WHEN THE SOLUTION BECOMES THE PROBLEM

Helping Families Struggling with Addiction and Trauma

By Michael F. Barnes, Ph.D., LAC, LPC
Chief Clinical Officer, Foundry Treatment Center
Owner, Barnes Education and Consulting, LLC
www.drmikebarnes.com

To Patrick, Aimee, and Beth

You have all played critical roles in my life. I am grateful for the love and support each of you has provided over the past 40 years. I could not have completed this project without each of you!

Thank You!!

Mike

AUTHOR'S NOTE

Most people who write books for families struggling with addiction tell them what to do and how to do it.

This book is different.

I wrote it to tell you why it's so hard to do any of the things the other books tell you to do. I wrote the most genuine and thorough book I could, based on 41 years of clinical experience working in addiction treatment and trauma research, personal events, and key relationships. I sought to answer two critical questions in these pages. The first is, "What gets in the way of doing the traditional things families are told to do when their loved one struggles with addiction?" The second is, "What is needed to heal traumatized families?"

This book might be challenging; I hope you'll find it worthwhile.

~Mike

PREFACE

Introduction

Several years ago, when I was a faculty member in the master's program in counseling at the University of Colorado Denver, a student asked me to share my thoughts on how to work with "unmotivated" clients. I thought momentarily and responded that I didn't know, as I had never worked with an unmotivated client. The students laughed at that statement. In many areas of the counseling profession, counselors measure clients' motivation by their willingness to try new solutions and behaviors. It implies that motivated clients are simply the ones who are willing to change. Wanting to deconstruct this faulty "either/or" belief system, I stated that all my clients are motivated to do something. Some clients are motivated to try new understandings and behaviors, while others are motivated to stay the same.

I finished my discussion by saying most of my clients wrestling with trauma are highly motivated to stay as safe as possible. I challenged the students to look closely at their understanding of the change process and what circumstances allow people the freedom to change. I used Maslow's Hierarchy of Needs as an example. In most therapy situations, the change process focuses on higher-order issues

associated with new insights, love and belonging, self-esteem, and self-actualization. What gets lost is that people can't move forward to focus on these issues if they continue to struggle with safety concerns. For most traumatized clients, there is a disconnect between their awareness of being safe and feeling safe. Until clients and families get help addressing this issue, they will continue to talk about change but struggle to overcome the anxiety, fear, and anger that prevent them from following through.

Since that class, I have tried to start my trauma-focused presentations by asking the audience if anyone has ever worked with an "unmotivated" client. Typically, the audience breaks into laughter, and many hands go up. I then tell the story of my discussion with the students about client motivation. The room gets quiet when I get to the part about how all clients are motivated by *something*. In treatment programs focusing on addiction, professionals wrestle with clients and families they and others have incorrectly labeled as unmotivated. I start my presentations this way because our shift to working with addiction and trauma requires us to understand that the addicted individual's and their family members' responses to trauma-related anxiety, fear, anger, and threat are almost always to cling to the old thoughts, feelings, behaviors, and the defenses they

developed during and after the traumatic event. On a nervous system level, getting "back to normal" is an attempt to ensure they survive and that the problem does not happen again.

Trauma and Addiction are Family Issues

While families don’t often talk about it, the patterns I just discussed regarding the incorrect and unhelpful labeling of a client as “unmotivated” happen in families, too. In family therapy, the person the family believes has the problem is often called the "identified patient." It is not unusual for clients to go through numerous treatment programs and for their families to attend numerous "Family Programs." Often, family programs focus on coaching families to better address their loved one's addiction-oriented behaviors. They discuss enabling, enmeshment (or over-involvement), boundaries, addiction as a chronic disease, and recovery. While each of these issues plays a role in how families cope with addiction, the *purpose* that each item on that list serves for the client and other family members is missing in that discussion. In large part, the list I just shared, starting with enabling, all grows out of a family's motivation to maintain safety.

