The Power of Powerless: Helping to Coach Youth and Families through a Life of Recovery

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Abstract

The purpose of the webinar is to create awareness around the need for continued support for families, and specifically parents, who have an adolescent or young adult suffering from the disease of addiction. The current acute care model functions to stabilize the addict and provide some form of psychoeducation for parents who have the time and resources to attend the family programs held at the center where their young person is receiving treatment. However, parents are then left on their own as they attempt to implement the concepts and skills highlighted in the family program. In the absence of a broader continuum of care for families and parents in recovery, professionals at all levels of care need to have the ability to empower and encourage parents and families to implement effective recovery skills and create lasting change within the individual and the family system.
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The Power of Powerlessness: Helping to Coach Youth and Families through a Life of Recovery

Adolescents’ misuse of alcohol and other drugs is recognized as one of the top public health problems in the United States (Dow & Kelly, 2013). For adolescents who meet the diagnostic criteria for a substance use disorder and receive some type of formal treatment service, relapse is common (Ramo & Brown, 2008). Adolescents who continue to use following treatment are at risk of returning to pre-treatment levels within 6 to 12 months (Burleson, Kaminer, & Burke 2012). There have been recent efforts to expand the continuum of care and improve treatment outcomes for youth struggling with addiction. However, outcome improvements have been modest at best (Kelly & White, 2010).

Groshkova, Best and White (2013) state that recovery is becoming the new organizing paradigm for policy and clinical treatment in both the United Kingdom and the United States. The authors report that this shift will go beyond reducing the harm caused by substance misuse and begin to offer every support for people to choose recovery as an achievable way out of dependence. The focus includes the concept of recovery capital which is defined as the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery. Addiction is a family disease. When a member of a family is struggling with the disease of addiction the entire family struggles. Addiction impacts the family system and stresses the family’s mental health, physical health, finances, unity and overall group dynamic. As professionals and policy makers begin to clearly define successful recovery strategies, the recovery paradigm needs to expand to include the resources available not just to individuals in recovery, but families in recovery as well.

Current treatment models focus on stabilizing the family member in active addiction. Chemical dependency treatment centers typically offer some type of family program for family
members of clients participating in treatment. These vary in length and content depending on the site and philosophy of the treatment center. Many offer an educational component and an opportunity to participate in a facilitated family conference. However, outside of peer support groups or individual and family therapy, families have few opportunities to step down their level of care from their initial participation in a family program (Sparks, Tisch, & Gardner, 2013).

While it is a well-known fact that addiction impacts the entire family system, most treatment models fall short of supporting the family as all individuals within it move into recovery. Therefore, professionals working with families in recovery need to utilize the time they have access to family members in an efficient and effective manner to increase the family’s likelihood of success in long term recovery. Treatment models need to expand to include a broader continuum of care, not only for individuals in early recovery, but families in early recovery as well.

**The Mirror Effect**

According to the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (2013) the eleven criteria for Substance Use Disorder are as follows:

1. Taking the substance in larger amounts or for longer than the you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts the you in danger
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance

10. Needing more of the substance to get the effect you want (tolerance)

11. Development of withdrawal symptoms, which can be relieved by taking more of the substance. (p. 490)

Two or three symptoms indicate a mild substance use disorder, four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder.

Professionals in the addiction field often state that addiction is a family disease. While this can mean a multitude of things, for the purpose of this project I will focus on how the parent’s behavior often mirrors their young addict’s behavior. During the family program at Hazelden Plymouth, a site licensed to serve youth ages 12-24, one of the exercises staff facilitate with parents and clients is to list the diagnostic criteria for addiction and ask those in the room to raise their hands if they meet the criteria for 1, 2, 3 items, etc. Staff asks the parents to think of their drug of choice as their child. When we do this we see that parents:

1. Progressively obsess about their child’s dysfunctional behavior/addiction

2. Want to reduce the amount of time they spend managing their child’s behavior but can’t seem to

3. Spend a lot of time helping, micromanaging, or recovering from their child’s behavior

4. Have cravings and urges to “use” or fix the situation

5. Are not managing to do what they should at work, home or school, because of their child’s addiction

6. Continue to do this, even when it causes problems in relationships
7. Give up important social, occupational or recreational activities because of their child’s addiction

8. Enable/punish again and again, even when it puts them in danger

9. Continue to “use”, even when they know this behavior is impacting their physical, emotional and mental health

10. Tolerate progressively dysfunctional behavior

11. Develop withdrawal symptoms, or feel the need to constantly be with or check in on their child when they are away (Hazelden Betty Ford Foundation, 2013)

As this brief exercise demonstrates, family members and parents have adapted to the pathology of addiction and have entered their own active addiction around their child’s behavior. Most professionals are able to see this as evidenced by the dysfunction present in many families when their young adult enters treatment. However, as stated earlier, minimal support is provided for family members attempting to engage in their own recovery process, regardless of the fact that they meet the diagnostic criteria for a severe “use” disorder.

Blumberg (2005) states that a major factor affecting chemically dependent adolescents is conflict with parents. This conflict increases as the adolescent’s chemical dependency progresses. Blumberg goes on to state that as the young person becomes progressively out of control their parents mirror this loss of control by becoming less effective at parenting and often losing control themselves.

In Blumberg’s (2005) stage model of recovery for chemically dependent adolescents, he poses that for adolescents in the contemplation phase of recovery observing the impact their addiction has had on their families, and particularly their parents, is often the major factor necessary to move the young person forward in recovery. In his 2005 study he found that
parents who encourage their adolescent assist in their progress through recovery as do parents who are working their own recovery program through organizations such as Al-Anon or Families Anonymous. Conversely, parent’s denial of their child’s chemical abuse or addiction is the most effective hindrance to an adolescent’s progress through recovery.

As stated previously, parents and loved ones often enter their own cycle of addictive behavior. Without adequate support and encouragement for their own recovery, many parents are at risk of relapsing into their previously dysfunctional patterns of behavior. As Blumberg (2005) highlights, the adolescent’s family, and particularly their parents, influence a young person’s recovery either positively through encouragement and role modeling of the recovery process or negatively through continued denial of their adolescent’s addiction. Otherwise stated, support for the family has a positive impact on the recovery process of young addicts.

**Self-Efficacy and Motivation as Predictors of Long-Term Recovery**

Ilgen, McKellar, and Tiet (2005) state that “theoretical models of relapse and stages of change for substance use disorders highlight the important role of self-efficacy in influencing the decision to decrease substance use and in maintaining gains following substance use disorder treatment” (p. 1175). In a study analyzing abstinence for patients one year following treatment for a substance use disorder, they found for patients treated in residential substance use disorder treatment, full confidence in abstinence at discharge was the strongest predictor of abstinence at 1 year. This held true above and beyond all other predictors of long-term abstinence including other measures of self-efficacy, baseline measures of alcohol and substance use, and other socioeconomic factors.

Kelly and Greene (2014) state that “it has been argued that among the types of thoughts that affect human behavior none is more significant or pervasive than people’s judgments of their
capabilities to cope effectively with different realities” (p. 928). The authors go on to highlight self-efficacy as the most consistent predictor of abstinence and substance use relapse. In their recent study, Kelly & Greene sought to improve their understanding of self-efficacy by considering an individual’s motivation to perform the skills needed to sustain long-term recovery.

Their findings were consistent with prior research and suggested that both self-efficacy and motivation were strong predictors of substance use. However, their findings also highlighted the strong interplay among these variables as they pertain to behavioral change, in this case the percentage of days abstinent post residential treatment. For participants who reported high levels of self-efficacy, motivation made a significant but not large difference in their outcome over time, with lower motivation reducing the percentage of days abstinent despite the individual’s high confidence.

