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Does family therapy help reduce relapse rates in people with opiate addiction?

Lynn Gillian

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**DOES FAMILY THERAPY HELP REDUCE
RELAPSE RATES
IN PEOPLE WITH OPIATE ADDICTION?**

A THESIS PRESENTED IN
PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF
MASTERS OF ARTS IN CLINICAL PSYCHOLOGY

BY

LYNN GILLIAN

DECEMBER 2015

THE DEPARTMENT OF PSYCHOLOGY
COLLECT OF ARTS AND SCIENCES
CARDINAL STRITCH UNIVERSITY
MILWAUKEE, WI

REPORT ON THESIS AND ORAL EXAMINATION

Name of Student Lynn Gillian

Title of Thesis Does Family Therapy Help Reduce Relapse Rates in
People With Opiate Addiction?

Report on Thesis and Oral Examination

Excellent/With Distinction _____

Good _____

Acceptable x

Unacceptable/Failure _____

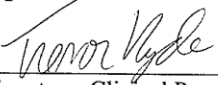
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VITA

The author was born in Menomonee Falls, Wisconsin on March 17, 1971. She received her Bachelor of Science Degree at Marian University in 2003. She also has a background in business and technology. The author served on the Drug Endangered Children Program and AODA Task Force in Washington County. She earned her Clinical Substance Abuse Counseling Certification earlier this year.

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ABSTRACT

This study explored the relationship between relapse rates in opiate users and the involvement of family therapy. The researcher studied twenty-seven adults involved in outpatient substance abuse treatment for opioid use disorder at Ozaukee County Counseling Center. All participants completed an initial questionnaire and two follow up questionnaires over a two month period. All participants also completed the AWARE questionnaire three times. The AWARE questionnaire measures potential relapse rates. Participants were divided into two groups. Family programming was offered to one group but not the other. The researcher hypothesized that participants who had family involvement had lower relapse rates. The researcher found there was a significant difference between the two groups; however it was significant before the family programming was implemented. The reason was likely to be due to the groups not being randomly assigned. They were arbitrarily assigned. Other reasons could be due to blinding and demand characteristics. In this study, family therapy did not affect relapse rates.

INTRODUCTION

Nearly two and a half million people in the United States suffer from opiate substance abuse disorders related to prescription opiate pain killers and heroin in 2012. The number of unintentional overdoses in the United States has more than quadrupled since 1999 (Valkow, 2014). In Wisconsin, the number of heroin crime lab cases has nearly tripled in the last four years. Ozaukee County has followed this same pattern (Wisconsin Department of Justice, n.d.). This study examines if including family therapy in an outpatient opiate treatment program will decrease relapse rates. Many studies have shown family therapy reduces relapse rates and longer retention in treatment.

Several studies have shown various benefits when families are included in family therapy related to their loved one's treatment for opiate addiction. Substance dependence can often lead to hostility, conflict, anger, frustration, and sometimes distance in families because family members are not sure how to handle their loved one's addiction. They try desperately to maintain the family's homeostasis (Bokos, 1985). At some point the family may move from desperation to despair and may "give up" on the addicted individual. The family dynamic changes when someone in the family is using alcohol or drugs and the family norms, rules, and expectations become disrupted. Improving family functioning may help a family cope with their loved one's addiction and help the addict remain abstinent.

One study followed eight families (Kosten et. al, 1986). They implemented 16 sessions of family therapy. The addicted person engaged in a naltrexone program for 6 months. They compared the families before their family therapy and after. Results showed improvement in the family's problem solving, family structure, and individual autonomy. Autonomy was evaluated by assessing by the addict's self-concept, responsibility, and evasiveness and openness to feedback items. One limitation in this study is the amount of families studied was only 8. They

went through two 30 minute video taped sessions using the Beavers Timberlawn Family Assessment Guide. One video was taped within the first four weeks and the second video was taped after 1 year. Participants might have behaved differently because they were on video. Addicts also had 6-18 months of weekly random urine drug screens. They included naltrexone with Multiple Family Therapy (MFT). The therapy lasted 16 weeks and focused on family bonds, expectations, and multi-generational patterns. The objective was to educate, do some immediate problem solving, set boundaries and limits, support the addict in gaining employment, and implement new responsibilities. The four areas evaluated were problem solving, family structure, affect, and individual autonomy. Affect was the only subscale that did not show significant change. Affect was assessed by evaluating expression of thoughts and feelings, tone and mood of family interactions, empathy, and open conflict items. Considering only 8 families completed the entire study, perhaps 16 weeks of sessions plus follow-ups for 18 months was too long of a commitment.

