PLAN B

1995 Hazelden Family Program Evaluation
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Abstract

The purpose of this study is to evaluate Hazelden's Family Program by measuring cognitive change in family members. The sample population consisted of 50 family members/significant others of chemically dependent individuals who participated on a voluntary basis for a period of five days. A self-administered 20-item inventory which tapped participant knowledge regarding three research questions was used to collect the data. The research questions were associated with participants' knowledge about chemical dependency, how they've been affected, and coping strategies. Participants completed a pretest on their first day of the program and a posttest on their final day. The time one and time two inventories were then compared and analyzed using McNemar's test for the significance of changes. Probability levels of $p<.01$ and $p<.05$ indicated levels of significance on 7 of the 20 items. Results suggest that the Hazelden Family Program is effective in educating participants about the disease of chemical dependency and its effect on the family using a psychoeducational model.
1995 Hazelden Family Program Evaluation

INTRODUCTION

Chemical dependency (CD) is a condition which imposes a tremendous burden on our society. For the purposes of this study, the term chemical dependency will be predominantly utilized and is interchangeable with alcoholism, drug addiction, and substance abuse. There are more deaths, illnesses, and disabilities from CD than any other preventable health condition and it is the ninth leading cause of death in this country (Institute for Health Policy, 1993). According to a recent publication, CD is our nation's number one health problem which places an enormous burden on our nation's health care system. As a result, it is also a major contributor to the high cost of health care (Institute for Health Policy, 1993). A recent report by the National Institute on Alcohol Abuse and Alcoholism (1990) stated that about one-fourth of all hospitalized patients have alcohol-related problems. Moreover, between twenty-five and forty percent of all general hospital patients are there because of complications related to alcoholism (Institute for Health Policy, 1993).

Results from recent studies on alcoholism and alcohol-related problems reported by the National Council on Alcoholism and Drug Dependence (NCADD) (1990) dramatically illuminate this significant national problem. According to the NCADD Fact Sheet, approximately 10.5 million
Americans exhibit signs of alcoholism or alcohol dependence, and it is predicted that by 1995, the number of alcohol dependent adults will increase to about 11.2 million. The financial burden this population places upon the country is staggering—an estimated 99 billion dollars for alcohol in 1990 alone (Institute for Health Policy, 1993).

Although there are many serious problems associated with CD, one of the most significant and tragic is the early and preventable loss of life. Nearly half of all fatal highway accidents are alcohol-related and those crashes involve two out of every five Americans in their lifetime. In 1987, nearly 300 people died each day from alcohol-related causes and each victim lost, on average, 25.9 years of life. Lastly, an average of 18% of alcoholic deaths are due to suicide, and 21% of all suicide victims are chemically dependent (NCADD, 1990).

Unfortunately, this pervasive tragedy is not restricted to the CD person alone. Others are significantly affected by this destructive condition as well. Gallup (1988) states that nearly 81 million U.S. adults have, to at least some degree, suffered physical, psychological, or social harm as a result of someone else's drinking. The most often affected population is the chemically dependent person's family. A 1988 survey conducted by the National Center for Health Statistics and the National Institute on Alcohol Abuse and Alcoholism, reports that approximately 76 million Americans have been exposed to
alcoholism in the family, and nearly one in five lived with an alcoholic while growing up (NCADD, 1991).

CD takes a tremendous psychological and financial toll on families. Nearly 20% of men and more than 25% of women report that drinking has been the primary cause of trouble in their families (NCADD, 1993). Mackey (1992) points out that there is an apparent link between CD and domestic violence in our society. While the cause and effect is not firmly established, a study by New York-based Abused Women’s Aid in Crisis reported that alcohol abuse on the part of the husband was a factor in over 80% of the cases. In another study, it was reported that 72% of one hundred wives of alcoholics who identified themselves as victims of abuse, indicated they had been physically threatened; 45% had been physically attacked; and 27% had experienced potentially lethal attacks (Mackey, 1992).

In addition, in excess of 33% of women who are separated or divorced had been married to an alcoholic (Institute for Health Policy, 1993), and almost two-thirds of separated and divorced women and about one-half of separated and divorced men under 45 have been exposed to alcoholism in their families. Overall, nearly 10% of the adults in our society have either been married to or had a marriage-like relationship with an alcoholic (NCADD, 1991).

Lastly, Spear (1991) suggests that there is also an apparent
link between CD and families' physical health stating that “... diminished physical health [is one way] in which... chemical dependency of one family member impacts on other family members” (p. 180). A comprehensive six-year study of health insurance claims found that there was a significant decline in families' medical insurance claims in the two years following CD treatment when compared to the two years prior to CD treatment of a family member.

This study proposes to focus on the efficacy of a treatment model for the family members of the CD person. Specifically, the purpose of this paper is to evaluate the effectiveness of the Hazelden Family Program, placing particular emphasis on the psychoeducational component as a major change facilitating factor. The study will expand upon a study by Laundergan and Williams (1979) "Hazelden: Evaluation of a Residential Family Program" which measured desired cognitive change in 207 family program participants over a five-day period.

LITERATURE REVIEW

There are two bodies of literature that apply to this study of family treatment: (a) family change theory, and (b) methods to facilitate change. Both will be covered in this literature review with particular emphasis upon the psychoeducational component as an effective change agent. This section will conclude with the research questions.

Forrest (1991) states that “Alcoholic and chemically
dependent family systems are pervasively dysfunctional" (p. 37). This has apparently been the case for quite some time, as Steinglass (1987) dates the earliest case histories involving alcohol's effect on the family back to the biblical times of Noah and Lot. Noah's family members attempted to cover up and hide his drunken behavior and Lot's daughters coerced their father to drink wine and then sleep with them, suggesting a possible correlation between alcohol and another serious family problem, incest.

Serious attention turned towards the family in 1939 with the publication of the classic Alcoholics Anonymous which included a discussion on the effect of alcoholism on the family unit (Mulry, 1987). Then in the '40s and '50s, two separate events began to shed some light on this matter. The first occurred in 1941 when some of the wives of members of Alcoholics Anonymous banded together in support of one another and created an organization called Al-Anon (Metzger, 1988). The second took place when Futterman (1953) embarked upon the first empirical studies of the CD family and concluded that the wife, unconsciously because of her own needs, seems to encourage her husband's alcoholism. The wife was perceived as a disturbed, pathological personality with conflicts in dependency that led her to choose an active alcoholic or someone likely to become one (Royce, 1989). Hence, it was the "co-alcoholic" wife who was to blame (Ablon,
A 1954 study by Joan Jackson challenged Futterman's theory of the predisposed pathological personality of the so-called co-alcoholic wife. Jackson presented the results of an eight-year study of 150 wives in Al-Anon, which revealed that the wife's behavior was more of a "reaction to a cumulative crisis whereby [she] experiences progressively more stress" (Royce, 1989, p. 141). As a result of her study, Jackson constructed a process consisting of seven stages through which many CD families pass (see Metzger, 1987 and Royce, 1989) and a new paradigm began to emerge.

**Family Systems**

Perhaps the most significant theoretical approach to emerge and impact the treatment and recovery of the CD family was one that did not focus on the pathology of an individual (a psychoanalytical approach), but centered on a more contextual-holistic approach based upon General Systems Theory. It was family systems theory (Bowen, 1978) that finally provided the necessity for inclusion of the CD person's family members in some type of treatment/recovery program in order to insure a greater level of recovery.

There is an abundance of literature that emphasizes the importance of defining the CD family in systemic terms in order to treat them (Starr, 1989; Elkin; 1984, Steinglass, 1987; & Isaacson, 1991). However, to better understand the devastating
effects CD has upon the entire family system, the focus will shift to a brief overview of family systems. Moyers (1991) succinctly states that:

A system consists of interdependent components organized to accomplish a specific function for the purpose of maintaining a level of equilibrium or homeostasis. A family system is made up of individual members that assume specific roles. These roles dictate the type of interactional patterns that develop between the family members. Family relationships conducted according to the rules of the system maintain the family balance . . . (p. 47).

When CD enters the family system, there is a chaotic shift in the equilibrium into which the family must adapt in order to survive. Excessive anxiety and stress begin to set up unhealthy interactional patterns and residual rules begin to develop which become established around the chemical. Family members also begin to assume adaptive roles which allow them to better cope with the changing and progressively dysfunctional family system. Over time, the family becomes conditioned to this unhealthy family structure establishing a pathological status quo, or as Edwards (1990) says, “a pervasive emotional pollution from which there seems no escape” (p. 17).

The literature is filled with an abundance of recent studies concerning the treatment and recovery of families with a chemically dependent member. From among these, several
different treatment models and/or methods designed to explore this unique and significant family problem emerge. A majority of the studies were found to focus on a more traditional conjoint family therapy model utilizing various recognized therapeutic techniques. In addition, it was assumed that the chemically dependent person was abstinent and participating in the family treatment process.

Starr (1989) presents an intergenerational three-stage family systems treatment model which helps the family redefine and restructure themselves while breaking the generational transmission to future generations. The concept of “systemic maturation” is applied to outline three stages of normal family development which become altered by the presence of CD. The counselor/practitioner helps the family by designating specific tasks that promote healthy family development. Starr asserts that “recovery consists of a three-part sequential redoing of the tasks of each of the three stages” (p. 349). The stages include (a) establishing boundaries, shared beliefs, and rules (holiday routines, mealtime rituals, role definitions, sexual expectations, etc.); (b) rebuilding of individual strengths, development of role flexibility, and adaptation to the ups and downs of family living; (c) a crisis marked by loss of alcohol/drug causes the family to redefine itself and achieve a unified understanding of its history and some shared definition of its future.
A conjoint four-phase treatment model emphasizing sobriety was introduced by Usher (1991) for couples and families complicated by CD. This model does not stop at the point of abstinence “but aims at the deeper goal of getting them sober” (p. 45). The treatment process is based on a systemic perspective including both object relations and self-psychology theory. The initial phase of treatment has a problem-solving orientation, with abstinence and AA/Al-Anon participation as key components of therapy. The final phase focuses on an internal change (development of intimacy), whereby family members shift from the organizing power of CD to the internal structure of self-guidance.

Briefly, the stages include: (a) The “Treatment Initiation” stage which requires the counselor to assess family functioning, identify the substance abuse (genogram), and devise a treatment strategy (contract for Al-Anon); (b) the “Learning” stage refers to the work that occurs when the family begins to deal with the “emotional desert” that appears after the chemical has been removed which results in members learning new problem-solving and communication skills to rebuild the family system; (c) “Reorganization” is characterized by a commitment to AA/Al-Anon, improving patterns of interaction through making amends and reaching out to others for support; (d) the “Consolidation” stage is where family members begin to act from their internal structure which involves “... being open,
being vulnerable, being heard, and being accepted . . . “ (p. 54).

Richardson (1991) describes an inpatient and outpatient treatment model that uses both strategic (Haley, 1986) and structural (Minuchin, 1981) family therapy orientations of the family systems approach. A healthy family system is marked by clear, definable, and permeable boundaries between the family subsystems. Similarly, Bepko (1989) outlines certain dynamics characteristic of CD families which include: (a) boundary rigidity and violation, (b) unresolved conflict, (c) parental conflict detoured through the addict, (d) enmeshment, and (e) overprotectiveness.