Let me explain what I mean here with a quick story: I was doing a group for the family program at

one of my former treatment centers. When asked to discuss enabling, all the group could do was ask questions about safety.

"How can I hold my loved one accountable without them getting angry and threatening me?"

"What if I don't pay her rent, and she becomes homeless?"

"What if I stop helping him, and he dies from an overdose?"

As I listened to their questions, it struck me how enabling was not only intended to solve the addicted family members' current problem but also served a purpose for the caregivers. For caregivers and partners, enabling provides a short-term solution to an ongoing problem. Paying a loved one's rent allows the caregiver to feel safe. They feel safe and assured that their loved one will not be homeless, vulnerable, or in danger. What was also clear was the amount of shame resulting from professionals telling them the behavior was doing more harm than good. It struck me that telling someone to stop enabling without teaching them how was like Nancy Reagan telling an individual struggling with addiction to "Just Say No." It missed the mark on the issue's complexity, why families do it, and how to create more effective plans for solving it! This message—Stop Enabling—

created more shame than it did healing.

To assist family members in understanding enabling through a different lens, I asked each person in attendance to quietly think of an instance when their loved one showed up at their home and asked for assistance others might consider enabling. I asked them to consider their loved one walking down the hall, greeting them, and asking them for rent money, for example. I asked them to imagine the thought of saying no and to pay attention to what they felt in their body and their thoughts, feelings, and impulses. After a few minutes, each family member shared similar body responses, including fear, tightness in their neck and chest, heart racing, rapid breathing, and feeling numb and disconnected. Many had the impulse to run away or escape the situation. After we had discussed their reactions, I described their responses as common symptoms experienced during and following traumatic events. Many family members engage in protective behaviors like enabling as a response to the trauma they have experienced.

Why Should I?

One evening, I watched a TED Talk by Simon Sinek, a business writer and thought leader who wrote a book called *Start with Why* (Sinek 2009). He

said many people ask two questions when trying to solve a problem. The first is, "What should we do?" and the second is, "How should we do it?" He said that most people who ask those questions do not follow through with the advice. He then said they failed to make the changes because they failed to ask the most crucial question: "Why should I do it?" Suddenly, my interactions with families made sense. Our conversations needed to include the critical component: Why?

From that day forward, when a family member asked me what to do, I would ask, "If I tell you, will you do it?" What is the most common answer I get? How would you answer that question? You would be incorrect if you believe the most common answer is yes. Most families say, “It depends on what you suggest!”

This response creates the opportunity to discuss what they are asking for. Some want affirmation that what they are currently doing is correct. Others are new to the process and legitimately ask for advice on what to do next. A third group is angry and feels treatment professionals have judged or blamed them. They have tried following recommendations in the past, which has yet to work for their family. Asking this question, then, is their opportunity to push back. For yet another group, this question creates distance,

so they don't have to look at their complex family of origin issues. In all cases, helping families to talk openly about their situation allows them to move toward a solution-oriented rather than problem-oriented discussion.

The *New American Oxford Dictionary* (Stevenson and Lindberg 2010) defines motivation as "the reason or reasons one has for acting or behaving in a particular way. It represents the general desire or willingness of someone to do something." As you begin reading this book, consider what motivates you to read it. What are you hoping to get from it? Why? How open are you to considering new information and recognizing the need for difficult discussions? Does your motivation extend beyond helping your loved one get help?

The Progression of Trauma and Addiction

My life's work is at the intersection of trauma and addiction and how the two play together in the same sandbox. I want to share how my experience and thinking on these complex topics evolved. As a kid, I was very anxious. I was overweight and put on diet pills—amphetamines—at age six. It was ridiculous. As a teen, I wrecked cars drunk and should have gotten DUIs, but I was fortunate and never got caught. My parents would be angry with me, but

ultimately, I got a pass. When I was in college, my mother threw me out of the family. I'd written a letter to my girlfriend that my mom found, and there was some stuff about partying, sitting in a bar, smoking pot. After reading the letter, Mom had had enough. When I said goodbye and walked towards the door to return to school, she said, "I watched my father die from alcoholism. I'm not going to watch you die. So, when you leave today, don't ever come back." I was furious. After all, I'd put up with her; she threw me out.