Another study included 65 clients who received naltrexone and counseling (Anton, 1981). Twenty-five families received 16 sessions of Multiple Family Therapy. The other 40 families received only naltrexone and counseling. The clients who had families receive the sessions remained in treatment longer and had naltrexone longer. The study also noticed the group whose families received MFT stayed on naltrexone longer.

In London, a clinic studied 119 patients and divided them into three groups (Yandoli, 2002). One group received family therapy (FT), another group received minimal intervention (LC), and the third group had standard treatment only (ST). It was found that the groups that received family therapy and minimal intervention showed lower relapse rates. The FT group followed a model from Stanton et al (1982). The family programming placed an emphasis on limits and boundaries first. The family and client were seen together for an hour every 2 weeks

then monthly for up to 16 sessions. The client also received methadone at a non-negotiable reduction. Their dose was reduced 5mg every 2 weeks. The ST group had a treatment team of mostly nursing staff. Methadone was reduced as recommended by the treatment team so it was flexible. The course of treatment was open ended. The LC group had 1-2 therapists. At the initial session, clients were given a packet of local resources to remain drug free (treatment programs, self-help groups, etc). They were seen monthly for 30 minutes for up to 12 months. The client also received methadone at a non-negotiable reduction. Their dose was reduced 5mg every 2 weeks. Follow-ups were conducted at 6 and 12 months. At 6 months 101 people were left in the study. At 12 months 84 were left. The FT group showed 22% were clean at 6 months and 15% at 12 months. The LC group had 8% clean at both 6 months and 12 months. The ST group had 5% clean at 6 months and 0% at 12 months. At 1 year there were 2 deaths that occurred and both were in the FT group. One died of a suicide and the other an overdose. Some things to consider for this study include assessing drug use and the high attrition rate. Drug use was relied on by self-report in most cases. Urine drug screens were difficult to gather at the initial assessment due to clients being in prison or in their homes instead of the clinic. However, given the nature of this population, there were bound to be some inaccurate reporting of drug use. Another point to consider is the high attrition rate. At 6 months there were 85% of the participants left but at 12 months there were 70% left.

A fourth study looked at 142 addicts who participated in a 12 month outpatient program where everyone received naltrexone and cognitive behavioral therapy (Baranok, 2013). They divided them into two groups. One group received naltrexone and CBT. The other group received naltrexone, CBT, and family therapy that focused on co-dependency. The results showed that the group receiving family therapy showed better retention in the program, a higher rate of abstinence, increased social functioning, and stronger motivation to stay clean. Initially

motivation to quit drug use did not differ significantly between the 2 groups. The strongest motivation in both groups was avoiding family problems. However, after 3 months, motivation to avoid family problems became significantly higher in the group whose family was receiving a codependent rehabilitation program. Another point to note is that as time went on, the study states that treating codependent relatives contributed to the decrease in desire to use drugs in addition to the increase for motivation for avoiding family problems. This may not be a cause and effect relationship. It could be that the family members are not setting limits and boundaries that prevent addicts from using, not because they necessarily desire to not use. It could be that it's just not as simple to use drugs as it once was before families became educated.

Family support for the addict to remain drug-free depends on if the family members are aware of the addiction. Addicts tend to hide their use from their family and minimize their substance use. In another one of Kosten's (1983) studies, the hypothesis is that addicts that hide or minimize their substance use have poor outcomes even if the family members they lived with are not addicted to substances themselves. Four groups were studied in a naltrexone program. There were 28 addicts with spouses, 27 addicts living with their parents, 23 addicts who lied about problem substance use to their families who lived with them, and 28 addicts who lived alone. The first 2 groups identified received family therapy. They remained drug-free longer. Addicts who lied about their use to family remained drug-free for less time than those who were honest about their problem substance use. Addicts who told their spouses about their use but not their parents had shorter periods of sobriety than those who told their spouses and parents. The more the family members were involved, the better the addict's progress. One thing to consider in this study is the demographics of the groups were not equal. There were more African American males present in the deniers category. There were considerably more white males in the family treatment group. Another consideration is the group that self-reported drug use. It's

common with this population to under report relapse, so those numbers may not be very accurate. Also, it would have been helpful to examine the long term outcome from the participants in this study.

