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FAMILY COMMUNICATION PATTERNS DURING RECOVERY MAINTENANCE:

RELAPSE PREVENTION FOR ALCOHOLICS & DRUG ADDICTS

by

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B.S. May 2018, Old Dominion University

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ABSTRACT

FAMILY COMMUNICATION PATTERNS DURING RECOVERY MAINTENANCE:
RELAPSE PREVENTION FOR ALCOHOLICS & DRUG ADDICTS

Adam J. Pyecha
Old Dominion University, 2020
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The following thesis is research into the Family Communication Patterns (FCP) (McLeod & Chaffee, 1972) of "alcoholics and drug addicts" (ADA) with long-term recovery stages III and IV. Improving relapse rates of ADA in early recovery stage I and stage II may require knowledge about the family communication environment and family type of those ADA with extended recovery time. This is an exploratory descriptive of FCP and family typology of 81 ADA identifying as Twelve-step fellowship (TSF) members recovering from the disease of addiction (Jellinek, 1947; 1960). Data was collected via online questionnaire with adapted scales; AWARE 3.0 relapse awareness warning (Miller & Harris, 1982) and Revised Family Communication Patterns Instrument (Koerner & Fitzpatrick 2002a; 2005). Data analysis of the 81 ADA found low-to-medium significant correlations within their FCP, typology, and the desire to relapse, supporting further research in the addiction rehab recovery counseling field with focus on family communication patterns and the communication field.

Keywords: addiction, alcohol, drugs, conformity orientation, consensual, conversation orientation, family communication patterns, family types, pluralistic, protective, recovery, relapse

For the family's, whose loved ones found recovery
For the garden's which thrive secure in fertile grounds
Supported in the actions of faith, charity, and love
To endure
To exist
Our humanity
Our future

ACKNOWLEDGMENTS

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CHAPTER 1

INTRODUCTION

Alcoholism and drug addiction have been destructive forces among individuals, families, and societies worldwide for thousands of years. In America, the 20th century instilled and enforced new drug legislature and many drug addicts were rounded up by law enforcement, sent to prisons, asylums, or left to die on the streets (Courtwright, 2015). Alcoholics of the down-and -out variety, unable to function and provide for their family left many families suffering with no means of support about their loved one and themselves. If the alcoholic/addict was able to function and support their family, social acceptance required no discussion of the abuse and insanity which occurred in the privacy of the family's home (Afifi & Olson, 2005; Keating et al, 2013).

1.1 THE PROBLEM

It is well-known that illicit street drugs are prevalent in many countries with devastating epidemics from crack, opiate, and methamphetamine. Alcohol is mostly legal throughout the world and there is a widely accepted notion that alcohol is a "healthier" and safer option compared to drugs. However, as recent as 2018, the World Health Organization (WHO) developed a standard measure of morbidity, with alcohol increasing to more than 5.0% compared to all illicit drugs combined at less than 1.5% with respects to the global disease burden.[1]

This disease burden just does not afflict the substance abuser physically, mentally, and spiritually, but it causes monumental conflicts among familial relations and societal functioning. Interpersonally, communication is greatly affected by the disease of alcoholism and addiction.

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[1] World Health Organization (WHO) Global Status Report on Alcohol. Canberra: Department of Mental Health and Substance Abuse, WHO; 2018.

The inability to tolerate and understand the alcoholic and drug addict (ADA)[2] has left societies and families without positive communication techniques to support all involved including ADAs, spouses, children, friends, employers, and the judicial system. Social stigmas around ADA can breed communication challenges within the family. ADAs only seem to bring added stressors to the family dynamic especially as the disease progresses without treatment.

Haverfield et al., (2016) suggested that general and overall family communication patterns are likely affected by the ADAs mental mood instability, conflict, aggression, and avoidance to remain in denial rather than face the truth (pp. 111–113). The reality is that many families are left financially fractured, angry, and ashamed in a state of communicative turmoil and purgatory (Afifi & Olson, 2005). Inevitably, the infrastructure of the family support system has cracked and the family has become as sick as their loved ones. How the family communicates and processes what are often difficult conversations, such as the loss of a stable job, getting in trouble with the law and reoccurring negligent behaviors by from the addicted family member, can make or break the family moving forward (Keating et al., 2013).

1.2 MEDICAL OPINIONS

Two Medical Doctors, Dr. William Silkworth and Dr. Harry Tiebout, anonymous advocates of Alcoholics Anonymous (1935), contributed to the publication of its *Big Book* of

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[2] It has been decided to use the term *alcohol and drug addict* (ADA) to indicate that alcohol is a drug, without omitting alcohol from any discussion about drugs. The term *illegal drugs* will be used in reference to federal government illegal laws, such as marijuana, cocaine, methamphetamine, ecstasy, heroin, and crack. *Illicit drugs* include illegal drugs and the misuse and abuse of prescription medications such as, benzodiazepine, amphetamine, and narcotic opiate pain killers. ADA to include substance abuse disorders, chemical dependency, drug addiction alcoholism, and Alcohol Use Disorder (AUD).

recovery *Alcoholics Anonymous* (1939).[3] Two chapters in this volume were dedicated to spouses and the family members and explained the approach:

> A doctor said to us, "Years of living with an alcoholic is almost sure to make any wife or child neurotic. The entire family is, to some extent, ill". All members of the family should meet upon the common ground of tolerance, understanding and love. This involves a process of deflation. The alcoholic, his wife, his children, his "in-laws", each one is likely to have fixed ideas about the family's attitude towards himself or herself. Each is interested in having his or her wishes respected. We find the more one member of the family demands that the others concede to him, the more resentful they become. This makes for discord and unhappiness. Cessation of drinking is but the first step away from a highly strained, abnormal condition. Let families realize, as they start their journey all will not be fair weather. Each in his turn may be footsore and may straggle. There will be alluring shortcuts and by-paths down which they may wander and lose their way. (pp. 122–123)

Life does not go back to normal for the family members of the alcoholic or drug addict who stops abusing the substance. The wreckage of the once normal family dynamic may be unsalvageable without continued recovery and the knowledge of how to communicate about pain caused during active addiction. If the family is unable to heal, especially for the impressionable children's sake, significant repercussions may lay in store for those children once they become adults. A critical component is that ADA families learn as they experience. A variety of psychological, sociological, medical, and communication theories have been advanced to understand and explain including the following ones:

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[3] Alcoholics Anonymous was founded by Bill W. and Dr. Bob whose spiritual steps concept, alcoholics working with other alcoholics, sponsorship, service and love were derived from Oxford Group (Buchanan, 1908) and Bill W.s famous spiritual transformation in Towns Hospital (1934).

1.3 SOCIAL LEARNING THEORY

Social Learning Theory (Bandura, 1977) concludes that learned behaviors and how or why someone acts the way they do to be influenced by an environment those specific behaviors were observed.[4] In the family dynamic, this repeated observing of behaviors is most important in the parent-to-child relationship. Taplin, et al., (2014) support that parental substance abuse has deleterious effects on childhood development because alcoholics and drug addicts often cycle between relapse and recovery. Family history of drug- and alcohol-use is strongly associated with a cycle of generational substance abusers. MacNish (1835) whose anti-alcohol American Temperance Movement theorized in *Anatomy of Drunkenness*:

> Drunkenness appears to be in some measure hereditary. We frequently see it descending from parents to their children. This may undoubtedly often arise from bad example and imitation, but there can be little question that, in many instances, it exists as a family predisposition. (p.61)

1.4 FAMILY DISEASE

McCrady and Epstein's (1996) family disease model looks at substance abuse as a disease that affects the entire family. Family members of the ADA may develop codependence, where they enable and allow repeated harmful behaviors that come with substance addiction. Limited controlled-research evidence is available to support the disease model, but it nonetheless

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[4] Bandura, Ross, and Ross (1961) used the Bobo Doll Experiment of aggression to show how children naturally mimic what they see occurring around them by their parents.

is influential in addiction rehab treatment facilities, twelve-step fellowship communities for family members of ADA[5] and society (Meyers et al., 2002).

Still, many years later, family members are often unaware of resources and options when it comes to helping their loved one's suffering from the disease of alcoholism or addiction. Even when studies support recovery for the family; spouse, children, or parents of, it may not matter if the ADA refuses to treat their disease. Substance abusers who do not receive treatment or are unable to recover, are more susceptible of passing down the addictive behavior to their children who begin engaging in drug and alcohol use earlier and with more prevalence. There remain studies that claim the disease of alcoholism and addiction to also be hereditary (Wang, Kapoor, & Goate, 2012) adding concern to those children whose parents continuously relapse or never find or practice recovery.

Jiji and Rakesh (2012) added support to the claim that alcoholism and addiction are passed down (genetically and social learning) from parents to children: a continuous family cycle, having long-lasting effects from generation to generation. Both genetic and environmental factors are of course primary socialization processes influencing children's development (pp. 67–70). Children of alcoholics/addicts (COA) are at a higher risk than other children for becoming the next generation of substance abusers. COA are more prone to parental neglect depending on the severity or rock bottom of the addicted parent (Haverfield et al, 2016). Kearns-Bodkins and Leonard's (2008) study of families with ADA show an increased likelihood that the children grow up struggling in school, experiencing domestic violence, engaging in crime and becoming substance abusers than compared to children of nonalcoholic families (pp. 941–943; 946–948).

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[5] Alanon (1951) was founded by Lois W. and Anne B. and Naranon (1968) was founded by Louise S. as a means for family members of ADA to find similarities with other family members of ADA. Both family recovery programs are derived from AA's spiritual concepts, steps, service, and sponsorship.

What about when parent and child roles are reversed? Addiction can severely disrupt the family roles, rituals, and relationships; frequency and quality of family interactions with kinship and social networks; and the global health and functioning of family members are all severely disrupted by addiction roles, rituals, and relationships (White, 2020). It isn't always the children who are victims but sometimes parents whose children are alcohol and drug addicts are left feeling a burdened (Gordon, 2018). In fact, the number of grandparents caring for COA continues to rise amid the prolific American opioid epidemic, leading to more incarcerations and overdose deaths of ADA. Haverfield et al, (2016) explains that parents of ADA take custody of their grandchildren whose ADA parents are caught in the system dealing with jails and institutions (pp. 276–280). Health care costs for COA are 32% greater than for children from nonalcoholic families and grandparents take on the financial burdens, added stressors which cause mental, emotional, and physical barriers (Burnette, 1999; Yancura, 2013).

1.5 RESEARCH OBJECTIVES

An exhaustive review of the literatures of communication and related fields (psychology, counseling, etc.) was unable to locate prior research that has examined specifically the family communication patterns of ADA families during the prolonged period of post-rehabilitation (extending initially two years from completion of successful rehabilitation and then indefinitely).Thus, this study examined the FCP of ADA who have extended recovery time from active addiction. Specifically, data from ADA in recovery stage III maintenance and IV advanced will be gathered and analyzed to address the following questions:

1. What does communication look like in the recovering ADA family environment?
2. How are FCP dimensions and family types influencing ADAs desire to relapse?

3. How are FCP of ADA likely to increase ADA mortality rates, improve life satisfaction and well-being for both ADA and family members?

4. Can this research be used to further educate societies, families, and ADA about the disease of addiction?

1.6 PURPOSE OF RESEARCH

Should this study find correlations concerning FCP of recovering ADAs with the decreased desire to relapse, this may influence further research to help educate ADAs about the important role FCP play in the success of their recovery. Finding predictors in FCP of alcoholics and addicts in recovery may reinforce the importance of communication during recovery maintenance. Haverfield's (2016) work on family communication about the topic of alcohol has the potential to decrease a child's chances of abusing the substance and increase the chances of their abstaining from it altogether (pp. 123–126).

The field of communication has certainly contributed to understanding drug-use prevention and children. Educating society begins with the ADA, the ADA family members, husbands', wives, children, and physicians, psychiatrists, and rehabilitation treatment experts about this disease. However, studies of families and positive family communication during recovery maintenance are needed to prevent the dreaded relapse and inspire resiliency among the entire family, both ADA and the family even in the event of relapse (e.g., see Beck & Socha, 2015). ADA parents who continue to relapse and leave their disease untreated, ultimately increases the likelihood that the alcoholism and drug addiction will be cycled down to the children. Finding significant correlations in FCP of ADA who continue to treat the disease may improve relapse prevention success rates of ADA in maintenance and recovery stages who are on

the brink of relapse. The concept of resiliency and the family may be harnessed as a means of communicative growth, the language of recovery for all members involved with ADA to recover together (Haverfield, 2016).

1.7 APPLICATION OF CONCEPT "FAMILY RECOVERY"

The family dynamic is regarded as a significant source of protection in which parents are able to establish, enforce and inspire sanctions against the members of the family, especially children, to not make the choice to abuse substances (Keating, et al., 2013). Patterns of establishment, enforcement, and inspiration conceptually link to FCP orientations and how encouraging, supportive, and open the environment is for learned optimism (Seligman, 1990) and building resiliency (Walsh, 1996). Recovering ADA showed improved behavior outcomes, less drinking and drug relapsing when family member involvement increased (Nattala, et al., 2010). Walsh's (1996) a "family- is-challenged- not-damaged" perspective suggests family resiliency built by the challenge of supporting the ADA in recovery maintenance (pp. 5 – 6).

White, Kurtz, and Sanders (2006) believe in the family disease concept because family do recover from the severe and persistent ADA problems. Family recovery is a process involving the individual family members, family communication subsystems (adult intimacy relationships, parent-child relationships, and sibling relationships) and the family dynamic (roles, rules, and rituals (pp. 10). Brown and Lewis (1999) introduce a resiliency barrier, "trauma of recovery", where survival of the family unit is often hanging by a thread if professional and social supports are not available (Rouhbakhsh, Lewis, & Allen-Byrd, 2004). How the family unit operates to meet the challenges, stress, coping and adaption (Lazarus, 1991; Lazaruz & Folkman, 1984) brought on by the ADA directly influences the probability to prevent intergenerational addiction

in the family (Wathen, 1998). Resiliency will be apparent in the FCP of ADA in recovery because they have communication insights and tools in relation to stress, coping and adaption (Walsh, 1996). Next, we turn to a review of past research literature upon which this study is based.

