Introduction

Addiction is a national mental health crisis, responsible for untold costs to our society and immense suffering for innumerable people. As I write this book, addiction treatment providers are failing to reach the vast majority of those who suffer from addiction. The stark reality is that 50 percent of those who receive addiction treatment fail to sustain recovery after treatment. This statistic has not improved throughout many decades of treating this problem (National Institute on Drug Abuse, 2020). Providers are also failing to address the collateral damage created by addiction. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* found that only 10 percent of addicts receive any treatment at all, and the number of addicts continues to increase as new, readily available, addictive substances and behaviors proliferate (Office of the Surgeon General, 2016).

I believe that a new and different approach is essential. And, after 25 years of successfully treating addicted families, by which I mean that most addicts and their families sustain their recovery after treatment, I know for a fact that this approach works significantly better than the addiction treatment model that is currently generally accepted and widely practiced.

In this book, I propose a radically different approach to the current addiction treatment paradigm. Specifically, I suggest organizing treatment around a single professional—a state-licensed, mental or medical health professional trained in Family Recovery Therapy (FRT)—who acts as a Treatment Team Manager and coordinates, case manages, oversees, and treats the members of the addicted/codependent system in an integrated continuum of care, from the first phone call through at least the first year of continuous sobriety. The FRT therapist, who is both case manager and primary treating clinician, bridges and integrates the benefits of evidence-based, medically assisted treatment with that of the widely available—and free—social support and mutual aid groups. This model stands in stark contrast to the traditional, unregulated, fragmented approach that treats the addict in the short term and does not directly address those who *enable* the addict.

Addiction has been with us since the beginning of humanity. And now, smartphones, TV, and other technology-based innovations offer us additional ways to trigger our brains' neurotransmitters, often resulting in out-of-control, compulsive, and life-threatening behaviors that are now being categorized as addictions.

My hope is that you, the practitioner who is interested in studying and treating addiction, will find that adopting this new model can help you achieve more successful outcomes with your clients. My hope is that families contending with addiction will find a clear road map with this approach to help them navigate the dizzying array of treatments and interventions offered in the largely unregulated American addiction treatment industry.

And my hope is that you, the family member who is concerned about an addicted loved one, will find solace in the knowledge that there is a path toward sustained recovery for you and your family, and that there are now practitioners who can help to guide you in that process.

Of course, private practitioners will encounter only a portion of the addicts who need treatment. This book is primarily addressed to those working with clients who have access to medical care. For this new method to succeed with the entire population, including with those who are dependent on government funding, it will need to be adopted by social service agencies, many of which have unwittingly enabled addiction by providing untreated addicts with money that they then use to buy alcohol and drugs. By making this model available to all, it is my hope that it will begin to be adopted by those who serve the populations I am not able to reach.

The goal of Family Recovery Therapy is to restore the addict, each family member, and the family system as a whole to healthy development. As illustrated by Erik Erikson's Eight Stages of Psycho-Social Development (see Appendix A), human beings go through predictable stages of growth, and the tasks of each stage optimally should be mastered before proceeding to the next stage. Effective treatment reestablishes the normal life progression that would have been achieved had addiction not derailed the process. Since recovery, just like development, is an ongoing process, it is customary to use the terms "in recovery" or "recovering" rather than "recovered" to describe the trajectory of growth and healing attained through treatment. Although in the ideal world, and particularly in families where addiction has wreaked havoc, it might be a relief to think that an addict "has recovered" or attained "full recovery," the nature of addiction, and also of human development, is such that recovery does not reach an end point.

It is finally time to move addiction treatment into the modern era. It is time to integrate modern mental and medical health treatment with the long-established residential rehab movement. It is time to acknowledge that addiction is almost always enabled by well-meaning individuals who need their own support. It is time to understand the need for addiction treatment to comprehensively treat the addict through at least the first year of continuous sobriety. This book, *Addiction Therapy and Treatment: A Systems Approach*, describes exactly how this will work. Individuals seeking treatment for addiction should start with a therapist certified in Family Recovery Therapy (FRT). And rehabs seeking interventionists are best served by referring to certified FRT therapists who will work with the addict and the family—the family system—hands on, before and after a residential stay and throughout the initial year of continuous sobriety.

Chapter 1

Addiction Treatment: Introducing a New Paradigm

We are finally getting a more complete, more accurate picture of the complex biological, psychological, social, and spiritual nature of addiction. We are beginning to fully understand the brain physiology of addiction and the social components that often support addiction, and we are developing new treatment modalities that can effectively address this medical and mental disorder.

To be clear, not all substance abuse is "addiction." Nor do all compulsive behaviors, like compulsive gambling or computer gaming, meet the criteria for addiction. This book, and Family Recovery Therapy (FRT), address the kind of "addiction" clearly spelled out in the "Long Definition of Addiction" of the American Society of Addiction Medicine (ASAM [2011]) which is reprinted with permission in Chapter 3.

ASAM describes an addicted brain as diseased and disordered. The underlying neurological changes associated with long-term addiction render an addict literally *incapable of refraining from ongoing usage without external support.* This reality speaks to a critical distinction between simple abuse—overuse of a substance or behavior—and medically defined addiction. And yet, before or during treatment, it is often difficult to differentiate between an addict and others who may not be addicts, but who exhibit symptoms of addiction. As with all medical disorders, diagnostic due diligence is necessary in order to identify or rule out a disease, as well as to modify treatment as new evidence emerges. And yes, there are a few who go through addiction treatment who were misdiagnosed and can actually control their behavior, but it is a very small minority.

Addiction in one form or another directly affects nearly half of all families (Gramlich, 2017). Family members, concerned about their addict, are drawn into the addict's drama, becoming interdependent (codependent) in ways that can profoundly disrupt their lives and their healthy development. While advances in addiction treatment continue to evolve, we still have to face the reality that approximately half of those who enter some sort of addiction treatment program relapse within a year and resume their addiction, resulting in costly, and potentially deadly, outcomes. This happens in part because, in the current, fragmented treatment model, a split exists between the abstinence-only social support group approach (such

as Alcoholics Anonymous) and the equally useful "medically assisted treatment" (M.A.T.). Each approach often fails to fully benefit from what the other offers.

This book proposes a plan to fundamentally alter the predominant, existing approach and set the stage for a new paradigm in treatment—one that integrates processes that are currently fragmented and ineffective into a model that can produce significantly better outcomes. This new paradigm is based on science, evidence, and research, and is supported by the findings in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (Office of the Surgeon General, 2016). I propose that treatment programs, government agencies, drug counselors, and all others involved in addiction treatment start to "row in the same direction," and that they all employ the Family Recovery Therapy (FRT) treatment model. According to this model, an addiction-trained, licensed mental health professional, an "FRT therapist," coordinates a treatment team that treats all aspects of the addictive/codependent family system from the very beginning—from the first phone call—through at least the initial year of sobriety.

Social support and mutual aid groups are central to the rehabilitation of addicts and are used in nearly all addiction treatment programs. The most widespread of these is Alcoholics Anonymous (AA). Others include LifeRing Secular Recovery (LifeRing), SMART Recovery®, and Women for Sobriety. The AA groups began in the 1930s, when several alcoholics met together to help each other not drink for that one day—and met again the next day to help each other not drink that day, and again the day after that—one day at a time. Today, nearly every approach to addiction treatment includes some kind of group support in which recovering individuals talk about what they are thinking and feeling, share their pain and their problems, and get support from each other—an authentic support that is absent elsewhere in the lives of most addicts.

I understand that AA meetings and other 12-Step fellowships comprise by far the majority—perhaps over 90 percent—of free social support and mutual aid groups for addicts. While 12-Step programs are not for everyone, they do dominate the recovery field. A professor in my graduate program once called 12-Step programs "the world's fastest-growing spiritual movement," and that is not hyperbole. The book *Alcoholics Anonymous* has sold more than 40 million copies (in English editions alone) (Alcoholics Anonymous®, n.d.-c). and has been translated into 72 other languages (Alcoholics Anonymous®, n.d.-a) (and counting) since it was first published in English in 1939. *Time* magazine, in 2011, placed the book on its list of the "100 best and most influential books written in English" (Sun, 2011). The Library of Congress designated it "one of the 88 books that shaped America" (Library of Congress, 2012).

