0.0%

Hypothesis 2

Hypothesis two states that there will be a relationship between the depth of commitment of recovery by the Luther/Midelfort client and the level of their family's life satisfaction. In the survey, questions 5, 7, 8, 10, and 11 address hypothesis two.

In question five, respondents were asked to indicate how often their family member attends self-help groups. 47.1% (N=8) of the respondents indicated regularly, 17.6% (N=3) indicated sometimes, 5.9% (N=1) indicated rarely, 17.6% (N=3) indicated seldom, and 11.8% (N=2) reported

never. In question seven, respondents were asked to indicate their family member's level of commitment to recovery. 94.1% (N=16) respondents reported a lot and 5.9% (N=1) indicated some. In question eight, the respondents were asked to assess their level of commitment to recovery. 58.8% (N=10) of the respondents indicated a lot, 35.3% (N=6) indicated some, and 5.9% (N=1) indicated very little. Question eleven asked whether or not the family members were satisfied with the programming of the New Journey Family Night Program. They were asked to rate the different components of the program from very helpful to not helpful. The majority of the family members rated group therapy as the most helpful component of the program. Reciprocally, group therapy was the only component marked as not helpful. The frequencies of the family member's responses are reported in Table 2.

Table 2

Frequencies reported by study participants on helpfulness
of the New Journey Family Program

Components Of Program	Very Helpful	Moderately Helpful	Slightly Helpful	Not Helpful	Don't Know
assignments	23.5%	5.9%	11.8%	0.0%	0.0%
topic lectures	52.9%	23.9%	5.9%	0.0%	0.0%
group therapy	58.8%	23.5%	0.0%	5.9%	0.0%
films	35.5%	29.4%	11.8%	0.0%	0.0%
speakers	52.9%	11.8%	5.9%	0.0%	11.8%
peer support	47.1%	5.9%	11.8%	0.0%	5.9%
individual counseling	35.5%	5.9%	11.8%	0.0%	17.6%

Participant Comments

Eight of the respondents commented on the Journey Family Night Program. Their comments provided some of the most valuable insights into family involvement in the New Journey's family program. A mother of one of the clients suggested that the program should provide sessions on the weekends, "Maybe something on Friday or weekends when the addict is on his own." Another respondent indicated that assignments would be valuable, "We weren't given any assignments and I think that would have been helpful. I think that doing specific things and reporting back with outcomes would be helpful . . ." Other respondents

commented that they would like to be included and supported more in the program. One respondent stated, "Include spouse and family members in a more active manner in the recovery process. Discuss how the alcoholism affects the total family more and help more in the process of bringing the family back together again." Another family member wrote, "I think that more time should be devoted to the family members attending. Issues that relate more to them."

One spouse commented, ". . . We have become more open and communicate better than ever before. We share more. Our lives have become fuller and richer and I know that we would not have had any kind of a future together if the program had not been available to help us learn and grow." Still another spouse commented, "I enjoyed the family night program. I learned a lot from the speakers. It made me feel a part of the recovery process, and helped me to understand that alcoholism is a family disease. The family counseling sessions offered to me and my wife were especially helpful."

Summary

This chapter reported the results of a survey designed to assess certain effects on family involvement in the Luther-Midelfort New Journey Family Night Program.

Out of the 217 surveys mailed and distributed to the New Journey Treatment Program's family members, only 17 completed surveys were returned. Due to the low number of surveys returned, meaningful statistical results could not be produced. However, the frequencies and participant comments reported in this chapter produced interesting and thought provoking information. Chapter five will summarize the findings, make inferences from the reported frequencies, and state implications of this and future research.

CHAPTER FIVE

Conclusions

Summary

The purpose of the study was to determine if a positive relationship exists between the length of time the client has been in treatment and their families level of involvement in the treatment program. In addition, the study attempted to determine if a positive relationship exists between the clients' commitment to recovery and their families increased life satisfaction.