CHAPTER 2

LITERATURE REVIEW

2.1 ALCOHOLICS & DRUG ADDICTS (ADA)

There seems to be a fine line between understanding the difference between a substance abuse disorder and an addiction due to terminology such as physical dependency, withdrawal, and chronic pain. *The Diagnostic and Statistical Manual of Mental Disorders*[6] (5th ed.; *DSM–5*; American Psychiatric Association, 2013) convened a panel of experts—the DSM-5 Substance Related Work Group (Appendix F)—to expand knowledge about addiction and substance-related disorders. In the United States and around the world, drinking alcohol is a lifespan rite of passage. It is an indicator of maturity across the lifespan from early adulthood to seniors and is commonly paired with humanity's expression to celebrate accomplishments, special occasions, life, and leisure. Historical etymology of medicinal, psychiatric, and spiritual treatment proves to be complex, fragile, and complicated because ADA was not all inclusive. Abusing the substance of alcohol, alcohol addicts or alcoholics, was not regarding, conceptually, the same as abusing drugs. Alcohol is legal to consume and socially acceptable, while drug consumption (and dependency) presumes a seedy underworld of crime, prostitution, poverty, and degradation. While most individuals exercise the freedom to fancy having a drink or two, there are those who "have the habit of, or to favor" alcohol with such desire that it disrupts the individual's ability to function normally in society (behavior that is not socially acceptable).

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[6] DSM-5 is to alter the chapter name to 'Addiction and Related Disorders', which will include disordered gambling. The specific substance use disorders may be referred to as 'alcohol use' or 'opioid use' disorders. The criteria for the disorders are likely to remain similar, with the exception of removal of the 'committing illegal acts' criterion and addition of a 'craving' criterion. The other major change relates to the elimination of the abuse/dependence dichotomy, given the lack of data supporting an intermediate stage. These changes are anticipated to improve clarification and diagnosis and treatment of substance use and related disorders.

What is addiction? The label of addict, or to be an addict, is derived from the Latin root addicere: assuétude [having the habit] to favor, adjudge (Haldipur, 2018). Addiction, or Substance Abuse Disorder (SUD)[7] has been classified as the perpetual use of chemical substance(s), alcohol and/or other drugs, in spite of continued adverse consequences leading to unmanageability in one or more areas of an individual's life (Koob, 2013). Addiction is the obsession proceeded by the compulsive behavior to use alcohol or drugs in spite of these enduring negative outcomes (e.g., physical, health, mental health, spiritual well-being, family, job, financial, legal, social status) (Fisher & Harrison, 2018).

Long before the label of Alcohol Use Disorder (AUD)[8] or alcoholic, Aristotle's writings from 323 B.C., indicated Alexander the Great's copious alcohol consumption led to his onerous battle with death. Huss (1849) coined the term "alcoholism" which claimed those with the baffling alcohol problem to suffer metabolism and ingestion malfunctions compared to the normal drinker. Alcoholism and the alcoholic are more than just having an alcohol addiction. Koob (2013) defines alcoholism and addiction as parallels with the insidious ADA symptom of the chronic relapsing disorder:

> Alcoholism, and more generically drug addiction, can be defined as a chronically
>
> relapsing disorder characterized by: (i) compulsion to seek and take the drug (alcohol),
>
> (ii) loss of control in limiting (alcohol/drug) intake, and (iii) emergence of a negative

---

[7] SUD Substance use disorder in DSM-5 combines the DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Each specific substance (other than caffeine, which cannot be diagnosed as a substance use disorder) is addressed as a separate use disorder (e.g., alcohol use disorder, stimulant use disorder, etc.), but nearly all substances are diagnosed based on the same overarching criteria. Substance abuse and substance dependence is one disorder and addictive disorders, like gambling, sex and internet are closely related to the SUD.

[8] AUD is a chronic relapsing brain disease characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences. AUD can range from mild to severe, and recovery is possible regardless of severity. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV), published by the American Psychiatric Association, described two distinct disorders—alcohol abuse and alcohol dependence—with specific criteria for each. The fifth edition, DSM–5, integrates the two DSM–IV disorders.

emotional state (e.g., dysphoria, anxiety and irritability) reflecting a motivational

withdrawal syndrome when access to the drug (alcohol) is prevented. (pp. 4–5)

Alcoholism, and drug addiction may also medically indicate as separate diseases. On the surface,

the individual may experience different symptoms depending on the substance, such as, physical,

and mental dependence, behavior analysis, and mental illness traits which run comorbid along

with the disease (Jellinek, 1960).

2.2 RELAPSE

Preventing the ADA from returning to using alcohol or drugs is a process known as

relapse prevention. Once an alcoholic or addict stops using alcohol or drugs, the focus of concern

is helping the individual from relapse or making a conscious choice to return to abusing alcohol

or drugs. However, relapse can and only occurs once an individual has admitted they need help,

sought treatment on their own or through family intervention that the recovery process begins.

Gorski and Miller (1982) created the Relapse Warning AWARE Questionnaire as a

warning sign with an attempt to measure the ADA's desire or closeness to the act of relapse. It is

impossible to know without a doubt the specific desire-level to which an individual throws-in the

towel and goes out to get a drink or drug. However, Miller et al., (1996; 2000) found supportive

research that aligns with the views *AA Big Book* that relapse occurs in the brain long before the

ADA acts out on the impulse to relapse (see Table 1).

Melemis (2015)[9] converts Gorski's relapse three specific stages: (1) Emotional Relapse

occurs when ADA are unable to handle feelings, life on life's terms, leading to repression and

---

[9] Family resiliency perspectives directly relate to the individual ADA to not relapse, but to build and practice emotional and coping skills of resiliency with recovery (Lazaruz & Folkman, 1984; Lazarus, 1991).

reservation.[10] (2) Mental Relapse is the rationalization to deal with the feelings, usually

obsessions to escape reality, which over time become disorganized and distorted. (3) Physical

Relapse is the acting out of the repetitive, continuous obsessions, a willing desire to use alcohol

or drugs.

Table 1. *AWARE 2.0 Relapse Awareness Warning Probability*

	Probability of ADA Relapse	
AWARE Score	ADA already drinking prior 2 months	ADA abstinent during prior 2 months
28-55	37%	11%
56-69	62%	21%
70-83	72%	24%
84-97	82%	25%
98-111	86%	28%
112-125	77%	37%
126-168	90%	43%
169-196	>95%	53%

Miller & Harris (2000)

Note. This instrument is in the public domain and may be used without specific permission provided that proper acknowledgement is given to its source.

It is not uncommon for ADA to encounter numerous relapses especially without professional

help (White, 2007). Moos and Moss (2006) estimate nearly 60% of ADA who initially achieved

natural recovery (defined as problem remission without the aid of professional treatment or

recovery mutual aid groups) later experienced one or more relapses (White, 2007, pp. 236).[11]

---

[10] Reservation is a recovery term associated with ADA who plan to relapse after a length of abstinence.

[11] For this research, 54 of the 81 (67%) ADA who participated in this research went through a rehabilitation facility one time. Of those 54 ADA, 35 (65%) of them relapsed. In fact, 18 of those 35 (52%) ADA relapsed and returned to rehab four or more times (see Table 5.1). These figures are similar to National Institute on Drug Abuse from chronic relapse (2000).

Kelly et al, (2017) just like Wilson (1939) are adamant that the ADA must completely change

everything about themselves, emotionally, socially, physically, and spiritually. There must be

continued adaptions within the field of addiction treatment. It is hard to change stigmas about the

ADA when more than half who seek treatment to recovery, have either already went to treatment

and relapsed multiple times, or are more likely to relapse then continue recovering upon

treatment release. The National Association of Addiction Treatment Providers (NAATP)[12]

reported (Kelly et al, 2017):

> Sixty-three percent of participants had received treatment for a substance use disorder
>
> prior to admission. The amount of time since last treatment ranged between 0 months and
>
> 30 years with an average of 2 years and 5 months. (pp. 2–3)

2.3 RECOVERY

"Recovery" is not the conceptual equivalent of an ADA "quitting" the use of substances.

White (2004) is one of many addiction treatment experts who adamantly agree that there must be

a transformation, a complete change in personality, perception, and behavior, or the ADA is

likely to relapse. White, Kurtz, and Sanders (2006) define recovery as "the process through

which severe alcohol and other drug problems (defined by DSM-5 criteria addictive and

substance abuse disorders) are resolved in tandem with the development of physical, emotional,

ontological (spirituality, life meaning), relational, and occupational health" (pp. 9). It is this same

concept for the family member of ADA when recovering. This is done because ADA are likely

to relapse and the family member and family unit must stand on their own.

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[12] The National Association of Addiction Treatment Providers (NAATP) Outcome Pilot Program (OPP) is a multisite study designed to measure long-term outcomes for patients who receive inpatient substance use disorder services. Nine substance abuse treatment providers and 723 ADA participated in the study.

The recovery process for ADAs has four stages: Stage I pre-covery admission of substance problem and life unmanageability, Stage II rehabilitation treatment and early recovery which involves abstaining from alcohol and drugs, Stage III is sustained recovery maintenance starting 1 year to 5 years and is considered a crucial period when relapse is most likely to occur and Stage IV advanced or long-term recovery is 5 years and more continuously living without abusing alcohol and drugs. Experts agree abstinence time from substance with vigilant cognitive behavioral treatment is required to remain recovering without increased likelihood of relapsing (Gorski, 1982; Jellinek, 1960; Miller, 2000; White, 2005; Wilson, 1939).[13] Transformations will occur physically, mentally, and even spiritually as ADA progress through the stages of recovery (White, 2004).

Stage I pre-covery/admission and Stage II treatment/early recovery has turned into a big corporate business of sorts. During the 1800s, inebriate homes (asylums) were the common places where ADA's could be separated from the substance in a process known as "drying out" (Henninger & Sung, 2014). Dr. Lambert and Charles Towns opened one of the first substance abuse rehab centers in New York City, called the Charles B. Towns Hospital (1901). AA co-founder Bill Wilson would be one of the many thousand ADA that would continuously check in, spending hundreds of dollars a day. ADA whose rock bottom left them penniless and without health care insurance could always dry out in jail. Father Dan Egan, commonly referred to as the Junkie Priest, shares his experiences helping women junkies find TSF of AA or NA. On more than one occasion, ADA may get picked up for prostituting in order to fix[14] and thrown in jail

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[13] Bill Wilson refers to this as "emotional recovery" and only after ADA have stopped drinking and or using drugs (1939).

[14] Fix is a street term meaning to get better, get well from being dope sick in which ADA get fixed. It also is used to describe the methodology by with the ADA fixes up the drug from powder or rock form to liquid in order to intravenously inject.

and upon "drying out", get re-released and within the hour try to score from undercover and then get thrown right back in jail (Harris, 1965).

If the drug clinics and rehabs were curing alcoholics and addicts then why once released from treatment do so many revert back to drinking and drugging again and again? At an AA Medical Panel Convention in 1983, AA member and skid row mission facilitator Clancy I. spoke (2018):

> I know it is the posture of the National Council of the State that there are a number of self-health groups for alcoholics and addicts. The truth is the National Council is not connected with any of them formally but, years ago I was giving a good degree of public information speaking for the Los Angeles National Council on Alcoholism and whenever we went out it was the necessary that the moderator include all places to recover. To stay safe the moderator would say, "And now we have a representative here of one of the ways to stay sober and there are many other ways to stay sober but we have a representative here from one of the ways". The moderator must say that. After about the tenth year of this it dawned on me and I told them, "It feels if I'm giving a one picture to the recovery program from alcoholism. All these poor people, the medical professionals, are ever hearing from is me, one of the ways to stay sober, there are many ways but here is one of the ways and so next time why don't you bring representatives from all the ways to stay sober and we can all talk and when you get them together let me know?" Somehow or other I never got called back to do it again. I know that that it is necessary and true, there are other people out there who are clean and sober in other disciplines or self-help programs. It's just sometimes hard to locate them, any of them and I don't mean

that with derogatory, rather I just mean that I'm implying derogatory. (Clancy I., "His

Famous Medical Convention Talk)

2.4 TWELVE STEP FELLOWSHIP & PSYCHIATRY

Former First Lady, alcoholic, and addict, Betty Ford, who founded the Betty Ford Center

(1982) (a drug and alcohol rehabilitation center) admits in an interview (Fitzpatrick, 2019):

Those listening now, those women who needing help, the best place to find this help is in

the fellowship of Alcoholics Anonymous. That is where the answer is, Twelve-step

fellowships, where alcoholics and addicts have the most success in getting those the help

they need. (B. Ford, personal communication, November 19, 2019)

The Twelve-step fellowship (TSF) support systems have become instrumental for ADA to live

and function normally in society, all the while actively practicing recovery. Alcoholics

Anonymous (AA) and Narcotics Anonymous (NA) have proven to be beneficial for those

suffering from alcohol and drug addiction. TSF programs, AA, and NA, are widely known as

having a rich heritage with a vibrant worldwide network (Best & Lubman, 2012). The

fellowships are prevalent all over the world and anonymity of the recovering ADA is protected.

White et al, (2020) compiles a list of just how inspirational the AA Twelve-step program

has been in the lives of ADA as there have been countless adaptions focused on the substance

and spiritual or religious belief (pp. 1–2) (see Table 3). There are millions of ADA who find

recovery, especially in the more well-known secular TSF adapted programs such as Self-

Management and Recovery Training--SMART Recovery (1994), LifeRing Secular Recovery

(1999), and Refuge Recovery (2009). Those ADA have a glaring similarity about religious

terminologies associated with the conceptualization of spirituality, higher power, and God as a

medical means to recover (Pennelle, 2017; O'Connor, 2020).