Successful application of the techniques of structural family therapy intervene in three important ways: (a) to help the family develop more healthy and permeable boundaries between the subsystems, (b) to help curb triangulation between and among subsystems, and (c) to promote individuation found lacking in CD families.

The notion of the “self-reinforcing cycle” was introduced by Richardson (1991). This model emphasizes the problem that CD causes in living, which creates a context that reinforces its continuation. As a result, the techniques of strategic therapy, which involve direct instructions called “prescriptions,” attempt to change the context in order to stop the cycle. Two of the techniques used to accomplish this task include reframing the problem in a different context and a unique technique called
“paradoxical” intervention.

A practical developmental model, described by Horberg and Schlesinger (1992), focuses on four developmental tasks that promote family recovery “from chaos to integration” (p. 47). Also highlighted are the therapeutic methods that facilitate accomplishment of the tasks. This model borrows elements from systems theory, cognitive-behavioral and psychodynamic approaches. Only family members who are truly interested and ready to work on the problem are encouraged to participate.

The tasks that promote the development of successful recovery include: (a) “Getting started”—family members define their problems to promote action, develop a realistic basis for hope that there is a solution, and refocus attention on their own lives so they can begin the process of psychological separation from the addict; (b) “Strengthening the family”—members focus on learning self-care and developing supportive relationships in order to face the addiction; (c) “Confronting the addiction”—Families begin to focus on their own “enabling” behaviors. Members begin to withdraw from the destructive experiences related to addiction so as to avoid inadvertent support of the addiction, and begin to set healthy limits for their own protection; and (d) “Flourishing”—after family members are able to withdraw from the addiction, they are ready to “replace a survivor mentality with a flourishing mentality” (p. 48). At this
stage, family members begin to let go of past traumatic experiences associated with addiction, identify some common pitfalls in recovery, build healthy communication patterns, and move on to "resume normal family development" (p. 48).

Some of the therapeutic techniques utilized in this approach include (a) use of a metaphor that casts recovery as a journey rather than an event, which helps family members to make better sense of their pain and to work past it; (b) a cognitive-behavioral approach to help family members identify the dysfunctional philosophies that keep them isolated and block the development of personal and community resources; (c) a stress management approach to help family members focus on self-care; (d) helping families develop networks of social support so they can begin to help themselves through involvement with others; and (e) an intervention strategy is employed which focuses on family health. The goal is to safely sever support for destructive "enabling" behaviors while selectively increasing the family's ability to support and participate in healthy patterns.

Finally, Edwards (1990) presents a practical systems approach for treating chemically dependent families. Many of the techniques and approaches used in this model come from the structural and strategic schools of family therapy, which are brief, systems-oriented, goal-directed models that have been adapted to working with CD families. This approach also
assumes that the CD person is part of a separate treatment program, either outpatient, inpatient and/or AA/NA, Al-Anon/Alateen.

The author first identifies and discusses five general goals of therapy followed by some practical suggestions that address these goals. Attainment of the goals can be accomplished in five to ten one-hour sessions. The goals include (a) increasing motivation for recovery through family sessions, (b) conveying the “Whole-Family-Message” (p. 29) that states all members are affected by the problem, (c) changing family patterns that work against recovery (enabling, conflicts, coalitions, and the peripheral CD family member), (d) preparing the family for what to expect in early recovery, and (e) encouraging family members’ long-term support via a twelve step group.

Next, Edwards (1990) discusses the various tools and techniques used in this family systems approach. These techniques include (a) mapping common patterns in CD families, which uses symbols to draw the therapist’s impressions of the family structure; (b) joining the family system to establish rapport between the members; (c) assigning tasks, which provides between-session assignments for the family; (d) creating enactments encourages conversations between family members; and (e) segmenting, which subdivides the family for a particular therapeutic purpose. Some of the other techniques used are “sculpting, alter ego, circular questions,
reframing, and drawing” (p. 109).

Lastly, Edwards (1990) cautions counselors who are still using an individual, medical model approach as their only conceptual guide. The author outlines four “traps” that the counselor/therapist must be aware of when working with the CD family system: (a) Focusing too much attention on an individual instead of the family system, (b) becoming bogged down and pulled into the family’s emotional network, (c) switching the problem person as a way of entering the family system, and (d) working alone without the support of colleagues.

This researcher discovered a common component in all of the above methods of treating CD families. There appears to be a diversion in focus away from the CD person to a refocus toward the family members and the family system. It is only by placing the focus on the family that the family members can begin to learn more about the disease, begin to identify unhealthy patterns of interaction that have developed over time in the family system, and begin to make positive changes in themselves, regardless of what the CD person chooses to do.

**Psychoeducation**

The preceding discussion summarizes the literature that addresses family treatment in terms of family systems theory utilizing various traditional psychotherapeutic techniques/approaches. Although there appears to be an
abundance of literature on treatment programs for families, there also seems to be a lack of studies that evaluate the efficacy of these programs/models. The following discussion will review literature associated with a relatively new approach in dealing with a variety of life problems, including treatment of families with a chemically dependent member, psychoeducation.

There has recently been a shift from approaches emphasizing insight or interpretation (psychotherapeutic) to those providing support and education for individuals with psychiatric problems as well as for their families (Daley, Bowler, and Cahalane, 1992). According to Hunter, Hoffnung, and Ferholt (1988) criticism of psychoanalytically oriented work with families has raised questions “about the repeated failure of psychoanalytically oriented family psychotherapy to produce demonstrable gains and worse, its capacity to do significant damage” (p. 328). As a response, particularly in the past fifteen years, psychoeducation has become an important treatment of choice for families of patients diagnosed with a variety of mental, emotional and social problems (Hayes and Gnatt, 1992).

Ryglewicz (1991) states that psychoeducation originally developed as a response to schizophrenia. Perhaps the most sophisticated psychoeducational family treatment program reported to date is that of Anderson and her colleagues (Anderson, Hogarty, & Reiss, 1980). Their study indicated that
after stabilizing the family system, members were then provided with education about schizophrenia, stress, family isolation, and the necessity of tolerating low levels of dysfunction in the patient.

More recently, psychoeducational approaches have become accepted ways of reaching out and appealing to individuals who face a variety of everyday concerns as well as those with a variety of social and emotional problems (Aguilar, DiNitto, Franklin, & Lopez-Pilkinton, 1991). As the term suggests, psychoeducation appears to be a synthesis of psychology and education (Ryglewicz, 1989). Ivey (1977) defines psychoeducation as “A deliberate and planned effort to teach individuals or groups understandings, skills or competencies in the area of human relations” (p. 23). It is a model of working with families that provides a framework within which families can begin to not only understand the behaviors and actions of their loved ones, but allows them to step back and get a more objective view of their own reactional behavior (Anderson et al. 1981).

According to Hayes and Gnatt (1992) the philosophy underlying psychoeducational programs is that a degree of cognitive mastery about the disorder/disease enables families to better tolerate the psychopathology of their ill family member and helps them discover new ways to manage their own lives in spite of the untoward situation. Psychoeducation has been
described as a model that empowers. For families, the authors argue that "psychoeducation provides a format that helps them move beyond shame and stigma, to develop useful skills and knowledge . . . , to expect respect, support, and help for their ill family member" (p. 65). Rygiewicz (1991) succinctly states the essence of this approach suggesting that family psychoeducation attempts to intervene respectfully, helpfully, supportively, and reverently, in a down-to-earth and immediately useful manner, in situations that are debilitating, anxiety-provoking, and ongoing in the lives of people who do not necessarily need to be patients (p. 87).

A psychoeducational group model utilized by Gross and McCaul (1992) tested an intervention with children of alcoholics directed at enhancing social skills, social support and knowledge of parental addiction. Hayes and Gnatt (1992) reported on a psychoeducational program for groups of psychiatric patients in a day treatment program which illustrated to both patients and staff, how knowledge of their illness can possibly affect patients' functioning and attitudes. Rygiewicz (1991) also explored some of the benefits and considerations in psychoeducational group approaches for people with dual (psychiatric/substance abuse) disorders and their families. The study concluded that both individual and family psychoeducation groups for dual disorder clients hold promise as a "low-key" approach to engagement. In yet another study,
Goldman and Rossland (1992) report on a model which combines a psychoeducation and treatment approach to the ongoing treatment of latency age children whose lives have been affected by parental alcoholism.

Finally, Daley et al. (1992) presented an overview of prevalence, types, effects, and treatment for affective disorders with particular emphasis on educational and psychoeducational interventions. Conclusions from this study suggest that psychoeducational treatment models "are efficacious both in terms of helping participants learn useful information, increasing their coping skills and reducing the emotional burden experienced as a result of having an affective disorder or living with an ill family member" (p. 163).

There is scant literature that addresses the treatment and evaluation of families with a chemically dependent family member utilizing a predominantly psychoeducational approach. However, a study by Aguilar, DiNitto, Franklin, and Lopez-Pilkinton (1991) described some of the ethnic-sensitive techniques used in a psychoeducational program to help Mexican-American parents, primarily mothers whose children are involved with drugs, better address the problem. The authors used the psychoeducational approach to educate families in a culturally relevant manner and presented specific examples of how to adapt this approach so that it is congruent with the unique cultural considerations of Mexican-American
families.

**Hazelden Family Program**

Three studies and a descriptive chapter have been written about an educational and supportive residential family program at the Hazelden Foundation in Center City, Minnesota. The three studies are forerunners of the psychoeducational approach which is described in the chapter as the main focus of the current program. Laundergan and Williams (1979) performed an evaluative study of Hazelden's three-day residential family program and measured clients' cognitive change over a three-day period. Change was facilitated by providing a "therapeutic community that emphasized the primary concepts of Al-Anon—especially detachment—attitude change and self-help through sharing of experiences" (p. 13). Some of the change agents include (a) client behavioral expectations, (b) "critical norms" (confidentiality, participation, and honesty), (c) a "therapeutic atmosphere" (staff-facilitated activities, informal interaction), (d) an "initial conference", and (e) educational presentations (lectures, videos, discussion groups).

Using the 20-item Hazelden Family Program Inventory in a one-group pretest-posttest design, the authors gathered data from 207 family program participants over a three-month period (January - March) in 1977. Results of this study indicate that participants' significant cognitive change appeared to occur in
four main areas: (a) realizing that they cannot change the addict, (b) that they are not responsible for the addict's using, (c) that they are only responsible for their own behavior, and (d) it's more important to change behavior patterns than to continue searching for unknown answers to unanswerable questions.

In a second study of the Hazelden Family Program, which encompassed the last six months of 1978 and the first six months of 1979, Laundergan, Schroeder, and Barnett (1980) performed a more extensive program evaluation on 381 family program participants. At this time, the residential program had expanded to a five-day program for participants. A revised Hazelden Family Program Inventory was administered to program participants at three different times—upon entering the program, on their last day, and six months after leaving the family program. A total of 366 participants responded to the six-month follow-up questionnaire which also included questions associated with social functioning and Al-Anon attendance. Results from this study indicate “that the attitude changes that occurred during the family program were, for the most part, sustained 6 months later” (Laundergan & Williams, 1993, p. 166).