The subjects consisted of male and female family members (N=17) from the Luther-Midelfort Outpatient Chemical Dependency New Journey Family Night Program in Eau Claire, Wisconsin. The data was collected between May 2000-August 2000. Due to the low number of surveys returned, the Pearson Correlation Coefficient could not be used on the data to address this researcher's hypotheses. Therefore, frequencies of the results are reported and non-statistical inferences are made from these frequencies.

Discussion

Alcoholism is the third greatest health problem in America, following cancer and heart disease. Considering the relationship between alcohol abuse, cancer, and heart disease, alcoholism may actually rank much higher (Lawson

et al., 1983). It has also been determined that many addicts suffer from marital and family problems (O'Farrell, 1989; O'Farrell, 1992; Rotunda et al., 1995). Non-alcoholic family members of alcoholics often experience premature death, health problems, psychological distress, divorce, abuse and unemployment (Edwards & Steinglass, 1995). Research on family factors related to alcoholism suggests that there may be familial predisposition regarding the development of chemical dependency (Cadoret, 1992; Pickens et al., 1991). There is further evidence to suggest family environmental factors play a role in the development, course, and cessation or progression of chemical dependency (Jacob, 1992; Lawson et al., 1983; O'Farrell, 1989; O'Farrell, 1992; O'Farrell & Feehan, 1999). Given all of the evidence, it is important to continue to research the impact family processes have on the treatment of chemical dependency (Edwards & Steinglass, 1995; Jacob, 1992; O'Farrell, 1989; O'Farrell, 1992; O'Farrell & Feehan, 1999; Rotunda et al., 1995; Steinglass et al., 1987).

Over the past thirty years the research of family in the etiology, progression, and cessation of alcoholism has been expanding. The family members that participated in this survey have contributed to the process of

understanding the value of family participation in the treatment and recovery of addiction.

The results of this study could have been more precise had more trials and revisions of this survey been executed. For example, some of the respondents did not answer certain questions. It might have been valuable to assess patterns of confusion or non-responses to certain questions. Also, if entry and exist surveys were used changes from the start to the end of treatment might have produced more meaningful results.

In addition, the population used in this study was ultimately too small and homogeneous for meaningful results. A larger more diverse sample of the entire population would have provided greater validity and greater generalizability of the study's results. However, certain limited inferences can be drawn despite the extremely low sample size in this study (N=17).

Conclusion

Hypothesis number one projected that there would be a positive relationship between the length of time clients' have been in AODA treatment and their families' increased involvement in the treatment program. Hypothesis two projected that a positive relationship would exist between the clients' commitment to recovery and their families'

increased life satisfaction. Even though the number of completed surveys was too low to produce statistically meaningful results for the hypotheses, positive inferences can be made from the frequencies reported by the respondents.

Regarding the hypotheses, the general trend summarized in table 1 suggests that family members who attended the family night program and responded to the survey experienced improvement in their personal life and their life with the client in treatment. For example, family members reported anywhere from "stayed the same", to "improved some", to "greatly improved" in their answers related to improved satisfaction of life. Only one respondent reported that her satisfaction of life had "gotten worse" on the question regarding self-esteem. This suggests that most family members who attended the family program were helped by it.

In this survey, 58.8% (N=10) family members reported that their family life had "improved." Also, 52.9% (N=9) of the respondents reported that their communication with the family member in treatment had "greatly improved." The answers to questions directed toward self-improvement were not as positive. Most family members reported "improved some" or "stayed the same" for questions

concerning self- development. This may suggest that the New Journey family program did not place enough emphasis on the family members' personal development and growth.

Question six asks whether the attending family member was "encouraged" or "discouraged" to attend the family night program. 82.4% (N=14) indicated of the respondents that they had been "encouraged" by the recovering member to attend, while only 17.6% (N=3) indicated they were neither "encouraged nor discouraged" to attend. None of the respondents reported being actively "discouraged" from attending the family program. On question nine, 88.2% (N=15) of the respondents reported that they had spent more quality time with their recovering family member since they had been involved in treatment. Only one respondent indicated that he/she had not spent more time with the family member in treatment. These responses seem to indicate a desire on the part of the recovering member to include and spend time with their family members while they were in treatment.