Table 3. *AA Twelve-Step Sampling Adaptions*[*]

AA ADAPTATIONS FOR ADA	SECULAR AND RELIGIOUS ADAPTIONS
Narcotics Anonymous (NY, 1950)[15]	Alcoholics for Christ (1977)
Narcotics Anonymous (CA, 1953)	Overcomers Outreach (1977)
Habit Forming Drugs (1951)	Jewish Alcoholics, Chemically Dependent
Hypes and Alcoholics (early 1950s)	People and Significant Others (JACS, 1979)
All Addicts Anonymous (1959)	Secular Organization for Sobriety (1985)
Potsmokers Anonymous (1968)	Addictions Victorious (1986)
Drug Abusers Anonymous (1972)	Rational Recovery (1986)
Pills Anonymous (1975)	Addicts Victorious (1987)
Chemically Dependent Anonymous (1980)	Overcomers in Christ (1987)
Cocaine Anonymous (1982)	Men for Sobriety (1988)
Dual Disorder Anonymous (1982)	Millati Islami (1989)
Nicotine Anonymous (1985)	Celebrate Recovery (1991)
Benzodiazepines Anonymous (1989)	Christians in Recovery (1992)
Double Trouble in Recovery (1989)	16 Step Empowerment & Discovery Groups
Marijuana Anonymous (1989)	(1992)
Methadone Anonymous (1991)	Moderation Management (1994)
Crystal Meth Anonymous (1995)	Self-Management and Recovery Training--
Dual Diagnosis Anonymous (1998)	SMART Recovery (1994)
Prescription Drugs Anonymous (1998)	LifeRing Secular Recovery (1999)
Heroin Anonymous (2004)	Buddhist Recovery Network (2008)
Opiates Anonymous (2013)	Harm Reduction, Abstinence, and Moderation
Medication-Assisted Recovery Anonymous	Support Network (2009)
(MARA) (2018)	Refuge Recovery (2009)
	Recovery Dharma (2019)

Note. Reprinted from *"We Do Recover" Scientific Studies on Narcotics Anonymous* (pp. 1–2), by W.L. White et al, 2020, Center for Substance Abuse Treatment's Great Lakes Addiction Technology Transfer Center and the Institute for Research Education and Training in Addiction. Copyright (2020) by William L. White. Reprinted with permission.

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[15] *Twelve-Step groups for dependence on drugs other than alcohol and secular and religious recovery mutual aid adjuncts or alternatives to AA have received far less public, professional, and scientific scrutiny. The paucity of research attention to these adaptations and alternatives is surprising given their number and, in some cases, their growth and international reach (White et al, 2020, pp. 2).

Most meetings are open to anyone who thinks they may be having a problem with alcohol and drugs, and before anyone speaks its customary tradition is the following *"My name is Bill and I am an addict-alcoholic."* Traditions, spiritual concepts, service concepts and one-on-one step work between members has kept AA and NA thriving for many years. Kelly, Humphreys and Ferri (2020) show increasingly high quality of evidence in TSF to be more effective than the for-profit rehab center and established treatment facility.

Clinical and medical approaches have diagnosed alcohol and drug addicted individuals to be suffering from a substance use disorder. American Psychiatric Association (APA) and its revised 2013 Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines each specific substance abused as its own separate mental disorder.[16] Galanter, Reis and Tonigan (2015) suggest psychiatric practitioners responsible for treating alcoholics and addicts to adapt TSF program methods. TSF Treating patients with psychiatric medications and the principles, content, and support of TSF is becoming typical (pp. 411–412).

2.5 BRICKMAN'S MODEL OF HELPING & COPING

Brickman's et al. (1982) Model of Helping and Coping Applied to Addictive Behaviors can be directly applied to both individual, family, and societal perspectives in order to understand what it means to be ADA. There are four models used to understand how the non-ADA family members comprehend and communicate about the disease and recovery (Marlatt, 1996; 2006; 2010).

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[16] DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. APA is a national medical specialty society whose more than 37,000 physician members specialize in the diagnosis, treatment, prevention, and research of mental illnesses, including substance use disorders.

Here are descriptions of the four models; The Enlightenment Model (Spiritual) where ADAs are not responsible for their solutions only their problems; The Medical Model (Disease) is where ADAs are not responsible for their problem or their solution; The Moral Model finds ADAs are responsible for their problems and solutions, and The Compensatory Model argues ADAs aren't responsible for their problems only their solutions (Marlatt, 2006; 2010).[17] Next each model is reviewed at length though focus will be on The Enlightenment Model and The Medical Model because they are the basis by which Twelve-step fellowship programs of AA and NA use to educate ADA members (see Table 2).

Table 2. *Brickman's Model of Helping & Coping Applied to Addictive Behaviors**

		Is the ADA responsible for changing the addictive behaviors?	
		YES	NO
Is the ADA responsible for the development of the addictive behavior?	YES	MORAL MODEL "War on Drugs" Relapse = Crime or the lack of willpower	ENLIGHTENMENT MODEL (SPIRITUAL) "Twelve Step Fellowship" Relapse = Sin or the loss of contact with Higher Power
	NO	COMPENSATORY MODEL "Cognitive-Behavioral" Relapse = Mistake, Error, or Temporary Setback	MEDICAL MODEL (DISEASE) "Hereditary/Physiological" Relapse = Reactivation of the progressive disease

Marlatt *Relapse Prevention* (2006) & *Addiction and the Mind* (2010)
Note. This instrument is in the public domain and may be used without specific permission provided that proper acknowledgement is given to its source.
*Theoretical framework adapted from Brickman et al., 1982

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[17] The Enlightenment Model is Spiritual and The Medical Model is Disease (Marlatt, 2006; 2010).

The Enlightenment or Spiritual Model used in the TSF programs views alcoholism and addiction to be a disease by which only a Higher Power or God along with fellowship support can change the behavior. Individuals are not responsible for their disease; however, they are responsible for their recovery. It would be Dr. Carl Jung whose inspirational counseling experience with the prominent businessman Roland Hazard would lead into both the spiritual and disease models becoming the foundation of TSFs (Wilson, 1939; Jung, 2019). Jung tells Hazard:

> You have the mind of a chronic alcoholic. I have never seen one single case recover, where that state of mind existed to the extent that it does in you. In the rarest instances there are such exceptions to cases such as yours which have been occurring since early times. Here and there, once in a while, alcoholics have had what are called vital spiritual experiences. It is my opinion that these occurrences are phenomena. They appear to be in the natures of huge emotional displacements and rearrangements. Ideas, emotions, and attitudes once the guiding forces in the lives these men are suddenly cast to one side, and a completely new set of conceptions and motives begin to dominate them. In fact, I have been trying to produce such emotional rearrangements with you but have never been successful with an alcoholic of your type. (Wilson, 1939, p. 27; and see Jung, 2019, p. 473)

Rowland Hazard would sponsor Ebby Thatcher who then sponsored Bill Wilson the founder of AA. There are letters of correspondence between Wilson and Jung that support the counselor to client relationship between Jung and Roland Hazard (see Appendix G). This recovery model paved the way for new perceptions that ADA is in fact a mental, emotional, physical, and spiritual disease, chronic in nature, progressive, incurable and in most instances fatal (*Narcotics*

Anonymous Basic Text, 1981; p. 6–7; 2008, p. 7). Addiction is an illness of the body, mind, and soul. When the body is sober and clean from the substance, the mind and moral dilemma of the soul must be treated or the individual will again abuse alcohol or drugs. It is here too; we find this medical model or disease concept as further pillars to the foundation of TSF.

Ward et al, (2016) credits modern day ADA treatment center to E. M. Jellinek (1890-1963) famous for his Jellinek Curve (1946;1950), Disease Concept of Alcoholism (1960) and establishing the National Council on Alcoholism and Drug Dependence[18] (pp. 375–377). The Jellinek Curve (1946) and disease model of addiction (1960) continue to gain support that ADAs suffer from a disease both physiological and hereditary (Bandura, 1977; Marlatt, 1992; 2006). (see Appendix F). It is the Jellinek curve that gave way to the disease model concept and became instrumental for the pioneers of the twelve-step recovery fellowships, Alcoholics Anonymous (1935) and Narcotics Anonymous (1953).[19] Coincidently, in 1939, the same year Wilson (1939) *Alcoholics Anonymous* was published, the Carnegie Corporation commissions Jellinek to begin research about the effects of alcohol on the individual (Ward et al, 2016).[20]

2.6 CHRONIC & SPIRITUAL DISEASE

Alcoholics Anonymous (Wilson, 1939) includes an entire chapter to this ultra-sensitive, very personal dilemma for ADA in active addiction called "We Agnostics" (pp. 44–57). Whether a prideful or humble ADA claiming to be Agnostic, Atheist or whatever, recovery is about

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[18] Jellinek (1944) launches the National Committee for Education on Alcoholism (now the National Council on Alcoholism and Drug Dependence) with Marty Mann and Howard Haggard (Ward et al, 2016).
[19] Narcotics Anonymous (1953) was founded by Jimmy Kinnon and a group of addicts who adapted the AA spiritual steps concept, addicts working with other addicts, sponsorship, service, and love.
[20] Martin (2015) explains how Carnegie Corporation funded the grant for alcohol research helping Jellinek join Yale in 1941. That same year Jellinek is elected to the board of editors of the *Quarterly Journal of Studies on Alcohol* and AA is brought into the public scope thanks to donations from John Rockefeller Jr. and The Saturday Evening Post magazine publication with Jack Alexander (p. 1457-1458).

exercising the individuals' freedom of conceptualizing one's own understanding. Vasconcelos (2017) believes the implications in spiritual based research to be scientifically valid claiming:

> Evidence gathered shows that developing our own spirituality we transform ourselves, our creations, including society and institutions. Approaching this endeavor reveals both science and religion agree that spiritual elements permeate all things. (pp. 600–601)

Changing the beliefs about ADA as having a disease remains difficult. Many still believe alcoholism and addiction to be a moral, social, and psychological problem (Marlatt, 2006). Even with the field of psychiatry becoming more open-minded accepting the medical model, disease concept along with cognitive behavioral therapy. Mignon (1996) estimated that only 5 percent of physicians believe alcoholism and addiction to be a disease (pp. 35). However, the Jellinek disease model (1960) combined with Brickman's (1982) enlightenment and medical models were inspired by the twelve-step fellowship of AA (1939).

Substance addiction parallels with the physical and emotional conditions of the following chronic diseases; Alzheimer's disease, heart disease, cancer, and diabetes (Fisher & Wells, 2000). ADA can find recovery but the high probability of relapse suggests addiction to be a long-standing, incurable, and progressive just like the chronic disease. Chronic diseases can be traced to family hereditary and the individual behavior choices (Marlatt, 2006; Wang, Kapoor, & Goate, 2012). Individual with a chronic disease have been known to resist treatment, especially if spirituality and support systems are not in place (Keating et al., 2013; Haverfield et al., 2016).

National Institute on Alcohol Abuse and Addiction (NIAAA) recognizes alcoholism and addiction to be a chronic disease and because of relapse proceeds to last an entire lifetime.[21] The most dangerous part with the relapse of disease is that the ADA has an allergy to psychoactive

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[21] One of the U.S. National Institutes of Health, the National Institute on Alcohol Abuse and Alcoholism center was founded in 1974 and is currently headed by Director Dr. George Koob, supporting the medical model (disease) supporting and conducting research on the impact of alcohol use on human health and well-being.

substances (Fillmore & Rush, 2002). Although potentially confusing, the logic of the allergy analogy is straightforward. Someone breaks-out in hives every time she or he eats bananas. The solution to prevent the breakout would be to stop eating bananas. If alcohol and drugs is the problem, then those individuals should quit the substance. Same as an allergy. Alcohol and drugs, like bananas, initiate the allergy, however, they are a symptom of the disease or the addition. Unlike allergies, it remains impossible to know the actual percentage of those who recover (fully or partially) and remain active or die from the disease. Just like cancer, the disease of alcoholism and addiction is chronic and notorious for relapse. Addiction is an "incurable disease that if not arrested will continue to progress over time" (*Narcotics Anonymous*, 1981; 2011).

The moral dilemma of ADA goes back to ancient societies who sneered harshly at addiction as it implies old religious sins, greed, gluttony, and the over-indulging behavior to choose voluntarily and repetitively to use (Haldipur, 2018). Inevitably, it was the individual who proceeded to drink and drug irresponsibly and so they should be held accountable and labeled "once an addict, always an addict" (*Narcotics Anonymous Basic Text*, 1981; 2008). The Moral Model of addiction is in part the Sociocultural Model because it is engrained in social, psychological, biological, and spiritual perspectives (Marlatt, 2006). Sociocultural Model of addiction separate ADA behaviors, alcohol different from drugs, and that drug addiction is a factor of low socio-economic populations (Fisher & Harrison, 2016). Society and family member perceptions are influenced by Brickman's Moral Model that the alcoholic-addict is bad, irresponsible, and lacking willpower because of morality is how society labels an individual's character (Marlatt, 1992; 2006). An important but under-researched element with this model is the role played by family systems, specifically, families' communication.

2.7 FAMILY COMMUNICATION PATTERNS THEORY

Family Communication Patterns Theory (FCPT) was developed by Mcleod and Chaffee (1970; 1972) and is the one of the leading theoretical frameworks used to study family communication styles and beliefs (Ritchie, 1991; Koerner & Fitzpatrick, 2002a). Ritchie and Fitzpatrick (1990) describe the family communication environment as one involving norms of control and supportive messages. These competing norms of exercising authority and encouraging conversation are based on the family communication patterns parent to child (Fitzpatrick & Koener, 2005). FCPT considers the harmonious relations between parent and child, the intrapersonal perceptions in conformity and parental authority and the interpersonal relationship concepts expressed by parental encouraging of ideas and attitudes like politics and religion (Mcleod & Chaffee, 1972).[22] Let's examine these two dimensions more closely.

2.7.1 FAMILY DIMENSIONS

There are two main components by encompassing *(CV) conversation orientation* and *(CF) conformity orientation*.[23] Keating et al, (2016) describes *CV* is the honest disclosing of communication, an environment conducive for open-mindedness and acceptance, where family members "are encouraged to participate and share about many different types of topics and or feelings" (pp. 161). The environment is accepting and encourages autonomy of ideas and opinions. It is normal for the family members to interact as a unit with every member having a role in activities. The degree to which a family adheres to and practices a system of beliefs, attitudes and values is *CF* communication. Relationships are focused on obedience with respect

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[22] Chaffee, McLeod and Wackman (1966) created the original FCPI to measure both communication norms concept-orientation and socio-orientation (Ritchie & Fitzpatrick, 1990).

[23] Fitzpatrick & Koerner (2005) explain originally conversation orientation or concept-orientation to be preference for ideas over relationships and conformity orientation or socio-orientation as harmonious social relationships over ideas.

to the family hierarchy or parental authority. Roles in the family dynamic are usually consistent with cohesion between parent and child expectations (Compton et al, 2019).

Keating et al, (2016) indicates *CF* scores a good predictor of family communicative behaviors specific to avoiding stress and conflict. Compton et al. (2019) indicate that families who score high in *CF* with adherence to rules and structures are trying to maintain harmony. On the contrary, families with low *CF* orientation may promote fewer rules and more autonomy fostering an ideology of independence. Establishing relationships outside the family dynamic to inspire the personal growth and identity of its members.