In a final study, Williams, Schroeder, Spicer, and Laundergan (1981) used the same methodology as the 1980 study, but this time studied a much larger sample of participants
(N = 922). Of the 922 family members and significant others participating in the study, 702 responded to a six-month follow-up attitude-change questionnaire. The results, as expected, were similar to those reported in the 1980 study with group discussions, program atmosphere, and informal communication with one another having the most positive impact.

Lastly, Laundergan and Williams (1993) collaborated once again and penned a descriptive chapter entitled “The Hazelden Residential Family Program: A Combined Systems and Disease Model Approach.” In the chapter, the authors provide a thorough and accurate description of the current family program. The following is a summary of that descriptive chapter.

The Hazelden Family Program is a 5-day residential, psychoeducational, and supportive program designed to aid in the recovery process of people who are or have been emotionally involved with a chemically dependent person(s). In a supportive, open, and nurturing environment, the program emphasizes creative living through calm thinking, self-assessment and awareness, learning new behaviors and attitudes, and by utilizing Al-Anon Twelve Step principles (see Appendix A). Program expectations include: “. . . improved self-awareness, recognition of the disease concept of chemical dependency, knowledge of how chemical dependency affects the family, and improved awareness of the change options that
are available" (Laundergan & Williams, 1993, p. 145).

A unique aspect of Hazelden’s Family Program is that it is not a conjoint experience. In other words, family members do not focus on the CD person and do not participate in the program with their CD family member. Family members are encouraged to keep the focus on themselves and identify ways they may have been affected by the CD problem. Select primary rehabilitation patients do participate in the family program for a period of three days, however, they do so with family members previously unknown to them.

This novel idea is extremely helpful because when family members interact with a CD person who was heretofore a stranger to them, the information exchange is on a much more objective, rather than emotional, level. The result of this unusual relationship for the family is greater insight into the “no fault” aspect of the disease and a greater understanding and compassion for their CD family member. Likewise, the CD person learns from the heretofore unknown family members how the family has been adversely affected and exactly what they have been experiencing living in the midst of a chaotic family system brought about by the onset of chemical dependency in a family member.

Staff involvement, by design, is minimal. The primary function of the staff is to structure the environment, facilitate activities and groups, and conduct one goal-setting interview
with each participant upon arrival. This nondirective approach allows both formal and informal group process to occur without staff interference in a calm, nonjudgmental, and supportive environment. Informal interaction between the participants during free time constitutes a very important part of the learning process. During these informal groups, family members connect and bond with other families who are in similar situations. The result is an almost instant calming effect as families realize that they are not alone in dealing with the problem of CD.

The Hazelden Family Program embodies specific objectives and key elements. Program objectives include:

1. Becoming more knowledgeable about chemical dependency and the process of recovery.
2. Recognizing how chemical dependency involves family and friends.
3. Developing new strategies for coping with family relationships and lowering anxiety.
4. Sharing thoughts and feelings with others, learning to trust.
5. Accepting Al-Anon and the Twelve Step Program.

Key program elements are the methods by which family program participants go about achieving program objectives. A brief explanation will accompany each element:

1. Personal plan and inventory: A personal plan (see
Appendix B) form is given to each participant during their initial interview with a counselor upon arrival. This form is to be completed by the fifth and final day and will be read aloud to the entire group during a medallion ceremony. The completed form provides the participant with an aftercare plan for when she/he leaves Hazelden. Participants are encouraged to keep the plan specific and realistic.

2. Daily schedule of activities: (see Appendix C). For a detailed discussion of the daily schedule, see the descriptive chapter by Laundergan and Williams (1993).

3. Information to achieve program objectives: Psychoeducation, the main thrust of the Hazelden Family Program, will be discussed in some detail here. Laundergan and Williams (1993) apply Ryglewicz's (1989) five essentials of psychoeducation to the Hazelden Family Program. A brief summary of the five essentials will follow.

The first essential, a Body of Information includes information about the disease of chemical dependency, including the “no fault” approach, the treatment process, and the ongoing recovery process. Family members are informed about the destructive role anxiety plays, learn how they have been affected by the problem and how they may have inadvertently perpetuated the CD simply by trying to unsuccessfully control the situation and the CD person.

Two theoretical approaches are utilized by the staff to help
family members to better understand their involvement in the unhealthy family system. Basic principles of Rational Emotive Therapy (RET) are applied to help family members identify "...how their ideas and actions support negative self-fulfilling prophesies when they believe that they can help the chemically dependent persons and that those persons cannot help themselves" (Laundergan & Williams, 1993, p. 153).

The other approach, which was an early influence in the design of the Hazelden Family Program concerns the contribution by Murray Bowen (Bowen, 1978; Kerr & Bowen, 1988). Two fundamental principles from Bowen are emphasized by the staff. The first derives from Bowen's idea of the differentiation of self. Laundergan and Williams (1993) interpret this idea stating "...although you care deeply about another person, the other person is separate, not under your control, and responsible for their own action, and that you are not dependent on their approval for your actions" (p. 153). The second principle is associated with chronic anxiety. Again, Bowen theory states that there is a reciprocal relationship between ongoing personal anxiety and situational anxiety, and that they both maintain and provoke each other.

The final component of information provided to the participants involves learning about the basic principles of self-help support in Al-Anon and the Twelve Step philosophy (see Appendix A). This combined body of knowledge is
communicated by the staff via lectures, worksheets, small and large group facilitated discussions, video tapes, and informal group interaction.

The second essential, the Family Entity Assumption, states that "... disorder[s] ... being addressed are at least in part an independent entity" (Ryglewicz, 1989). Again, Bowen theory is applicable here. Bowen viewed the family as a system and that change needed to occur in that system. Laundergan and Williams (1993) state "The part of the family having the most capability for change should then be encouraged to recognize the ability to change and to begin to consider alternative family roles and responses" (p. 155). In other words, each individual in the family has her or his choice whether to change or not change their thinking or behavior, regardless of what happens to the chemically dependent family member. They can decide for themselves not to continue in the unhealthy patterns that have developed in the family and begin to make some positive changes in their own lives, again, regardless of the outcome of the situation.

Guidelines established from the knowledge base is the third essential of psychoeducation. The guidelines in the Family Program include the five program objectives: (a) Become more knowledgeable about chemical dependency, (b) recognize how chemical dependency involves family members, (c) develop new strategies for coping, (d) share
thoughts and feeling with others, (e) learn about the value of Al-Anon, the Twelve Steps and the recovery process.

Education and Role Redefinition which embody the fourth essential is best described by the “active learning” that occurs as a result of lectures, worksheet completion and small group discussion. This learning process helps participants to begin to identify unhealthy roles which they have assumed over time and to discover new ways they can begin to change.

The fifth essential, Information Conveying and Processing, “... is the use of individual and/or group situations for processing information conveyed in a supportive manner” (Laundergan & Williams, 1993, p. 156). Again, lectures, worksheets, and peer group discussions facilitate this process. The emphasis here is on process which occurs both in structured discussion groups, informal participant interaction or staff and participant one-on-one meetings. Lecture topics which provide the information include “What is Chemical Dependency,” “Detaching with Love,” “Family and Change,” “Fear,” “Getting Rid of Resentments,” “Spirituality,” “Shame,” “Family Rules/Roles,” “Redefining Self in Recovery,” “Grief and Grieving,” and “Hope for Relationships.”

SIGNIFICANCE TO SOCIAL WORK

It would appear that the psychoeducational approach to helping families, versus the psychotherapeutic approach, is a natural fit for the profession of social work. Various authors
describe psychoeducation using many of the same terms that are used to describe the profession of social work. Ryglewicz (1991) uses words like “respectfully, helpfully, supportively and relevantly” (p. 87) in her description of family psychoeducation. She goes on to state that it intervenes in a “down to earth and immediately useful manner” (p. 87). Hayes and Gnatt (1992) state that psychoeducation is “a model that empowers . . . [and] provides a format that helps [families] move beyond shame and stigma . . . “ (p. 65). Springboarding off the idea of empowerment, Ryglewicz (1991) asserts that psychoeducation . . . does not require self-labeling nor definitive labeling. It opens up to the client a role of student and active decision-maker that is far more egalitarian than the usual client role. This is an important consideration in our present time of enhanced concern with the role and rights of clients/consumers, and an important factor in any case for people who do not want to be patients (p. 83).

Social work promotes concepts such as empowerment, self-determination, social support, respect for the person, and anti-labeling. It also views the person as a client or participant, and not as a pathological or sick patient. A recent article by Gantt, Hopkins, Pinsky, and Tuzman (1989) describes a training program in the psychoeducation model of family treatment for graduate social work students involved in psychiatric social work. Instead of focusing on family pathology, the emphasis
for students "was on teaching families management skills in
caring for [a] sick family member" (p. 40).

This would easily transfer to working with families with a
chemically dependent member. The psychoeducational
approach views the family as "affected" by the disease, not sick,
and attempts to educate them rather than therapize or "treat" them. In addition, a psychoeducational approach seeks to
empower individuals rather than shame or stigmatize them.
The results of this study hopefully demonstrate the efficacy of
the psychoeducational model in treating families with a
chemically dependent member in a brief, comprehensive five-
day residential program. Although there are other important
components that contribute to the successful outcome that
participants experience in the program, the overall program
strength is derived from the psychoeducational approach.

RESEARCH QUESTIONS

The Hazelden Family Program's primary goal seeks to
promote positive cognitive change in family participants,
resulting in positive behavioral change. In order to determine
whether cognitive change has occurred, the following questions
will be explored:

1. Do participants in the Hazelden Family Program become
more knowledgeable about chemical dependency?

2. Do participants in the Hazelden Family Program
recognize how chemical dependency involves family and
significant others?

3. Do participants in the Hazelden Family Program learn new strategies for coping with family relationships and lowering anxiety?

**METHODOLOGY**

**Population and Sample**

The study population consisted of a sample of convenience which included 50 eligible family members and significant others (SO) consecutively admitted to Hazelden's Family Program between January 29, 1995 and March 2, 1995. For the purposes of this study, family is defined as "those individuals who have the closest or most significant relationships with the chemically dependent person. Family members include [significant others (SO)], spouse, . . . , parents, roommates or close friends, siblings, or some combination of these" (Koffinke, 1991, p. 195).

Participants had to meet three criteria in order to qualify to participate in the study: a) family participants must have a CD family member/SO either in or out of a CD treatment program; b) participants must be at least 18 years of age; c) participation in the family program must be no less than four consecutive days.

A total of 68 individuals initially qualified and agreed to participate in the study. Of these, 50 (74%) completed and returned both the pretest and posttest with 18 (26%) not
Speculation as to why participants were not able to complete the survey included a) the survey was not considered a priority, too many other more important things to do; b) overwhelmed with the situation they were experiencing; c) concerned about confidentiality; d) simply chose not to participate; e) forgot to return either pretest or posttest to researcher; and f) researcher forgot to distribute posttest on the final day.