In one of McLellan's (1993) studies, they examined if counseling, medical care, and psychosocial services improve the effectiveness of methadone therapy in opiate addicted clients. This study took place at the Veteran's Assistance Center in Philadelphia. There were 92 male IV opiate users present in the study. Participants were randomly assigned to three groups. One group was a minimum methadone services (MMS) where only methadone treatment was performed. They received 60mg/d. A second group was a standard methadone services group (SMS). They received the same 60mg/d of methadone plus counseling. A third group was enhanced methadone services. They received the same 60mg/d of methadone, counseling, onsite medical and psychiatric services, employment, and family therapy. In the MMS group, 69% were "protectively transferred" due to continuous use of opiates or medical or psychiatric emergencies. At 24 weeks, minimal improvements were seen among the 10 MMS patients who remained left in the program. The SMS group showed significantly more improvements than the MMS group. The EMS group showed even more significant better results than the SMS group. Overall, when the program included counseling efficacy was increased. However, the EMS group showed even more effective outcomes. An interesting fact to note is the use of other drugs during the study. When compared to the MMS and SMS groups, the EMS group showed a slightly higher rate of opiate and cocaine use at 24 weeks despite them being surrounded by additional services. However, there was still a significant decrease in use when compared to baseline scores. This struggle for sobriety is not only being clean from the drug of choice, but reducing or eliminating the drive to reach that high or satisfaction they once achieved during

actively using drugs. Changing the behavior is just as important as abstinence from the drug of choice (Palmer, 1999 p. 153).

In Duncan's (1997) study, he completed a meta-analysis reviewing the outcomes of substance abuse treatment with methadone maintenance studies involving family and couples therapy in 1571 cases. Participants favored family therapy over individual therapy, peer group therapy, and family psychoeducation. Family therapy was shown to be effective in conjunction with methadone maintenance and had much less attrition. A particular challenge was engaging opiate addicts in psychotherapy services. That is one reason this report only has 15 studies, which is not as many as a typical meta-analysis. Another important thing noted in this analysis is that people who stop using opiates sometimes turn to use cocaine or crack. Also, superior results were shown for family therapy when compared to individual therapy, peer therapy, and family psychoeducation. For example, increased rates of engagement in treatment and staying in treatment were discovered in those groups who received family therapy. This is true for both adult and adolescent studies. Control groups for family and couples therapy for drug abuse have attained a good level of design quality. A tool called the Design Quality Scale was used to measure the design quality. Dropout rates were excluded from the outcome analysis. This is important to know because this population can have a high dropout rate from treatment. If the dropout rate is measured, it should include the reason such as relapse, moving to a different area, overdose, dissatisfaction with treatment, etc. Also, if the same individual re-engages in treatment, this should be noted and explained.

In Philadelphia, McLellan (1994) studied similarities in outcome predictors. He examined treatment and patient factors associated with 6 months of outcome data in 649 adults dependent on opiates, alcohol, or cocaine. Patients were inpatient or outpatient settings, city or suburban locations, and in 22 public and private programs. They studied substance abuse treatment and its

effectiveness on decreasing alcohol or drug use. Also evaluated were social factors such as employment, criminal acts, social adjustment, and the use of health care services. At the 12 month follow up at one location, 12% showed total abstinence from alcohol and drugs, having a job, no new criminal activity, and no family or psychological problems. Eighteen percent were jailed. Twenty-nine percent relapsed to significant use. Thirteen percent entered additional treatment. At another location 31% were abstinent and had no social problems. Forty-one percent relapsed. Nineteen percent had additional treatment. Each agency measured different variables using different tools. One observation noted overall was substance abuse services (treatment groups, 12-step meetings, etc) effected changes in substance use but had little effect on psychosocial problems. Psychosocial services (employment, family therapy, etc) were not well related to substance use but they were related to psychosocial adjustments.