Koerner and Fitzpatrick (2005) described families with high *CV* to possess consistent optimism about togetherness. Unity and honest sharing are an integral part of child development. Low *CV* may be less accepting of how family members are feeling and in many cases family members naturally hide personal thoughts for the openness holds no value towards what the family represents. Families with lower *CV* believe the frequent expression of opinions and ideas have no importance in the socialization or success of the children.

2.7.2 FAMILY TYPES

Conversation and conformity orientations can be subdivided along the median of both scales: low or high conversation and low or high conformity (Fitzpatrick & Koerner, 2002a). Ritchie and Fitzpatrick (1990) describe four specific family types (and see McLeod & Chaffee, 1972); consensual, pluralistic, protective, and laissez-faire Ritchie and Fitzpatrick (1990) and Fitzpatrick and Koerner (2005) define the *consensual* family as scoring high on both conversation and conformity scales (see Table 4).

Table 4. *Characteristics of Family Types*

	HIGH CONVERSATION		
LOW CONFORMITY	Pluralistic Type *Open communication and discussion of ideas is encouraged but with little* *Fosters communication competence as well as independence of ideas* *Stereotypical gendered-parental roles to keep cohesion (dad is strict and loving, mom is gentle, understanding and nurturing)*	Consensual Type *Strong pressures toward agreement* *Child encouraged to take interest in emphasis on social constraint ideas without disturbing power in family hierarchy* *Child may adopt parents' views or may escape from parent-child interaction into fantasy*	**HIGH CONFORMITY**
	Laissez-Faire Type *Little parent-child interaction (less connectivity, less nurturing)* *Individual first, survival of fittest* *Child relatively more influenced by external social settings (peer groups)*	Protective Type *Obedience is prized* *Little concern with conceptual matters* *Child is not well-prepared for dealing with outside influences and is easily influenced and persuaded*	
	LOW CONVERSATION		

Note. Characteristics of Family Types, Family Communication Schemata (Fitzpatrick & Koerner, 2005, p. 36).

The giving and sharing authoritative relationships create a line of balance with respect for openness and conformity between child and parent. Examples of FCP from television families resembling the *consensual* family type include The *Cosby's* and *Kardashians*. Haverfield et al. (2013) interviewed family members of a recovering ADA and found more honest dialogue about the recovery process "brought the family closer and happier" (pp. 115).

The *pluralistic* family type score high conversation and low conformity with the relationship focus centered on child autonomy about social concepts and media issues and very little disciplined parental authority (Fitzpatrick & Koerner, 2005; Ritchie & Fitzpatrick, 1990, pp. 527). Television shows like *The Middle* or *That 70's Show* the freedom within the *pluralistic* family type. *Pluralistic* family types may create inconsistent communication patterns in that family members, spouses, or oldest child, may enable ADA (Haverfield et al. 2013).

Fitzpatrick and Koerner (2005) label *protective* family types as scoring low conversation and high conformity orientation with authoritarian relationships between parent and child where consistency, obedience and conformity are more prevalent (p. 40–41). Television shows that would be considered family type *protective* are *The Bernie Mac Show, The Sopranos* and *All in the Family.* Haverfield et al, (2013) finds inconsistencies in *protective* family types with ADA as the denial about the breaking of conformity may lead to tense communication and outbreaks of aggression (pp. 115; 120–121).

Ritchie and Fitzpatrick (1990) explain *laissez-faire* family as scoring low on both conversation and conformity dimensions scales, suggesting a communicative environment lacking communication norms and very little communication parent-to-child (p. 528). *Laissez-faire* may indicate the possibility of neglect with the lack of interest towards personal well-being, goals, and conformity. FCP of the television series *Married with Children* and *Shameless* are similar to *laissez-faire*. Haverfield et al, (2013) "alcoholics may neglect family and work responsibilities, display inconsistent messages of affection and aggression, and in some cases become verbally and physically abusive" (pp. 111).

2.8 SUMMARY

Overall, this research is designed to build an outline for resiliency with a better knowledge about the language of recovery for family members of ADA. Psychiatrist-Physician Carl Jung would come to play a huge role in the development of AA, the Big Book, Jellinek's Curve (1960) and Brickman's Model of Helping & Coping (1982) which was then applied to addictive behaviors. Kelly, Humphreys and Ferri (2020) find TSF with psychiatric treatment

such as cognitive behavioral therapy (CBT) to increase abstinence and recovery longevity (pp. 2).

Kopak et al., (2012) has identified research claiming the importance communicating about drug and alcohol abuse enhancing family relationship openness and attitudes about ADA and that they suffer from a disease (pp. 35). Each stage of recovery is a positive communication process which involves action, change, and inter/intrapersonal dialogue to begin healing from the ADAs experiences leading up to and during active addiction (White, 2004). Recovery, once the ADA stops using, is built upon support systems concept of positive communication, frameworks found in family resiliency, community rehabilitation, 12-step support groups and psychotherapy (Socha & Pitts, 2012).

The American Psychiatric Association (2013) confirms Jellinek's disease model (1960) that addiction and substance abuse is a chronic disease. Keating et al, (2013) finds families scoring low in *CV conversation orientation*, *laissez-faire,* and *protective* family types,

> Unwilling and in some cases unable to have difficult conversations. Significant relationships are found between communication patterns within the family and various psychological, social, and behavioral outcomes. Not only may this help inform our understanding of difficult conversations about addiction but it may also give indications about ADA family types and the family disease cycle. (pp. 163–165)

Even family's high in *CV conversation orientation*, who are *pluralistic* and *consensual*, may react to hardships and tragedy by closing off or shutting down. This type of behavior has been assumed typical in the family of ADA who are actively in the grips of the disease.

Adapting counseling and rehab literature with the addition of communication theories with research of recovering ADA family communication patterns in recovery maintenance may

decrease relapse rates of those ADA in early recovery, especially upon release from treatment. TSF are standard individualized programs holding the individual seeking treatment responsible for their own recovery. The cure for the ADA and family suffering from the disease is the combination of communication methods like the TSF, psychiatry and family recovery.

CHAPTER 3

METHODOLOGY

The following exploratory descriptive research was conducted on 81 recovering

alcoholics and drug addicts (ADA) whose anonymity is protected by the Twelve-step fellowships

(TSF) of Alcoholics Anonymous (1935) and Narcotics Anonymous (1953). Ngali (2010)

explains "an exploratory descriptive survey attempts to picture or document the current

conditions or attitudes, that is, to describe what exists at the moment while utilizing a variety of

techniques" (pp. 8 & 21). This thesis specifically investigated the attitudes, ideals, and

communication type in the family with recovering ADA. In accordance with the Twelve

Traditions formulated in AA and adapted by NA, this research protects the anonymity of both

fellowships, with data collection and analysis referring only as TSF rather than AA or NA as a

whole.[24] This study has been reviewed by the College of Arts & Letters Human Subjects

Committee and found in compliance with the human subjects' rules and regulations and was

exempted from further review by full IRB (1571839-1, March 5, 2020).

3.1 PARTICIPANTS

A final sample of 81 ADA Twelve-step members claiming at least 2-years of recovery,

sobriety, or clean time were recruited as volunteers to participate in this study (see Table 5).

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[24] Traditions 8,9,10,11 and 12 encompass that AA or NA; should remain forever nonprofessional, but our service centers may employ special workers, ought never be organized, but we may create service boards or committees directly responsible to those they serve; has no opinion on outside issues; hence the NA name ought never be drawn into public controversy; public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films; and anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities. (see Appendix I)

Table 5. *ADA Demographics (Ethnicity, Education, Age, etc.)*

Ethnicity

	White/Caucasian	African American/Black	Hispanic/Latino	Asian/Pacific	Multi-Race	Native/Other
N	55 (67%)	18 (22%)	3 (4%)	3 (4%)	2 (3%)	0 (0%)

 Education

	Attended High	Diploma GED	Attended College	Associates	Bachelors	Graduate
N	3	13	30	16	12	7

Age

	20-29 years	30-39 years	40-49 years	50-59 years	60-69 years	70-79 years
N	3	18	23	18	19	1

ADA Identity

	Alcoholic	Addict	Both
N	1	58	22

ADA in the Family

	Yes	No
N	47	34

ADA Rehabilitation

	Yes	No
N	54 (67%)	27 (33%)

Note. N = 81

Table 5.1. *ADA Number of Rehabs*

Rehabs

	Once	Twice	3	4	5	6 or more
N	20*	10	5	3	4	12

Note. N = 54

*There were 4 ADA who went to rehab but did not report how many times so we can only assume they went once.

ADA participants were given access to an online Qualtrics survey about FCP and the desire to relapse (see Appendix B). This allowed easy access for recruitment which initially began face-to-face before Covid-19 pandemic guidelines were put in place by Human Research Review Board, WHO, and Centers for Disease Control and Prevention (CDC) that prohibited face to face contact. [25]Instead, online means (emails) where used to recruit participants via an anonymous questionnaire, 81 adults (18 – 89) subjects self-identified as either alcoholic, addict, or dual combined alcoholic-addict. Although import to study, vulnerable age groups, children (birth – 17) and elderly (90 + years or older) were excluded from this research project.

AA and NA membership is very diverse because alcohol and drug addiction does not discriminate (White et al, 2020). Anyone may join these fellowships regardless of age, race, sexual identity, creed, religion, or lack of religion.[26] It is this diversity, along with public and professional knowledge about the legacies of Alcoholics Anonymous (1935) and Narcotics Anonymous (1953), that accessibility to recovering ADA made data collection easy. Meetings are open to non-ADA who think they may be ADA, family members, students, educators, and health experts. In-person and virtual online forums are available to public access unless the meeting is designated closed or being held in an institution or rehabilitation center.

ADA in active addiction display common character traits such as dishonesty and close-mindedness, with innate ability to manipulate (Wilson, 1939). Addiction being a progressive and chronic disease these same traits or indicative to recovering ADA who may be struggling with different levels of denial and desires to relapse (Gorski & Miller, 1982). To prove without a doubt that all ADA were, or are presently, clean, and sober is not definitive. TSF programs do

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[25] The worldwide novelty of the coronavirus pandemic began at the end of 2019 and in writing this thesis CDC guidelines remain in effect.
[26] Tradition 3 states the only requirement for membership is the desire to stop drinking alcohol or using drugs (see Appendix I).

not require a urinalysis for membership and each member is responsible for their own recovery program. In light of this margin for error it only made sense to focus on those ADA most likely to be actively clean, sober, and recovering. White et al, (2020) reports,

> Twelve-step fellowship participation is associated with decreased drug use, increased rates of abstinence, improved global (physical, emotional, spiritual) health, enhanced social functioning, increased involvement with mainstream community institutions, and decreased health care costs. These effects are amplified by intensity (activities beyond meeting attendance e.g., reading literature, active sponsorship, step work helping others) and duration of twelve-step participation. Positive effects within ADA fellowship participation extending to adolescents, women, and people of color. (pp. 55)

White, Kurtz, and Sanders (2006) research on ADA finds that peer-based support groups like AA and NA constitute a major resource for the resolution of alcohol and other drug problems (pp. 26).

It is difficult to find recovering ADA with more than one year clean "not active" in TSF fellowships. Rehabs and treatment centers only work with ADA in stage I admission and stage II treatment of disease which is 90 days or less. White (2007) explains benchmarks of recovery in the fellowships of AA and NA. Once ADA sustain cessation for 30 days, 60 days, 90 days etc., they collect a chip or key tag denoted by color. ADA take accountability of their recovery with the admission and clean date. TSF birthdays are celebrated yearly and after the 18-months ADA will only celebrate yearly birthdays (pp. 235–236).

In order to analyze the concept of resiliency among ADA families, data from ADA with twelve-step fellowship programs from maintenance recovery phase III (1 year or more) to advanced recovery phase IV (more than 5 years) were collected. Applying the concept of

resiliency is a family communication practice would be an effect growing strong over a period of time (Campbell et al, 2016). Length of recovery time as an effect of resiliency in this research was most practical in order to collect data most associated with family resiliency, spiritual principles such as honesty, courage, perseverance, integrity, and mindfulness (Walsh, 2006). Also, there seemed more willingness of ADA to participate in the questionnaire with longer recovery time which correlates with White et al, (2020) positive effects of TSF of service to others (see Table 6, White et al. 2020, p. 55).

Table 6. *ADA Length of Recovery Time*

Length of Recovery in Years

	2 – 5	6-10	11-20	21+
N	29	14	19	18

Note. There is 1 ADA who only had a year.

3.2 SCALES & RELIABILITY ASSESSMENT

For this research, the substance(s) related to addiction will be all inclusive so that alcoholic and drug(s) addict (ADA) can stand as a single variable. The Revised Family Communication Pattern Instrument (Koerner & Fitzpatrick, 2002a; 2006), a 26-item 5-point Likert-scale question survey was used combined with the 35-item 7-point Likert-scale AWARE Questionnaire (Gorski and Miller, 1982). Here are descriptions of each measure.

Ritchie and Fitzpatrick (1990) suggest each individual family member's perception is influenced by concept and socio-orientations, concept for encouraging autonomy, social schemata, family hierarchical and parental authority. RFCPI expanded and adapted FCPT to measure the full scope of the family communication environment both parent-to-child and child-to-parent (Ritchie, 1988; 1989, Koerner & Fitzpatrick, 2002a; 2006). Variables from FCP are

low or high *(CV) conversation orientation* and low or high *(CF) conformity orientation*. Koerner

and Fitzpatrick (2002; 2006) Revised Family Communication Patterns Instrument as explained,

> Scores are simply the scale averages with each item contributing equally to the mean
>
> score. The scale scores can be used directly as independent variables, or they can be used
>
> to compute family types by assigning families to high versus low conversation and
>
> conformity orientation, respectively, either based on median splits or based on population
>
> means. (pp. 2)

The FCPT and RFCPI has precedence among experts in the family communication field for

decades (Haverfield, 2016; Keating, 2016). For this study, Cronbach's alpha was found to be

.904 for *CV conversation orientation* and .819 for *CF conformity orientation*. This indicates the

scale was measuring FCP's reliably (see Table 7).