For participants who reported low levels of self-efficacy, motivation made a significantly positive impact that appeared to completely compensate for the individual’s perceived lower confidence. The authors state that highly motivated patients may be able to maintain high levels of abstinence despite the individual’s disbelief in their ability to do so. The authors conclude that despite low confidence in one’s ability to achieve an outcome, it may nevertheless still be attempted and achieved by mobilizing strong intrinsic motivational drives (Kelly & Greene 2014).

Professionals working to support individuals and families in early recovery can integrate these findings into the framework they use to engage their participants in the recovery process. Similar to the participants in the previous study, parents and family members leave residential treatment center family programs with varying degrees of self-efficacy and motivation to make
the changes needed to support their individual recovery process and increase the health and well-being of the family system as a whole, thereby influencing the recovery process of their adolescent or young adult.

Recovery coaches working with individuals and their family members in early recovery, often see one of two scenarios play out as parents attempt to implement the skills and embody the concepts of recovery. The first involves a parent who is highly motivated to change but is completely overwhelmed by the enormity of the task at hand and lacks the confidence to choose a starting point and move forward. The parent returns home motivated to change only to find themselves paralyzed by the complexity of the situation. These parents often become discouraged and retreat into the comfort of their old behavior patterns.

The second scenario involves a parent who is both highly motivated and highly confident in their ability to implement the skills and concepts of recovery into their family life. However, as they begin to do so they find that the desired outcomes of their behavior are not as forthcoming as they had originally assumed. They begin to realize that not all members of the family system are adhering to the rate of change they are attempting to implement. The lack of immediate progress, relapse, or the realization that the process of change is difficult and ongoing overwhelms them and they too become discouraged as their motivation and confidence decrease.

Brown uses the phrase “trauma of recovery” to highlight the difficult phase families face when entering early recovery. The author explains that most people expect that when an individual stops using, everything will be fine. However, what research shows is that it is not. She reports that new problems arise with recovery and these are totally unexpected because no one knows what to expect with abstinence. The family system in active addiction achieves homeostasis by adapting to the pathology of addiction. However, when a family enters recovery
the mechanisms used to maintain the status quo no longer work. New skills and processes have yet to be developed to support healthy functioning and relationships. Brown states that this leaves a family in early recovery without the structure to support and nurture the family members or family as a whole. The author concludes that this is clearly a time when the family needs much greater external support to help sustain them in their new recovery process (Brown & Lewis 1999).

An Adlerian View of Addiction: The Neurotic and Pampered Lifestyle

Several of the characteristics of what Adler described as the neurotic and the pampered lifestyles are synonymous with the most common characteristics of addiction, namely a tendency to blame external factors for perceived failures, isolation or lack of social interest, and the demand of instant gratification.

Ansbacher and Ansbacher (1956) report that Adler theorized neurotic symptoms develop to safeguard an individual’s self-esteem. In theory, the individual will create a distraction or sideshow in their life in an attempt to excuse themselves from performing effectively in the main areas of one’s life. Adler described the main tasks of life to include: work/occupation, love, and friendship/society. Adler’s life tasks were later expanded to include self-development and spiritual development (Mosak & Dreikurs, 2000). As the neurotic strives to defend their perceived inferiority they become symptomatic and use this as a defense mechanism against insecurity.

Steffenhagen (1974) collaborated with Ansbacher to author a paper titled, drug abuse and related phenomena: an Adlerian approach. Steffenhagen proposes that the addict or neurotic safeguards his self-esteem by blaming an outside agent. The author suggests that the addict protects their self-esteem by blaming their poor interpersonal, social or school performance on
the drugs. Steffenhagen states, “Thus the neurotic drug abuser gains freedom from responsibility, a general neurotic goal” (p. 241).

Steffenhagen (1974) highlights the addict’s tendency to isolate and withdraw from society. As drug abuse progresses, addicts social interest decreases and they tend to isolate. Their decrease in social interest and increased isolation typically leads to increased use. Many addicts will attempt to compensate for their lack of social interest and connection by using greater amounts of substances more often. They often use in isolation and their primary relationship is with their drug of choice.