The sample consisted of 17 (34%) males and 33 (66%) females ranging in age from 20 to 72 years. There were 17 participants (34%) labeled “younger adults” (20 - 34), 25 participants (50%) labeled “middle age” (35 - 57), and seven participants (14%) labeled “older adults” (61 - 72). The mean age was 42. One case did not report an age. Twenty-two (44%) of the 50 individuals participating in the study reported an income in excess of $50,000.00 annually and seven participants (14%) reported incomes between $40,000.00 and $50,000.00. Three participants (6%) reported an income between $30,000.00 and $40,000.00 and three (6%) also reported incomes between $20,000.00 and $30,000.00. Only eight participants (16%) had an annual income of $20,000.00 or less and seven participants (14%) did not report an income. As might be expected, on average, education levels were found to be fairly high. Twenty-three participants (46%) reported having attended some college with 11 (22%) completing a four-year
Interestingly, 15 participants (30%) had education levels in excess of 16 years and only one person reported not finishing high school. The mean for years of education was 16. Of the 50 participating, four did not report their education. Finally, 44 participants (88%) were white, three (6%) were Asian/Pacific Islander, one (2%) was Black, and one (2%) was American Indian.

**Research Design and Data Collection**

This study is descriptive in nature and consisted of a one-group pretest-posttest design. A self-administered 20-item inventory (see Appendix D) was presented to qualifying participants upon arrival in the Family Program (pretest). If they chose to participate, an identical inventory was given to them on their final day (posttest). The inventory was designed to measure participants' knowledge of the content embodied in the three research questions listed above, including their beliefs, attitudes, and thoughts regarding the CD situation in which they have been living. This instrument, developed by Laundergan and Williams (1979) was designed to measure cognitive change in their 1979 evaluation study of the family program. However, because this instrument has only been used in one previous evaluation study, reliability of the inventory has not been systematically established. The inventory does appear to have content validity, since it was specifically designed to demonstrate cognitive change in the original study thereby
reflecting program content.

After participants completed and returned both inventories, a comparison and statistical analysis of the pretests and posttests provided the researcher with a means to measure participants' cognitive or attitudinal change over an average of five days. All of the statements on the inventory were answered with a predetermined and desired "yes" or "no" response. Predetermined select statements on the inventory were assigned to each of the three research questions (see Operational Definitions). These select statements were then understood as indicators for measuring participants' knowledge, or lack of knowledge concerning each of the three research questions. Each item on the inventory is seen as a "facet" of the idea behind each of the research questions.

In summary, this researcher attempted to measure each research question by asking family participants to respond to the 20 statements on the inventory with a desired "yes" or "no" answer. Certain pre-selected statements "tapped" into the concept behind each of the research questions and indicated either a change in the desired direction or no change concerning knowledge gained about CD, family involvement and change strategies.

**Operational Definitions**

1) Psychoeducation: A deliberate and planned effort to
teach family members and significant others about the following: a) The disease of chemical dependency, b) how CD involves family members, c) ways to develop new strategies to cope with the family situation and lower anxiety. The methods used to disseminate information include lectures, videos, interviews, bibliotherapy, worksheets, and group discussions.

2) Research question number one asks whether family participants become more knowledgeable about chemical dependency. Knowledge of CD is indicated by items 3, 5, 7, 9, 12, and 14 on the Hazelden Family Program Inventory (see Appendix D).

3) Research question number two asks whether family participants recognize the extent of family involvement with chemical dependency. Involvement is indicated by items 4, 10, 11, 15, 18, and 19 on the Hazelden Family Program Inventory (see Appendix D).

4) Research question number three asks whether family participants develop new strategies for coping with family relationships and lowering anxiety. Development of new coping strategies is indicated by items 1, 2, 6, 8, 13, 16, 17, and 20 on the inventory (see Appendix D).

**Data Analysis**

Quantitative data was statistically analyzed using a two-tailed McNemar's test for significance, which focused on direction of participants' cognitive change. McNemar's two-
tailed test was chosen to analyze the data because it is specifically designed for use with two related samples. Weinbach and Grinnell (1991) state that this test "is most commonly applied in research situations that employ a 'before-and-after' research design that measures a single variable two different times using the same subjects" (p. 177). Even though McNemar's test is somewhat limited, it is best applied when the study involves nominal variables utilizing a one-group pretest-posttest design. Statistical significance levels were set at $p<.05$, although levels of $p<.01$ were also reported. Both pretest and posttest percentages of "correct" responses for each of the statements on the inventory were reported. This was included to help the reader easily see differences between the pretest and posttest. Lastly, descriptive statistics were provided regarding participant age, race, levels of education and income.

**RESULTS**

Findings gathered from the analyzed data reflect the following results for each of the research questions:

Research question number one asks "Do program participants gain knowledge about the disease of chemical dependency?"

Results indicate that there was statistically significant change on 3 of the 6 indicators associated with the first question. Inventory statements 3, 7, and 14 denote significant change in participant knowledge in the desired direction.
Statements 5, 9, and 12 exhibited a change in the desired direction, however, were not found to be statistically significant. Table 1 describes the findings of research question number one.

**Table 1**
**Participant Knowledge About CD Before and After Program Participation**

<table>
<thead>
<tr>
<th>ITEM#</th>
<th>STATEMENT</th>
<th>DESIRED RESPONSE</th>
<th>PRETEST</th>
<th>POSTTEST</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>I'm fairly certain that stressful working conditions and/or particular kinds of family pressure frequently cause people to abuse drugs/alcohol.</td>
<td>NO</td>
<td>28.6%</td>
<td>52.1%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>5</td>
<td>I would do almost anything to find out what causes drug and alcohol abuse.</td>
<td>NO</td>
<td>28.0%</td>
<td>36.0%</td>
<td>NS</td>
</tr>
<tr>
<td>7</td>
<td>I can't help feeling that addictions particularly affect people who lack willpower and determination.</td>
<td>NO</td>
<td>70.8%</td>
<td>90.0%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>9</td>
<td>I would say that unhappy childhood experiences often cause people to abuse alcohol/drugs.</td>
<td>NO</td>
<td>34.7%</td>
<td>35.6%</td>
<td>NS</td>
</tr>
<tr>
<td>12</td>
<td>Addicts and their families usually find that the home cure fails.</td>
<td>YES</td>
<td>87.5%</td>
<td>92.0%</td>
<td>NS</td>
</tr>
</tbody>
</table>

*(table continued)*
Family Program Evaluation

<table>
<thead>
<tr>
<th>ITEM#</th>
<th>STATEMENT</th>
<th>DESIRED RESPONSE</th>
<th>PRETEST</th>
<th>POSTTEST</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>It is important for the family to know what they have been doing to make the chemically dependent person drink and/or use other drugs.</td>
<td>NO</td>
<td>30.6%</td>
<td>57.1%</td>
<td>&lt;.01</td>
</tr>
</tbody>
</table>

Item three, "I'm fairly certain that stressful working conditions and/or particular kinds of family pressure frequently cause people to abuse drugs/alcohol," reveals a pretest score of nearly 30% and a posttest score of about 52%. Even though the change is significant, almost half of the participants still held on to the belief that stressful working conditions or family pressures cause CD. On item number seven, "I can't help feeling that addictions particularly affect people who lack willpower and determination," nearly 71% of the participants answered in the desired direction on the pretest as opposed to 90% on the posttest. The high percentage on both tests may indicate that many participants arrived with this knowledge and almost all had gained understanding by their last day in the program.

On item 14, "It is important for the family to know what they have been doing to make the chemically dependent person drink and/or use drugs," approximately 31% answered in the desired direction on the pretest compared to about 57%
on the posttest. A significance level of $p<.01$ indicates that participants gained knowledge about the disease due to the education provided by the Family Program. The posttest score also reveals that 43% still cling to the belief that CD is caused by family interaction/behavior.

Statement five, "I would do almost anything to find out what causes drug and alcohol abuse," received a low desired response of 28% in the pretest with no significant shift in the posttest--36%. It appears that approximately 70% of the participants arrive with the idea that it is necessary to discover the cause of chemical dependency. As indicated by the relatively low response on the posttest, most seem to cling to this notion even though the program teaches otherwise.

Item 12, "Addicts and their families usually find that the home cure fails," received a high 87.5% desired response in the pretest with a shift to 92% in the posttest. Due to the high level of preferred response agreement on the pretest, it would be very difficult to attain statistical significance on this particular item. Hence, this particular finding does not necessarily weaken the results.

Research question number two asks "Do program participants recognize the negative impact chemical dependency has on family members and the family system?"

Results regarding research question number two, knowledge of family involvement, indicate statistically
significant change on only inventory statement number four. Items associated with this question that were not found to be statistically significant but did indicate some change in the desired direction were statement numbers 10, 11, and 18. Interestingly, some change appeared to occur (not significant) on items 15 and 19, but movement was in the undesired direction (see Table 2).

**Table 2**  
**Participant Knowledge of Impact of CD on Family Systems Before and After Program Participation**

<table>
<thead>
<tr>
<th>ITEM#</th>
<th>STATEMENT</th>
<th>DESIRED RESPONSE</th>
<th>PRETEST</th>
<th>POSTTEST</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>I have to be careful not to upset others in my family.</td>
<td>NO</td>
<td>46.9%</td>
<td>74.0%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>10</td>
<td>I can feel OK even if my significant other does not feel OK.</td>
<td>YES</td>
<td>81.6%</td>
<td>86.0%</td>
<td>NS</td>
</tr>
<tr>
<td>11</td>
<td>Almost everyone in the family finds it difficult to accept that alcohol/drug abuse is a problem amongst them.</td>
<td>YES</td>
<td>46.9%</td>
<td>56.0%</td>
<td>NS</td>
</tr>
<tr>
<td>15</td>
<td>Even though living in an addictive relationship is often intolerable, I have</td>
<td>YES</td>
<td>60.9%</td>
<td>54.3%</td>
<td>NS</td>
</tr>
</tbody>
</table>

*Table continued*
Shame and fear often cause families and addicts to isolate themselves socially and to avoid sources of help.

Usually the family and the addict are unable to recognize harmful addiction behavior until their problems have become very serious.

Item four states “I have to be careful not to upset others in my family.” This statement is tied to the notion that family members are somehow responsible for the manner in which the chemically dependent person reacts or responds. Almost half (46.9%) of the participants responded in the desired direction on the pretest with a significant shift to 74% on the posttest.

Two items from the inventory indicated change in the wrong direction. Statement 15 states “Even though living in an addictive relationship is often intolerable, I have somehow become accustomed to this way of life, and I’m aware that I

<table>
<thead>
<tr>
<th>ITEM#</th>
<th>STATEMENT</th>
<th>DESIRED RESPONSE</th>
<th>PRETEST</th>
<th>POSTTEST</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>somehow become accustomed to this kind of life, and I’m aware that I may find it very difficult to change.</td>
<td>YES</td>
<td>94.0%</td>
<td>100%</td>
<td>NS</td>
</tr>
<tr>
<td>19</td>
<td>Shame and fear often cause families and addicts to isolate themselves socially and to avoid sources of help.</td>
<td>YES</td>
<td>96.0%</td>
<td>92.0%</td>
<td>NS</td>
</tr>
</tbody>
</table>
may find it very difficult to change.” About 61% answered “yes” (desired direction) to this item on the pretest as opposed to slightly more than 54% on the posttest. That is, on the posttest, a little less than 7% either changed their previous answer or did not answer at all.