The majority of family members reported better communication, shared life satisfaction, and increased quality time spent with the recovering member. They also reported overwhelmingly that they had been encouraged to join the recovering member in his/her treatment process.

Regarding commitment to treatment, question five asked respondents to indicate how often their family member in treatment attends self-help groups. Half of respondents indicated that their recovering family member attended self-help groups regularly 47.1% (N=8). Question seven asked respondents to indicate their family member's level of commitment to recovery. 94.1% (N=16) of the respondents indicated their recovering member has "a lot" of commitment to recovery, while only one respondent indicated "some." Family members were also asked to indicate their own level of commitment to recovery in question eight. The majority of respondents 58.8% (N=10) indicated they had "a lot" of commitment to their recovery. The respondents reported high levels of commitment to treatment and family life satisfaction with their family member in treatment. These high positive responses may suggest that commitment to treatment by the client does increase family life satisfaction.

Out of the seventeen (N=17) respondents, 52.9% (N=9) reported that their family member had completed the entire treatment and aftercare program. 35.3% (N=6) respondents indicated that their family member had completed primary treatment. Only 11.8% (N=2) respondents indicated that their family member had not completed either program. The

high level of treatment completion indicated by respondents may suggest that the length of time the client was in treatment did increase family involvement in the program.

In conclusion, 14 (82.4%) respondents had attended four to six or more times. Overall, the majority of the family members reported fair to excellent attendance. The high numbers reported for family attendance and client program completion may further indicate that client commitment to recovery does increase family involvement in the treatment process. Although these inferences do not reflect statistically valid results, they are encouraging responses to the effects of family participation in the treatment process.

Implications

A statistically meaningful relationship between family involvement in treatment and length of time a client has been in treatment was not established. Also, the client's increased commitment to recovery and increased family life satisfaction was not statistically established. However, family members' positive responses validated cause for further research into family involvement in the treatment process.

There are at least three significant changes that would improve this study design for future research. The sample size and diversity are the most important factors in need of improvement. The survey population size should be large enough to derive statistically meaningful results. The survey population should be more representative of the larger population. Inclusion of a range of ethnic minority families would be more representative of the entire treatment population.

A second factor in need of improvement is the use of more controls on the population surveyed. The study should be designed to accommodate both an entry and exit analysis of the status of family life satisfaction and depth of commitment to recovery. Also, the results would be more meaningful if a follow-up survey were conducted at regular intervals post-treatment.

Finally, use of an experimental research design instead of a descriptive research design would have increased the validity of the research study. In an experimental research design, control groups could have been divided into groups that receive different types and varying degrees of family interventions. This research design could compare varying degrees of family

intervention for success or failure of a family member in treatment for chemical dependency.

Recommendations for Further Research

Considering the preceding discussion and conclusions, the following recommendations are made:

1. Gather more information on the attending family members' feelings about their own personal self-development in recovery.
2. Attempt to collect information on the children of the alcoholic families, and survey any observed changes in the children's self-development throughout the process of recovery.
3. Gather more information on what commitment to recovery is perceived as being by the family members.
4. Gather additional demographic data about the family members such as age, cultural identification, religious identification, and number of years they have known the recovering member.

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APPENDIX A:

Luther Midelfort
New Journey Family Night Program Survey

1. How many times did you attend the Journey Family Night?
___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 or more
2. Gender: ___ male ___ female
3. Relationship to the client: _____

