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Working with Families of Chemically Dependent Criminal Justice Offenders

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This distance learning coursework was developed for CEUMatrix by James D. Shelton, M.S., MAC., LCDC.

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About the Instructor:

James D. Shelton has been a professional in the treatment and recovery field for the past twenty-five years. Jim holds a Bachelors Degree from the University of California at Berkeley in Labor and Industrial Relations. He holds a Masters Degree from the University of North Texas in Addiction Studies. He is certified as a Licensed Chemical Dependency Counselor, A Masters Addiction Counselor and a Loss and Grief Specialist.

Jim spent six years in the Betty Ford Center Family Program working with families of the chemically dependent. While at Betty Ford, Jim developed a program for working with the chemically dependent patients on their codependent behaviors, attitudes, beliefs and their inabilities to set boundaries or practice self-care. For Jim, these behaviors and inabilities are primary relapse triggers and impediments to emotionally contented sobriety.

Presently, Jim's primary focus is on addiction interventions. He also presents workshops on codependency and boundary setting. Quarterly, Jim presents these workshops for the Betty Ford Center Family Program in Rancho Mirage, Ca. He appears in two vhs/dvds titled *What is Codependency?* and *Setting Personal Boundaries*. These were produced and are distributed by FMS Productions of Carpinteria, California. He is also the author of a workbook that accompanies the productions.

He currently lives in California where he is in private practice as the owner of Addiction Intervention Services.

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WORKING WITH FAMILIES OF CHEMICALLY DEPENDENT CRIMINAL JUSTICE OFFENDERS

Introduction

Professionals working with families of chemically dependent criminal justice offenders know that this is a very challenging population. Working with families of the chemically dependent in open society is in itself challenging. The families of chemically dependent offenders have all of the problems of the general population only more! There is more denial, more pain, more loneliness, more anger, more misunderstanding, more abandonment, more trauma and more chaos in the family systems. These families have all of this but with less access to resources. In this writer's opinion, it is a much studied and researched population, but rarely effectively treated.

Goals

The goals for this course are to:

- Estimate the scope of the problem,
- Identify from statistics the majority of the families needing services
- Gain an understanding of effective family theory and therapy
- Have a working knowledge of the systems approach to family therapy, as it pertains to families of chemically dependent offenders
- Identify problems for the chemically dependent family, with special emphasis on the families of offenders
- Assist these family members to see how codependency and lack of setting personal boundaries keeps them stuck and unable to move on in their lives, regardless of what happens with the chemically dependent offender

This course is not a research paper about the families of chemically dependent offenders, but an educational effort to understand addiction and what happens to family members of the chemically dependent offender. It is the hope of this author, that from this knowledge, professionals in both the criminal justice system and the chemical dependency fields will create new ways to assist these people, whose lives are affected by addictive disease.

THE SCOPE OF THE PROBLEM

* Statistical date from the government agencies is several years in arrears because of the time it takes to gather the research and publish it. This fact does not diminish the impact of the data for purposes of this course.

According to the Bureau of Justice Statistics on Criminal Offenders, as of December 31, 2001 there was an estimated 5.6 million adults who had served time in state or federal prisons, including 4.3 million former prisoners and 1.3 million adults in prison. Of interest is:

Between 1996 - 2002, half of jail inmates were held for a violent or drug offense.

Drug offenders, up 37%, represented the largest source of jail population growth between 1996 - 2002.

Approximately half of all offenders convicted of intimate violence and confined in a local jail of a state prison had been drinking at the time of the offense. Jail inmates who had been drinking prior to the intimate violence consumed an average amount of ethanol, which is the equivalent to 10 beers.

Thirty-one percent of jail inmates had grown up with a parent or guardian who abused alcohol and/or other drugs.

Two million, or 36% of the 5.3 million convicted offenders under the jurisdiction of corrections agencies, were estimated to have been drinking alcohol at the time of the offense.

Among violent offenders, 41% of probationers, 41% of those in local jails, 38% of those in State prisons and 20% of those in Federal prison were estimated to have been drinking when they committed the crime.