Item 19 says “Usually the family and the addict are unable to recognize harmful addiction behavior until their problems have become very serious.” Ninety-six percent answered in the desired direction on the pretest and 92% responded “yes” on the posttest. Although the difference of 4% is a very small and a seemingly insignificant amount, the fact remains that movement was in the undesired direction.

Item number 10, “I can feel OK even if my significant other does not feel OK,” and item number 18, “Shame and fear often cause families and addicts to isolate themselves socially and to avoid sources of help,” both received high levels of initial desired response, almost 82% and 94% respectively. Again, as in item 12 above, even though the shift was not significant, the high levels of pretest agreement do not allow much room for significant change to occur. Therefore, because of the limited change potential, the results are not necessarily weakened.

Research question number three asks “Do program participants learn new strategies designed to help them better cope with family relationships and lower anxiety?”
Results associated with learning new coping strategies indicate change of a significant level in three of the eight statements affiliated with the third research question--numbers 1, 2, and 8. Items 6, 13, 17, and 20 all exhibited various degrees of change in the desired direction, but did not reach the established level of significance. Inventory indicator number 16 evidenced change, but again, the direction was undesirable. Table 3 describes the results of research question number 3.

### Table 3
**Participant Knowledge of New Coping Strategies Before and After Program Participation**

<table>
<thead>
<tr>
<th>ITEM #</th>
<th>STATEMENT</th>
<th>DESIRED RESPONSE</th>
<th>PRETEST</th>
<th>POSTTEST</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I think that I am more sensitive than most people.</td>
<td>NO</td>
<td>26.0%</td>
<td>55.1%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>2</td>
<td>I feel like a victim.</td>
<td>NO</td>
<td>69.4%</td>
<td>88.0%</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>6</td>
<td>I feel that my significant other is largely responsible for the bad feelings I have.</td>
<td>NO</td>
<td>78.7%</td>
<td>91.8%</td>
<td>NS</td>
</tr>
<tr>
<td>8</td>
<td>I have helped/been helped to avoid the harmful consequences of the drinking and/or drug use.</td>
<td>YES</td>
<td>75.0%</td>
<td>91.5%</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>13</td>
<td>I can choose to be responsible for my own behavior whatever</td>
<td>YES</td>
<td>96.0%</td>
<td>100%</td>
<td>NS</td>
</tr>
</tbody>
</table>

*Table continued*
ITEM# | STATEMENT                                                                 | DESIRED RESPONSE | PRETEST | POSTTEST | P
--- | --- | --- | --- | --- | ---
16  | I'm sure that I have learned to deny, minimize, and rationalize the chaos we have experienced in our family. | YES | 77.6% | 73.5% | NS
17  | In recovery I must devote my energies helping loved ones solve their problems. | NO | 74.0% | 88.0% | NS
20  | Participation in a self-help program, such as Al-Anon or A.A., could be helpful to me. | YES | 98.0% | 100% | NS

Item one states “I think that I am more sensitive than most people.” A relatively low 26% answered in the desired direction on the pretest with slightly more than half (55.1%) responding “no” on the posttest. About 45% hung on to the idea that they think they are more sensitive than others.

Statement two, “I feel like a victim,” embodies a similar idea. Nearly 70% of the participants responded in the desired direction on the pretest with 88% doing so on the posttest. This finding indicates that most came in not feeling stuck in this role and almost all gained that knowledge within five days.

Lastly, item eight states “I have helped/been helped to avoid the harmful consequences of the drinking and/or drug use.” Three-quarters (75%) of the participants responded in the
desired direction on the pretest as did nearly 92% on the posttest. Again, most of the participants arrived having already gathered this knowledge, and by the end of the five days all but 8.5% gained insight into the concept of enabling behavior.

Item 13, "I can choose to be responsible for my own behavior whatever my significant other may choose to do," and item 20, "Participation in a self-help program such as Al-Anon or A.A. could be helpful to me," both had high levels of initial desired response, 96% and 98% respectively, each increasing to 100% on the posttest. Due to the limited change potential for both of these items, statistical significance was not possible nor necessary. Again, because of the high percentage of initial response, there is not a negative impact on the overall results.

Change in item number 16, "I'm sure that I have learned to deny, minimize, and rationalize the chaos we have experienced in our family," occurred in the undesired direction. Pretest response reports almost 78% in the desired direction, but the posttest score decreased to about 74%. Although the change was less than 4%, it was nonetheless undesirable.

The final two items, number six, "I feel that my significant other is largely responsible for the bad feelings I have," and number 17, "In recovery, I must devote my energies helping loved ones solve their problems," both had pretest scores of nearly 80% and 74% respectively. Posttest results yielded almost 92% for item six and 88% for item 17. Even though the
findings were not significant for either of these, only a small percentage of the participants seemed to still be struggling with the idea of letting go of the chemically dependent person in their lives.

**Summary of Results**

Even though only seven of the 20 inventory statements achieved statistical significance (35%), overall results appear to indicate that Hazelden's Family Program is effective in affecting cognitive change over a five-day period. Table 4 allows the reader a complete picture of the findings, including desired response of pretest and posttest, and probability levels.

**Table 4**  
**Hazelden Family Program Inventory**  
(Before and After Response)

<table>
<thead>
<tr>
<th>ITEM#</th>
<th>STATEMENT</th>
<th>DESIRED RESPONSE</th>
<th>Percent answered in desired direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I think that I am more sensitive than most people.</td>
<td>NO</td>
<td>26.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>55.1%</td>
</tr>
<tr>
<td>2</td>
<td>I feel like a victim.</td>
<td>NO</td>
<td>69.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>88.0%</td>
</tr>
<tr>
<td>3</td>
<td>I'm fairly certain that stressful working conditions and/or particular kinds of family pressure frequently cause people to abuse drugs/alcohol.</td>
<td>NO</td>
<td>28.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>52.1%, &lt;.01</td>
</tr>
<tr>
<td>4</td>
<td>I have to be careful not to upset others in my family.</td>
<td>NO</td>
<td>46.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>74.0%, &lt;.01</td>
</tr>
<tr>
<td>5</td>
<td>I would do almost anything to find out what causes drug and alcohol abuse.</td>
<td>NO</td>
<td>28.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>36.0%, NS</td>
</tr>
</tbody>
</table>

(table continued)
<table>
<thead>
<tr>
<th>ITEM#</th>
<th>STATEMENT</th>
<th>DESIRED RESPONSE</th>
<th>PRETEST</th>
<th>POSTTEST</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>I feel that my significant other is largely responsible for the bad feelings I have.</td>
<td>NO</td>
<td>78.7%</td>
<td>91.8%</td>
<td>NS</td>
</tr>
<tr>
<td>7</td>
<td>I can't help feeling that addictions particularly affect people who lack willpower and determination.</td>
<td>NO</td>
<td>70.8%</td>
<td>90.0%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>8</td>
<td>I have helped/been helped to avoid the harmful consequences of the drinking and/or drug use.</td>
<td>YES</td>
<td>75.0%</td>
<td>91.5%</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>9</td>
<td>I would say that unhappy childhood experiences often cause people to abuse alcohol/drugs.</td>
<td>NO</td>
<td>34.7%</td>
<td>35.6%</td>
<td>NS</td>
</tr>
<tr>
<td>10</td>
<td>I can feel OK even if my significant other does not feel OK.</td>
<td>YES</td>
<td>81.6%</td>
<td>86.0%</td>
<td>NS</td>
</tr>
<tr>
<td>11</td>
<td>Almost everyone in the family finds it difficult to accept that alcohol/drug abuse is a problem amongst them.</td>
<td>YES</td>
<td>46.9%</td>
<td>56.0%</td>
<td>NS</td>
</tr>
<tr>
<td>12</td>
<td>Addicts and their families usually find that the home cure fails.</td>
<td>YES</td>
<td>87.5%</td>
<td>92.0%</td>
<td>NS</td>
</tr>
<tr>
<td>13</td>
<td>I can choose to be responsible for my own behavior whatever my significant other may choose to do.</td>
<td>YES</td>
<td>96.0%</td>
<td>100%</td>
<td>NS</td>
</tr>
<tr>
<td>14</td>
<td>It is important for the family to know what they have been doing to make the chemically dependent person drink and/or use drugs.</td>
<td>NO</td>
<td>30.6%</td>
<td>57.1%</td>
<td>&lt;.01</td>
</tr>
</tbody>
</table>

*Note: (table continued)*
<table>
<thead>
<tr>
<th>ITEM#</th>
<th>STATEMENT</th>
<th>RESPONSE</th>
<th>DESIRED RESPONSE</th>
<th>PRETEST</th>
<th>POSTTEST</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Even though living in an addictive relationship is often intolerable, I have somehow become accustomed to this kind of life, and I'm aware that I may find it very difficult to change.</td>
<td>YES</td>
<td></td>
<td>*60.9%</td>
<td>*54.3%</td>
<td>NS</td>
</tr>
<tr>
<td>16</td>
<td>I'm sure that I have learned to deny, minimize and rationalize the chaos we have experienced in our family.</td>
<td>YES</td>
<td></td>
<td>*77.6%</td>
<td>*73.5%</td>
<td>NS</td>
</tr>
<tr>
<td>17</td>
<td>In recovery I must devote my energies helping loved ones solve their problems.</td>
<td>NO</td>
<td></td>
<td>74.0%</td>
<td>88.0%</td>
<td>NS</td>
</tr>
<tr>
<td>18</td>
<td>Shame and fear often cause families and addicts to isolate themselves socially and to avoid sources of help.</td>
<td>YES</td>
<td></td>
<td>94.0%</td>
<td>100%</td>
<td>NS</td>
</tr>
<tr>
<td>19</td>
<td>Usually the family and the addict are unable to recognize harmful addiction behavior until their problems have become very serious.</td>
<td>YES</td>
<td></td>
<td>*96.0%</td>
<td>*92.0%</td>
<td>NS</td>
</tr>
<tr>
<td>20</td>
<td>Participation in a self-help program, such as Al-Anon or A.A., could be helpful to me.</td>
<td>YES</td>
<td></td>
<td>98.0%</td>
<td>100%</td>
<td>NS</td>
</tr>
</tbody>
</table>

*Indicates movement in undesired direction.

Statements number one, two, three, four, seven, eight, and fourteen all indicated significant change in the desired direction. Items 10, 12, 13, 18, and 20 all showed more than 80% participant agreement in the desired direction on the pretest.
with increases in those numbers on the posttest. In fact, numbers 13, 18, and 20 all indicated 100% response in the desired direction on the posttest. Posttest scores on items number 10 and 12 were 86% and 92% respectively. Hence, because of the limited change potential of these particular items, they do not appear to negatively effect the overall findings. Taken together, the items above account for 60% of the reported results.