The 12-Step approach for alcoholics has spawned dozens of offshoots, such as Narcotics Anonymous, Overeaters Anonymous, Sex and Love Addicts Anonymous, Gamers Anonymous, Gamblers Anonymous, and Debtors Anonymous. These programs offer a practical, step-by-step solution to suffering addicts, whose disordered

midbrains have hijacked their thinking prefrontal cortices, rendering them susceptible to compulsive and self-harming behavior (see Figures 3.1, 3.2, and 3.3 in Chapter 3).

The 12-Step approach has many detractors, but the fact that its principles are based on anonymity makes it both an underappreciated gem and a defenseless target when it comes to documenting its successes and failures. Millions of its members, many of them famous, remain silent about their 12-Step involvement and their successful remission from this chronic disorder using the support of these free and readily available programs. And, as mentioned, there are other social support groups for addicts that may be a better fit for some individuals.

In considering treatment and addiction, it is critical to differentiate "true addicts" from those who engage in addictive behaviors but do not suffer from the brain disorder of addiction. The American Society of Addiction Medicine (ASAM) is unambivalent: substance addiction is fundamentally a neurological disorder, a disease of the brain (2011). For many years, neuroscientists, using a variety of complex imaging technologies, have delved deeply into the mysteries of how the brain works, and they have substantiated what the American Medical Association (AMA) pronounced in 1956, that addiction is a medical illness. Harm reduction approaches, such as psychodynamic therapy and cognitive behavioral therapy, are appropriate for treating individuals who exhibit obsessive and compulsive "addictive-like" thinking and behavior. Many afflicted individuals are successfully treated using these and similar approaches—but only if they are not "true" addicts who suffer from the neurological disorder of addiction.

How can we know if someone is a true addict? Often the answer comes from looking in a rearview mirror. In his book, *Harm Reduction Psychotherapy*, Andrew Tatarsky acknowledges the necessity of referral of "certain cases" to AA where abstinence, not harm reduction, is indicated (2002). Lance Dodes, author of *The Heart of Addiction* (2002), who advocates addressing the psychological issues underlying addictive behaviors, would welcome a client finding the help they needed in AA or another support group, if they fail to recover with the assistance of his psychodynamic approach. We clinicians may try a number of approaches to help relieve our clients' suffering, until hopefully we are able to guide an individual to remission. Like turtles and dolphins getting caught inadvertently in fishing nets, some individuals are referred to addiction treatment and then discover later, once their substance use has stopped and other issues have been addressed, that, in fact, they are not addicts, and they can use and control mood-altering substances, including alcohol, without developing a harmful dependency.

It is impossible to know 100 percent of the time if a new client is a true addict. Clinically speaking, it is appropriate to rapidly escalate treatment when clients are engaging in dangerous behavior. Of course, we continue to assess presenting issues and modify our approach as needed.

To be clear, this book and the 14 Principles described in it are intended to guide clinicians working with *addicts*—those who have the brain disease of addiction as defined by ASAM. (See Chapter 3 for more detail.)

Currently, two primary approaches dominate the addiction treatment field. One is the abstinence approach, which is espoused by the social support groups such as AA, and the other is medically assisted treatment (M.A.T.), which is advocated by medical doctors and is increasingly supported by the government. Both have strong evidence supporting their efficacy, but neither comes even close to offering a fully integrated, comprehensive, and unified treatment method. Hence each approach has less than optimal long-term success rates.

Psychiatrists who espouse using M.A.T. focus on possible organic deficits that will benefit from different kinds of medication. There are many recovering addicts with long-term "sobriety" who are taking any number of medications to help stabilize their nervous systems. The benefits of Suboxone (buprenorphine) are well established. Suboxone can get the user "high," but used correctly and under a doctor's care, it can allow an opiate addict to stabilize and stop using heroin and other opiates. Methadone has been used for many years to help keep opiate addicts from returning to dangerous street drugs. Naltrexone and Vivitrol will block the high from opiates and can assist opiate addicts resist relapse. Many other medications, such as antidepressants, can help addicts turn away from their addictive drug of choice and get their lives back on track.

Some AA members, especially "old-timers" who have been with the program for many decades, discourage the use of medication because they believe that only abstinence from all psychoactive drugs constitutes real sobriety. In fact, AA does not have an opinion—neither for nor against medication. Today we know that many addicts benefit from medical support, and others cannot thrive without it. The concern voiced by most proponents of the traditional, abstinence-based approaches is that M.A.T. fails to incorporate the use of social support and mutual aid groups. These groups provide a vital component of recovery—helping recovering individuals to connect with each other on a daily basis, to get and give mutual support, to be inspired by those with longer recovery, and to find a healthy community. Addicts in the throes of addiction have rarely experienced in any other context the kind of vital support these groups have offered for over 80 years.

Comprehensive treatment must utilize aspects of *both* medical and psychological best practices *and* abstinence-based social support and mutual aid groups. An important component of FRT is the reliance of recovering addicts and family members on community-based, free, social support groups. Chapter 13 is devoted to a discussion of these groups, which together constitute the world's most successful "mental health program" for the treatment of addiction.

Twelve-Step programs, for many, have certainly proven to be a simple and effective way to put many kinds of addiction into remission. However, nearly 40 percent of newly recovering addicts also suffer from dual or multiple mental illnesses, among them, depression, anxiety, bipolar disorder, post-traumatic stress disorder, or personality disorders (National Institute of Mental Health, 2016), and, further, have myriad other problems related to financial, legal, employment, housing, or

relationship issues. Various kinds of treatment to address these issues can be essential to recovery, which is why the FRT therapist, who can integrate and coordinate psychiatric, medical, therapeutic, and any other required professional services, plays a vital role in ensuring a continuum of care.

During the years he spent working as staff physician in a clinic on Vancouver's skid row, medical doctor Gabor Maté, author of *In the Realm of Hungry Ghosts* (2010), observed that people with severe substance abuse disorders had invariably suffered traumatic developmental deficits. He cites one of the most comprehensive and prominent studies on the long-term impacts of childhood abuse and neglect: the Adverse Childhood Experiences (ACE) study conducted by the Centers for Disease Control and Prevention in conjunction with Kaiser Permanente. The ACE findings amply demonstrate the crucial role adverse childhood experiences play in predisposing an individual to substance abuse disorders (Felitti, et al., 1998). Childhood trauma and the failure to form secure attachments with loving others early in life make an individual much more likely to fall prey to addiction, and the more severe the deficits in early care, the more likely someone will develop addiction.

For Maté, addiction is essentially a disorder of disconnection. When a child lacks a sense of safety and belonging, this deficit can impair healthy development of the neural pathways that facilitate their ability to feel at home in the world, to live, and love, and prosper in connection with others. We are an affiliative species. If we cannot achieve genuine connection, we seek other ways to repair the breach. Addicts bond with a substance or activity that simulates some of the feelings and sensations associated with healthy human relationships. Tragically, bonding with their drug or compulsive behaviors of choice further impairs the addict's ability to connect with people and to find a home in the human community.

Addicts and alcoholics in recovery from long-term addiction can be especially supportive in helping the practicing addict begin to feel less alone. They've been where the newcomer is and can empathize with his or her plight. The authentic connections that happen in social support and mutual aid groups are healing in and of themselves. Regularly meeting with a committed group of sincere, loving, caring people helps heal the disconnected, alienated soul, and helps ward off the pain of isolation. The significance of human connection in recovery is one of the reasons for the wide success of the many social support groups.

All social support groups provide both affiliation and specific recovery tools. SMART Recovery®, LifeRing, and other non–12-Step groups offer the opportunity for connection and interaction with others in recovery as well as substantial cognitive behavioral tools. Participants in these groups learn to address myriad aspects of recovery that foster healthy development—including preventing relapse, handling emotions, and learning effective and appropriate communication and relationship skills.

Twelve-Step programs offer both the fellowship of community members and the 12 steps, which the newly recovering addict is invited to "work" to recover from

the damage done by perhaps years of addiction. It is within the fellowship that addicts find the kind of understanding "others" that most of us need in our lives in order to feel safe and loved. And in "working" the steps, one at a time, with a "sponsor," the addict receives many benefits beyond remission from addiction. These benefits—self-exploration, self-responsibility, awareness of emotions, living with integrity, accepting reality, repairing relationships, embracing spirituality, relating to and helping others—address and ameliorate many mental health and relationship issues.