One cannot assume that an offender whose offense was alcohol or other drug related is chemically dependent. There is alcohol use, abuse and dependency. What are the criteria for substance dependency? According to the Diagnostic Criteria DSM IV, the criteria for diagnosing chemical dependency are:

- A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
- Diminished effect with continued use of the same amount of substance.
- Withdrawal symptoms or use of some closely related substance to relieve or avoid withdrawal symptoms.
- Substance is taken in larger amounts or over a longer period of time than intended.

- Consistent attempts to cut down or control the substance.
- A great deal of time is spent in obtaining the substance.
- Decreased time spent in social, occupational or leisure activities.
- Continued use in spite of physical or psychological problems caused by the substance.

In the non-offending population, it is estimated that each chemically dependent person affects six to ten people's lives. It is reasonable to assume that these numbers are significantly higher in the chemically dependent offending population, due to the involvement of criminal justice procedures and professionals. Conservatively speaking, if 20% of the people in the criminal justice system, between 1996 and 2001, were chemically dependent with an average family size of five people, 5.6 million family members would be in need of educational and recovery services.

According to the latest data from the Office of Justice Programs (OJP) Bureau of Justice Statistics (BJS):

- 68% of jail inmates reported substance dependency prior to incarceration, with 29% being under the influence at the time of the offense.
- 16% admitted to committing offenses in order to obtain money for drugs
- Of 665,000 inmates, two-thirds or approximately 440,000 admitted to being chemically dependent. Estimating an average of five family members would project 2.2 million family members in need of education and recovery from the family disease of addiction.
- Not only are these staggering statistics, to add to the problem, the BJS reported that 67% released from prison or jails were rearrested within three years of release.

Texas has the largest prison system in the U.S. and the second-highest rate of per capita incarceration after Louisiana. [1] In the late 1990s, one in 20 Texans was in jail or prison or on probation or parole. [2] From 1988-1998, 53% of inmates in Texas State jails were sent there for drug-related crimes. [3]

The problem is even more pervasive than these statistics suggest. According to the Texas Commission on Alcohol and Drug Abuse (TACADA), 59% of probationers and 63 % of prison inmates were substance abusers or substance dependent. [4]

TACADA also reported the 20% of inmates surveyed had spent more each week on drugs than they legally earned. These same inmates reported a median weekly drug expenditure of $660. [5]

Whatever agency statistics are used, it is evident that the scope of the problem is immense with millions of family members of offenders in need of education and

help. When chemically dependent offenders return home to their families, who have received no education or help about the disease, the family unintentionally becomes a major relapse trigger and accounts for some part of the high recidivism rate both to alcohol and other drugs, which often precedes repeat offending.

PROFILES, CULTURAL AND FAMILY BACKGROUND OF REPEAT OFFENDERS

Of the 55,183 prisoners released from the Texas Department of Criminal Justice custody in 2001:

- 84% were male; 18% were married
- 44% were non-Hispanic black; 32 % were non-Hispanic whites and 24% were Hispanics.
- The median age at release was 34 years old and 70% were under age 40. The youngest was 17 and the oldest was 97.
- 39% had been incarcerated for drug offenses, 33% for property crimes, 17% for violent crimes and 11% for other infractions, including driving while intoxicated.
- 60% were released through non-discretionary means, such as the end of court ordered sentence; nearly all of these rest were released through the approval of Boards of Pardons and Parole.
- 59% were subject to parole supervision or felony probation supervision after release and were required to abide conditions such as having a job and participating in alcohol or other drug treatment.
- In Texas and most other states, releasees tend to return to major metropolitan areas. [6]

What does this information indicate is germane to working with families of the chemically dependent offender?

- It is always important to have as much information as possible about the clients with whom you are working.
- This information is pertinent to the course of action to take when treatment planning.

- The data gives direction as to what questions to ask when taking the family history.