In regards to the pampered lifestyle, Steffenhagen (1974) references what Maslow referred to as “a gratification-produced pathology.” Maslow describes the phenomenon that with increased affluence, “pampered children” tend to depreciate their blessings and make increasingly unreasonable demands. Maslow states, “The demand is for Nirvana now!” (as cited in Steffenhagen, 1974, p. 242).

Parents of adolescents and young adults struggling with addiction mirror the common characteristics of the disease and the neurotic and pampered lifestyle. As their functioning progressively decreases in each area of their daily tasks of life, parents commonly reference the sideshow of their child’s addiction. The unnecessary expenditure of energy toward a goal that is unobtainable decreases the individual’s movement toward what Adler called the universal goal to belong and to feel safe and secure.

Parents will withdraw from society and isolate for various reasons. Many report feeling ashamed, embarrassed and misunderstood. As they become more focused on their drug of choice, their child’s addiction, they are unable, or unwilling, to engage with friends and family members in other areas. As a result, they withdraw and “use” in isolation.
Parents also often mirror the addict’s demand for instant gratification. Many parents hope and choose to believe that if they are able to place their young child in treatment they will be “cured.” Many also struggle with shallow attempts at new behaviors. Parents become quickly discouraged when the skills they are attempting to implement fail to immediately produce their desired outcome. As a result they become discouraged and revert to their previous attempts to control their child’s behavior.

**Adlerian Theory of Encouragement and Recovery Coaching**

Encouragement is one of the essential constructs of Adlerian Psychology (Carns & Carns 1998). Adlerian theory considers encouragement as a crucial aspect of human growth and development (Watts & Pietrzak 2000). The psychological principles and the education focused, strength based approach of Adlerian theory make it a well suited approach for prevention and intervention on substance abuse issues (Dinkmeyer, 1990). Adlerian theorists perceive many presenting problems as based on discouragement and the process of psychotherapy as a process of encouragement. The practitioner works in a collaborative effort with the client to restore faith in him or herself and thereby allow for the possibility of doing or functioning better. Watts and Pietrazak (2000) define encouragement skills as demonstrating concern for clients through active listening and empathy; communicating respect for and confidence in clients; focusing on clients’ strengths, assets and resources; helping clients generate perceptual alternatives for discouraging beliefs; focusing on efforts and progress and helping clients to see the humor in life experience. In regards to Adlerian theory, Dinter (2000) states that a state of discouragement is reached when an individual cannot conceive that making realistic efforts will improve the situation at hand. The author states that discouragement leads to a lack of courage in approaching life tasks.
A fundamental piece of recovery and finding the power in powerlessness is encouraging the young addict and their family members to turn their focus and energy back to the tasks of life. Coaches working with parents of young addicts continually turn their participant’s attention back to that which they can control, namely their own movement within the tasks of life. The Hazelden Betty Ford Foundation refers to this as the Whole Person Model. The Whole Person Model highlights six main areas of functions: physical, family and friends, feelings and moods, thinking and reasoning, work or school, and spiritual. Coaches and participants collaborate weekly to simplify the participant’s perception of their life tasks thereby reducing their tendency to feel overwhelmed and inferior and avoid the tasks at hand. Coaches assist participants in creating observable action steps toward their goals while simultaneously acknowledging and encouraging their efforts, accomplishments and strengths. As a result, participant’s faith in themselves, self-efficacy and motivation increase while their tendencies to blame external factors isolate and demand instant gratification or relief decrease.

**Connection**

Connection, a post-treatment support and accountability program implemented by the Hazelden Betty Ford Foundation in 2011, expands the continuum of care for both individuals and families in recovery. The program emphasizes recovery coaching, as well as monitoring, verification reports and drug testing, for 18 months post treatment. In addition to supporting the individual in early recovery, support is provided to loved ones through individual coaching calls at least once a week for the first 6 months. As the program progresses and participants gain confidence in their ability to implement the recovery skills and concepts taught in treatment or family programs and practiced in early recovery, participants reduce their calls to every other
week for the following six months and eventually once a month in the final 6 months. The goal is self-managed recovery for the entire family.