The Family Recovery Therapy model inserts a mental health professional, the FRT therapist, into a comprehensive treatment process that coordinates both M.A.T. and social support programs. This therapist can monitor and attend to an addict or a family member's co-occurring issues, and guide the addict and the afflicted family members in a timely way to the resources necessary to attain wellness. Through the Family Recovery Therapy process, addicts and codependents achieve recovery and health, and are therefore able to stop the addiction cycle, and to impart to the next generation freedom from a distorted and impoverished development and from the legacy of a poorly differentiated family.

Let's step back and review how we got to where we are now in addiction treatment. In the 1800s and early 1900s, addiction was generally seen as a moral failing or as a form of insanity or demonic possession. Of course, attempts at religious conversion or exorcism were almost always futile. Slowly, over the last hundred years, we have grown in our understanding of addiction and its impact on all of us.

In the early 1900s, Freud and others contributed the concept of the unconscious to our understanding of human behavior. This was important not only for understanding the psychology of the individual, but also for illuminating the underlying unconscious dynamics of family systems and of the larger society. In his book, *Can Love Last?* (2002, p. 22), Stephen Mitchell wrote of Sigmund Freud's work: "Our conscious experience is merely the tip of an immense iceberg of unconscious mental processes that really shape, unbeknownst to us, silently, impenetrably, and inexorably, our motives, our values, our actions."

Freud's contribution to our evolving understanding of addiction is profound, because he helped us to understand that the psychological underpinnings of addiction—on both an individual and a systemic level—are largely unconscious. But in practical terms, psychoanalysis did little to alleviate the suffering of addicts. Psychotherapy alone seldom resolved addiction.

In the 1930s, Bill Wilson and Dr. Bob Smith demonstrated that individuals who were addicted to alcohol could stop drinking simply by gathering together on a regular basis and supporting each other's sobriety—for just that day—one day at a time. Based on this principle, they founded Alcoholics Anonymous. Since then, millions of addicts have managed to achieve in AA what they could not with decades of psychotherapy alone—long-term sobriety and freedom from the ravages of ongoing addiction and relapse (Erikson, M., 2020).

The 1940s saw the beginning of residential treatment programs based on the principles of AA. The programs typically were run by recovering alcoholics who helped alcoholics get sober and get their feet back on the ground.

In the 1950s, Lois Wilson, Bill Wilson's wife, co-founded an organization modeled after AA, called Al-Anon, which offered support for the family members affected by their loved one's addiction. The need for Al-Anon spoke to a central issue in addiction: addiction can legitimately be called a "family disease," since the addict's presence profoundly disrupts family functioning and impedes healthy psychosocial development for all family members, and can lead to codependency. In that same decade, the first residential treatment centers for codependents opened.

Also in the 1950s, the American Medical Association (AMA) recognized that addiction has a biological basis, that it is a disease of an organ—the brain. In 1956, the AMA declared that "alcoholism is a medical illness" (Bettinardi-Angres & Angres, 2010). This acknowledgment began to help remove some of the stigma of alcoholism. In addition, in the 1950s, medical doctors who specialized in addiction medicine began to organize, and eventually formed the American Society of Addiction Medicine (ASAM) to advance both the understanding and the treatment of addiction.

In the 1960s and 1970s, Vernon Johnson, an Episcopal priest, developed the concept of an "intervention" (Johnson, 1990). His idea was to bring together family members—and others significant in an addict's life—in an attempt to motivate the addict to enter treatment. This model is now called the Johnson or "surprise model" of intervention. During the 1960s as well, the psychiatrist Murray Bowen developed a comprehensive psychological theory of family systems that embraced Freud's understanding of the role that the unconscious plays in our actions—in this case, the role of the unconscious in interpersonal relationships among family members (Bowen, 1978). Understanding the role of unconscious actions in a family system is central to the FRT model.

During the 1970s and 1980s, codependency came to be viewed as a psychological and relationship "disorder" (Lancer, 2017). It became clearer not only that codependents experience significant distress, but that unhealthy codependency exacts a severe toll on relationships.

In the 1970s, Dr. Stephanie Brown began her study of addiction. She studied the process of recovery for individuals who belong to Alcoholics Anonymous and published this work in her book, *Treating the Alcoholic: A Developmental Model of Recovery* (1985). In the 1970s and 1980s, she examined the impact on children and on adult children of alcoholics. Dr. Brown partnered with Dr. Virginia Lewis in 1990 to study the process of recovery for the addicted family as a system. Their research demonstrated how family members' pursuit of their own recoveries can contribute to the development of a new, healthy family system over time in recovery. They described their findings about families in recovery in their book *The Alcoholic Family in Recovery: A Developmental Model,* published in 1999.

In the mid–1990s, interventionists and family therapists who understood the dysfunctional roles of family members in addiction and codependency, as well as in recovery, introduced the concept of "systemic" interventions, in contrast to the formerly popular "Johnson" or "surprise" interventions, which can be shame-inducing and often ineffective (Office of the Surgeon General, 2016). This approach acknowledged the crucial role that family dynamics play in the "addictive/codependent system." Systemic interventionists understand the complex codependent enabling forces involved in addiction, and rather than focusing the intervention solely on the addict, offer treatment recommendations to all family members.

Additionally, beginning in the 1990s, scientists and neurophysiologists discovered the disordered structures and chemical reactivity of the addicted brain—features which helped explain why an addict, relying on their own brain, is typically incapable of stopping addictive behavior. The scientific research corroborated what AA had explained decades before—and what every addict self-reports—that willpower alone cannot overcome addiction.

Using modern imaging techniques, addiction researchers discovered that something very peculiar was going on in the brains of addicts who were caught in the throes of active craving (Goldstein & Volkow, 2002). While there was plenty of activity in their midbrain, the prefrontal cortex (that part of the brain responsible for executive functioning) was practically offline. Processes in the midbrain—that portion of the brain shared by all mammals and crucially important in fight-or-flight responses, emotional reactivity, and effective bonding—overwhelm the addict's thinking, reasoning, and decision-making, and drive the addict to repeat addictive behavior to reduce pain and/or to seek temporary euphoria. No amount of moralizing or reasoning can sway a person bereft of executive functioning. The addict is powerless to stop their addiction without external help.

That brings us up to date with where we are today.

Following (pages 19–22) is a graphic representation of the history of addiction treatment.

We have clearly learned a great deal about the disease of addiction and have developed and modified treatment models as new discoveries in biology, psychology, and social interactions have informed our treatment approaches. And yet, despite these advances, we are still stuck with the inconvenient fact that somewhere around fifty percent of those who seek treatment will return to their addiction. Even after attending a number of residential treatment programs, they still fail to maintain sobriety.

I'd like to use the "glass half full/glass half empty" analogy to offer a bird's-eye perspective on the current state of addiction treatment as practiced by medical doctors, mental health professionals, and addiction treatment programs.

Glass Half Full:

- Medical Doctors have deepened their understanding of addiction. A number of medicines have been developed which doctors can prescribe to

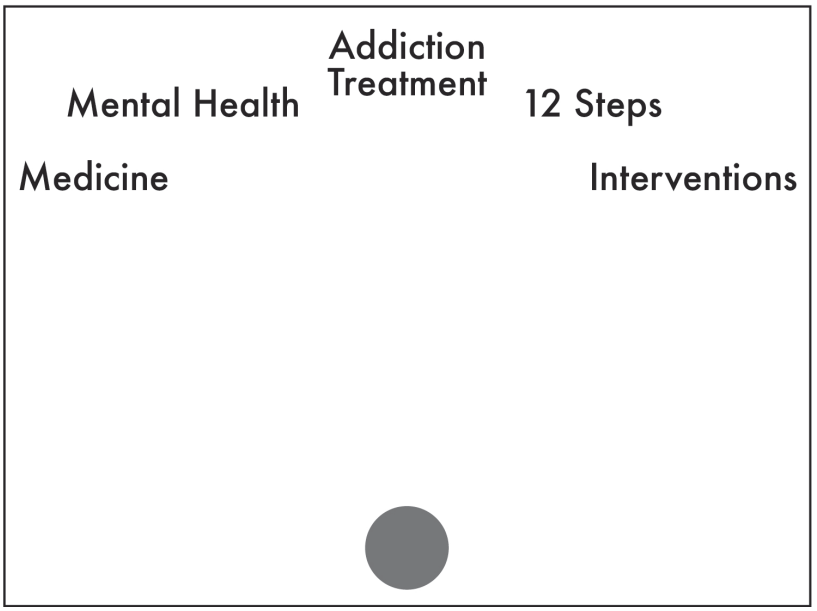

Figure 1.1 *The Year 1900*. At the start of the 20th century, no acceptable treatment for addiction existed.