Gorski and Miller (1982) created the variable *relapse desire* with their AWARE

Questionnaire (Advance Warning of Relapse) which measured warning signs of relapse to

indicate the ADA likelihood of returning to active addiction. Variable from AWARE Relapse

score *RAW* will be used as percentage probability to correlate the desire to relapse or not with

those family communication patterns in those ADA families. In a prospective study of relapse

following outpatient treatment, stage II, for alcohol abuse or dependence (Miller et al., 1996)

believes the AWARE score to be a strong predicator to future relapse occurrence ($r = .42$, $p <$

.001). Miller and Harris (2000) would adapt the instrument as AWARE Questionnaire 2.0

(Revised) with 28-item questionnaire on 7-point Likert-scale.[27] Kelly et al, (2011) conclude,

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[27] This instrument was developed through research funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA, contract ADM 281-91-0006). Public domain may use without specific permission provided that proper acknowledgment is given to its source. The appropriate citation is Miller & Harris (2000).

Relapse scale validity for youth or adult, first time treatment or chronic relapse

and easy to administer. Useful and efficient clinical tool for assessing short-term relapse

risk serving to enhance the effectiveness of relapse prevention efforts. (pp. 992–993).

ADA participants in this study have far longer recovery times than the Miller and Harris (2000)

research from AWARE 3.0 and so the decision was made to utilize and adapt the questionnaire

from 28-items to 35-items. Cronbach's alpha for AWARE this study was .919 (see Table 7).

Table 7. *Reliability Measures of RFCP and AWARE 3.0 scales*

Variables	Cronbach alpha	Items	N
RFCP *(CV)*	.904	15	75
RFCP *(CF)*	.819	11	74
AWARE *(RAW)*	.919	35	68

Note. N = valid ADA responses.

3.3 RESEARCH QUESTIONS

RQ1:   Are there any significant correlations between the FCP dimensions CV or CF of ADA

and the desire to relapse RAW during recovery maintenance and advanced recovery?

RQ2: What FCP dimension level is most common in the recovering ADA family; *CV*

conversation orientation high or low or *CF conformity orientation* high or low?

RQ3:   What FCP types; *(CNS) consensual, (PLR) pluralistic, (PRO) protective* and *(LZF)*

laissez-faire are most common among ADA recovering in stage III and IV?

RQ4:   Are their differences between FCP types [*(CNS) consensual, (PLR) pluralistic, (PRO)*

protective and *(LZF) laissez-faire*] and *(RAW) relapse awareness warning* score?

3.4 DATA COLLECTION

Data were collected amid the Human Research Review Board, WHO and CDC pandemic guidelines of no face-to-face contact. The survey used quantitative techniques to create an exploratory descriptive study about ADA FCP and desire to relapse. RFCPI and AWARE scales were combined to create variables from FCP are; low or high *(CV) conversation orientation* and low or high *(CF) conformity orientation* which then equates to one of the following four FCP types; *(CNS) consensual, (PLR) pluralistic, (PRO) protective* and *(LZF) laissez-faire*. Variable from AWARE *RAW (relapse desire)* will be used to correlate the desire to relapse with those family communication patterns in those ADA families.

3.5 SCALE ADAPTIONS

The original Koerner and Fitzpatrick (2002a; 2006) RFCPI consists of two 26 question 5-point Likert scales measuring the two dimensions of FCP: *(CV) conversation orientation* (15 items) and *(CF) conformity orientation* (11 items). Scale one measures the parent perception and scale two measures the child perception for each dimension. These items are listed below separately in phrasing appropriate for children and parents grouped by orientation dimension. First, is the RFCPI Conversation Orientation Scale (see Table 8).

Table 8. *RFCPI: Conversation Orientation*

CHILDREN'S VERSION	PARENT VERSION
1) In our family we often talk about topics like politics and religion where some persons disagree with others.	1) In our family we often talk about topics like politics and religion where some persons disagree with others.
2) My parents often say things like "Every member of the family should have a say in family decisions."	2) I often say things like "Every member of the family should have some say in family decisions."
3) My parents often ask my opinion when the family is talking about something.	3) I often ask my child's opinion when the family is talking about something.
4) My parents encourage me to challenge their ideas and beliefs.	4) I encourage my child to challenge my ideas and beliefs.

Table 8. *RFCPI: Conversation Orientation (continued)*

CHILDREN'S VERSION	PARENT VERSION
5) My parents often say something like "You should always look at both sides of an issue."	5) I often say things like "You should always look at both sides of an issue."
6) I usually tell my parents what I am thinking about things.	6) My child usually tells me what s/he is thinking about things.
7) I can tell my parents almost anything.	7) My child can tell me almost anything.
8) In our family we often talk about our feelings and emotions.	8) In our family we often talk about our feelings and emotions.
9) My parents and I often have long, relaxed conversations about nothing in particular.	9) My child and I often have long, relaxed conversations about nothing in particular.
10) I really enjoy talking with my parents, even when we disagree.	10) I think my child really enjoys talking with me, even when we disagree.
11) My parents encourage me to express my feelings.	11) I encourage my child to express his/her feelings.
12) My parents tend to be very open about their emotions.	12) I tend to be very open about my emotions.
13) We often talk as a family about things we have done during the day.	13) We often talk as a family about things we have done during the day.
14) In our family, we often talk about our plans and hopes for the future.	14) In our family, we often talk about our plans and hopes for the future.
15) My parents like to hear my opinion, even when I don't agree with them.	15) I like to hear my child's opinion, even when s/he doesn't agree with me.

Note. Copyright permission SAGE*,* Koerner & Fitzpatrick*, (2002a; 2006) RFCPI.*

The children's version uses phrasing "my parents" and the parent version uses "I", the adapted scale uses "in our family" and "my family" (see Table 9).

Table 9. *Adapted Conversation Orientation Scale*

1) In *my* family we often talk about topics like politics and religion where some persons disagree with others.
2) *Our family believes "every member should have some say in family decisions".*
3) *My family often asked my opinion* when they are taking about something.
4) *My family encourages me* to challenge their ideas and beliefs.
5) *My family members* often say something like "You should always look at both sides of an issue."
6) I usually tell my *family* what I am thinking about things.
7) I can tell my *family* almost anything.
8) In *my* family we often talk about our feelings and emotions.
9) My *family* and I often have long relaxed conversations about nothing in particular.
10) I really enjoy talking with my *family* even when we disagree.
11) My *family* encourages me to express my feelings.
12) My *family* tends to be very open about their emotions.
13) We often talk as a family about things we have done during the day.
14) In *my* family we often talk about our plans and hopes for the future.
15) My *family* likes to hear my opinion even when I don't agree with them.

Next is the RFCP Conformity Orientation Scale (see Table 10).

Table 10. *RFCPI: Conformity Orientation Scale*

CHILDREN'S VERSION	PARENT VERSION
1) When anything really important is involved, my parents expect me to obey without question. 2) In our home, my parents usually have the last word. 3) My parents feel that it is important to be the boss. 4) My parents sometimes become irritated with my views if they are different from theirs. 5) If my parents don't approve of it, they don't want to know about it. 6) When I am at home, I am expected to obey my parents' rules. 7) My parents often say things like "You'll know better when you grow up." 8) My parents often say things like "My ideas are right and you should not question them." 9) My parents often say things like "A child should not argue with adults." 10) My parents often say things like "There are some things that just shouldn't be talked about." 11) My parents often say things like "You should give in on arguments rather than risk making people mad."	1) When anything really important is involved, I expect my child to obey me without question. 2) In our home, the parents usually have the last word. 3) I feel that it is important for the parents to be the boss. 4) I sometimes become irritated with my child's views if they are different from mine. 5) If I don't approve of it, I don't want to know about it. 6) When my child is at home, it is expected to obey the parents' rules. 7) I often say things like "You'll know better when you grow up." 8) I often say things like "My ideas are right and you should not question them." 9) I often say things like "A child should not argue with adults." 10) I often say things like "There are some things that just shouldn't be talked about." 11) I often say things like "You should give in on arguments rather than risk making people mad."

Note. Copyright permission SAGE, Koerner & Fitzpatrick, *(2002a; 2006) RFCPI.*

The conformity orientation uses phrases synonymous with parent to child roles such as "my parents" as the child and "I" as the parent. In the adapted scale terminology is more consistent with an adult-child demographic such as "my family" and "older adult family members" or "family members" (see Table 11).

Table 11. *Adapted Conformity Orientation Scale*

1) When anything really important is involved *my family expects members* to obey without question. 2) In our home, *adult family members* usually have the last word.

Table 11. *Adapted Conformity Orientation Scale (continued)*

3) *Adult family members* feel it is important to be the boss.
4) *Family members* sometimes become irritated with *my* views if they are different from theirs.
5) If *family members* do not approve of it, they do not want to hear about it.
6) In *my* family, children are expected to obey the adults' rules.
7) *Adults in my family* often say, "you'll know better when you grow up."
8) *Adults in my family* often say things like "My ideas are right and you should not question them."
9) *Adults in my family* often say things like "A child should not argue with an adult."
10) *My family* of says things like, "There are some things that just shouldn't be talked over."
11) *My family* often says things like, "You should give in on arguments rather than risk making people mad.

The AWARE Questionnaire 3.0 (Miller & Harris, 2000) was adapted with the original

AWARE relapse warning signs (Gorski & Miller, 1982; 1986) in order to increase score counts.

This was done because ADA participating in this research had far more recovery time than those

from the Miller and Harris (2000) study. My thesis advisor (Socha) pointed our that the AWARE

3.0 (Miller & Harris, 2000), which consisted of 28-items, needed revision because of the

presence of a few double-barreled worded as well as the need to include items both alcoholics

and addicts. Thus I revised the ADA AWARE 3.0 by adding 2-items specifically centered

around the use of drugs, as well as added 5-items about ADA feelings by chopping 5-items in

half, and adding slight phrase changes in 3-items to keep alcohol and drugs as all inclusive (see

Table 12).

Table 12. *AWARE 3.0 Adaptions*

AWARE 3.0	ADA AWARE 3.0
3. I tend to overact and or act impulsively.	*3. I tend to overact* *4. I tend to act impulsively*
4. I keep to myself and feel lonely.	*5. I keep to myself* *6. I feel lonely*

Table 12. *AWARE 3.0 Adaptions (continued)*

9. I have trouble concentrating and prefer to dream about how things could be.	*11. I have trouble concentrating* *12. I prefer to dream about how things could be*
13. I feel angry or frustrated.	*16. I feel angry.* *17. I feel frustrated.*
24. I feel hopeful and confident.	*29. I feel hopeful.* *30. I feel confident.*

ITEM PHRASING CHANGED	
AWARE 3.0	ADA AWARE 3.0
1. I feel nervous or unsure of my ability to stay sober.	*1. I feel nervous/unsure of my ability to stay sober/clean.*
10. Things don't work out well for me.	*13. Things usually do not work out well for me.*
25. I feel angry at the world in general.	*31. I feel angry at the world.*

ITEM STATEMENTS ADDED	
AWARE 3.0	ADA AWARE 3.0
Not included on original AWARE 3.0	*27. I think about doing drugs.*
	35. I am using drugs out of control.

3.6 DATA ANALYSIS

The ADA FCPI is a 15-item for *CV conversation orientation* and 11-questions for *CF conformity orientation* both on a 5-point Likert scale (see Appendix B). The *CV* score ranges from lowest 15 to highest 75 with an origin line of 45. Scores below 45 mean family conversation is low while scores above 45 mean family conversation to be higher. *CF* score ranges from lowest 11 to highest 55 with an origin line of 33. Scores below 33 mean family conformity is low while scores above 33 mean family conformity to be higher. *CV* and *CF* scores are then plotted along a dual axis (y, x) and following within four quadrants equating to one of the following four FCP types; *(CNS) consensual, (PLR) pluralistic, (PRO) protective* and *(LZF) laissez-faire* (see Table 13).

Table 13. *FCP Family Type Scoring Example*

	HIGH CONVERSATION	

<div>

HIGH CONVERSATION

<u>Pluralistic Type</u>

CV scores > 45
CF scores < 33

<u>Laissez-Faire Type</u>

CV scores < 45
CF scores < 33

LOW CONFORMITY

<u>Consensual Type</u>

CV scores > 45
CF scores > 33

HIGH CONFORMITY

<u>Protective Type</u>

CV scores < 45
CF scores > 33

LOW CONVERSATION

</div>

Note. Family types that fall on the line of origin of either CV 45 or CF 33 are designated as follows; (CNS-PLR consensual-pluralistic), (CNS-PRO consensual-protective), or (PLR-LZF pluralistic-laissez-faire).

RAW scores for that study ranged from least likely 28 to most likely 196 (see Table 1 & Appendix D). Analysis for this research used the AWARE (Gorski & Miller, 1982) relapse warning signs, AWARE 3.0 (Miller & Harris, 2000) with an Adapted AWARE ADA 3.0 which gave *RAW* score range from least likely 35 to most likely 245 (see Appendix B). More questions allotted the higher *RAW* score focus on the likelihood to relapse because ADA relapse desire has been shown to decrease nearly 15% from stage III into stage IV (White et al, 2020). The numbers are all added together, however there is reverse scoring for the following items (see Table 14).

Table 14. *Adapted ADA AWARE 3.0 Reverse Scoring Items*

10. The plans I make succeed.
18. I have good eating habits.
24. I am able to think clearly.
29. I feel hopeful.
30. I feel confident.
32. I am doing things to stay sober.

Note. AWARE 3.0 (Miller & Harris, 2000) reversed "I feel hopeful and confident" and the Adapted ADA AWARE 3.0 (Socha, 2020) reversed "I feel hopeful" and "I feel confident" as two separate items.

Statistical Package for the Social Sciences, version 26.0 (SPSS-26) analysis was applied to the collected data during analysis of this thesis.[28] ADA participants would follow the Qualtrics survey link, email or text message, to complete the *Family Communication and Alcohol/Drug Recovery: Beyond Two Years* (Socha & Pyecha, 2020, see Appendix B). The survey data collected is then uploaded in an SPSS Statistics Data Editor input file. Research can be analyzed data view or variable view. Cronbach alphas are tested to confirm data scale validity and reliability analysis.[29] Variables are created, analyzed, and concluded as significant towards the specific research objectives, questions, hypotheses, etc.

Data from ADA in recovering was used to look at the family communication patterns and the desire to relapse. The demographics of these ADA were also collected and stored in SPSS, ethnicity, education, age, years in recovery, family members who also identify as ADA, number of rehabs, and number of relapses (see Table 5 & 5.1). Descriptive statistics, such as variable means, median and mode are analyzed and correlated. Bivariate correlations, Pearson

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[28] IBM Corp. Released 2019. IBM SPSS Statistics for Windows, Version 26.0. Armonk, NY: IBM Corp.