In a study by Fals-Stewart (2003), they studied individual and family counseling and naltrexone in male opiate addicts. They divided 124 men in outpatient treatment for opiate dependence into 2 groups. One group had 24 weeks of individual counseling and family counseling (BFT). Patients were given naltrexone to be taken in the presence of their family members. A second group received 24 weeks of individual counseling only (IBT). They were given naltrexone to take on their own and report their own compliance. They attended one of two treatment facilities and lived with at least one other family member who could be a parent, spouse, or significant other. This family member did not meet criteria for a substance use disorder nor a mental health diagnosis. Over the 24 week period of treatment, patients received 56 treatment sessions. In the IBT group, for the first 16 weeks they attended sessions 3 times per week. Two of the sessions lasted for an hour each. The other session for each week was a 90 minute therapy group. For the final 8 weeks they attended a one hour individual session once per week. In the BFT group, for the first 16 weeks they attended one 1 hour session individually, one

90 minute therapy group, and a one hour session with a family member. During the last 8 weeks they attended a one hour individual session once per week. During the family sessions, the families signed a “recovery contract” agreeing the family would monitor their addict’s naltrexone ingestion. Participants provided urine samples and breathalyzers weekly. Researchers used the Timeline Follow Back Interview and Addiction Severity Index for data collection and analysis. The results indicated that the group who received individual and family counseling took more doses of naltrexone, attended more treatment sessions, and had more days of abstinence from opiates and other drugs during their treatment and in the year after. They also had less drug-related, legal, and family problems reported at the one year follow-up.

These studies suggest that family involvement in substance abuse treatment provides better support for families and the addict during the initial recovery phases during outpatient treatment. Findings indicate families showed improvements in areas such as problem solving, family structure, and individual autonomy (Kosten, 1987), and clients stayed in treatment longer (Anton et al, 1981) when family education and therapy was implemented into treatment planning. The purpose of this study was to examine the relationship between family therapy and substance abuse outpatient treatment of opiate addicted adults. It was hypothesized that when including the family in the treatment process, adult opiate addicts have a lower probability of relapse of opiates during treatment.

METHODS

Participants

Twenty-seven adults involved in outpatient substance abuse treatment for opiate dependence participated in this study. The mean age of participants was 25. Participants were arbitrarily assigned to two different groups. They were not randomly assigned. Members of Group A received treatment as usual and were offered to participate in a family program. The family program was a group for family members of those who were in treatment for opiate addiction. Group B received treatment as usual, and not offered the family program. All but 2 participants completed all three questionnaires.

Measures

At the first data collection date, the client completed the questionnaire titled First Questionnaire for Study. This questionnaire includes basic demographics, employment status, referral source, jail status, relationship with family, and substance use information. After the first month of treatment, the client completed the Follow-Up Questionnaire. After the second month of treatment, the client completed the same Follow-Up Questionnaire. The Follow-Up Questionnaire includes employment status, jail status, relationships with family, and substance use information. Another questionnaire developed by Gorski called AWARE Questionnaire was completed by both groups at all three times of measures. The AWARE Questionnaire measures relapse potential. The AWARE Questionnaire has been found to have excellent internal consistency at a rate of .92 - .93. Test-retest stability is at .80 (Miller, 2000). All clients, regardless of which group they are in, completed the same questionnaires.

Procedure

Until this study, family programming was not part of the substance abuse treatment program at Ozaukee County. The researcher met with the current treatment groups as a whole to

explain the study and request participation. Upon agreement to participate in the study, the client received an informed consent form. The form was reviewed completely. The client received a copy. A signed copy was kept in the data collection. All participants then completed the First Questionnaire and an AWARE Questionnaire. Data collection occurred from clients from the outpatient clinic location and from the jail location on different dates. Before they were divided into the 2 groups, they were placed in a hanging folder until all initial data was collected and it was time to divide the groups. Current participants were assigned to 2 different groups called Group A and Group B. Questionnaire were removed from the folder, placed in a pile, and assigned to each group one after the other. As participants enter the treatment program, they were assigned to Group A and Group B. Names and phone numbers of family members were also gathered.

After the second week of treatment, family therapy began with Group A. Family therapy was conducted by the researcher who is a credentialed Clinical Substance Abuse Counselor with the State of Wisconsin. The program was in group form one hour per week for 4 weeks. Topics covered included family roles, education about addiction, understanding the recovery process for their loved one and their families, understand denial and acceptance, set boundaries and limits, and practice caring detachment. The first half of the one hour session was educational on the topics of the session. The second half was a group process and discussion. Al-Anon group information for Ozaukee County and surrounding cities were also included.

At the end of the first month of treatment, the follow up surveys were distributed to both groups. At the end of the second month of treatment, the same follow up surveys were distributed to both groups. Two participants dropped out of the program. For the purposes of data analysis, they were considered to have relapsed.