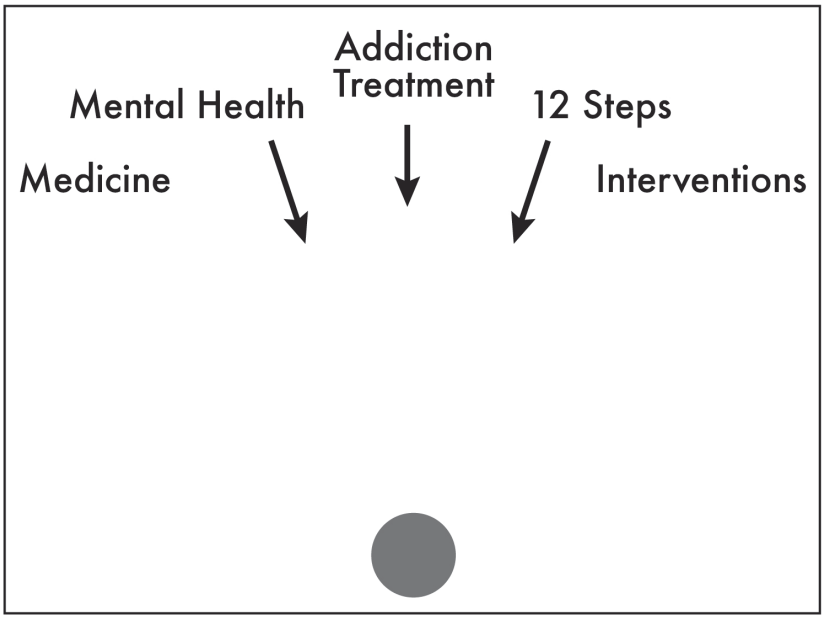

Figure 1.2 *1940s*. Freud, in the early 20th century, described the role of the unconscious in human behavior, and there was a growing awareness that psychological factors influence human thought and action. In the 1930s, AA was founded and began helping addicts get and stay sober, one day at a time. As each year passed, AA membership grew. In the 1940s, with the recognition of the need for addiction treatment, 12-Step-based residential treatment programs were founded.

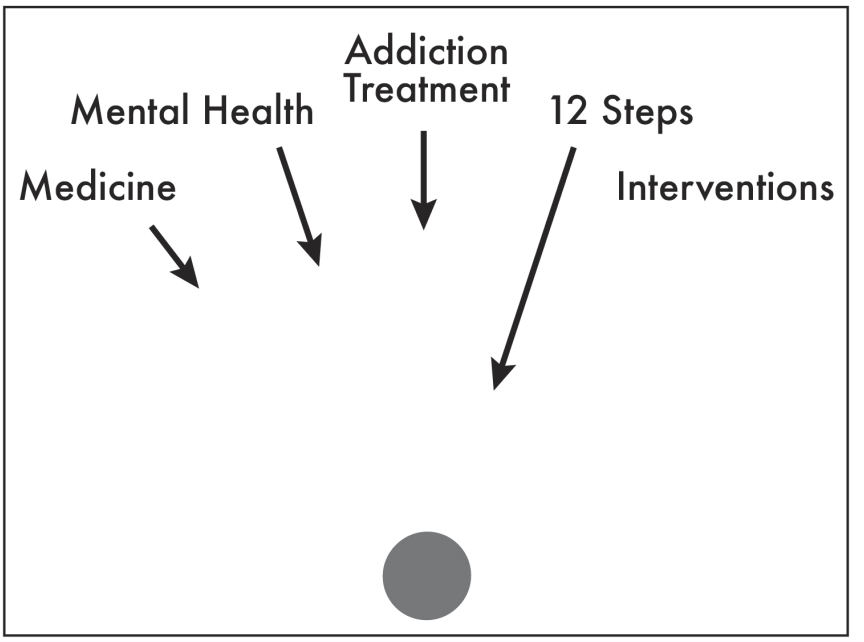

Figure 1.3 ***1950s.*** **The American Medical Association (AMA) acknowledged that addiction is a medical illness. The American Society of Addiction Medicine (ASAM) was established as a forum for doctors to share their knowledge about addiction. The 12-Step program Al-Anon was founded to offer support to family members impacted by addiction. Residential treatment programs for codependents opened.**

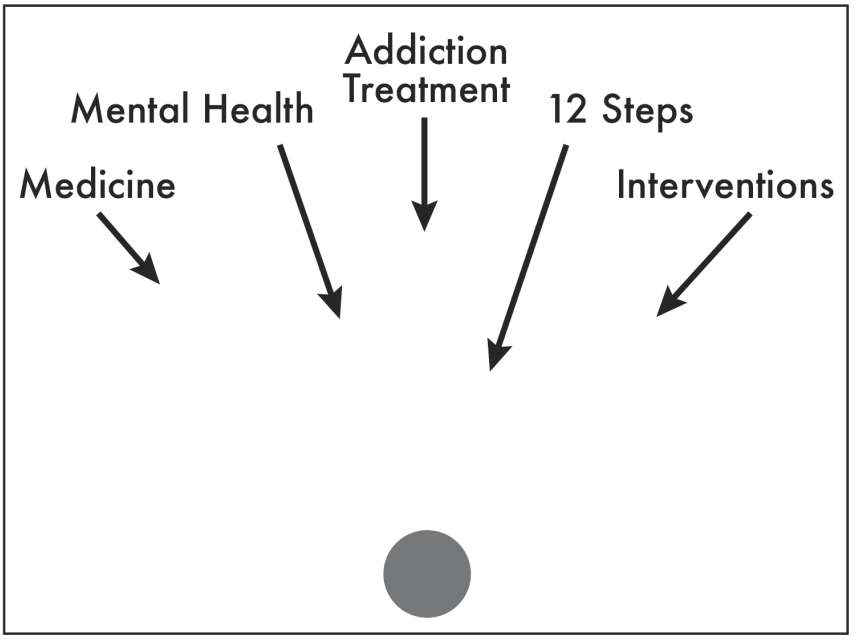

Figure 1.4 ***1960s and 1970s.*** **Murray Bowen described the role that the unconscious plays in family dynamics. Vernon Johnson introduced the "Surprise Model" of intervention.**

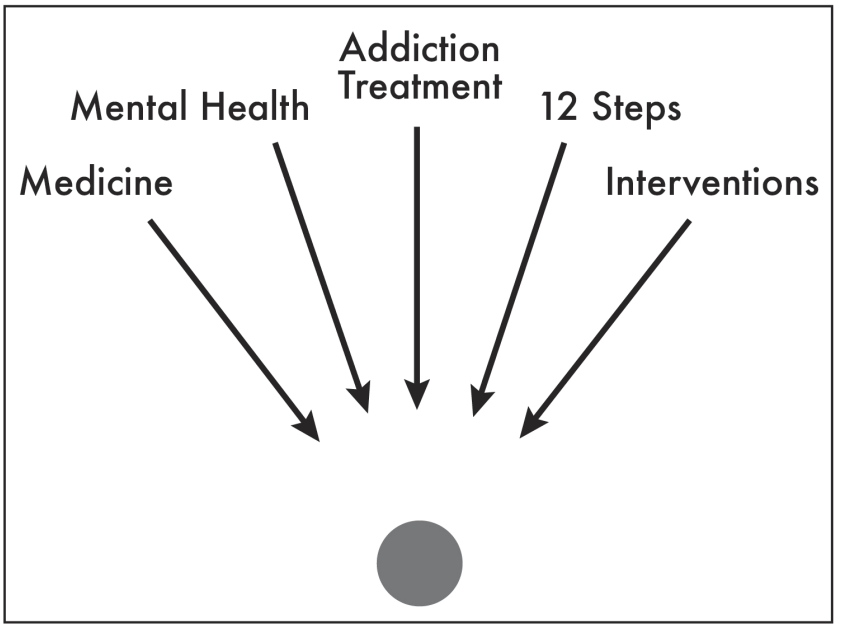

Figure 1.5 ***1980s and 1990s.*** **Brain imaging techniques were developed that could demonstrate differences between brains of addicts and brains of non-addicts. The "Systemic Intervention" was developed, which acknowledged the role of the family system in addiction and recovery. Brown and Lewis published their work on alcoholic families and the developmental model of addiction and recovery.**