[29] The scales utilized were the Revised Family Communication Patterns Instrument (Koerner & Fitzpatrick, 2006) and AWARE 3.0 (Miller & Harris, 2000) both adapted for ADA sensitivity and inclusivity.

significance, Independent sample T-Tests, and One-way ANOVA tests were used to validate the

research questions, hypothesis, and purpose of statement in this thesis.

CHAPTER 4

RESULTS

4.1 RESEARCH QUESTIONS

RQ1: Are there any significant correlations between the FCP dimensions *CV* or *CF* of ADA

and the desire to relapse *RAW* during recovery maintenance and advanced recovery?[30]

Results indicate statistically significant correlations between FCP dimensions *CV*

(conversation) orientation and *CF (conformity) orientation* and the *RAW* scores. ADA families

scoring higher in *CV* conversation orientation equated to lower *RAW* score desire to relapse. The

results for Pearson correlation analysis revealed a statically significant, negative correlation (r

(72) = -.462, p < .001) and *CV orientation.* Probability is that higher *CV* scores will 99.999%

equate to lower desires to relapse, 40% lower *RAW* scores at the .01 (2-Tailed level). So, yes,

there is a statistically significant negative correlation between increasing family conversation

orientation and recognition of returning to use drugs and alcohol. That is, the more that families

talk the less likely a person is to return to using/abusing. A statistically significant relationship

was also found between family *CF* conformity orientation and the awareness of returning to use

drugs and alcohol was also statistically significant (r (72) = .302, p < .009). Again, the

correlation is significant 99.991% at the .01 (2-Tailed level) that the more disciplined,

authoritarian FCP the 30% higher desire to relapse *RAW* scores were.

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[30] In measuring the *CV* and *CF* orientations, researchers like Keating (2016) often acknowledge that the empirical relationship between the two constructs tends to be negative and data analysis results. SPSS-26 Pearson coefficient bivariate correlation of FCP dimensions *CV* and *CF* in this study shows the negative empirical relationship CV = 1 and CF = -.582.

RQ2: What FCP dimension level is most common in the recovering ADA family; *CV*

conversation orientation high or low or *CF conformity orientation* high or low?

Results from the data conclude 57 (72%) ADA scored high *CV conversation orientation*

(> 45) while 22 (28%) ADA scored low *CV conversation orientation* (< 45). Results from the

data conclude 49 (65%) ADA scored high *CF conformity orientation* (> 33) while 26 (35%)

ADA scored low *CF conformity orientation* (< 33). For this research in can be said that a

majority of recovering ADA family dimension types from this particular sample are consistently

high, 55 (70%), in *CV conversation orientation* and also commonly high 49 (65%) in *CF*

conformity orientation (see Table 15). Because this is non-random convenience sample, it is left

to future studies to see if these results are contained this population.

Table 15. *ADA Family Dimension Demographics*

CV Orientation	High > 45	Low < 45	CF Orientation	High > 33	Low < 33
N	57 (72%)	22 (28%)	N	49 (65%)	26 (35%)

Note. N = 79   *Note. N = 75*

RQ3:   What FCP types; *(CNS) consensual, (PLR) pluralistic, (PRO) protective* and *(LZF)*

laissez-faire are most common among ADA recovering in stage III and IV?

The most common family type among recovering ADA in this sample was *PLR*

pluralistic 24 (32%) followed by *CNS consensual* 18 (24%) and *PRO protective* 16 (22%). *CNS-*

PLR consensual-pluralistic 9 (12%) are significant and common to the prevalence of ADA

family dimension high conversation orientation. *PRO protective* types are high conformity and high conversation orientation. *LZF laissez-faire* accounted for only 5 (7%) families and *CNS-PRO consensual-protective* just 2 (3%)(see Figure 1).

Figure 1. *ADA Family Types*
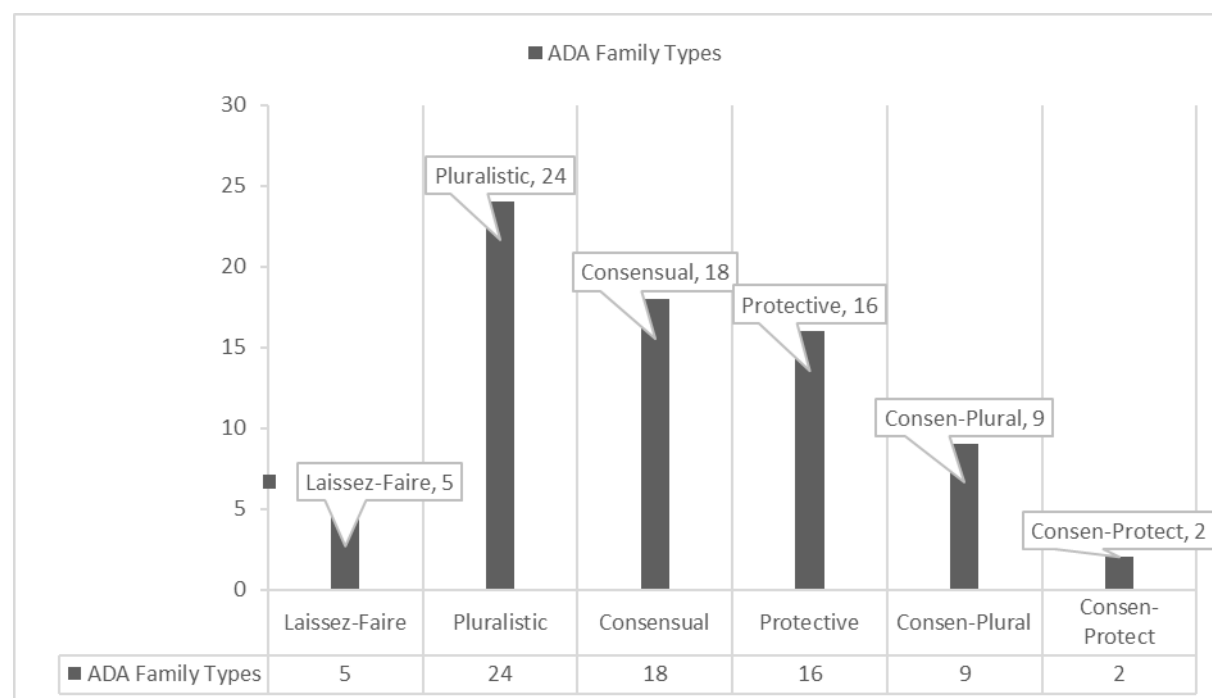
	Pluralistic (High CV/Low CF)	Consensual-Pluralistic (High CV/Medium CF)	Consensual (High CV/High CF)	Consensual-Protective (High CV/High CF)	Protective (Low CV/High CF)	Laissez-faire (Low CV/Low CF)
N	24	9	18	2	16	5

Note. N=74.

This research concludes 53 (72%) of recovering ADA family types in this sample are of high CV conversation orientation *PLU-pluralistic*, *CNS-consensual*, *PRO-protective*, and *CNS-PLU consensual-pluralistic* are most common.

RQ4:   Are there differences between the FCP types [*(CNS) consensual, (PLR) pluralistic,*

   (PRO) protective and *(LZF) laissez-faire*] and *(RAW) relapse awareness warning* score?

Because there were fewer than 5 families in the laissez-faire and consensual-protective categories, a single ANOVA could not be run. Instead a series of t-tests were run comparing pairs of mean AWARE scores of family types. The means and SD's for the raw awareness scores appear in Table 16.

Table 16. *ADA Family Type and RAW Mean Scores and Standard Deviations*

	Protective	Laissez-faire	Pluralistic	Consensual	Consensual-Protective	Consensual-Pluralistic
N	16	4	24	18	2	9
RAW M	107	96.4	88.4	87.6	85.5	82.8
SD	17.28	32.98	17.46	17.95	2.12	17.56

*Note. *The mean score for each family type group.*

Using t-tests I compared the means for the four remaining family types and found statistically significant differences between the following family types: Protective families (Mean = 107, SD = 17.28) were greater than: (a) pluralistic families (M = 88.4, SD = 17.46) ($t(38) = -4.403$, $p < .002$); (b) consensual families (M = 87.6, SD = 17.96) ($t(32) = -.3.13$, $p < .004$); and (c) consensual-pluralistic families (M= 82.8, SD = 17.56) ($t(32) = -3.113$, $p < .003$). No other comparisons were statistically significant.

CHAPTER 5

DISCUSSION

5.1 RESEARCH IMPLICATIONS

The overall results of this study provide evidence that family communication patterns are not all the same in preventing individuals from relapsing to drug-alcohol use during the period of at least two years post rehabilitation. Most of the ADA participating in this research already had multiple years of recovery. In fact, many ADA had decades and beyond. Specifically, conversation-oriented families were found to have a low-moderate effect on preventing an ADA family member from relapsing while families that are conformity-oriented were found to have a low-moderate effect on facilitating drug/alcohol relapsing. Compton et al, (2019)

This is consistent with previous work on FCP communication studies on ADA families that show happier, stable, and increased honest conversation among the family whose ADA member is practicing recovery (Haverfield et al, 2016). FCP of ADA show a significant correlation between high *CV*, more open and honest conversation dialogue within the family environment and less desires to relapses, ultimately increasing mortality rates of ADA from relapses. Life satisfaction and well-being most likely would not be negatively affected if the ADA is not relapsing. However, addiction is a chronic disease in which abstinence from drugs and alcohol there still proceeds erratic, risky, and mentally unstable behaviors like gambling, overeating, and cheating. And so, on the contrary, the sense of well-being within the family dynamic is challenged during active addiction as the family falls into communication roles of coping, protecting, and adapting in an effort to maintain functionality (pp. 111–113).

It is important to note that for ADA and family members of ADA, TSF are everywhere, free of cost, and a majority of the meetings are open for anyone who thinks they may have a

problem. In fact, recovery in TSF is based on the family dimension conversation orientation with a willingness for communication to honest and open-minded. *Narcotics Anonymous* (2008) tells ADA in "How it Works",

> There is one thing more than anything else that will defeat us in our recovery; this is an attitude of indifference or intolerance toward spiritual principles. Three of these that are indispensable are honesty, open-mindedness, and willingness. (pp. 18)

My research supports that the argument that family communication is important among the rarest ADAs who make it five years or more clean, along with many rehabs and many relapses before consistent recovery occurs.[31] Revising current drug/alcohol rehab treatment approaches to include the importance of educating families about pluralistic and consensual family communication typologies in this process may help to decrease ADA relapse-to-return-to-rehab. Families scoring high in conversation orientation dimension are facilitative for recovering ADA to naturally communicate a language of recovery with focus on the spiritual disease concept. Upon completion of treatment, the most likelihood for long-term recovery success is recipe of TSF affiliation with an increased focus on FCP pluralistic, consensual, and protective (Laudet et al, 2002; Haverfield et al, 2016). Relapse attitudes assessment questionnaire like the AWARE 3.0 (Miller & Harris, 2000) may also prove more beneficial to ADA family and support system if it is suggested to be completed every few months.

Kelly, Humphreys and Ferri (2020) suggest TSF beneficial for building resiliency among ADA family members because there is substantial healthcare cost savings among recovering ADA members of AA (pp. 2). The probability for more harmonious family interactions and family dynamics increases in the event the of less financial stressors because of addiction (Compton et al, 2019). Laudet et al, (2002) finds empirical data on the short-term (1-2 years)

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[31] Estimates that only 2% of ADA ever reach 5 years of continuous recovery (AA, 2012).

effectiveness and ineffectiveness of various treatment modalities but that very little is known about the processes of recovery over time (pp. 305).

5.2 RESEARCH LIMITATIONS

Exploratory descriptive research with TSF participants using quantitative measures allowed for a controlled snapshot of a single point in time of a diverse population that is subject to extreme fluctuations over time. Kelly et al, (2017) conclude:[32]

Tens of millions of Americans have successfully resolved the ADA "problem" with a variety of traditional and nontraditional means. Findings suggest a need for a broadening of the menu of self-change and community-based options that can facilitate and support long-term ADA problem resolution.(p. 1).

Long-term solution is key and the ADA in Kelly et al, (2017) findings took a probability survey responding to the following question, "Did you use to have a problem with alcohol or drugs but no longer do?". Most ADA in a drunken haze could answer yes and submit to that question.

In the future, time-series studies and diary studies gathering qualitative data are important to gaining accurate family member perspectives (Haverfield et al, 2016; Werner & Malterud, 2016). The impacts of untreated addiction in the family of ADA is evident affect the entire family system. Lander et al, (2013) addiction in the family "affects emotional and behavioral patterns from the inception of the family, resulting in poor outcomes for all family members, children, and adults" (pp. 194–195). Haverfield (2016) researched many areas of neglect, denial, and unmanageability within ADA families. FCP becomes conducive for ADA to maintain the addiction as non-ADA members take character roles which to protect and lead the family by

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[32] Secular recovery programs such as Self-Management and Recovery Training--SMART Recovery (1994), LifeRing Secular Recovery (1999), or complete cold turkey abstinence.

accepting to avoid the difficult conversation. The lack of qualitative research left gaps in the why and how of recovery as a concept of family resiliency, specifically what type of conversations occur inside the family types pluralist, consensual, and protective.

An important part the concept of resiliency concept is sharing of the narrative, storytelling, and group support (Walsh, 1996; Beck & Socha, 2015). ADA are isolated and hopeless, especially in early stage I and treatment stage II recovery. More detail from this research into the exact nature of the communication and messages from early experiences of ADA who found the support and similarities to believe in a new way of living. Looking deeper into the FCP and family type to get narratives from both family members and ADA may give researchers an outline of how family's in recovery participate in activities (Haverfield et al, 2016). It's great to know that pluralistic and consensual families help recovering ADA lose the desire to relapse but finding out specifics such as group eating, exercise, religion, education and even if the family members attend Al-Anon or Nar-Anon (Zimmerman & Winek, 2012).

While this research was able to find 81 ADA clean and sober or practicing recovery there were a part of the TSF, it is difficult to find other ADA who are not in TSF which makes this research bias towards the TSF. The ADA in this research chose, made an option to continue recovering but why them and not the countless other ADA who don't seem to get it? Most importantly what about the family members of those ADA who don't ever get it? FCP in this research are higher in conversation orientation because these ADA participants are not using alcohol and drugs and actively seeking recovery. There was far more than just ADA abstaining from drugs and alcohol. The family was recovering too.