As mentioned previously, professional recovery coaches work with individuals and their family members to simplify the recovery process through the creation of weekly and ongoing goals. Coaches and participants work collaboratively to pinpoint areas of weakness and to build on participant’s strengths. Coaches assist participants and their family members in moving from concept to practice by creating functional, observable, action-oriented steps to achieve the desired goal.

The Butler Center for Research has analyzed data for participants who utilized the program between 2011 and 2014. Since the program launched in April of 2011, 452 individuals have been admitted. The data suggests that for participants completing the first 10 months of the program, 69.7% reports continuous abstinence. If relapse was reported, it most likely occurred within the first 3 months of participation. At each interview period participant’s overall recovery was rated on a scale of 1 (excellent) to 5 (poor). The majority of participants rated their recovery as positive, excellent, very good or good (Hazelden Betty Ford Foundation, 2015).

Connection, and programs like it, are attempting to fill the vacuum and support families through the trauma of early recovery. The program is designed to provide support and accountability through the first 18 months of early recovery. Professional recovery coaches assist family members as they develop new skills and processes to support healthy functioning and relationships. Family members’ self-efficacy and motivation may fluctuate as they attempt to implement common recovery concepts and skills. The recovery coach’s roll is to provide a mirror of the individual’s movement and encourage them to focus their efforts toward useful goals.
Striving for Success in Long Term Recovery

Powerlessness and detaching with love are common themes discussed in family programs. They can appear to be lofty and abstract concepts to parents who are struggling to keep their child alive and relatively on track to a successful life as they have defined it. Most families attending family programs are in crisis. Most parents seeking support for their child’s addiction suffer from the symptoms of chronic stress including but not limited to headache, fatigue, sleep problems, anxiety, restlessness, lack of focus/concentration, irritability, and depression (Miller, Chen, & Zhou, 2007). It is in this state that mental health professionals provide the bulk of information and support to families in recovery. Following their participation in a family program many return home to make an attempt at self-managed recovery. Family programs are designed to provide psychoeducational interventions for families. They successfully provide an abundance of information to parents and other family members attempting to heal from addiction. However, once the family member leaves the relative safety of the treatment center and returns home, parents often find themselves at a loss for how to understand and implement the concepts discussed in the family program in a functional, practical way. Coaching parents to embody the concepts of recovery provides them with the foundation to create lasting change.

Powerlessness: Moving from Concept to Practice

The admission of powerlessness makes many people feel uncomfortable. As individuals, we want to believe we have full control over our life. As parents and loved ones of addicts, we want to believe that our actions can control the fate of our loved one’s addiction. Many people equate powerlessness with a total and utter loss of control. Many parents panic at the realization that all their attempts, both subtle and wildly over the top, have failed to “cure” their child’s
addiction. Many addicts feel great shame that they are unable to simply stop using. Like it or not, the reality is we are all powerless to control the outcome of any given situation. The energy we direct toward attempting to do so is wasted. Picture an individual sitting in their car which is knee deep in mud and they have the gas pedal slammed to the ground. They are burning through resources, in this case fuel, but their tires are spinning wildly in the mud and they are going nowhere.

However, the paradox of admitting powerlessness over something or someone other than yourself is that it allows you to take control back in regards to your own life (Matheson & McCollum, 2008). Total control and complete freedom lie at the extremes on the spectrum of powerlessness. Somewhere balanced in the middle is an important concept to consider when navigating a life in recovery. That concept is influence. Coaching parents to understand the differences between control and influence is the first step toward family recovery. We are capable of influencing movement in the life of another with our own movement. As we become aware of what we cannot control we also become aware of that which we can control. Once we move through the shock and fear of feeling powerless and the euphoria of being responsibility free, we find ourselves in a very powerful place.