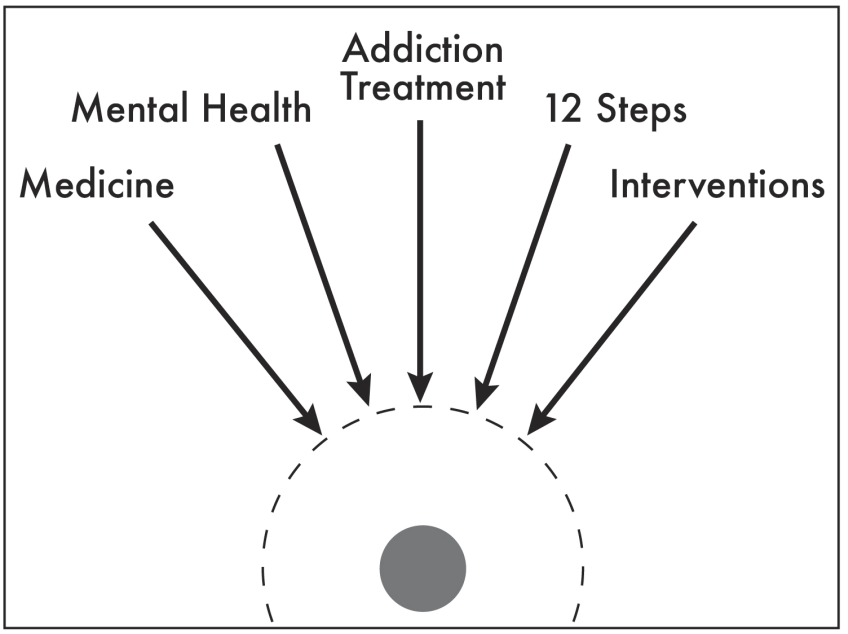

Figure 1.6 ***Present Day.*** **Knowledge about the medical and mental health aspects of addiction has grown, 12-Step programs are thriving, and addiction treatment has improved from where it was decades earlier. However, there is still a 50 percent failure rate of addiction treatment.**

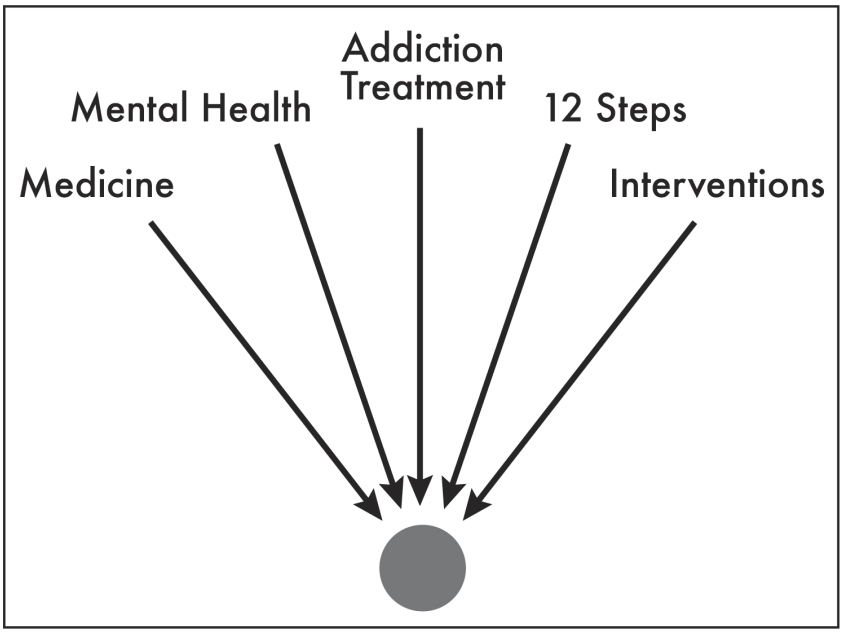

Figure 1.7 ***The New Paradigm—Family Recovery Therapy.*** **In Family Recovery Therapy, the FRT therapist coordinates the treatment of the addictive/codependent family system, facilitating and integrating medicine, social support groups and all adjunctive therapeutic services. Using the FRT model, we can move towards a time when active addiction is rare and, when present, is diagnosed and treated at an early stage, just like any other chronic medical disease.**

help the addict go through withdrawal without serious discomfort. Doctors are now able to prescribe legal and readily available medicines that can allow, for instance, opioid addicts to offset their drug cravings. They offer medical treatments for many of the co-occurring physical and psychological disorders that afflict addicts. Doctors are an essential part of an integrated approach to addiction treatment.

- Mental health professionals are highly trained to help relieve the pain of mental disorders. Nearly all addicts entering addiction treatment suffer from mental disorders, which are exacerbated by their addiction-based lifestyle.
- Addiction treatment programs have, for decades, taken in the addict, detoxed and stabilized them, educated them, and given them common sense recommendations upon discharge.

Glass Half Empty:

- Medical doctors get very little training in recognizing addictive disorders, and often treat the *symptoms* of addiction, failing to diagnose the underlying disorder. When they do treat addiction as a medical disorder, they often fail to understand the complex addictive/codependent family system and the social systems surrounding and supporting the addict's malady. They often

do not think to refer the family members for treatment. They often fail to recognize that regular, long-term, attendance in support groups (rather than the brief exposure they may get to such groups during residential treatment) is essential to keeping this chronic brain disorder in remission.

- Mental health professionals are trained to help those suffering from psychological problems to "get a grip" on their problem in order to reestablish mental health and a sense of wellbeing. However, often these professionals have little training in addiction and fail to understand that addiction, by definition, is a disorder characterized by a brain that is *incapable* of control: addicts can control neither their craving nor their subsequent drug-seeking and drug-using behavior. The addicted mind, by definition, will not respond to those who try to strengthen the ego or willpower—something the addict is incapable of benefiting from. Mental health professionals are trying to instruct a brain that has been hijacked to *choose* not to be hijacked. This is demoralizing for the addict who has repeatedly tried and failed to control their behavior.
- Addiction treatment programs, in nearly all cases, fail to address and treat the systemic dynamics underlying, impacting, influencing and enabling the addictive/codependent family system. They acknowledge that the family has a role, but their focus on the addict colludes with the family's denial that family members have a role in the problem. The treatment programs, as well as most family members, continue to believe that the addict "is the problem." Hence, the codependent enablers' "treatment" typically consists of brief education about addiction, and perhaps one meeting with a counselor. But a treatment program's "family program" generally neither engages the codependent family members in long-term treatment, nor addresses the perhaps decades-long, multi-generational, entrenched codependency and lack of differentiation that support the homeostasis of the addictive/codependent system. Differentiation is discussed more fully in the chapters ahead. It is the ability of a person to individuate especially in relation to their family of origin.
- Additionally, treatment for the addict is typically 30, 60, or 90 days in duration. This length of time is simply insufficient to address a long-standing, even decades-long disorder. In some cases, it can take many years for a person to make the substantive changes needed to create a foundation for resuming healthy development. In the current paradigm, everyone crosses their fingers and hopes the patient is "cured," when in fact the work, in most cases, has barely begun.

There is a better way. One that makes the "glass half full/glass half empty" metaphor no longer relevant. This is where we are now.

The current state of addiction treatment brings to mind the parable of the four

blind men describing an elephant. One man, holding the trunk, says, "An elephant is like a snake." Another, holding the tail, says, "No, an elephant is like a rope." A third, his arms encircling a leg, says, "No, an elephant is like a tree." And the fourth, grasping an ear, says, "No, an elephant is like a large leaf."