RESULTS

Results of this study was tested by comparing t-tests between the group that received family programming ($N = 13$) and the group that did not ($N = 12$). T-tests were run for each of the three sets of data collected for each participant. Twenty-seven adults in treatment for opioid use disorder participated in the study. Two participants did not complete all the questionnaires. For the initial AWARE questionnaire, the warning signs of relapse score was lower for the participants receiving family therapy ($M=77.923$, $SD=23.4573$) as compared with participants not receiving family therapy ($M=113.167$, $SD=13.1898$). Participants who received family programming showed significantly fewer warning signs of relapse, $t(23) = 4.575$, $p = .000$. This is before the intervention occurred, so it should be noted that the difference was significant before Group A received family therapy. No further analysis can be taken as meaningful tests of hypothesis. Participants completed the AWARE questionnaire again after 30 days. By this time a portion of the family programming was implemented. The warning signs of relapse score again was lower for the participants receiving family therapy ($M=70.077$, $SD=23.5954$) as compared with participants not receiving family therapy ($M=101.500$, $SD=19.9613$). Participants who received family programming again showed significantly fewer warning signs of relapse, $t(23) = 3.579$, $p = .002$. Participants completed the AWARE questionnaire again after 60 days. By this time families had completed the family programming. The warning signs of relapse score again was lower for the participants receiving family therapy ($M=66.308$, $SD=19.8258$) as compared with participants not receiving family therapy ($M=87.333$, $SD=22.9122$). Participants who received family programming again showed significantly fewer warning signs of relapse, $t(23) = 2.459$, $p = .022$. In both groups, the AWARE scores decreased over all three measures (see Table 2).

Chi-square Analysis

Chi-square analyses were conducted to determine what demographic characteristics were not evenly distributed between the groups at baseline. There was a significant relationship between the group assigned and participants in the jail, $X^2(1, N = 25) = 3.31, p = .07$. There were more participants who were not incarcerated who received family therapy. There was also a significant relationship between the group assigned and the first reported relationship with their family, $X^2(3, N = 25) = 6.12, p = .11$. Three quarters of participants who received family therapy rated their relationship with their family as excellent or good before family therapy was implemented.

DISCUSSION

The literature review studies provide us with good information and the benefits of involving families in various capacities. Schwartzman (1988) explains that families become a part of the dysfunction in addicted families. Parents often feel the need to help their son or daughter but parents don't always agree on what is helpful. For example, when an addict fails living on his own he is rescued over and over again. The dysfunction in families with addiction is similar to that of families with other problems such as gambling or violence. They have problems communicating feelings, especially anger, by either not expressing the feeling or expressing it inappropriately. As noted by many family members during family programming in this study, they found it helpful to gain skills to cope with their loved one's substance use.

This study was not successful. After running a chi-squared and crosstabs analysis, a few elements were discovered that may indicate the reasons the study was not successful. One point noticed is there were a higher number of participants who were not incarcerated who received family therapy. Only two of the nine people incarcerated received family therapy. Another point discovered involves the relationship with family during the first data gathering. Seventy-five percent (9 of 12) participants who received family therapy rated their relationship with their family as excellent or good before family therapy was implemented. Furthermore, both of the participants who were in the jail and received family therapy rated their relationship with their family excellent. It appears as though a bias was present before the family therapy was implemented.

The way the two groups were created may have also played a role in the results of this study. As the initial groups were created, data was not gathered all at one time. As the questionnaires were turned in, they were placed in a hanging folder. The questionnaires were not

placed on top of each other so it's possible the jail group mixed in weighting out higher in one group than the other.

The issues of blinding needed to be examined as another potential reason for the failure of this study. Blinding in a study occurs when participants aren't aware of which group they are assigned. The consent form was reviewed with all participants before they were asked to complete any questionnaires. In the consent form, it states that the participants would be divided into 2 groups, what the differences would be between the 2 groups, and what the desired outcome is particularly referring to the group receiving family treatment. Participants knew the desired outcome right away, even before completing questionnaires.

Another reason the study failed may have to do with demand characteristics. Demand characteristics is a situation where the results of an experiment are biased because the person doing the experiment expects the performance of the participants on a particular task create an implicit demand for those participants to perform as expected. Participants ended up knowing which group they were in. Participants were told about the purpose of the study and the anticipated outcome in the consent form. These two indicators combined resulted in the presence of demand characteristics.