**Creating influence.** By admitting we are powerless over someone or something, we turn the center of our control back to ourselves. We actually place ourselves in the power seat. Recovery coaches attempt to communicate and demonstrate the observable skills of admitting powerlessness by encouraging parents to see the concept in other situations that are not as emotionally charged as their child’s addiction. To illustrate this coaches use examples that are less emotionally charged for parents in recovery. When we incorporate examples or stories that parents see as outside of themselves or their situation their common sense kicks in. If coaches
continually use emotionally charged examples parents get hung up in their own private logic, misinterpretations or mistaken beliefs.

Coaches encourage parents to think about how many times they have tried to change another person in any given situation: How many of you have ever looked at your tantruming child and screamed, “Stop screaming! Stop throwing a fit!” How did that end for you? Did your child calm down or did their behavior escalate even more? By focusing one’s energy on attempting to control their child’s behavior parents typically lose control themselves. They become frustrated, angry and it’s not long before they have joined their child in a full blown tantrum. They have given their power away to a person or thing outside of their control. If one is able to see their tantruming child and admit that they are powerless over his/her behavior and their life is quickly becoming unmanageable, they turn their focus to their internal seat of power. In that moment they can control their emotional response, the sound of their voice, breathing, physical location, body, etc. How one decides to control and utilize that which they can control will influence their child’s behavior. A parent’s choices won’t guarantee the child will stop screaming, but it will guarantee that the parent won’t start.

As mentioned previously, addiction is perceived as a family disease. When a child within a family system is carrying the burden of addiction, each member of the family will somehow begin to carry the weight of that burden as well. Their behaviors and movement influences changes within the entire family. As the weight of the burden of addiction causes the family system to shift from its “normal” state, parents will attempt to rebalance the system by enabling their addicted young person or micromanaging their behaviors. Siblings take on a variety of new roles in an attempt to establish balance within the family system. Many siblings will act as a parent themselves and take responsibility for the young addict’s behaviors. Others will attempt
to become the “perfect” child. Some siblings describe themselves as ghosts because they have become silent and unseen members of their families. As each member shoulders the burden of addiction the family system rebalances. However, it is balanced through dysfunctional and unhealthy behaviors.

When a member of the family system chooses recovery, whether it’s the addict or another family member, the family system will shift again. The movement of one member of the family, to some degree, influences the balance within the entire family system.

Brown (2012), in the book *Daring Greatly*, writes about what the author calls wholehearted parenting. Brown states that many of us believe that once we have children our journey ends and their journey begins. We sacrifice our goals and dreams for the goals and dreams of our children, or what we think are or should be the goals and dreams of our children. However, she challenges the reader to consider that one of the best gifts you can give your child is to be the type of adult you hope they become. The author suggests we invite our children to join us in our journey. We influence the values and movement of our children the most by who we are as people. Our children are on their own journey and we do not serve them by ending ours. Modeling good behavior, self-care, work life balance, healthy eating habits and healthy relationships in no way guarantees your child will grow into an adult who succeeds in those areas. However, modeling those behaviors is your best chance at influencing how much they value those things.

**Detachment.** Al-Anon (2007) is a mutual-help group for friends, family members and loved ones of addicts and alcoholics. The organization pioneered the idea of detachment with love. A core principle of Al-Anon is that alcoholics cannot learn from their mistakes if they do not experience the natural and logical consequences of their behavior. Detachment with love has
historically been a call for family members to stop enabling the addict’s dysfunctional and unhealthy behavior. Many people misunderstand detachment with love as a way to scare or force an addict into changing. However, detachment with love means caring enough about others to allow them to learn from their mistakes. It also means being responsible for our own welfare and making decisions without ulterior motives or the desire to control others.