It is always dangerous to generalize; however, just from the above data one could assume that the most typical family with whom professionals can expect to work is the family of an unmarried African American male who is in his late thirties and who has had at least one previous incarceration, who will return to a major metropolitan area and who has a history of being chemically dependent.

To work effectively with a family whose offender meets this description, professionals need to know the cultural in which the family functions. This data gives rise to pertinent questions, which are necessary to make a family evaluation and determine a reasonable approach of assistance. Some helpful questions are:

- What family attitudes do members have about alcohol and other drugs?
- What are the family feelings about having a member incarcerated again?
- Who do they blame for the situation?
- How strong is their denial?
- What is the level of anger and to whom or what is it directed?
- Do members see themselves affected by the situation?
- Do they blame themselves for the situation?
- Will they allow the chemically dependent offender to return home to live if nothing has changed in the offender's behavior?
- Do they see themselves as playing any part in the chemical dependency and/or the criminal behavior?
- How much willingness is there for the family to change themselves?

Understanding How Families Operate:

To make sense or understand how any family operates, it is necessary to have some type of structure or construct against which one can identify behaviors and family dynamics. Another name for these constructs or structures is family theory. Anytime one is evaluating a family or attempting to "figure out" what is going on within the family, there is the need to make assumptions and observations based on one's beliefs and knowledge of how families operate.

There are many theories about how families operate. The theory always comes before the therapy. The therapy is based on interventions which are based on the assumptions and beliefs of the family theorist. For the purpose of this course we are going to study the theories of two family theorists, and how their theory can be applied to families of the chemically dependent offender. The theories, which this author believes, are the most applicable to understanding chemical dependency are those of Murray Bowen, M.D. and Virginia Satir.

"All human groups, including families, have four major characteristics:

- Organization: role and task assignments that divide functions of the systems among its elements.
- Interaction: communication among the elements to achieve the purpose of the group.
- Interdependence: mutuality of influence; action by one part affects one or more of the other parts; the elements do not operate independently.
- Stability: balance and predictability over time; the tendency to remain the same until internal or external pressures require a change." [7]

It takes some kind of organization to conduct the business of being a family. Organization is required to provide emotional and economic stability to family members. Preparing children with the tools and abilities to live independently in society require organization. Even family systems, which appear to be extremely chaotic, have some form of organization. Without a form of organization and the assignment of roles, a group of individuals would not be considered a family unit.

There is always interaction among family members, even with those who appear to be detached and do not communicate well or often. In order to conduct family therapy, there is an assumption that the family is important to each family member for the purposes of providing emotional, social and economic functions.

In every family system there is a mutual interdependence. An action by one member sets off a reaction by one or more of the other members. This in turn changes the reaction which then changes the system. For example, in a chemically dependent family, if the alcoholic/addict is drinking or using, then the spouse will react by being angry which in turn makes the alcoholic more angry, and he reacts by drinking more. Both the addict and the family member are mutually dependent upon each other for actions and reactions. Should the alcoholic/ addict then re-offend and become incarcerated again, this sets off yet other reactions from family members. They may react in any ways, but it is reasonable to assume they could be disappointed, angry and may even leave the relationship. Over time, such a radical change in the family will be the result of actions and reactions.

Family systems, even though in a state of constant flux, change and chaos, are consistently attempting to reach or maintain some kind of stability. Families will display patterns in dealing with ups and downs and become extremely resistant should anyone attempt to change these patterns, even their therapist. The family system is continually attempting to return to the familiar.

This is particularly true in the chemically dependent family, even after receiving education and assistance. Families learn to adapt to and live with dysfunction.

Usually they have prayed and pleaded that the chemically dependent member will get clean and sober, only to inadvertently return to their old patterns, and in effect, sabotage the loved one's recovery. In therapeutic terms, this process is called homeostasis, which means a complex system seeking stability after some kind of change in the system.