Items of most concern are those statements which indicated a low response rate on the pretest with a low to moderate increase on the posttest. These items include numbers 5 and 9. Most participants continue to adhere to the belief that it is important that they find a cause for the disease (item 5) and they also want to blame the cause on something that occurred in the CD person's past history (item 9).

Other statements of interest include items 15, 16 and 19. In each of these, responses on the posttest indicated movement in the undesired direction. Even though the percentage of negative change between tests is quite small in all three statements (4% - 6%), it is important to consider why this may have occurred. Two of these items (15 and 19) were associated with research question number two, and item 16 was tied to question number three. Movement in an undesired direction was not a concern for research question number one.

The remaining statements, 6, 11, and 17, all indicate
change in the desired direction, with items number 6 and 17 revealing a fairly high percentage of initial agreement (78.7% and 74% respectively) on the pretest. Response on the posttest concerning both of these items increased to almost 92% and 88% respectively. Hence, it would appear that neither of these items would have a great negative impact on the findings.

Number 11 indicates that less than half responded in the desired direction on the pretest (46.9%) with slightly more than half (56%) answering “yes” on the posttest. Because it suggests denial, which is a hallmark of the disease of chemical dependency, and because so much of the educational focus is centered on this particular aspect, it is of interest as to why there wasn’t a considerably higher response rate on the posttest.

Since indication of cognitive change in program participants is only meaningful when inventory statements achieve statistical significance (confidence that change is not due to pure chance), those statements which attained levels of \( p < .01 \) and \( p < .05 \) will be examined more closely in the following section. Other items worthy of discussion include those statements with movement in the undesired direction, those with a high level of initial preferred response agreement, and those which had a very low pretest preferred response.

Of special interest are six inventory statements (30%) which appear to be particularly problematic to the findings in
this study. Two of them (items five and nine) are associated with research question number one; three indicators (11, 15 and 19) are connected to research question number two; and only item number 16 is tied to research question number three. These six indicators in association with their respective research questions will be the focus of discussion in the following section.

**Discussion**

The 20-item inventory was designed to tap into participants' knowledge of the disease of chemical dependency vis-a-vis the three research questions. Six statements were assigned to reflect knowledge of research question number one, six were ascribed to question number two, and eight were designated to question number three. After a comparison of pretests and posttests using McNemar's test, it was discovered that seven, or 35%, of the twenty items indicated statistical significance (see Table 4). In the original study by Laundergan and Williams (1979), 14 of the 20 items, or 70%, indicated statistical significance using the same 20-item inventory and test.

As was found by the authors of the 1979 study, some of the items on the test had limited change potential because of the initial high rate of agreement on the pretest. Items reflecting this high response rate were items 12, 13, 18, and 20. Except for item number 19, these were the very same statements which indicated a high initial response rate in the
1979 study.

Possible reasons for initial high pretest response in these items may include participants' prior knowledge about the following: (a) the futility of continually trying to "cure" or "fix" the CD person (item 12), (b) what they can and cannot change/control (item 13), (c) the stigma and fear that the disease promulgates (item 18), and (d) that joining a support group may be helpful to them (item 20). Three possible ways in which family members may have learned about the information embodied in the above statements include: (a) The addicted family member or another family member may have been in some kind of rehabilitation program before and the family had received some prior education, (b) family members had attended a twelve step support group sometime in the past, (c) public education about addiction may have provided the participants with some prior knowledge.

Research question number one asks "Do participants in Hazelden's Family Program become more knowledgeable about chemical dependency?" The statements on the inventory associated with this question include items 3, 5, 7, 9, 12, and 14. Of these, items 3, 7, and 14 indicate statistical significance; all three attained levels of p<.01. This suggests that, overall, participants appear to learn that: (a) chemical dependency is not caused by stressful life situations or family pressures (item 3); (b) chemically dependent people are not morally weak, they
have a disease which removes any choice to use or not to use (item 7); and (c) the family members are not responsible for the chemically dependent person's drinking or using drugs (item 14).

Inventory statement number three states "I am fairly certain that stressful working conditions and/or particular kinds of family pressure frequently cause people to abuse drugs/alcohol." One of the questions most often asked by affected family members is "What caused this disease?" They reason that if they can just understand the cause, they will be able to find a solution. Their need to know the etiology of the illness often overshadows all else. Hence, an important part of their education involves information about CD as a "no fault" disease. Family members learn Al-Anon's three C's: They didn't cause it, they can't control it, and they can't cure it.

Statement three infers that environmental/social conditions cause addiction to occur. More than half of the participants answered in the desired direction after five days, which indicated a significant change in their knowledge of this important concept. Without family members gaining an understanding of the "no fault" aspect, they may simply continue to blame the disease on themselves or external factors and forever attempt to make nonproductive changes. Or, they may continue looking for an obscure cause, thereby keeping the focus on the problem of addiction and not the solution.
which involves letting go, acceptance and engaging in a program of recovery for themselves.

Item seven states "I can't help feeling that addictions particularly affect people who lack willpower and determination." Again, family members often reason that their loved one should just be able to control their condition and simply stop the using and destructive behavior. Some appear to equate CD with a bad habit and since many of them have been able to extinguish problematic behaviors in their own lives by sheer determination, they reason that their loved one ought to do the same. What they fail to understand is that the addict has lost all control, including the choice to use or not to use. Stigma, a major problem embodied in this statement, often causes families to adhere to the belief that their loved one is morally weak. As a result, they often adopt hurtful attitudes which only act to increase the misery in their lives and perpetuate the shame cycle within which the addict is deeply embedded.

Finally, statement 14 states "It is important for the family to know what they have been doing to make the CD person drink and/or use drugs." Again, part of the educational focus includes teaching the family members that they are powerless over the disease of CD and the CD person. In addition, their own lives to some extent have also become unmanageable. This idea embodies the message in Step 1 (see Appendix A).
The more family members continue to concentrate their undivided attention and energies toward "fixing" the problem, the more chaotic and complicated the problem becomes. Acceptance of what is, holds the key to peace of mind for the family. Learning about and understanding the concept of detaching with love (emotional disengagement) from the addiction, allows them to begin to refocus their attention on their own needs and allows the addict to become responsible for themselves. As a result, they begin to experience more peace and freedom in their lives, regardless of what the addict chooses to do.

Items 5 and 9 are of particular concern here. Item 5 states "I would do almost anything to find out what causes drug and alcohol abuse." The desired response is "no" and the pretest score was 28% answered in the desired direction and 36% on the posttest. As was mentioned earlier, it is not so important to determine cause (at this time there isn't any known cause) as it is to begin to learn ways to change the unhealthy behaviors which have developed in the family over time. If one is adamant about discovering the cause of chemical dependency and is focused solely upon that goal, that person can then avoid looking at what she/he may have to do to change themselves in order to change the entire system.

Statement number 9 says "I would say that unhappy childhood experiences often cause people to abuse
alcohol/drugs.” Again, the desired response is “no” with almost 35% answering correctly on the pretest and less than 36% answering correctly on the posttest. Blame and not assuming responsibility for one’s own behavior is the issue here. If a chemically dependent person can continue to blame past events and an unfortunate history for her/his addictions then she/he does not have to assume responsibility for recovery. Family members must be aware of the blame-game and not buy into it if their CD family member continues to use it. It will simply delay recovery and replace responsibility with excuses and rationalizations.

Initial responses on items 5 and 9 were quite low, 28% and 34.7% respectively. Statement 5 had a higher response rate on the posttest than statement 9, but neither were significant, 36% and 35.6% respectively. Speculation as to why a more meaningful change did not occur may include the following: (a) The Family Program did not provide adequate education concerning these items; (b) family members, particularly parents, may still feel somewhat responsible for the chemically dependent person’s condition. “If I had only been a better parent” is often heard amongst the participants. Hence, they feel that if they discover a cause it may either help them to change something in their own lives, or get them off the “bad parent” hook; and (c) they may be so conditioned to the stigmatic view society continues to promote that five days may
not be enough time to convince them that chemical dependency is a "no fault" disease.

It is interesting that item three, "I'm fairly certain that stressful working conditions and/or particular kinds of family pressure frequently cause people to abuse drugs/alcohol," and item nine embody the same idea, yet item three changed significantly and item nine changed little. However, even though item three increased significantly on the posttest, nearly half of the participants still answered "yes" to that statement. Therefore, it appears that participants are clinging to the idea that there must be a specific etiology for the disease of chemical dependency. Since most other diseases have known causes, it is not surprising that family members tend to adhere to this belief. Hopefully, if they continue in their own recovery, they will come to realize that uncovering a cause is simply not very important.

Research question two asks "Do participants in Hazelden's Family Program recognize how chemical dependency involves family and significant others?" Statements on the inventory associated with this question include items 4, 10, 11, 15, 18, and 19. Of the six statements, only item four, "I have to be careful not to upset others in my family," met the requirements for significance. Nearly half (47%) of the participants answered in the desired direction on the pretest with 74% in agreement on the posttest. This appears to indicate that family members learn
that they need not continue to cater and conform to the whims and manipulative behavior of the CD person. Family members' behavior is not what is causing the CD person to use alcohol or drugs.

Statement number four has to do with the mistaken idea that family members are somehow responsible for the way others feel or live their lives. Participants answering "yes" to this statement may still believe that they are somehow to blame for the addiction and the surrounding problems, or that something they do or say could set off another drinking/using bout. This is what often happens with young children of addicted parents. They begin to believe that it is something about them that causes their parent(s) to continue to use drugs or alcohol. As a result, many adult children of addicted parents develop unhealthy behavior patterns to help them survive the crazy family they are a part of. They may keep on adapting, hoping that something they try will work to stop the addiction. Perfectionism, one of the adaptive behaviors and also one of the most destructive, can negatively impact a person's relationships with others for a lifetime.

Therefore, continued belief in this statement may keep family members walking on eggshells and, by doing so, maintain the addictive patterns and restrict one's freedom. Family members must realize that the CD person covertly negotiates alliances with family members to keep her/his
disease progressing. If everybody in the family believes that by not rocking the boat, all will hopefully be well, the addiction often progresses and the addict may not experience the needed consequences because of the family’s protection. By understanding the impact of CD on families, members can begin to once again live their own lives and allow the CD person to become responsible for themselves, for their actions and their behavior. Again, learning what is and what is not within one’s control is crucial.

Item 18, “Shame and fear often cause families and addicts to isolate themselves socially and to avoid sources of help,” had fairly high levels of initial agreement in the desired direction on the pretest, 94%, and increased to 100% on the posttest. Again, the limited change potential of the item would not appear to negatively affect the outcome of the study.

Item number 10, “I can feel OK even if my significant other does not feel OK,” also had a fairly high response on the pretest (81.6%) with an increase to 86% on the posttest. This would indicate that most participants arrive with at least some understanding of the concept of “detaching with love” or unhooking emotionally from the disease. Once again, because the idea of taking the focus off changing the addict and placing it on changing oneself is one of the most important educational components of the Family Program, it is of some concern as to why the change was not significant. One reason might be that
the remaining 14% could possibly have spent so much of their lives in a CD environment and may have become so conditioned to surviving in that unhealthy system that five days of education did not adequately change their perception of reality.