For parents of adolescent addicts and alcoholics, detaching with love presents additional challenges. Most parents are biologically programmed to protect their children. In this sense we are asking parents to overcome a well engrained, biological reaction. Prior to detaching from their young loved one’s behavior and the resulting consequences, most parents needs to detach from the defined outcome they had envisioned for their child. Letting go of control and embracing influence involves detaching from a defined path and outcome. Life is not linear. There are many paths to get there from here. Recovery coaches can encourage parents to look at the desire behind the outcome they have attached to their child. Many parents come through our family programs grieving the dream of their child graduating from college in four years and landing the perfect job right after graduation. Coaches can challenge parents to look at the basic desire that is the foundation of the defined outcome they have described. Ultimately parents want their child to feel successful. There are many paths to success and success looks many different ways.

Parents attachment to specific paths and outcomes perseverate their tendencies to enable and protect their child. They work diligently to keep their young addict on track. Parents often find themselves working harder at their child’s life than their child. Parent must detach from and grieve their well laid plans for their children. Al-Anon’s Twelve Steps & Twelve Traditions (2007) describes the benefits of this emotional detachment. They include the reduction of
destructive emotions such as guilt, fear, self-pity and resentment and an increase in positive, relaxed states. The book states, “Freed from the obsession with another person, we could focus our attention on ourselves…some order came out of chaos. It became easier and easier to accept the idea we could take charge of ourselves. Each time we detached we moved forward” (Al-Anon, 2007, p. 9).

Recovery coaches can encourage parents and family members to find choice in any given situation. Detaching from an expectation of a person’s behavior or a defined outcome allows parents the flexibility to choose how they will respond within the situation. Detachment with love helps parents to respond as opposed to emotionally react to their loved one’s behavior. Detachment fosters a connection that allows parents to love their child without liking their behavior. In order to maintain this connection, parents and family members must learn to communicate about and value each other’s subjective experiences.

**Communicating subjective reality.** Adler theorized that humans construct their reality according to the way they individually look at the world. In The Individual Psychology of Alfred Adler, Ansbacher and Ansbacher state, “I am convinced that a person’s behavior springs from his opinion. We should not be surprised by this because our senses do not receive actual facts, but merely a subjective image of them, a reflection of the external world” (1956, p. 182).

Recovery coaches can encourage parents to focus on communicating their subjective experience. At Hazelden Plymouth, parents and clients are coached in assertive communication skills. Using the formulas below, family members are encouraged to describe their experience of an event or situation:

I feel…

When you…
Because…
Or the following:
I see…
I feel…
I hope and expect…
I will/will not… (Hazelden Betty Ford Foundation, 2014)

Parents are encouraged to become curious about their child’s subjective experience and reminded not to make assumptions. As stated previously, it is possible to love someone without liking their behavior. It is also possible to validate a person’s subjective experience without agreeing with it. Parents are coached to validate their child’s emotion without condoning inappropriate responses. Communicating and asking about a person’s subjective reality encourages compassion in the relationship and fosters connection even in the presence of differing opinions.

**Conclusion**

As mentioned previously, parents are often left on their own as they attempt to implement the concepts and skills highlighted in chemical dependency treatment family programs. The acute model of care fails to support families in recovery. Treatment models need to expand to include a broader continuum of care, not only for individuals in early recovery, but families in early recovery as well. Programs providing coaching services to families and individuals in early recovery have significant impact on an individual’s self-efficacy and motivation to remain in recovery.

People in recovery and family members recovering from a loved one’s addiction benefit from the strength-based, purposeful and individual psychology of Adlerian theory. By encouraging family members to create simple, functional and useful goals in their daily lives,
recovery coaches create movement toward the universal goal to belong and to feel secure and safe. Recovery coaches encourage participants to simplify the process of recovering by redirecting their attention to the tasks of life. As participants begin to successfully navigate the basic tasks of life they gain confidence and their motivation to sustain long-term recovery increases.

In the absence of programing developed to support families in early recovery, professionals engaging with families at varying levels of care for chemical dependency treatment need to utilize the time spent with them to encourage a practical knowledge of common treatment concepts. Professionals can do this by encouraging parents and family members to find their own power by identifying their choice in any given situation, detaching from a defined outcome and focusing on their individual journey and communicating their subjective experience while validating the subjective experience of their loved one.
References