Murray Bowen, M.D. Bowen Theory and Its Application to Families of Chemically Dependent Offenders:

Murray Bowen, M.D (1913-1990) was born in Waverly, Tennessee on January 31.1913. In 1937 Dr. Bowen received his medical degree from the University of Tennessee. After medical school, Dr. Bowen served in the armed services in Europe during World War I. He had originally thought he would be a surgeon, but during the war he observed human behaviors under stress, which led him to go into psychiatry.

Upon his return to the United States, he accepted a position to train with the Menninger Clinic in Topeka, Kansas. He later worked in research at the N.I.M.H; and in 1959, he became a full time faculty member in the Department of Psychiatry at Georgetown Medical Center. In 1975 he founded the Georgetown Family Center.

"He has been credited as being one of those rare human beings who had a genius, new idea. He had the courage to go against the psychiatric and societal mainstream and stand up for what he believed about human behavior. Thanks to his efforts the world has been rewarded with a new theory of human behavior, one with the potential to replace Freudian theory with a radically new method of psychotherapy based on a new Theory." [8]

Bowen Theory:

Bowen Theory is about human behavior, using family systemic thinking to describe complex interaction, and views the family unit as an emotional unit (Georgetown Family Center-Bowen Theory, 2001-2004). Bowen viewed families as follows:

- By nature, families are intensively connected emotionally, even when some members feel detached or disconnected.
- Family members affect each other's thoughts, feelings and actions.
- Family members want each other's approval, attention and support; and they react to each other's needs, expectations and distress.
- By being connected to each other and reacting to each other, family functioning is interdependent.
- A change in one person's functioning results in changes in other family members' reactions.

- Individual family members vary as to the degree of interdependence, but it is always there to some degree.
- This emotional interdependence has a positive and negative function. On the positive side, it promotes healthy family functioning; such as collectively providing food, shelter and protection to family members. On the negative side, when anxiety and stress occurs to the system, the anxiety does not happen to just one member but infectiously affects all family members. Over time one of more family members will feel isolated, out of control and overwhelmed. These are the people within the family who will start to adapt to the tension and literally absorb the family anxiety.

Dr. Bowen formulated the systems theory and the eight interlocking concepts. He used systems thinking to integrate knowledge about human behavior. He saw human behavior as a product of evolution. "His core assumption is that an emotional system has evolved over billion of years and governs current human relationships." [9]

For the purposes of this course, only four of the interlocking conflicts will be studied because these four are most applicable to chemically dependent families of offenders. The four will be:

- differentiation of self,
- triangles,
- family projection process and
- emotional cut off.

How does Bowen Theory apply to the family of chemically dependent offenders? Family members are the people in a chemically dependent family who do the adapting. One or more family members will take on the responsibility for any dysfunction, anxiety or stress in the family system, while at the same time becoming extremely vulnerable to problems such as depression and addictions; e.g., alcohol, other drugs, gambling, sex, food, working, multiple relationships and perhaps criminal behavior. In some way, their pain, anxiety and feelings of being overwhelmed will be acted upon; and the behaviors that work by temporarily reducing the anxiety and emptiness will be compulsively repeated.

Today, alcoholism and other addictions are considered brain dysfunctions. Murray Bowen did not have the benefit of this knowledge. Bowen believed that all emotional problems are created in the dysfunction of the family; and, therefore, all emotional solutions can be found by correcting the family dynamics. Current thinking does not view family dysfunction in chemically dependent families as either/or but as a combination of psycho, social and spiritual illness; however, Bowen Theory and the eight interlocking concepts are extremely applicable in understanding the dynamics of the chemically dependent family.

Differentiation of Self:

It is the job of every human being to both remain a part of the family of origin system, and also to grow and mature while becoming an increasingly separate individual. Bowen called this the differentiation of self. The process of becoming an individual is called individuation.

If a child is born to parents who themselves have high levels of differentiation, then the process of individuation is relatively simple; however, if the parents of this child have low levels of self-differentiation, then the child will have low levels of differentiation. In time, the child will predictability marry a person with low self-differentiation. This process will keep repeating itself generation to generation until intervened upon. It is very difficult to raise ones level of differentiation without a structured effort.