That was the beginning of a massive shift for me. I had to decide, "Do I want to lose this family or not?" I had an avoidant attachment style; people could quickly be dead to me. Thus, I stayed away from home and didn't call that whole semester. But then I talked with my sister at the start of the summer break; she said, "Just walk into the house as if you own it. Don't even indicate that you remember what happened. If they throw you out, you can come live with us." So, I walked in, and my father said, "Where did you go? I haven't seen you in forever." My mother said, "Did you get it worked out?" I said, "Yes," and she said, "Good." That's the only time that we ever talked about it.

I wanted to share all of this with you to provide some insight into the progression of my work on

trauma and addiction. When I was a kid, I thought: She's crazy. My mom is crazy. But then I got my master's degree, and books about Adult Children of Alcoholics were popular then. I knew that an alcoholic father raised her, and after reading the books, it explained her behavior clearly. Her life was such chaos, just relentless when she was young, so I thought, "Okay, it's all about alcohol. Her stuff is all a result of living in her alcoholic family."

I enrolled in the Ph.D. program in Marriage and the Family at Florida State University, unaware of how it would change my personal and professional life. When I got to FSU, I wanted to focus my study on addiction in the family. However, my professor, Dr. Charles Figley, was one of the top traumatologists in the world. He brought me in to work with veterans and their families. So much of the work focused on addiction and trauma there. After serving as a Vietnam Combat Veteran, Dr. Figley published the first book on PTSD and Vietnam Veterans. He also wrote the first book on helping traumatized families. It was an honor to have him as my advisor and mentor in my work in the Vietnam Veterans Families Program and throughout my Ph.D. program.

A car hit our five-year-old son at the start of my second semester at Florida State. He experienced

life-threatening injuries requiring three weeks of treatment in a pediatric intensive care unit, three weeks in a pediatric unit, and months in a cast. When Patrick got hit, I began to experience the impact of family trauma firsthand. As I began to recognize the trauma our family was experiencing after the accident, I started to look for information that could help us cope. It became clear there was very little literature on how to help families like ours. It became the impetus for my shift from focusing on the impact of addiction on a family system to the effects of trauma on a family system. I tried to expand my understanding of traumatic stress and how it impacts families with every paper I wrote. Dr. Figley served as my "Major Professor" and supervised my research on the secondary trauma of parents who experience Pediatric Intensive Care (PICU) treatment. While his support as a mentor was so valuable, his willingness to support our family as we struggled through the accident experience is what I am most grateful for.

A light gradually went off in my head: “It’s the combination. Growing up with an addicted family member is traumatizing; therefore, you must address both addiction and trauma simultaneously."

It became clear that addiction and trauma have a completely intertwined relationship. When I train other professionals in the field to introduce the

importance of family history to the families they work with, I instruct them to talk about trauma first. The family members focus on their loved one's trauma experiences. They're hoping the discussion about trauma can shed light onto what caused the addiction and that it wasn't them. Then, once the group starts talking about trauma symptoms, I begin infusing things that I know the family members feel. Eventually, someone raises their hand and says, "I have the same things." It never fails. The group can then shift the focus from the "identified patient" and work on healing each individual and the system as a whole.