Item number 11, “Almost everyone in the family finds it difficult to accept that alcohol/drug abuse is a problem amongst them,” had a pretest response of almost 47% and a posttest response of 56%. Again, only about half of the participants answered in the desired direction initially and slightly more than half on the posttest. Since this item also is tied to denial, it is of concern as to why the posttest score did not increase to a significant level. Possible reasons may include (a) participants did not receive adequate education; (b) since participants did not know there was a desired response, some may have answered “yes” on the pretest and thought that the “correct” answer on the posttest must be the opposite; (c) family members may have thought that since they now had some education about denial and now knew that addiction was the problem, the answer to this question at the end of the five days must be “no.”

Items 15, “Even though living in an addictive relationship is often intolerable, I have somehow become accustomed to this kind of life, and I’m aware that I may find it very difficult to change,” and 19, “Usually the family and the addict are
unable to recognize harmful addiction behavior until their problems have become very serious," both had lower posttest scores, 54.3% and 92% respectively, than pretest scores, 60.9% and 96% respectively. Item 15 is of more concern than item 19 because of the considerably lower scores on both tests. A possible reason may be that some participants once again thought that since they had received some education about how CD impacts family systems, it may not have seemed as difficult to change at the end of the five days as it had at the beginning.

One of the tasks that participants complete before departing the program is the development of a personal plan for the future. In this plan, they identify some goals and objectives that will enable them to live better, more healthy lives. This plan, as well as the posttest, is to be completed on the participant's final day. Perhaps, after designing a future self-care plan for themselves, they also chose to change their answer to this statement simply because they had learned that it was possible to change their own lives armed with the new information they had received. Some may have also felt that in order to indicate learning had occurred, the logical response on the posttest would be opposite of the pretest response.

Item 19 is not of great concern here simply because of the very high initial response on the pretest (96%) and a mere 4% decrease on the posttest (92%). Almost all the participants
arrived knowing that there were some very serious problems occurring in their families and in retrospect, saw that they had truly been unable to recognize how destructive the addictive behavior had become. However, education about the harmful effects of the disease of addiction on the family system may have caused some participants to answer differently on the posttest. Participants receive information which helps them to identify unhealthy patterns of behavior and they also have the opportunity to learn directly from CD people themselves as they spend some time on the family unit. There may have also been some confusion and misunderstanding concerning both items 15 and 19. Participants may have thought that if their answer was the same on both tests it did not indicate program knowledge gained. Hence, the potential for social desirability bias was present and participants may have changed their response on the posttest to appear more knowledgeable.

Results regarding research question number two seem to indicate that Hazelden's Family Program is only somewhat effective in educating participants about how CD impacts family systems. However, since three of the six statements indicated limited change potential due to the high response in the desired direction on the pretest, it appears that most of the participants already have gained considerable knowledge about the effects of CD on families.

Research question number three asks "Do participants in
the Hazelden Family Program learn new strategies for coping with family relationships and lowering anxiety?" Inventory items associated with this question include numbers 1, 2, 6, 8, 13, 16, 17, and 20. Of the eight statements, three reached levels of p<.01 or p<.05. These include items: one, "I think that I am more sensitive than most people," (p<.01); two, "I feel like a victim," (p<.05); and eight, "I have helped/been helped to avoid the harmful consequences of the drinking and/or drug use," (p<.05).

Even though the finding on item number one indicates significance, almost half, nearly 45%, still responded "yes" on the posttest. As the disease of CD progresses in the family, it appears that members' coping skills dwindle and they begin to feel more and more out of control due to a progressively hopeless situation. They may begin to believe that there is something wrong with them—if only they were stronger, then they would be able to "fix" the problem. As a result of disappointment after disappointment, the family starts to think that the problem must be about them. This, of course, is playing right into the addiction, keeping the focus off the real problem and on everyone else. The addict perpetuates this further by blaming all her/his woes on the family members and their behavior.

Hazelden's Family Program helps participants understand that they are reacting normally to an abnormal situation. They
begin to view CD as a disease that they cannot control and all their efforts to control it have been useless. They begin to understand that they are truly powerless over the disease and that again their lives have become unmanageable. As a result of this knowledge, family members can then move on to the Second Step which states “Came to believe that a Power greater than [themselves] could restore [them] to sanity” (see Appendix A). This is where family members begin to allow others to help them to change and they start to develop new ways with which to cope based on a much different perspective of themselves in relation to the disease of CD.

Perhaps some participants have been in the unhealthy relationship for so long, they have difficulty not blaming someone or something for all that’s occurred. Hopefully, by continuing in a recovery program, they will learn that their perceived sensitivity was simply a normal reaction to a difficult situation.

Regarding statement two, it appears that a majority of the participants came to the program not feeling victimized (69.4%). At the end of the five days, 88% reported that they did not feel like victims. The role of victim contains feelings of helplessness and hopelessness which family members often experience after living with the disease of CD for a period of time. These feelings appear very real and families often begin to sense that the situation they are in is of a “no win” nature. They often
begin to think that there is nothing they can do to change things and all choice has gone out of their lives.

The program teaches that the family cannot force the addict to make decisions that they would like her/him to make, but they can make decisions that will improve their own personal situation. They learn that they are not helpless, that they can choose to live differently whether the addict chooses to live differently or not. They learn by detaching emotionally from the problem and by not reacting in the same predictable ways, that the addict often begins to change in the direction that the family initially wanted her/him to change in the first place. They begin to understand the power contained in letting go and putting the focus on one's own life situation. Again, by redefining themselves as survivors rather than victims, they can begin to adopt new patterns of interaction by which the family can flourish whether the addict changes or not.

Statement eight, the last item to achieve significance related to question three, says "I have helped/been helped to avoid the harmful consequences of the drinking and/or drug use." Seventy-five percent of the participants responded in the desired direction initially with nearly 92% in agreement on the posttest. As evidenced by the probability level of p<.05, this shift was significant.

Because denial plays such a significant role in the disease of CD for both addict and family members, the family will often
unknowingly buffer the consequences caused by the addict's behavior. As unfortunate as it may seem, it is only by suffering the consequences of her/his actions that the addict has cause to take a good honest look at her/himself. If the family continues to "enable" the addict by doing things like calling in sick for her/him, making excuses for her/him to friends and family, lying to children about unusual behavior, bailing her/him out of jail, and countless other things, the addict really has no good reason to take an honest appraisal of her/his behavior. As the family continues to protect, there is often a proliferation of irresponsible behavior because the addict knows that the family will always be there to clean up whatever mess has been created. Hence, the enabling behavior actually perpetuates the progression of the disease.

While in the Family Program, participants learn how their protective behavior has really been an impediment to not only the addict's recovery process, but their own well-being as well. By preventing the addict from experiencing the rancid fruits of their destructive behavior, they have inadvertently been aiding in the addict's downward spiral. Again, a refocusing on self and one's own behavior allows family members to assess their own position and role in an unhealthy system and begin to make the necessary changes which will allow them to regain a sense of peace within themselves.

When family members learn that they have been reacting
normally to a lousy situation and there are others just like them, they can begin to identify protective behaviors they have been using to shield the addict from her/his consequences and discover that they have the choice to change their lives whether the addict decides to change or not. They have learned new ways of relating to themselves and others in the family system and have discovered much about themselves which helps decrease systemic anxiety.

Two of the inventory items, numbers 13, "I can choose to be responsible for my own behavior whatever my significant other may choose to do," and 20, "Participation in a self-help program, such as Al-Anon or A.A., could be helpful to me," had very high initial desired response, 96% and 98% respectively. Hence, again due to the limited change potential, statistical significance is of no concern.

It is obvious that almost all the participants arrived in the program with some knowledge of the need to let go and detach from the addict's behavior and of the importance of a support group to focus on their own lives. Since the concept of detaching with love was founded in Al-Anon and is a major part of the Al-Anon program, it is possible that some of the participants have had at least some exposure to Al-Anon. Furthermore, because a portion of the patients had been in chemical dependency treatment previously (some more than once), perhaps family members had gone through some sort of
twelve step education prior to coming to Hazelden's Family Program. According to the results indicated here, it appears that many participants had already developed some very beneficial coping strategies.

Statement 16, "I'm sure that I have learned to deny, minimize, and rationalize the chaos we have experienced in our family," had a pretest response of nearly 78% and a posttest response of about 74%. According to the findings, there was a 4% change in the wrong direction. It is encouraging to see that almost 80% of the participants recognized some of the defense behaviors family members develop as a result of living with a CD person. One must first identify these before she/he can begin to change the old unhealthy patterns that have often become institutionalized in the family system. However, why 4% of the participants changed their answers on the posttest is quite puzzling. One possible reason for the posttest decline may be the way in which a few participants read the statement the second time. Perhaps they read it to mean that after five days of Family Program, they "still" tend to deny, minimize, and rationalize the chaos that occurred as a result of CD. If this is the case, then their answer would have to be "no" because of the education they received on defense behaviors.

The final two statements, number six, "I feel that my significant other is largely responsible for the bad feelings I have," and number 17, "In recovery I must devote my energies
helping loved ones solve their problems," both indicated fairly high levels of initial response, nearly 80% and 74% respectively. Both scores increased on the posttest with number six reporting almost 92% and number 17 indicating 88%. These results indicate that most participants realized at the end of five days that they are only responsible for their own feelings regardless of what the addict does, and that they no longer need to feel responsible for helping the addict solve her/his problems. It appears that most family members have realized the absolute necessity of letting go and allowing the addict the dignity to become responsible for her/his own behavior. Most also appear to have learned that they need no longer let another human being dictate the way they will feel. Many family members report a real sense of relief and freedom when this finally rings true for them.

It appears that the current study's findings substantiate most of the findings of Laundergan and Williams' original 1979 study. Results of that study concluded that family members cannot insure abstinence by adapting to the needs of the addict, the family is not responsible for the addict's drug/alcohol use, both family members and addict must take primary responsibility for facing their own life problems, and the cause of drug and alcohol abuse is of less importance than changing the addictive behavior and its distinctive impact on the psychological and interpersonal patterns of family members.
Overall, it appears that participants in this study made the most significant cognitive change in all the above areas except for one. It seems that participants in this study continued to cling to the belief that it was very important to find the cause for their family member's addiction.

**Limitations of the study**

Because the posttest and the pretest are identical and are completed within a short five-day period, social desirability bias will be of significant concern regarding the possibility of a systematic error. Participants may answer differently on the posttest simply because they think that a different answer will indicate to the researcher that learning has occurred. Also, because the pretest and posttest are in such close temporal proximity, participants may remember some of the statements between time one and time two and choose the answer they think is more desirable or preferred.

Another concern has to do with a possible random error. Because the inventory is rather lengthy (20 items) and because the statements may appear ambiguous or even abstract to some participants, family members could have simply answered without giving much thought to the meaning behind the statement.