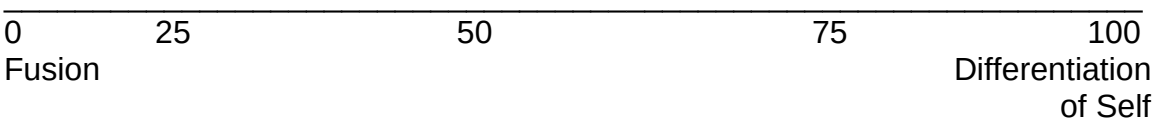
According to Goldberg and Goldberg (1991), “To Bowen, the degree to which a differentiation of self occurs in an individual reflects the extent to which that person is able to distinguish between the intellectual process and the feeling process he or she is experiencing. Thus, differentiation of self is related to the degree to which one is able to choose between having his or her functions guided by feelings or thoughts.

Those individuals with the greatest fusion between the two, function most poorly. They are likely to be at the mercy of involuntarily emotional reactions and tend to become dysfunctional even at low levels of stress. Just as they are unable to differentiate thought from feeling, such persons have trouble differentiating themselves from others and thus fuse easily with whatever emotions dominate the family.” [10]

It was Bowen’s contention that family members, with low self-differentiation levels, have what he called either undifferentiated family ego mass or fusion mass. There are highly fused families where family members interact with others, in and outside the family, on an emotional, feeling level with little or no logic or intellectual reasoning. A key point in understanding Bowen Theory is his insistence that to achieve maturity and self actualization, an individual must become free of unresolved emotional attachments to his or her family or origin.

!n 1966, Bowen devised a theoretical scale for evaluating an individual's differentiation of self:

Figure 1.1



According to Bowen:

- The differentiation of self-scale distinguishes between peoples' emotional and intellectual functioning.
- People at the lower end of the scale (0-25) are emotionally fused to their families and others and lead lives where feelings dominate their thinking.
- People in the 25 to 50 range are still emotionally fused to the family but have some degree of differentiation, that allows them some independence, but their actions are driven by seeking the approval of others.
- In the 75 to 100 range, people have a high degree of differentiation between their emotional and intellectual functioning, and their behavior is not dominated by emotions. When stress occurs, they are able to separate their feelings from their thoughts, while still being able to remain emotionally involved and intact.
- Bowen (1978) considered those in the 75 percent range highly differentiated, and those in the 60 percent and above range to be very rare.
- People at the low end of the self differentiation scale develop what Bowen called the pseudo self. They see themselves as real, but in reality their personalities are a mixture of opinions and values of others.
- Those on the high end of the scale are able to act independently of their emotions, while still having feelings. When people enter into relationships they find those of similar levels of differentiation with whom to connect.

<u>Relevance of Bowen Theory to the Families of Chemically Dependent Offenders:</u>

Of all family theories, Bowen Theory appears to most applicable to the chemically dependent family, particularly the chemically dependent family of offenders. Alcohol and other drug addictions are known as "feeling illnesses." Alcoholics and other drug addicts have very poor impulse control, indicating that decisions and reactions are poorly thought out. The addicted react to themselves, others and situations on a feeling level; but without knowing what they are feeling; either because their feelings are drug effected or because they never stop to determine what they are feeling.

Alcoholics are both sensitive and easily frustrated, thus, the most frequent emotion is anger. Generally, anger is the expression of hurt and fear, but since the impulse to act or react has bi-passed the intellectual portion of the brain, all that the alcoholic/addicts know is that they seem to stay in a constant state of irritability, restlessness and discontent.

Alcoholics and addicts, who are active in their disease, rarely function above the 50 percent level on the self-differentiation scale. Since they are most likely to enter into relationships with other emotionally and intellectually fused people, they are very reactive to each other and will create a highly fused ego mass with a prevailing emotion of anger. Children born into such a union are at very high risk to be triangulated into this stressful family system. Family members of the chemically dependent offender live with fear, shame, hurt, chaos, violent emotions and often physical and sexual violence.