Defensive Avoidance

Most humans are traumatized to varying degrees. Sometimes, it causes posttraumatic stress disorder, and sometimes, it causes developmental or complex traumatic stress. While developmental trauma is not a diagnosis in our DSM-V, it is in the World Health Organization's ICD 10. The idea is that you can be traumatized not by something happening to you but by not getting your needs met as a child. Understanding this is critical for clients and family members trying to cope with and heal from active addiction. When I was at The Center for Dependency, Addiction, and Rehabilitation (CeDAR) at the University of Colorado Hospital, our

clinical team kept comprehensive statistics regarding the number of clients who were admitted into treatment with a PTSD diagnosis. The numbers always varied; 25 to 35 percent of our clients were diagnosed with PTSD. In my clinical opinion, when we assessed other clients who came to treatment with numerous adverse childhood experiences (ACES), while they may not have met the full criteria for PTSD, they met the criteria for complex or developmental traumatic stress. I would say that somewhere between 60 and 75 percent of our clients had PTSD or complex/developmental trauma on any given day.

We could say the same for the family members who attended our family program. As trauma-informed and trauma-integrated addiction treatment becomes increasingly popular, it should become routine for family programs to educate, coach, and support family members to recognize their trauma histories and how history has impacted their efforts to cope and assist their loved ones. In this book, I ask people to consider that living with trauma and addiction is much more complicated than they imagine.

It's one of the reasons I started developing trauma-integrated addiction treatment programs in 2012. Clients will invariably share a substantial

traumatic event or say nothing happened. Then you start talking to their families and find out they've had nine concussions from football or hockey. They have crashed two cars, or their sibling was killed in a car accident. Given this reality, I believe treating the client and their family with the same trauma-integrated interventions intended to help calm the nervous system would be a positive move.

My mistake after Patrick's accident was thinking our family could return to normal. I hoped we could return to a way of being together that was comfortable and familiar. What I missed was the impossibility of returning to the routine and comfort. Unfortunately, this would require me to return to using the same defenses, avoidant approach to emotions, and the same absent-minded professor schtick I had long relied on to get through life. But that was never going to work again and did not, in fact, work. The only way I could save my marriage to Aimee was to create a "newer" normal. That sounds good, of course, but creating a newer normal in yourself, your relationships, and your family takes time and effort. It requires self-reflection and change.

The process you will walk through in this book, the approach we take families through in our program, is complex. No 900-word article or blog post you can read will solve or heal your family's

trauma and addiction. There are no simple steps. People who have trauma also have defensive avoidance. To avoid triggers related to past traumatic events, they tend to avoid delving into anything that will remind them of their painful past. Instead, they let the solution become the problem, meaning they'll come to therapy for the pain caused by their inability to solve the more complex situation they have been avoiding. What is going on is that they're just trying to stay as safe as they can. What I am asking you to do in this book may initially feel threatening. Looking at the addiction in new ways and assessing how you and your family acted during the addiction can be pretty scary. Applying these principles to yourself can be even more challenging.

My mother did not heal her traumas. She wasn't willing to try because that would have been too frightening. Is there anything anyone could have ever said to her that would have started her on this path? I'm not sure. As I have been writing this book, it has become clear what I wished I said 20 years ago: "Mom, there's an explanation for everything you do and feel and fear. And it's called trauma." That's the only way healing would have begun for my mother—with an empathetic guide.

Terminology

Before you go further, I'd like to briefly explain some of the terms I'll use throughout this book. First, you won't see me referring to individuals struggling with addiction and trauma as "addicts;" instead, I choose to refer to them as persons "struggling with addiction," "loved ones," or "clients," as these individuals sometimes become our clients at Foundry Treatment Center or clients of other treatment centers. Second, given the varied and diverse nature of families, when I wish to refer to the persons who play a leadership role in a family unit, I will use the term "caregiver" rather than "parent" in recognition of the fact that family leaders are often grandparents, stepparents, aunts, uncles, adult children, etc. Finally, a note on pronouns: Foundry Treatment Center treats male clients exclusively, so it's been my default to refer to individuals struggling with addiction with "he/him" pronouns. In this book, I will use "he/him," she/her," and "they/them" throughout, balancing my commitment to inclusiveness with readability.

Let’s begin!