4. Did your significant other, spouse or family member complete (please check one):
 ___ (a) the first five weeks of the New Journey Treatment Program
 ___ (b) the recommended twelve week New Journey Aftercare Program
 ___ (c) completed both of the programs
 ___ (d) did not complete either of the programs
5. How often would you say that your spouse, significant other or family member attends self-help groups, such as Alcoholics Anonymous?
 ___ Regularly ___ Sometimes ___ Rarely ___ Seldom ___ Never
6. Did you feel that your significant other, spouse or family member encouraged or discouraged you to attend the Journey Family Night Program?
 ___ Encouraged ___ Discouraged ___ Neither
7. Please indicate the level of commitment you feel that your significant other, spouse or family member has invested in his/her recovery process from addiction?
 ___ A lot ___ Some ___ A little ___ Very little ___ Nothing
8. As the spouse, significant other or family member of the alcoholic/addict in recovery, please indicate the level of commitment you feel that you have invested in your recovery process from the effects of addiction?
 ___ A lot ___ Some ___ A little ___ Very little ___ Nothing
9. Have you been able to spend more quality time with your spouse, significant other or family member since you have been involved in treatment?
 ___ Yes ___ No

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10. My involvement in treatment/self help with my significant other, spouse or family member has helped improve the following areas in my life (please check):

	Greatly Improved	Improved Some	Stayed the same	Gotten Worse	Much Worse
a. My family life has					
b. My work has					

c. My communication with Significant other, Spouse or family Member has					
d. My spiritual life has					
e. My self worth has					
f. My overall quality of life has					

11. Please rate the components of the Journey Family NightProgram on how helpful they were to you.

	Very Helpful	Moderately Helpful	Slightly Helpful	Not Helpful	Don't know
a. assignments (couples dates etc...)					
b. Topic Lectures					
c. group therapy					
d. films					
e. speakers, Alanon, AA, or other					
f. peer support					
g. Individual Counseling					

12. Did the New Journey Family Night Program help connect you and your family members to Alanon, Adult Children of Alcoholics, Alateen and/or Open AA meetings?

Yes No

13. How often do you attend Alanon or any other self-help group?

Regularly Sometimes Rarely Seldom Never

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14. Do you feel that Alcoholism/addiction is a family disease that has affected you and your family members negatively

Yes No

15. Would you recommend the New Journey Family Night Program to a friend?

Yes No

16. If you were unable to attend the Journey Family Night regularly with your with your significant other/spouse or family member, please indicate the most appropriate reason for why you were unable to attend?

- (a)work or school
- (b)babysitter for the kids
- (c)after school activities or meetings
- (d)problems with the person in treatment
- (e)Wanted the personal time for self
- (f)Did not like the New Journey Family Night Program
- (g)Other: _____

17. What, if any, changes would you recommend in the New Journey Family Night Program to provide more effective services? All comments are welcome.

Thank you again for your time.

APPENDIX B:

June 6, 2000

Dear Family Member,

I work with Scott Hansen, Barb Westerberg and Jim Schriener in the Alcohol and Drug Behavioral Health Department at Luther/Midelfort Hospital. The New Journey Family Night

Program has undergone a number of changes. As a result of those changes, the New Journey Staff would like to get your feedback on the quality and outcome of services provided on Family Night.

We are doing a study on families in recovery, and how the New Journey Family Night Program can benefit the family. Your involvement in this study will help the New Journey Staff and myself gain a better understanding of the effectiveness of the Journey Family Night Program for you, and your family members. Your confidential responses will allow us to make improvements in our education of families in recovery. Your satisfaction and participation in the New Journey Family Night is important to us.

Additionally, I am currently pursuing a Master's Degree in Alcohol and Drug Counseling at UW-Stout in Menomonie. Your completely confidential participation in this study will also help me to gain a better overall understanding of families in recovery. My part of this research effort is to attempt to relate changes in your family to the recovery of the family member in treatment.

Enclosed is a self-addressed stamped envelope for your convenience. Your participation is voluntary and your responses are confidential. You may have access to any results concluded from this study. Please complete the entire survey and return it to Mr. Scott Hansen by June 16, 2000. Your time will be greatly appreciated. If you have any questions, or want to know the results of this study, please contact Mr. Hansen at (715) 838-5369.

Thank you for your time,

Scott Hansen, AODA Supervisor

Laura Cooper, AODA Intern