In addition, this particular experimental design (one-group pretest-posttest) does not take into account or control for factors other than the independent variable that might cause
cognitive change between time one and time two. Hence, extraneous variables may pose a threat to internal validity. Again, because the participants will be completing the same inventory at time one and time two within a short five-day period, the testing process itself could enhance participant's performance without any corresponding improvement in the real construct (cognitive change) that the instrument attempts to measure.

Other limitations refer to the external validity of the study, or the extent to which one can generalize the results of this study to a larger population. The first problem involves research reactivity. The participants were aware that they were participating in a study that was measuring learning over a five-day period. This awareness could cause changes in the dependent variable (cognitive change) which would result in limiting the generalizability of the study to other populations. The second concern again involves testing, whereby performance on a test is enhanced without necessarily any improvement in learning. Taking the pretest can have an effect on the posttest scores which would then impact the generalizability of the study.

Another consideration involving external validity concerns sample size and sampling bias. Because the sample is fairly small (n = 50) and because it happens to be quite homogeneous (predominantly white middle-class) it is possible
that those who participated in the study are not typical or truly representative of the larger population of all chemically dependent families. In addition, because the sample was a sample of convenience rather than randomly selected, it is questionable whether it is representative of a larger population. Furthermore, as mentioned earlier, because the 20-item inventory used to measure participants’ cognitive change has not been systematically used in other evaluative studies, reliability of the instrument remains questionable.

Finally, one possible reason that there were exactly half as many statistically significant items on this study as there were on Laundergan and Willams' (1979) study, could be due to this study's fairly small sample size (n = 50). The sample size in the original 1979 Hazelden Family Program Evaluation study was 207 which may have had a greater impact on the results.

**Summary and Conclusions**

As evidenced in the literature review, there is very little written about programs for family members with a significant other who is chemically dependent. There are virtually no evaluation studies available on family programs in the current literature other than the program evaluation studies that were conducted at Hazelden's Family Program. Since it is widely known, and has been for some time, that alcoholism/drug addiction significantly and negatively impacts family systems and interaction, there appears to be a dire need for much more
systematic investigation into the family's dilemma. Perhaps more research providing evidence of the need for and effectiveness of various family programs would attract more attention and support to this often overlooked population.

Concerning the current study, results appear to indicate that Hazelden's Family Program is, for the most part, realizing its program goals and objectives. According to the findings, cognitive change seems to occur as a result of the psychoeducational component and the formal and informal interaction of the participants. However, the results of this study appear to indicate that the program may be somewhat less effective today than it was 16 years ago. Various reasons for this phenomenon occurring were discussed previously. Therefore, in order to determine whether the findings of this study truly indicate program effectiveness, it is strongly recommended that the study be replicated with a considerably larger and more diverse population.

Another recommendation would be to revise or develop a more succinct and concise inventory or questionnaire. The 20-item inventory used to measure cognitive change in this study seemed rather cumbersome and confusing to some participants, including the researcher. A revised and less complicated nine-item inventory was developed for a 1980 study of the Hazelden Family Program. This later inventory was designed to access virtually the same information as the 20-item inventory, but
used a much more understandable and less confusing format. Because family members most often arrive experiencing significant amounts of stress and anxiety, the nine-item inventory would be easier to complete and demand less of the participant attempting to participate in a voluntary study.

Finally, since the discovery of systems theory, the education and support of family members living with the disease of chemical dependency, or any other chronic condition for that matter, appears to be of utmost importance for all involved. Without the family gaining some knowledge about the disease, without learning how they have been affected by it and without discovering ways they can begin to cope and change, they will continue to experience systemic and personal problems in their lives. To accomplish this, Hazelden's Family Program embodies a unique psychoeducational focus provided through a lightly structured safe and supportive environment, facilitated by an empathetic staff utilizing a nondirective and empowering approach, working with people of kind who participate in a peer group driven process for a period of five days. In today's world, in a country experiencing significant problems with health care, this would indeed seem to be an ideal program for family members. Hence, in order for such a comprehensive service to continue, subsequent outcome studies must follow. In addition, follow-up studies at six, twelve, eighteen, and twenty-four months would give a better indication of the efficacy of the program.
REFERENCES


Appendix A

THE TWELVE STEPS OF AL-ANON

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made the decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs.
Appendix B

HAZELDEN CONFIDENTIAL

FAMILY CENTER PERSONAL PLAN

When you leave the Family Center, how will you use what you have learned here? Please take some time to write down a specific, realistic, and creative plan that will help guide you through the days ahead.

BE SPECIFIC: “I'm going to get more exercise” might be a good general goal, but a more specific goal is to decide that “I will walk for a half-hour at 7:30 a.m. on Mondays, Wednesdays and Fridays.”

BE REALISTIC: To say “I'm going to quit worrying about X's drinking” is a big order; however, deciding that “I will leave the porch light on and go to bed instead of waiting up for X” is possible.

BE CREATIVE: Think of something you could do that would be especially enjoyable or important to you. Maybe you want to learn how to drive a car and get your license. Or you may want to learn karate, or meditation. Or do some traveling you've always hoped to do. Create a plan that will help you enjoy life more thoroughly.

(appendix continued)
1. I make the following commitment to myself for continuing help and support from others:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
(Al-Anon contact number) ________________

2. To reduce stress, I will make the following specific change in my daily routine:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

3. In order to enjoy life more thoroughly, I commit myself to the following plan:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

**HAND IN LAST DAY**
Name: ________________________________
Date: ________________________________

White: Participant file
Yellow: Participant's copy
Appendix C

FAMILY CENTER DAILY SCHEDULE OF ACTIVITIES

6:30 - 7:45 a.m. Early Risers Exercises
Coffee, tea and fruit juice are available in the Unit kitchen area. We encourage you to spend some of this early morning time in personal meditation or relaxation exercises or in physical exercise. The gymnasium with its running track and basketball and volleyball courts is open for you, and so is the swimming pool, Monday through Friday. The nature trails are there for early morning walkers.

8:00 - 8:15 a.m. Morning Roll Call
All Family Program participants gather in the lounge of the Family Center for announcements and for a review of information that you need to know each day. Newcomers will be oriented at this time and those who are leaving will receive discharge information.

8:15 - 9:00 a.m. Breakfast (Family Dining Room)

9:00 - 10:15 a.m. Community Meeting and Morning Lecture
Everyone meets in the large lecture room of the Family Center for introductions all around and for comments on personal plans for the day. This is followed by a lecture by a staff member on the theme for the day. The lecture is preparation for the group discussion period that follows later. Everyone is given a printed outline of the lecture and a "worksheet," a set of questions for personal reflection.

(appendix continued)
10:15 - 10:45 a.m. **Worksheet Preparation**

Quiet time for preparation of the worksheet, which will be your guide for group discussion.

10:45 - 12:15 p.m. **Small Group Discussion**

Staff remain in the background during this small group discussion period. We hope that in these groups people will “experience the shared honesty of mutual vulnerability, openly acknowledged” that is the heart of the Al-Anon program.

12:15 - 1:15 p.m. **Lunch (Family Dining Room)**

- **Sunday and Holidays: 1:15 p.m.-2:00 p.m. Step Discussion and Afternoon Community Meeting and Medallion Ceremony**

All Family Center Program participants gather in Rooms A & B for discussion of the 12 Steps and Afternoon Community Meeting and presentation of medallions.

**2:15 p.m. Film (Optional Activity)**

1:30 p.m. **Roll Call**

Please gather in the Family Center lower lounge area for roll call and any messages.

1:30 - 2:30 p.m. **Stress Management**

You will learn some good stress management techniques and try them out yourself. We want you to know several techniques that will help you take time from daily activities—at home or work—and restore yourself physically and mentally.

2:45 - 3:30 p.m. **Step Discussion**

All Family Center Program participants gather in Rooms A & B for discussion of the 12 Steps.

(appendix continued)
3:30 - 4:00 p.m. **Afternoon Community Meeting and Medallion Ceremony**

Participants share their thoughts about their day and those departing the program read their Personal Plan and receive their medallion.

4:00 - 4:30 p.m. **Film (Optional Activity)**

4:00 - 5:15 p.m. **Free Time**

Take time to get to know each other, take a walk along the walking trails, take some quiet time, play a game. If you have a significant other in treatment at the Center City campus, you may visit on his or her Unit from 4:00--5:15 p.m.

5:15 - 6:15 p.m. **Dinner (Private Dining Room)**

7:00 - 7:30 p.m. **Evening Lecture or Film in Bigelow Auditorium**

If you have a significant other in treatment, you may sit together during this presentation. At 8:00 p.m. please gather in the large lecture room to discuss your thoughts about the presentation. As an option, the Cork recreational facilities are also available for your use at this time.

8:00 p.m. **Open 12 Step Meeting (Optional Activity)**

*If you have just arrived, you will find a Family Information Form in your Family Center packet. Please take some time this evening or during free time on your first day here to complete this form. If you are a Rehab patient, we ask that you complete this form before your first morning here. We will collect the forms during “Roll Call” each morning, or you may give the form to a staff member.*
### Appendix D

#### FAMILY CENTER PROGRAM INVENTORY

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<thead>
<tr>
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<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>1. I think that I am more sensitive than most people.</td>
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<tr>
<td>2. I feel like a victim.</td>
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<td>3. I'm fairly certain that stressful working conditions and/or particular kinds of family pressure frequently cause people to abuse drugs/alcohol.</td>
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<td>4. I have to be careful not to upset others in my family.</td>
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<td>5. I would do almost anything to find out what causes drug and alcohol abuse.</td>
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<tr>
<td>6. I feel that my significant other is largely responsible for the bad feelings I have.</td>
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<tr>
<td>7. I can't help feeling that addictions particularly affect people who lack willpower and determination.</td>
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<tr>
<td>8. I have helped/been helped to avoid the harmful consequences of the drinking/drug use.</td>
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<tr>
<td>9. I would say that unhappy childhood experiences often cause people to abuse alcohol/drugs.</td>
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<td>10. I can feel OK even if my significant other does not feel OK.</td>
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<td>11. Almost everyone in the family finds it difficult to accept that alcohol/drug abuse is a problem amongst them.</td>
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<td>12. Addicts and their families usually find that the home cure fails.</td>
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<tr>
<td>13. I can choose to be responsible for my own behavior whatever my significant other may choose to do.</td>
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(appendix continued)
14. It is important for the family to know what they have been doing to make the chemically dependent person drink and/or use other drugs.  

15. Even though living in an addictive relationship is often intolerable, I have somehow become accustomed to this kind of life, and I'm aware that I may find it very difficult to change.  

16. I'm sure that I have learned to deny and minimize and rationalize the chaos we have experienced in our family.  

17. In recovery I must devote my energies helping loved ones solve their problems.  

18. Shame and fear often cause families and addicts to isolate themselves socially and to avoid sources of help.  

19. Usually the family and the addict are unable to recognize harmful addiction behavior until their problems have become very serious.  

20. Participation in a self-help program, such as Al-Anon or A.A., could be helpful to me.