It is possible too that my research has left an important and unexamined aspect of recovery for researchers because of the "spiritual" aspect claimed as the result from TSF

recovery. Society and ADA who choose not to recover through TSF process is the spirituality, higher power, or religious connotation of the God concept. Scientific empirical research in the area of spirituality can show evidence through communication and social science research. If ADA in recovery claim a spiritual connection as the basis to prevent relapse from the fatal disease of addiction then research into FCP, ADA, and TSF is warranted. Bliss (2007) reminds ADA and those professionals of addiction specialist and AA supporter Harry Tiebout, MD professed (1944; 1961) the growing success ADA find in the spiritual transformations practiced in TSF and they should be further studied (pp. 6–7). Spirituality, alcoholism, and addictive disorders has been furthered studied since AA (1935) and NA (1953) inception shown from White et al, (2020, pp. 2) TSF program adaptions (see Table 3).

5.3 FUTURE RESEARCH

Significant correlations among 81 participants should prompt discussions about further research into the FCP of ADA with continued recovery. Educating the professionals and addiction experts in early recovery stage I and rehabilitation treatment stage II, and even ADA incarcerated, may initiate out of treatment ADA FCP recovery plans. My findings, even low to moderate, suggest improving ADA relapse rates, extending recovery length, and lowering overdose rates takes a combined effort between family and professionals. Improving recovery success for ADA after treatment does not bode well for the insurance companies and rehab drug counselors who depend on the chronic relapsing ADA, saving lives should take precedence. Finding new methods by which to transform the family communication environment influencing more conversation orientation and setting conformity orientation boundaries to be very possible with technological advances and increasingly more ADA in stage III and stage IV recovery.

5.3.1 COMMUNICATION DURING PANDEMIC

Technology does and will continue to influence across the lifespan, especially family communication patterns, with enhanced message efficiency and accessibility. Specific populations like recovering ADA can be easily accessed with proficient and expeditious data collection and analysis. Communication as a practical piece during the pandemic has been an essential tool for the survival of all humans, especially the ADA. Amid the current COVID-19 pandemic rehabilitation treatment centers following social distancing CDC guidelines have to manage intake capacities leaving ADA on already backed up waitlists. The most important asset for the ADA families is the message of recovery, the experience, strength, and hope found in TSF. AA, NA, and the multitudes of adapted TSF programs have information instantly downloadable for those suffering from addiction.

Digital communication has been crucial for the entire world and recovering ADA have committed to social platforms like Zoom and Blue Jeans in order to continue meetings without leaving quarantine. The use of smartphone applications for ADA resilience treatment for behavioral self-control training, such as AA Daily Meditations, NA Just for Today, and 12-Step Tool Kits which allow journaling, reading, and addict-to-addict connecting (Yu et al, 2012). Also, web-based family programs are now available as preventive education and awareness. Influencing FCP and making the difficult conversation easier, Scull et al, (2017) shows the effectiveness of family unity through,

> Web-based substance use prevention programs using an MLE framework and designed
> for use by families could be an effective intervention for reduction of children's
> substance use experimentation. After receiving the program, parents reported an
> increased readiness to critically interpret media messages about substances with their

children. The parent's high satisfaction ratings of the program also give weight to the use

of MLE as an engaging and convenient family activity. (p. 804–807)

The world of technology is influencing how families communicate messages, changing how the

dynamic accesses, engages and critically interprets substance abuse education. FCP are focused

on dyadic conversation, parent-to-child, teacher-to-child, in an attempt to prevent alcohol and

drug experimentation (Haverfield et al, 2016). However, alcohol and drug abuse worldwide

continue to rise with alcohol death rates 5 times the equivalent of drugs (WHO, 2018). TSF,

psychiatry, and technology, there has never been a better time for the recovering ADA which

suggests there has never been a better time for research on resiliency in ADA family.

5.3.2 THEORETICAL AND PRACTICAL FRAMEWORKS

Keating (2103) and Haverfield (2016) have opened the doors to those family messages

and beliefs with qualitative analyses from individuals in the family. This research of FCP of

ADA gives a glimpse into recovery's influence on what the ADA family type becomes. Deeper

analysis into the family of ADA with long-term recovery suggests we examine the initial family

type, categorize them, and look beyond family dimensions conversation and conformity. First, is

using descriptions of the ADA family structure such as; nuclear, extended, open, closed, single

parent, grandparent, stepfamily, and adopted. Giving distinct narratives for each unique ADA

family type influences those family to implement practical frameworks, to initiate conversation

like that extended family did when their loved on come home from treatment because that ADA

is still recovering years later. What do communication environments of ADA family

conversations, messages, and relationships look like beyond the initial family type category?

Future qualitative research into the narratives of all family members apart of ADA recovery

maintenance may prove beneficial for guiding ADA families during treatment and early recovery.

The practical implications of thorough Family Narrative Theory of ADA families during recovery maintenance increases knowledge about recovering ADA the "group" from the "family" (Socha, 1999, p. 481; 487). Commonalities found in those family conversations may show ADA the "group" to have communication and language abnormalities rather than a genetic or physiological disposition. Instead, what about the communication in the recovering ADA single-parent family was harmonious? Specifically, let's focus on assets of that specific ADA family unit like communication strengths and building on those conversation strengths. Depending on the family structure which members are communicating and what are the conversations like? How can the concept of recovery become an outline, a language by which the resilient recovering ADA can transcend their success to the ADA seeking treatment? Rehabs could offer structured therapeutic family communication workshops around hope, support, and active conversation starters when interaction is not occurring. For example, "thank you for being honest", "this sacrifice you are willing to make gives us hope", "your open-mindedness to understand why I am afraid to trust you this time", "I want to do more of this because its positive, it's helpful, for you, for me, and for us", and "I am present and understand your feelings, you are not alone, I am there with you". Conversation transitions during moments of conflict and outside network support like Al-Anon and Nar-Anon to show the ADA after treatment that the family is willing to get involved.

This research should not disregard family conformity orientation because the consensual family score high in conformity. How can we influence and enhance conversation in the protective family? Rehabilitation centers are strict, with ADA adhering to non-negotiable

guidelines, one being participate in group therapy sessions. Similar to this is the ADA who are court mandated counseling programs as part of their requirements is to get involved in drug therapy. Just like court mandated divorce mediations, could ADA felons be mandated to participate in similar family communication workshops? Although these and many more questions are left for future discovery, the clear news of this study is that family communication matters in ADA's successful recovery.

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APPENDIX A

PARTICIPANT NOTIFICATION FORM

RESEARCHERS

Investigator: Adam J. Pyecha, Masters Candidate, College of Arts & Letters, Communication

Department, (apyec001@odu.edu), 757-683-5213

Advisor: Thomas Socha, Professor and Graduate Program Director, PhD, College of Arts &

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DESCRIPTION OF RESEARCH STUDY

The purpose of this survey study is to gain an improved understanding of how to increase

recovery, sobriety and abstinence rates of individuals suffering from the incurable disease of

alcoholism and addiction. Specifically, this 26-item questionnaire is intended to show any

correlation between the alcoholics and addicts family communication patterns during successful

recovery, sobriety, and abstinence periods.

PARTICIPANT REQUIREMENTS

To participate in this study, you must be: (1) at least 18 years old, (2) an addict or alcoholic with

at least 1 year clean (2 years is preferred) (3) family member (parent, sibling, stepfamily or an

adult child of) an alcoholic or addict.

RISKS AND BENEFITS

RISKS: There are no risks of participation. Your survey response will be kept confidential and

after data analysis is completed will be destroyed.

BENEFITS: The main benefits for participating in this study is the potential for further

alcoholism and addiction education for the improving of treatment and relapse prevention. It is

possible that this study may save lives while preventing individual and family suffering at the hands of alcoholism and addiction.

CONFIDENTIALITY

All information obtained about you in this study is strictly confidential. The results of this study may be used in reports, presentations, and publications but the researcher will not identify you.

VOLUNTARY CONSENT

By agreeing to participate in the study and responding to questions, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them:

Please contact the primary researcher, Adam J. Pyecha at 757-683-5213 or by email at apyec001@odu.edu. You may also contact the LSDC Graduate Program Advisor, Dr. Thomas Socha, in the Department of Communication at 757-683-3833, or by email at tsocha@odu.edu.

INVESTIGATOR'S STATEMENT

I certify that I have explained to this participant the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws and promise compliance. I have witnessed the above signature(s) on this consent form.

APPENDIX B

FAMILY COMMUNICATION AND ALCOHOL/DRUG RECOVERY BEYOND 2 YEARS

This study examines the role of family communication in long term alcohol/drug recovery (beyond two years). It is being conducted by Adam Pyecha as part of his MA Thesis in Old Dominion University's Graduate Program in Lifespan & Digital Communication. His thesis director is Dr. Thomas Socha (tsocha@odu.edu). The study has been reviewed by the Human Subjects Committee of the College of Arts & Letters. Should you have any questions about your rights as a participant in research please contact Dr. Randy Gainey (rgainey@odu.edu). All questions can be directed to me (apyec001@odu.edu) or my advisor (tsocha@odu.edu).

This is an anonymous survey only for those who consider themselves either an alcoholic or addict. Your responses cannot be traced back to you in any way. It is important that you complete all the items and be as honest as you can in responding to all the items. However, if an item upsets you for whatever reason, please leave it blank.

FAMILY COMMUNICATION & ALCOHOL/DRUG RECOVERY: BEYOND TWO YEARS
I. DEMOGRAPHICS

1) What is your age (in years)?

2) What is your ethnicity (check one)?

White/Caucasian	Black/African American	Hispanic/Latino	Biracial	Asian/Pacific Islander	Native American	Multi-racial

3) What is your highest level of education completed?

Attended High School	High School Diploma/GED	Attended college	Associates degree	Bachelor's degree	Graduate degree

4) Do you consider yourself:

Alcoholic	Addict	Alcoholic-Addict

FAMILY COMMUNICATION & ALCOHOL/DRUG RECOVERY: BEYOND TWO YEARS (continued)

I. DEMOGRAPHICS (continued)

5) Do any of the members of your immediate family identify as any of the following?

Alcoholic	Addict	Alcoholic-Addict

6) If a member your family identifies as an alcoholic, addict, or both, who are they (check all that apply)?

Mother	Father	Brother	Sister
Stepmother	Stepfather	Stepbrother	Stepsister
No member of my family identifies in this way			

7) Have you completed drug/alcohol rehab treatment?

Yes	No

8) Have you ever attended a 12-step program?

Yes	No

9) Have you relapsed at any time after rehab treatment?

Yes	No

10) How many times have you relapsed after rehab treatment?

0	1	2	3	4	5	6	6 +

11) Were you attending a 12-step program during any of your relapses?

Yes	No

12) Are you currently practicing recovery/sobriety/abstinence?

Yes	No

13) How long have you been in recovery/sobriety/abstinence?

FAMILY COMMUNICATION & ALCOHOL/DRUG RECOVERY: BEYOND TWO YEARS (continued)

II. ADA ADAPTED FAMILY COMMUNICATION PATTERNS INSTRUMENT

We would like to learn more about how you communicate in your family. Please use this scale to indicate your agreement with the following statements listed below.

| Disagree Strongly | Disagree | Neutral | Agree | Agree Strongly |

1----------------2--------------3---------------4----------------5

CONVERSATION ORIENTATION

1. In my family we often talk about topics like politics and religion where some persons disagree with others.
2. Our family believes "every member should have some say in family decisions".
3. My family often asked my opinion when they are taking about something.
4. My family encourages me to challenge their ideas and beliefs.
5. My family members often say something like "You should always look at both sides of an issue."
6. I usually tell my family what I am thinking about things.
7. I can tell my family almost anything.
8. In my family we often talk about our feelings and emotions.
9. My family and I often have long relaxed conversations about nothing in particular.
10. I really enjoy talking with my family even when we disagree.
11. My family encourages me to express my feelings.
12. My family tends to be very open about their emotions.
13. We often talk as a family about things we have done during the day.
14. In my family we often talk about our plans and hopes for the future.
15. My family likes to hear my opinion even when I don't agree with them.

CONFORMITY ORIENTATION

1. When anything really important is involved my family expects members to obey without question.
2. In our home, adult family members usually have the last word.
3. Adult family members feel it is important to be the boss.
4. Family members sometimes become irritated with my views if they are different from theirs.
5. If family members do not approve of it, they do not want to hear about it.
6. In my family, children are expected to obey the adults' rules.
7. Adults in my family often say, "you'll know better when you grow up."
8. Adults in my family often say things like "My ideas are right and you should not question them."
9. Adults in my family often say things like "A child should not argue with an adult."
10. My family of says things like, "There are some things that just shouldn't be talked over."
11. My family often says things like, "You should give in on arguments rather than risk making people mad."

FAMILY COMMUNICATION & ALCOHOL/DRUG RECOVERY: BEYOND TWO YEARS (continued)						

III. ADA ADAPTED AWARE QUESTIONAIRRE (SOCHA, 2020)							
	Never	Rarely	Sometimes	Fairly-often	Often	Almost always	Always
1. I feel nervous/unsure of my ability to stay sober/clean.	1	2	3	4	5	6	7
2. I have many problems in my life.	1	2	3	4	5	6	7
3. I tend to overreact.	1	2	3	4	5	6	7
4. I tend to act impulsively.	1	2	3	4	5	6	7
5. I keep to myself.	1	2	3	4	5	6	7
6. I feel lonely.	1	2	3	4	5	6	7
7. I get too focused on one area of my life.	1	2	3	4	5	6	7
8. I feel blue, down, listless, or depressed.	1	2	3	4	5	6	7
9. I engage in wishful thinking.	1	2	3	4	5	6	7
10. The plans that I make succeed.	1	2	3	4	5	6	7
11. I have trouble concentrating.	1	2	3	4	5	6	7
12. I prefer to dream about how things could be.	1	2	3	4	5	6	7
13. Things usually don't work out well for me.	1	2	3	4	5	6	7
14. I feel confused.	1	2	3	4	5	6	7
15. I get irritated or annoyed with my friends.	1	2	3	4	5	6	7
16. I feel angry.	1	2	3	4	5	6	7
17. I feel frustrated.	1	2	3	4	5	6	7
18. I have good eating habits.	1	2	3	4	5	6	7
19. I feel trapped and stuck, like there is no way out.	1	2	3	4	5	6	7
20. I have trouble sleeping.	1	2	3	4	5	6	7
21. I have long periods of serious depression.	1	2	3	4	5	6	7
22.. I don't really care what happens.	1	2	3	4	5	6	7
23. I feel like things are so bad I might as well drink.	1	2	3	4	5	6	7
24. I am able to think clearly.	1	2	3	4	5	6	7
25. I feel sorry for myself.	1	2	3	4	5	6	7
26. I think about drinking.	1	2	3	4	5	6	7
27. I think about using drugs.	1	2	3	4	5	6	7
28. I lie to other people.	1	2	3	4	5	6	7
29. I feel hopeful.	1	2	3	4	5	6	7
30. I feel confident.	1	2	3	4	5	6	7
31. I feel angry at the world.	1	2	3	4	5	6	7
32. I am doing things to stay sober.	1	2	3	4	5	6	7
33. I am afraid that I am losing my mind.	1	2	3	4	5	6	7
34. I am drinking out of control.	1	2	3	4	5	6	7
35. I am using drugs out of control.	1	2	3	4	5	6	7

APPENDIX C

REVISED FAMILY COMMUNICATION PATTERN INSTRUMENT

The Revised Family Communication Pattern Instrument (Koerner & Fitzpatrick, 2002)

The RFCP consists of 26 Likert type items measuring two underlying dimension of family communication patterns: Conversation orientation (15 items) and Conformity orientation (11 items). These items are listed below separately in phrasing appropriate for parents and children grouped by orientation.