The parable is an apropos analogy. Different phases of treatment are not coordinated into a cohesive whole. I suggest that those in the addiction treatment field step away from the dominant paradigm, and look at the larger picture from a bird's-eye perspective that includes not only the addict, but the family members, as well as the addictive/codependent family and peer system. The blind men above were all correct in their description of the elephant, but they could not see that the part they held was only one portion of a larger whole.

I propose nothing less than a systemic intervention on the addiction treatment field itself. I believe that the addiction treatment industry is addicted to a failed approach and needs an intervention—not unlike an addictive/codependent family system. Such an intervention will give way to a new addiction treatment model—in the same way that an interventionist working with a family recommends new behavior for the codependents and the addict that will create radically different and healthier family dynamics.

This new treatment model is based on current research and evidence-based outcome studies that underpin the guidelines for "best practices" that we know are effective. Unfortunately, the current addiction treatment industry is, like the four blind men, unable to see some key elements, and also not yet equipped to implement them.

Residential treatment programs, drug counselors, family therapists, interventionists, doctors, outpatient programs, government agencies, and others treating addiction are mostly doing their jobs with conviction and dedication—just like the man holding the tail of an elephant would accurately say it was "like a rope."

We are now poised to take the next step in the long evolution from Freud, and AA's founding in the 1930s, incorporating all of the advances in medicine, psychology, clinical practice, and our understanding of family dynamics. It's time to ask the question, "What would it take to put 100% of addicts and their enabling codependent family systems into a treatment process that *effectively* stops this systemic disease in this generation and doesn't pass it on to the next?"

I can imagine a future where teams of doctors, psychologists, drug counselors, treatment programs, and government agencies, working together, put addiction into the category of diseases—like smallpox—that are diagnosed early, treated, and arrested when the first symptoms appear, and even eventually eradicated.

I believe we are ready to adopt a new paradigm. Paradigm shifts are no small thing. Let's take a deeper look at the concept of paradigms, paradigm shifts, and how they relate to addiction treatment. Thomas Kuhn, in his seminal book, *The Structure of Scientific Revolutions* (1962), discusses the stages that science progresses through as it evolves over time. He conceives of the process as traversing four phases. Kuhn

suggests that significant change in our perspective and understanding of science occurs not through a linear accumulation of new data, but through revolutionary transformations, which he later termed "paradigm shifts." I think the metaphor is a useful one. Let's explore further.

In Kuhn's view of the evolution of science, during Phase One, or "pre-science," there exist several discordant theories to explain a particular phenomenon. In Phase Two, which Kuhn terms "normal science," a dominant paradigm evolves from the disparate theories, and inconsistencies are resolved within that framework. During Phase Three, anomalies arise that cannot be explained by the dominant paradigm. And finally, in Phase Four, a "scientific revolution" occurs, and a new paradigm emerges which allows for the resolution of previous anomalies.

When the evolution of addiction treatment is viewed through the lens of Kuhn's theory of change, Phase One, the era of pre-science, is comparable to the state of addiction treatment prior to 1956—the point at which the American Medical Association recognized addiction as a medical illness. Before this time, there was no consensus about the nature of addiction or how to treat it. Addiction was viewed variously as evidence of mental illness, lack of willpower, Satanism, or a moral failing. Neither religion nor medicine had been able to effectively offer a "treatment" for addiction.

However, there were a few attempts at treatment as early as 1784, Dr. Benjamin Rush, a civic leader in Philadelphia and signer of the U.S. *Declaration of Independence*, argued that alcoholism was a medical disease that rendered its victims incapable of choosing sobriety. Alcohol, he believed, was the causative agent, not the alcoholic. The alcoholic, Rush contended, should be treated with compassion and weaned from his addiction by the administration of less potent medications (White, 1998).

Decades before Rush, some Native Americans had already begun establishing mutual aid circles and using traditional healing practices (White, 1998) to contend with the terrific toll alcohol abuse and addiction had wrought on an oppressed population living under colonial rule. They were visionaries, but their insights and understanding were lost. Only later would the mainstream scientific community and American society come to similar realizations about the value of peer support in addiction recovery.

Alcoholics Anonymous, founded in the 1930s, offered a glimmer of hope for some addicts, but it was unknown to most people, not widely accepted by medicine, and viewed by many as "religious."

In 1956, Phase Two, the "normal science" stage of addiction treatment, began, and continued through the early 2000s. In this second phase, puzzles are solved within the context of the dominant paradigm. As noted above, doctors began to treat addiction as a *chronic* medical illness that required ongoing, possibly lifelong, monitoring. AA and other social support groups grew, and residential treatment programs emerged as resources to help stabilize addicts.

Murray Bowen and other family systems researchers and practitioners

deepened our understanding of the unconscious dynamics that maintain dysfunctional homeostasis in families across generations. Stephanie Brown and her colleagues used this knowledge to delineate these dynamics in families with addicted members.

Medical research expanded our understanding of the neurobiological underpinnings of addiction, giving us a more precise understanding of how the disease of addiction alters the brain.

In 2004, the U.S. government recognized that family-focused therapy was the exception rather than the rule, and that lack of coordination of treatment was a serious concern. The Substance Abuse and Mental Health Services Administration (SAMHSA) also noted that new models of family systems therapy were being adapted that showed promise in treating families with addicted members, including multidimensional family therapy (Center for Substance Abuse Treatment, 2004). You will find that elements of the 14 FRT Principles described in the next chapter appear in other treatment models (see Appendix B for a list of the 14 FRT Principles).

Addiction specialists began integrating findings from biological, psychological, social, and spiritual perspectives. **However, the addict-centered treatment most commonly practiced resulted in approximately 50 percent of addicts not remaining sober—a fairly major anomaly in treatment outcomes.** Clearly, there is a problem with the current addiction treatment paradigm, as addressed by Thomas Kuhn in his theories of scientific revolutions and paradigm shifts (1962). Kuhn recognized that progress in science often resulted from "anomalies" or facts that were difficult to explain within existing models and theories. As his model suggests, anomalies reveal weaknesses in the original paradigm resulting in the need for a break with the old ways of thinking and necessitating a new paradigm.

In the evolution of addiction treatment, cracks in the old paradigm began in 2008 when insurance began to cover addiction treatment, and much of addiction treatment morphed into a money-making business. The addiction treatment "industry" was born, and profit became a driving force. The Mental Health Parity and Addiction Equity Act of 2008 ruled that insurance reimbursement of addiction treatment be on a par with reimbursement for treatment of other mental and medical disorders (Centers for Medicare & Medicaid Services, n.d.). When insurance companies were suddenly mandated to pay for addiction treatment at levels similar to other medical conditions, new residential treatment centers, intensive outpatient programs, and sober houses sprang up across the country. My colleagues and I observed corporations buying up long established, stand-alone residential programs, resulting in slick marketing to lure vulnerable families to their facilities. We also observed unscrupulous companies going to great lengths to fill beds in order to profit from insurance money. Meanwhile, reputable treatment providers continued their work, and tried to stay afloat, despite severe competition. For a graphic illustration of the sad state of addiction treatment today, see the eye-opening 19-minute YouTube video by comedian John Oliver entitled *Rehab* (Oliver, 2018).

It is estimated that the addiction treatment industry was worth $42 billion in 2020, and with passage of the Affordable Care Act in 2010, "3 to 5 million new patients entered the system in need of substance abuse treatment, resulting in the opening of more treatment centers and 'sober homes,' many of which engaged in overbilling, patient brokering, and deceptive marketing" (LaRosa, 2020). And while some addiction treatment centers rake in large amounts of money for company executives and industry investors, approximately 90 percent of addicts in need of treatment still get no treatment at all (LaRosa, 2020), and the type of treatment an addict receives is far more dependent on chance, financial status, and profit-driven advertising campaigns than informed clinical judgment. Predictably, the 50 percent success rate of addiction treatment hasn't budged.

What has been lacking is an overall plan to address the national addiction crisis, a clear set of principles to establish best practices and minimum standards, and a willingness to aggressively take on a largely unregulated, multibillion-dollar addiction treatment industry that is fragmented and highly resistant to change.

Of course, there are thousands of well-trained professionals striving sincerely for better outcomes. I have visited many dozens of treatment centers across the country, and met with countless reputable clinical directors, addiction therapists, and interventionists. For the past 25 years, I have collaborated with scores of these professionals for the benefit of our mutual clients. Although my treatment model was unfamiliar to them, and I sometimes encountered initial resistance, when the FRT goals and priorities were understood, I received almost universal encouragement and support from colleagues.