There are several suggestions that could be implemented to make this study successful. First of all, the groups should be divided differently. These groups were not divided using simple randomization. Using this technique allows each participant the same opportunity to be assigned to a group. The researcher should have used simple randomization.

Another way this could be corrected is to have a double blind study. An additional researcher could have been added to the study. This researcher could have been the only researcher interacting with the participants. If the researcher and participants don't know what

group the participants are assigned to or even if there are different groups, the effects of demand characteristics should be eliminated.

One way to deal with the demand characteristics is to use deception. Instead of the consent form briefly describing the procedure and desired outcome, participants could have been told something else. They could have been told the study will examine how family involvement affects families or the study was evaluating behaviors of families of addicts. They also didn't need to be notified of the comparison of two groups. Participants could have assumed that everyone was going to be studied the same way.

The United States clearly has seen an increase in heroin and other opiate related deaths and tragedies over the past decade. Recently, many campaigns have been implemented. Laws have changed regarding prescription drugs, allowing pharmacies and doctors to take steps to limit access to opiates and other drugs of abuse to addicts. Advances in medicine and treatment have helped those who want help. However, more needs to be done to effectively treat this population who suffer from this deadly disease of opiate addiction.

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Table 1

Demographic Characteristics of Participants

Gender	
Male	19
Female	8
Employed	
Yes	18
No	9
Marital Status	
Single	23
Divorced	2
Married	2
Referral Source	
Probation	10
Child Protective Services	2
Voluntary	12
Other	3
Jail	
Yes	10
No	17
Age	
25 or <	10
26 - 30	11
31 - 36	6

Table 2

Consistent Decreased AWARE Mean Scores with Both Groups



APPENDIX A

Informed Consent Form

for men and women who are in substance abuse treatment for opiate addiction at Ozaukee County Counseling Center, and who are invited to participate in research on the impact of family therapy and relapse rates.

Introduction

I am Lynn Gillian, a master's level student at Cardinal Stritch University in the Department of Psychology. We are doing research on family therapy and its impact on relapse rates on individuals in outpatient treatment for opiate addiction. I am going to give you information and invite you to be part of this research. Before you decide, you can ask any questions you would like in order to make an informed decision about participating.

Purpose of the Research

The addiction of heroin and pain medications has increased drastically in Wisconsin over the last several years. There have been several interventions implemented to keep opiate addicts from relapsing. Family members voice frustration in dealing with their addicted love ones. The reason we are doing this research is to find out if including the family in the treatment process will help lower relapse rates.

Type of Research Intervention

Participants will be randomly divided into two groups. One group will receive family therapy. The other group will not receive family therapy. This research will involve implementing 4 weeks of family education for families of individuals enrolled in outpatient treatment at Ozaukee County Counseling Center for treatment of opiate addiction. The four weeks will be consecutive and will last one hour each week.

Confidentiality

We will keep your information confidential and protect it from unauthorized disclosure, tampering, or damage. Data entered into a statistical program will be identified through a unique client identification number, which is assigned automatically. Your name will not be included in the data analysis in a statistical program. Your name and client number will not appear on the presentation of study results.

Benefits

If the experimental intervention is successful, we predict that they may have longer periods of sobriety, better family relationships, and prevent further complications with the law. There will be no benefits or

harm if the intervention is not helpful. If the experimental intervention is successful, this could reduce continued drug related activity in the community. If you are not chosen for the family treatment group for the study, your family will be offered family treatment after the study is complete.

Risks

The risk in this study is that you will be asked to answer questions related to your illegal drug use. There is a risk to your reputation and employment if your illegal drug use was made public. However, I guarantee your responses will not be revealed to anyone.

Use of Information

The results of this information will be used to defend a thesis and presented to the Ozaukee County Counseling Center. Identifying information will not be included.

Your Rights as a Research Participant

Participation in this study is voluntary. You have the right not to participate at all or to leave the study at any time. If you decide not to participate or leave the study early it will not harm your relationship with staff members at Ozaukee County Counseling Center.

Contacts for Questions or Problems

Call Lynn Gillian at 262-284-8157 or email Lynn at lgillian@co.ozaukee.wi.us if you have any questions about the study, any problems, unexpected physical or psychological discomforts, any injuries, or think that something unusual or unexpected is happening.