When administering the questionnaire, we recommend mixing the two scales and to randomize the order of presentation. Scores are simply the scale averages with each item contributing equally to the mean score. The scale scores can be used directly as independent variables, or they can be used to compute family types by assigning families to high versus low conversation and conformity orientation, respectively, either based on median splits or based on population means.

Instructions:

We would like to learn more about how you communicate in your family. Please use this scale to indicate your agreement with the following statements.

THE REVISED FAMILY COMMUNICATION PATTERNS INSTRUMENT *(Children's & Parent's Version)*

We would like to learn more about how you communicate in your family. Please use this scale to indicate your agreement with the following statements listed below.
 	
  Disagree Strongly   Disagree   Neutral   Agree   Agree Strongly
 	
  1-----------------2--------------3---------------4----------------5

The Revised Family Communication Pattern Instrument *(Children's Version)*
Conversation Orientation
1) In our family we often talk about topics like politics and religion where some persons disagree with others. 2) My parents often say something like "Every member of the family should have some say in family decisions." 3) My parents often ask my opinion when the family is talking about something. 4) My parents encourage me to challenge their ideas and beliefs. 5) My parents often say something like "You should always look at both sides of an issue."

The Revised Family Communication Pattern Instrument *(Children's Version continued)*
Conversation Orientation (continued)
6) I usually tell my parents what I am thinking about things.
7) I can tell my parents almost anything.
8) In our family we often talk about our feelings and emotions.
9) My parents and I often have long, relaxed conversations about nothing in particular.
10) I really enjoy talking with my parents, even when we disagree.
11) My parents encourage me to express my feelings.
12) My parents tend to be very open about their emotions.
13) We often talk as a family about things we have done during the day.
14) In our family, we often talk about our plans and hopes for the future.
15) My parents like to hear my opinion, even when I don't agree with them.
Conformity Orientation
1) When anything really important is involved, my parents expect me to obey without question.
2) In our home, my parents usually have the last word.
3) My parents feel that it is important to be the boss.
4) My parents sometimes become irritated with my views if they are different from theirs.
5) If my parents don't approve of it, they don't want to know about it.
6) When I am at home, I am expected to obey my parents' rules.
7) My parents often say things like "You'll know better when you grow up."
8) My parents often say things like "My ideas are right and you should not question them."
9) My parents often say things like "A child should not argue with adults."
10) My parents often say things like "There are some things that just shouldn't be talked about."
11) My parents often say things like "You should give in on arguments rather than risk making people mad."
The Revised Family Communication Pattern Instrument *(Parent Version)*
Conversation Orientation
1) In our family we often talk about topics like politics and religion where some persons disagree with others.
2) I often say things like "Every member of the family should have some say in family decisions."
3) I often ask my child's opinion when the family is talking about something.
4) I encourage my child to challenge my ideas and beliefs.
5) I often say things like "You should always look at both sides of an issue."
6) My child usually tells me what s/he is thinking about things.
7) My child can tell me almost anything.
8) In our family we often talk about our feelings and emotions.
9) My child and I often have long, relaxed conversations about nothing in particular.
10) I think my child really enjoys talking with me, even when we disagree.
11) I encourage my child to express his/her feelings.
12) I tend to be very open about my emotions.
13) We often talk as a family about things we have done during the day.
14) In our family, we often talk about our plans and hopes for the future.
15) I like to hear my child's opinion, even when s/he doesn't agree with me.
Conformity Orientation
1) When anything really important is involved, I expect my child to obey me without question.
2) In our home, the parents usually have the last word.
3) I feel that it is important for the parents to be the boss.

The Revised Family Communication Pattern Instrument *(Parent Version continued)*
Conformity Orientation (continued)
4) I sometimes become irritated with my child's views if they are different from mine.
5) If I don't approve of it, I don't want to know about it.
6) When my child is at home, it is expected to obey the parents' rules.
7) I often say things like "You'll know better when you grow up."
8) I often say things like "My ideas are right and you should not question them."
9) I often say things like "A child should not argue with adults."
10) I often say things like "There are some things that just shouldn't be talked about."
11) I often say things like "You should give in on arguments rather than risk making people mad."

APPENDIX D

AWARE QUESTIONNAIRE 3.0

	Never	Rarely	Sometimes	Fairly-often	Often	Almost always	Always
1. I feel nervous or unsure of my ability to stay sober.	1	2	3	4	5	6	7
2. I have many problems in my life.	1	2	3	4	5	6	7
3. I tend to overreact or act impulsively.	1	2	3	4	5	6	7
4. I keep to myself and feel lonely.	1	2	3	4	5	6	7
5. I get too focused on one area of my life.	1	2	3	4	5	6	7
6. I feel blue, down, listless, or depressed.	1	2	3	4	5	6	7
7. I engage in wishful thinking.	1	2	3	4	5	6	7
8. The plans that I make succeed.	1	2	3	4	5	6	7
9. I have trouble concentrating and prefer to dream about how things could be.	1	2	3	4	5	6	7
10. Things don't work out well for me.	1	2	3	4	5	6	7
11. I feel confused.	1	2	3	4	5	6	7
12. I get irritated or annoyed with my friends.	1	2	3	4	5	6	7
13. I feel angry or frustrated.	1	2	3	4	5	6	7
14. I have good eating habits.	1	2	3	4	5	6	7
15. I feel trapped and stuck, like there is no way out.	1	2	3	4	5	6	7
16. I have trouble sleeping.	1	2	3	4	5	6	7
17. I have long periods of serious depression.	1	2	3	4	5	6	7
18. I don't really care what happens.	1	2	3	4	5	6	7
19. I feel like things are so bad that I might as well drink.	1	2	3	4	5	6	7
20. I am able to think clearly.	1	2	3	4	5	6	7
21. I feel sorry for myself.	1	2	3	4	5	6	7
22. I think about drinking.	1	2	3	4	5	6	7
23. I lie to other people.	1	2	3	4	5	6	7
24. I feel hopeful and confident.	1	2	3	4	5	6	7
25. I feel angry at the world in general.	1	2	3	4	5	6	7
26. I am doing things to stay sober.	1	2	3	4	5	6	7
27. I am afraid that I am losing my mind.	1	2	3	4	5	6	7
28. I am drinking out of control.	1	2	3	4	5	6	7

APPENDIX E

DSM-5 SUBSTANCE-RELATED DISORDERS WORK GROUP[A]

Name	Degree(s)	Specialization	Country
Charles O'Brien (chair)[b]	M.D., Ph.D.	Addiction psychiatry	USA
Marc Auriacombe	M.D.	Addiction psychiatry	France
Guilherme Borges	Sc.D.	Epidemiology	Mexico
Kathleen Bucholz	Ph.D.	Epidemiology	USA
Alan Budney	Ph.D.	Substance use disorder treatment, marijuana	USA
Wilson Compton[b]	M.D., M.P.E	Epidemiology, addiction psychiatry	USA
Thomas Crowley[c]	M.D.	Psychiatry	USA
Bridget F. Grant[b]	Ph.D., Ph.D.	Epidemiology, biostatistics, survey research	USA
Deborah S. Hasin	Ph.D.	Epidemiology of substance use and psychiatric disorders	USA
Walter Ling	M.D.	Addiction psychiatry	USA
Nancy M. Petry	Ph.D.	Substance use and gambling treatment	USA
Marc Schuckit	M.D.	Genetics and comorbidity	USA

[a]In addition to the scientists listed here who were members during the entire duration of the process, a list of consultants and advisers who served on various subcommittees and contributed substantially to the discussion is contained in the official publication of DSM-5.
[b]Also a DSM-5 Task Force member.
[c]Co-chair, 2007–2011.

APPENDIX F

CARL JUNG LETTER TO BILL WILSON

PROF. DR. C. G. JUNG

KÜSNACHT-ZÜRICH
SEESTRASSE 228

January 30, 1961

Mr. William G. Wilson
Alcoholics Anonymous
Box 459 Grand Central Station
New York 17, N.Y.
==============

Dear Mr. Wilson,
your letter has been very welcome indeed.
I had no news from Roland H. anymore and often wondered what has been his fate.
Our conversation which he has adequately reported to you had an aspect of which
he did not know. The reason was, that I could not tell him everything, was that
those days I had to be exceedingly careful of what I said. I had found out that
I was misunderstood in every possible way. Thus I was very careful when I talked
to Roland H. But what I really thought about, was the result of many experiences
with men of his kind.
His craving for alcohol was the equivalent on a low level of the spiritual
thirst of our being for wholeness, expressed in mediaeval language: the union
with God.[1]
How could one formulate such an insight in a language that is not misunderstood
in our days?
The only right and legitimate way to such an experience is, that it happens to
you in reality and it can only happen to you when you walk on a path, which leads
you to higher understanding. You might be led to that goal by an act of grace
or through a personal and honest contact with friends, or through a higher
education of the mind beyond the confines of mere rationalism. I see from your
letter that Roland H. has chosen the second way, which was, under the circum-
stances, obviously the best one.
I am strongly convinced that the evil principle prevailing in this world, leads
the unrecognized spiritual need into perdition, if it is not counteracted either
by a real religious insight or by the protective wall of human community. An
ordinary man, not protected by an action from above and isolated in society
cannot resist the power of evil, which is called very aptly the Devil. But the
use of such words arouse so many mistakes that one can only keep aloof from
them as much as possible.
These are the reasons why I could not give a full and sufficiant explanation to
Roland H. but I am risking it with you, because I conclude from your very
decent and honest letter, that you have acquired a point of view above the mis-
leading platitudes, one usually hears about alcoholism.
You see, Alcohol in Latin is "spiritus" and you use the same word for the
highest religious experience as well as for the most depraving poison. The help-
ful formula therefore is: spiritus contra spiritum.

Thanking you again for your kind letter
                                    I remain
                                        yours sincerely   C. G. Jung.

[1] "As the hart panteth after the water brooks, so
panteth my soul after thee, O God." (Psalm 42,1)

APPENDIX G

THE TWELVE TRADITIONS OF NA

We keep what we have only with vigilance, and just as freedom for the individual comes from the Twelve Steps, so freedom for the group springs from our Traditions.
As long as the ties that bind us together are stronger than those that would tear us apart, all will be well.

1. Our common welfare should come first; personal recovery depends on NA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for membership is a desire to stop using.
4. Each group should be autonomous except in matters affecting other groups or NA as a whole.
5. Each group has but one primary purpose—to carry the message to the addict who still suffers.
6. An NA group ought never endorse, finance, or lend the NA name to any related facility or outside enterprise, lest problems of money, property, or prestige divert us from our primary purpose.
7. Every NA group ought to be fully self-supporting, declining outside contributions.
8. Narcotics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. NA, as such, ought never be organized, but we may create service boards or committees directly responsible to those they serve.
10. Narcotics Anonymous has no opinion on outside issues; hence the NA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

APPENDIX H

ODU THESIS GUIDE STATEMENT

The Old Dominion University guide for preparation of theses and dissertations provided guidance for appendices. The following information is directly taken from the guide.

1. Heading(s) is/are bold if major headings are in bold.

2. Appendix headings may either be on a separate cover sheet before appendix material or at the top of the first page of each appendix. Be consistent from appendix to appendix.

3. Appendix headings are centered. Appendix titles are centered, in all capital letters and appear at least one double space below heading.

4. Page numbering is continued from the last page of references.

5. All material must be within margins.

6. Tables and figures in appendices may be numbered consecutively following the text, or they may be numbered with an appendix designation. If numbered consecutively from the text, they must be included in the List of Tables or List of Figures

7. Material may be reduced but must conform to minimum size and legibility requirements.

8. Material may have mixed fonts and point sizes and may be single spaced.

VITA

Adam J. Pyecha
Old Dominion University
5115 Hampton Boulevard
Norfolk, VA 23503

<u>Education and Training</u>

M.A.	Old Dominion University, Norfolk, VA Lifespan & Digital Communication Thesis Advisor: Dr. Thomas Socha	Expected Dec, 2020
Graduate Certificate	Old Dominion University, Norfolk, VA Certificate in Health & the Humanities Health, Communication and Culture	June, 2019
B.S.	Old Dominion University, Norfolk, VA Lifespan Communication	May, 2018
A.S.	Tidewater Community College, Norfolk, VA Psychology	May, 2016

<u>Selected Presentations</u>

Pyecha, A. (March 2019). Communication across the lifespan: Emerging adults, alcohol & the college experience. Poster Session at *Graduate Research Day at Old Dominion University*.

Pyecha, A. (April 2020). Positive communication across the lifespan: Early childhood ACEs to VIAs. Virtual Poster Session at *Graduate Research Day at Old Dominion University.*

Socha, T. J., Daniel, T., Jones, D., Pyecha, A., Stanley-Costanzo, S., Smith, R., & Williams, A. (2020, May*). Communicating with Anti-Social Outgroups: An Exploratory Intergroup Study of Grouches, Bullies, Assholes, and Bitches*. A competitive paper presented at the annual meeting of the International Communication Association, Gold Coast, Australia.