The vast majority of them, however, did not invite me to teach my model to other clinicians, nor did they emulate it, despite greatly improved results for our clients. The addict in isolation, rather than the addictive/codependent system, almost always remains the focus of treatment; auxiliary codependency "workshops" and "family weekends" at addiction centers notwithstanding. I do not believe this is conscious resistance on the part of colleagues, but an inability to see beyond the current paradigm, to step outside their comfort zone and take in the larger picture. They are attached to the approach they and the addiction treatment industry have relied on in the past.

In Kuhn's Phase Four, a "scientific revolution" occurs. The old paradigm no longer works, and a paradigm shift ensues. As underlying assumptions are reexamined, and former anomalies are resolved, a new paradigm emerges.

I believe that addiction treatment is at this very threshold. It is time to integrate modern mental and medical health treatment with the long-established residential rehab movement. This book's bold premise is to establish a new paradigm, a new treatment model based on science, research, evidence, and best practices. The information is available, the facts are on the table. The current paradigm has failed *half* the addicts who enter treatment, and has largely ignored the beleaguered family members.

The new treatment model that I propose is based on the 14 FRT Principles presented in Chapter 2. I fully understand that in time, further evolution of science and

additional research and outcome studies will suggest a new model to replace FRT, but my experience using this model over the last 25 years points to one clear fact: it is better, by a long shot, at treating addiction than is the addict-focused approach. Instead of only 50 percent of addicts remaining sober, close to 100 percent of the addicts I have worked with from a family systems perspective, using the model described in this book, have maintained sobriety, and are well on their way to developing healthy lives.

This outcome applies, of course, to those who follow the simple, step-by-step treatment plan outlined in these pages. As Gabor Maté poignantly recounts, some addicts' attachment to their drug of choice runs so deep, and their traumatic wounding is so debilitating that they truly cannot imagine life without it (2008). (And, sadly, there are government institutions and legal systems in place that enable addicts to prolong their addiction—for instance, government agencies that give money to addicts who then use that money to purchase drugs.) However, when addicts and those who enable them follow this model, remission and sustained recovery can be achieved.

Here is what the Clinical Director of the Betty Ford Treatment Center replied when I asked him in 2010 about the treatment center's recovery rates: "Those who follow our discharge recommendations have a success rate of staying sober through the critical first year that approaches 100%, and those who do not follow our discharge recommendations have a success rate that approaches zero." I asked him, "What are those discharge recommendations that result in a 'nearly 100% success rate'?" He replied:

> We advise them, upon discharge, to transfer to a family-based intensive outpatient program, go to daily AA meetings—90 meetings in 90 days—and then keep going—and get a sponsor and work the Steps. And that the family members, the codependents, do the same in Al-Anon. And, depending on the circumstances, for the addict to move into a Sober Living Environment.

I further propose we put the addict and the addictive/codependent family system under the care of one mental health professional—instead of shunting the addict from an interventionist to a detox facility to a counselor at a rehab program, then to an IOP (Intensive Outpatient Program) with yet another counselor, and to an SLE (Sober Living Environment) managed by still another individual, while the family's issues are largely ignored (see Figure 1.8). I propose that this one professional case manage the addict and the addict's family in a wrap-around treatment program that extends from the first contact with the FRT therapist through at least the first year of the addict's sobriety. The FRT therapist is uniquely qualified to lead this nascent field into the next treatment paradigm. The clinician who is trained to think systemically and to understand the unconscious dynamics at play in both enabling and perpetuating the disease of addiction is the right person for this job (see Figure 1.9).

We need all of the adjunctive services—doctors, detox facilities, rehab programs, step-down programs, sober living facilities, support groups, etc. But, more

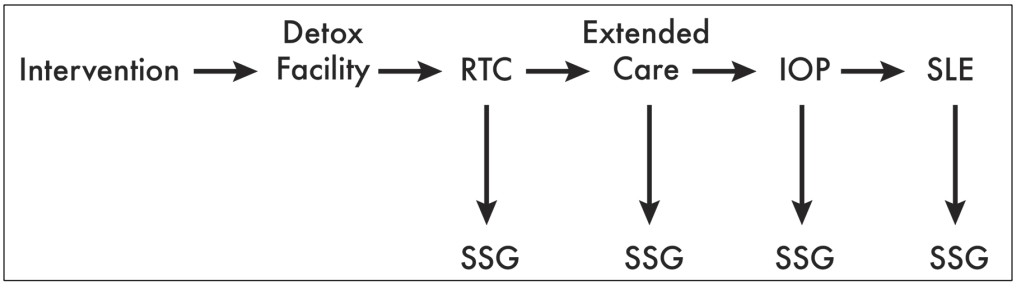

Figure 1.8 ***Current Paradigm of Addiction Treatment.*** **Addiction treatment focuses only on the addict. The addict is shunted from one provider to the next: Interventionist (2 hours to 2 days), Detox physician (3 to 7 days), Residential Treatment Program (RTC) counselor (30 days), Extended Care counselor (30 to 60 days), Intensive Outpatient Program (IOP) counselor (3 to 6 months), and Sober Living Environment (SLE) manager (3 to 6 months). In this model, the addict may attend Social Support Groups (SSG) in multiple locations, some of them far away from home.**

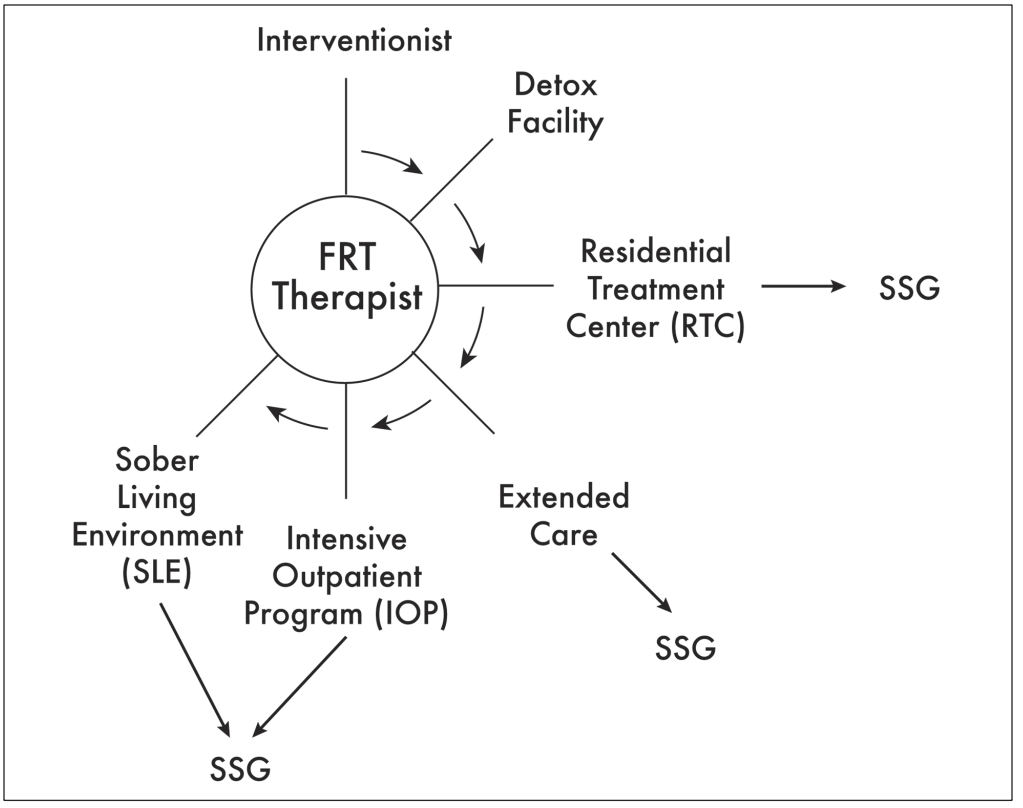

Figure 1.9 ***The FRT Treatment Model.*** **The FRT therapist is the licensed mental health professional who intervenes, beginning with the first phone call, and treats the family system, the addict, and the enabling codependents. The FRT therapist works hand in hand with all therapeutic resources and adjunctive services, coordinating treatment through the initial year of continuous sobriety. In this model, the addict and the codependents (not pictured) will attend social support groups near their home while they are in outpatient treatment. The addict may be living in a sober living environment during outpatient treatment.**

than anything, we need an addiction-trained, family-based mental health professional to treat the addict *and* the family, and to guide all aspects of the addiction treatment process, from the first phone call through at least the first year of continuous sobriety.