If you have any complaints about this study, please call or write:

Dr. Terrance Steele

Cardinal Stritch University
6801 N. Yates Rd., Box 358
Milwaukee WI 53217
414-410-4474
tlsteele@stritch.edu

Although your name may be asked, all complaints are kept in confidence.

Participation is voluntary. Please respond by signing below if you are interested in participating in this study. If you wish to withdraw from the study at any time, you may do so without prejudice or penalty.

If you have any questions regarding this research, please call or write:

Investigator:

Lynn Gillian, BS, CSAC, IDP-AT
121 W Main St
Port Washington WI 53074
262-284-8157
lgillian@co.ozaukee.wi.us

Advisor:

Dr. Trevor Hyde, Ph.D., Assistant Professor of Psychology
Cardinal Stritch University
6801 N. Yates Rd., Box 102
Milwaukee WI 53217
414-410-4489
tfhyde@stritch.edu

I have received an explanation of the study. I agree to have family members involved in my therapy. I am interested in participating in this study.

Signature

Date

This research has been approved by Cardinal Stritch University's Institutional Review Board on May 13, 2015 for a period of 12 months.

APPENDIX B

AFFILIATION AGREEMENT

Affiliation Agreement: Ozaukee County Counseling Center is giving permission to Lynn Gillian, graduate student in the Clinical Psychology program at Cardinal Stritch University, to conduct research at Ozaukee County Counseling Center.

Nature of the Research Project: The researcher will conduct a research study on determining the effectiveness of family therapy on clients receiving outpatient substance abuse treatment for opiate addiction. Two groups will be randomly assigned. One group will have their family receive family therapy and the other group will not. Family therapy will include 4 one hour sessions once per week. Family therapy will include topics such as family roles, addiction, understanding the recovery process, and boundaries and setting limits. An initial questionnaire will be given to clients upon entering the study. A follow up questionnaire will be given monthly for 2 months after the initial start.

Contact Person at Ozaukee County Counseling Center: The contact person at our organization with whom the researcher is to communicate regarding the research project is:

Dr. Charles Grade
121 W Main St
Port Washington WI 53074
262-284-8200
cgrade@co.ozaukee.wi.us

Contact Person at Cardinal Stritch University: The contact person at Stritch with whom our organization is to communicate regarding the research project is:

Dr. Trevor Hyde, Ph.D., Assistant Professor of Psychology
Cardinal Stritch University
6801 N. Yates Rd., Box 435
Milwaukee WI 53217
414-410-4489
tyhyde@stritch.edu

Confidentially of Data: The researcher has agreed to protect the confidentiality of data collected. Participants will not be individually identifiable.

Report: The researcher will share a copy of the final report with our organization upon our written request.

Thank you for your cooperation.

Signature of Research Student

Date

Signature of Official of Cooperating Organization

Date

Signature of Faculty/Staff/Faculty Advisor

Date

APPENDIX C

First Questionnaire for Study

Today's date: _____

Please complete all sections. Ask questions if necessary.

Name: _____ DOB: _____

Age at admission _____

Marital status: single married divorced

Gender: male female

Employed at admission: yes no

Referral source: probation CPS voluntary other: _____

Currently in jail: yes no

Relationship w/family: excellent good fair poor none at all

Drug of choice: heroin pain meds

How long have you been using your drug of choice? _____

Other drugs used in the past year: _____

Date you last used your drug of choice: ____ / ____ / ____

Are/were you on a Suboxone maintenance program before or during treatment here? Yes No

If yes, for how long (how many weeks, months, or years)? _____

How many times did you attend 12 step meetings in the last 30 days? _____

Are you on the Vivitrol shot? Yes No

APPENDIX D

Follow-Up Questionnaire

Today's date: _____

Please complete all sections. Ask questions if necessary.

Name: _____ DOB: _____

Currently in jail: yes no

Relationship w/family: excellent good fair poor none at all

Are you on the Vivitrol shot? Yes No

Have you relapsed on an OPIATE in the last month? YES NO

If yes, how many times? _____

How many times have you relapsed on a different drug in the last 30 days? _____

If you relapsed on a different drug, which drug(s)? _____

How many times did you attend 12 step meetings in the last 30 days? _____

Appendix E

AWARE Questionnaire 3.0

Please read the following statements and for each one circle a number, from 1 to 7, to indicate *how much this has been true for you recently*. Please circle one and only one number for each statement.