I have used this FRT model successfully with hundreds of family members over the last twenty-five years, and I describe the specifics of this model in detail in this book. It is my goal to train and enlist other therapists to step into this new, far more effective paradigm, with me. It is my hope that person may be you.

Given the ubiquity and profitability of residential rehab facilities, it is not surprising that I have encountered plenty of pushback when I have maintained that residential treatment is contraindicated in most circumstances. This is my reasoning:

- The real work for the addicted family system will happen at home, where the family members—the system—will recover together. (A common refrain often heard in treatment settings is: "You have to stand up where you fell down.") The recovery work occurs when the addict and the codependents regularly attend social support groups and attend therapy with an FRT therapist. The FRT therapist will guide them in addressing their issues, and coordinate their involvement in social support groups, as they mend the damage done, return to a trajectory of normal development, and begin creating a new future, one day at a time.
- Residential treatment programs are often seen as the "easier, softer way" for addicts. Most families are resistant to looking at the painful issues they have lived with and contributed to, and they want to avoid hard lifestyle changes themselves. "Hey, the problem is the addict, let's just send them away to be fixed." This is commonly known as "IP-ing"—labeling the addict as the "identified patient." This stance allows the codependents to stay in denial and avoid acknowledging their own issues, rather than seeking help for their role in supporting and enabling the unconscious homeostasis of their addictive/codependent family system.
- Many addicts come to see a residential treatment center as a "time-out" in a spa or retreat center, as merely an interlude between periods of addictive behavior.
- Many recovering addicts don't find residential treatment programs cost effective. Overheard at a social support group: "Shit, I could have saved 90K by just going to AA meetings."
- And, if the codependents refuse to "step up," a residential program may fail to keep the addict sober in the months after he or she leaves treatment and returns to the unchanged, enabling, codependent family and peer culture. We see addicts over and over again depleting their families' resources by attending a succession of costly rehabs.

I began my own recovery from alcoholism in 1979, entered graduate school in 1990, began my clinical work in a family-based adolescent outpatient program in

1992, and became a licensed therapist in 1996. Along the way, I have been guided by a number of mentors—all authors and experts in the addiction field—including the family systems-oriented addiction psychologist, Stephanie Brown, Ph.D.; the family systems addiction psychiatrist and addictionologist, Timmen Cermak, M.D.; Brad Reedy, Ph.D., director of a family-based wilderness treatment program; and addictionologist, Kevin McCauley, M.D. These individuals have guided my work during, and since, the time when I founded and directed two family-based outpatient addiction treatment programs—one for teens and one for adults. I've made many mistakes on the road to learning about effective addiction treatment, and figured out along the way what works and what doesn't.

Based on what I have learned during the last two and a half decades, I have developed a program that has produced a nearly 100 percent success rate for those who have followed the guidelines that I established—the same guidelines that I'm proposing in this book. And, like anyone working in this field, I have met many families who, for various reasons, were resistant to take on the serious work needed to change.

As I mentioned, when I have described my treatment model to other addiction treatment providers, they have been interested and receptive, but have expressed little desire to consider adopting it. It was as if they had the elephant's tail in their hands and were happily calling it a rope and were unaware of, or uninterested in, a larger perspective. They were unaware that their paradigm, "normal science" to them, was in crisis. And, if they were aware of the crisis, they did not have any suggestions for what to do to achieve more successful outcomes, so they chose to deny the anomalies they couldn't resolve.

I've come to understand that these treatment providers, doctors, interventionists, and others were, just like addicted families, caught in a systemic homeostasis. Like the treatment field in general, they adhere to an addict-centered approach which has long been the model in addiction treatment. They were simply doing things "the way they have always been done," thinking that tweaks here and there were enough to improve their programs. Meanwhile, half of their patients relapse, return to their addiction, and far too often, die.

Their treatment and interventions were successful—but only in half the cases! All of us feel good when just *one* addict under our guidance does the work to achieve and maintain remission—to return to normal development and create a happy and fulfilling life. We know that there are no guarantees when it comes to recovery for the addict or the codependent. And as a result of the tireless work of all of us in the addiction treatment field, there are many millions of addicts who have put their disease into remission and who have returned to healthy lives.

What about the others? What about the families and children who are still suffering, who are still in the throes of addiction and codependency, the addicts who perhaps have been to multiple treatment programs, but who are still in their disease? Maybe they do not even know they have this brain disorder, and maybe they don't

know their families are part of the problem, because we providers have failed to ask the right questions, have failed to include the enablers, have failed to educate medical doctors, and have failed to follow a comprehensive, long-term approach.

In the next chapter, I will outline the 14 Principles of Family Recovery Therapy. I believe that clinicians who apply these principles and use the treatment guidelines described in this book will achieve much higher rates of success—families that become healthier and happier, codependents who heal and grow, and addicts who sustain remission and live fulfilling lives.

In order to do this work, you will need to modify your approach to treating addiction. Or, if you are new to the field, you will need to adopt an approach that is different from the current addict-focused, multiple-provider model you were doubtless trained in. You will need to collaborate closely with the members of your team—the other professionals working with a particular family. You will need to join the team, take the helm, and coordinate with your oarsmen to row together.

More than anything, we need addiction-trained, family systems-based mental health professionals who will treat the family system, the addict *and* the enabling codependents, and who will guide the treatment, from day one. The right person for this job is a therapist/clinician who is trained to think systemically and to understand the unconscious dynamics at play both in the enabling system's support and in its perpetuation of the container in which the addict lives. Just as an air traffic controller saves lives by directing pilots to follow flight paths, and the primary care physician interacts with specialists, addicts and their families are best served when treatment is carefully coordinated.

As the FRT therapist guiding treatment, once you have stepped into the role of team leader, you will oversee the continuum of care for the family members, beginning with the first call from the family through at least the first year of continuous sobriety. I invite you, as someone interested in improving outcomes in your treatment of addiction, to read on, and consider what we tell the newcomer, the addict in early recovery: "Trust the process."

Three key points:

First, throughout this book, I primarily write about substance addiction, but this model can be applied to addiction of any kind—to any condition that meets the criteria for addiction: craving, loss of control, adverse consequences, and chronicity. Compulsive behaviors related to food, gambling, sex, spending, and other repetitive, self-harming behaviors that can be categorized as addictions also benefit from the kind of treatment that I describe in this book. This model can also be applied to new kinds of addiction that have developed with the increased use—and misuse—of technology. The 2013 *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (American Psychiatric Association), described Internet Gaming Disorder as a "condition for further study." And on June 18, 2018, the World Health Organization announced that the forthcoming *International Statistical Classification of Diseases and Related Health Problems* (ICD) would include "Gaming Disorder" as a new

category. Gamers that meet the criteria for addiction, and other addictive or compulsive users of technology, respond well to treatment with this model.

Second, I talk throughout this book about the "family system." The reality is that each of us lives in a complex web of interpersonal relationships, which also comprise systems. An FRT therapist needs to consider the various important influences on an individual when assessing a family and developing a treatment plan. The "system" surrounding an addict can include work, legal, peer, and other social networks with which they are involved. Comprehensive treatment must include coordination with a variety of entities or communities that may play a role in enabling the addiction.

And third, as therapists, we are not immune to becoming enabling codependents who let our own "stuff" blind us to the reality of the unconscious dynamics at play in working with an addicted family. Murray Bowen is reputed to have said, "After four sessions, we are inducted into a family's system." We addiction therapists need to continue to get consultation, lest we fall prey to the seductive influences of the family members who are caught in a dilemma—they "want to recover," but they are also powerfully affected by their unconscious drive to maintain the previously existing systemic homeostasis, and will predictably tend to resist aspects of recovery. FRT therapists, grounded in the dynamics of addiction and codependency and alert to the potential for induction into addictive family systems, must rely on outside consultation to preserve as much objectivity as possible.