	Never	Rarely	Some- times	Fairly often	Often	Almost always	Always
1. I feel nervous or unsure of my ability to stay sober.							
2. I have many problems in my life.							
3. I tend to overreact or act impulsively.							
4. I keep to myself and feel lonely.							
5. I get too focused on one area of my life.							
6. I feel blue, down, listless, or depressed.							
7. I engage in wishful thinking.							
8. The plans that I make succeed.							
9. I have trouble concentrating and prefer to dream about how things could be.							
10. Things don't work out well for me.							
11. I feel confused.							
12. I get irritated or annoyed with my friends.							
13. I feel angry or frustrated.							
14. I have good eating habits.							
	Never	Rarely	Some- times	Fairly often	Often	Almost always	Always

	Never	Rarely	Some- times	Fairly often	Often	Almost always	Always
15. I feel trapped and stuck, like there is no way out.							
16. I have trouble sleeping.							
17. I have long periods of serious depression.							
18. I don't really care what happens.							
19. I feel like things are so bad that I might as well drink/use.							
20. I am able to think clearly.							
21. I feel sorry for myself.							
22. I think about drinking/using.							
23. I lie to other people.							
24. I feel hopeful and confident.							
25. I feel angry at the world in general.							
26. I am doing things to stay sober.							
27. I am afraid that I am losing my mind.							
28. I am drinking/using out of control.							
	Never	Rarely	Some- times	Fairly often	Often	Almost always	Always

APPENDIX F

Informed Consent Form

For family members of men and women who are in substance abuse treatment for opiate addiction at Ozaukee County Counseling Center, and who are invited to participate in research on the impact of family therapy and relapse rates.

Introduction

I am Lynn Gillian, a master's level student at Cardinal Stritch University in the Department of Psychology. We are doing research on family therapy and its impact on relapse rates on individuals in outpatient treatment for opiate addiction. I am going to give you information and invite you to be part of this research.

Purpose of the Research

The addiction of heroin and pain medications has increased drastically in Wisconsin over the last several years. There have been several interventions implemented to keep opiate addicts from relapsing. Family members voice frustration in dealing with their addicted love ones. The reason we are doing this research is to find out if including the family in the treatment process will help lower relapse rates.

Type of Research Intervention

Participants will be randomly divided into two groups. One group will receive family therapy. The other group will not receive family therapy. This research will involve implementing 4 weeks of family education for families of individuals enrolled in outpatient treatment at Ozaukee County Counseling Center for treatment of opiate addiction. The four weeks will be consecutive and will last one hour each week.

Confidentiality

No personal data will be collected from you other than your name for attendance. Your name will not be used in presenting data.

Benefits

If the experimental intervention is successful, we predict that they may have longer periods of sobriety, better family relationships, and prevent further complications with the law. There will be no benefits or harm if the intervention is not helpful. If the experimental intervention is successful, this could reduce continued drug related activity in the community. If you are not chosen for the family treatment group for the study, your family will be offered family treatment after the study is complete.

Risks

The risk in this study as a family member is that other family members in this study will know you are attending family programming. I guarantee your personal attendance will not be revealed to anyone outside of this study.

Use of Information

The results of this information will be used to defend a thesis and presented to the Ozaukee County Counseling Center. Identifying information will not be included.

Your Rights as a Research Participant

Participation in this study is voluntary. You have the right not to participate at all or to leave the study at any time. If you decide not to participate or leave the study early it will not harm your relationship with staff members at Ozaukee County Counseling Center.

Contacts for Questions or Problems

Call Lynn Gillian at 262-284-8157 or email Lynn at lgillian@co.ozaukee.wi.us if you have any questions about the study, any problems, unexpected physical or psychological discomforts, any injuries, or think that something unusual or unexpected is happening.

APPENDIX G

Family Recovery Program

We invite you to participate in Ozaukee County's Family Program for families with loved ones addicted to opiates. This is a 4 week program offered once a week. Learn about addiction and the recovery process (for your loved one and your family), explore family roles, understand denial and acceptance, and learn how to practice caring detachment.

June 8, 15, 22, and 29

5:30—6:30pm

We encourage you to attend all 4 sessions.

To register, contact
Lynn Gillian at
262-284-8157.

Refreshments will be served

WHERE:

Ozaukee County Administration Building

121 W Main Street, Port Washington

Room 313



Please contact Lynn Gillian at Ozaukee County Counseling Center
at 262-284-8157 for more information.