It is important to point out that low differentiation does not mean that a person is intellectually challenged! Indeed, quite the opposite is true. Most alcoholics, drug addicts and their families are extremely intelligent and highly functional in areas not related to their family interactions. What it does mean is that when it comes to the emotional aspects of their lives, their feelings dominate their thoughts.

Another crucial point is that Bowen did not blame families for these dynamics. On the contrary, he saw these dynamics being passed on from generation to generation. For those who work with addicted family systems, this adds credence to the generational aspect of alcoholism and addiction without sacrificing current knowledge about the relapsing brain disease. Addiction cannot be explained by looking at just one aspect. It is not an either/or explanation. Bowen encouraged systems thinking and staying away from cause and effect. He once said, “To the degree we blame others is the degree to which we are still stuck in our family of origin.”

A metaphor for the alcoholic family is one in which the addicted family member and other family members are together on an elevator going down. It is a myth that the alcoholic/addict and the family members have to ride the elevator to the basement. Traditionally, the basement was called “hitting bottom.” We currently know that any person, be it the addicted person or the family members, can get off the elevator at any floor. Education and therapy have made this possible, giving a new meaning to “hitting bottom”. People make changes in their lives when the unknown becomes better than the known. The elevator metaphor is consistent with the Bowen Theory because it illustrates all family members being affected by the behavior of another family member. If one person gets off the elevator, the system has changed and those remaining on the elevator must adapt to the change. Again, this is consistent with the Bowen Theory that any change in the system affects the entire system.

It is important to note that the change in the system does not have to come from the addict. Most families wait around for the chemically dependent person to become clean and sober, which may or may not ever happen. This is why family education and treatment is vitally necessary. It is not uncommon for a family member to "to step off the elevator" first. When this happens, the system often changes and stops enabling the addicted member to continue drinking and/or using, which then results in the addict seeking help. Bowen (1978) taught that a change in the functioning of one family member is automatically followed by a compensatory change in another family member.

Furthermore, Bowen Theory teaches that the over-functioning of some family members will result in the under-functioning of others. This is clearly evident in the families of chemically dependent offenders. With the under-functioning of alcoholics/addicts due to their addiction and the added physical abandonment caused by their incarceration, family members are left with all the responsibilities of the chemically dependent offender and see little choice but to over-function.

The dynamic of over and under-functioning describes the typical alcoholic/addict and codependent relationship. The dynamic of over and under-functioning will be explored in depth later in this course. When working with under-functioning/ over-functioning addicted/codependent relationship, it is much easier to get the over-functioning person to tone down the over-functioning than to get the under-functioning member to function at a higher level.

In the chemically dependent family of non-offenders, family members are assisted through self-help programs such as Al Anon. They are taught to stop enabling the irresponsibility of the addict/alcoholic by surrendering or just "giving up." In the incarcerated family system, family members have little choice but to assume the responsibilities of child raising, working to pay the bills and keeping the household and family functioning. In the families of the chemically dependent offender, there is often domestic violence. Because the victims of domestic abuse will likely interpret the concept of "giving up" as an excuse to remain in an abusive, codependent relationship, they should be referred to agencies dealing with domestic violence instead of to programs such as Al Anon. (Springer, McNeece, Mayfield-Arnold)

In the cycle of addiction, the chemically dependent family member drinks to relieve anxiety, which in turn increases the anxiety level of other family members, particularly the spouse or significant other. The higher the dependency of the family members upon the chemically dependent person, the higher the anxiety level of the family system. As the overall anxiety level of the family rises, the more the chemically dependent member drinks or uses. The anxiety of the family is greatly escalated in the offending family system. Based on past experiences, they are aware that relapse is often the precursor to re-offending and the possible return to jail or prison. When working with these families,

assessing the anxiety level will give the professional an indication of the level of family dysfunction.

Triangulation:

Two-member relationships can be mutually gratifying and stable so long as there are low levels of stress; however, when stress and high levels of anxiety enter the picture, the relationship becomes unstable. The couple in the relationship will bring in a third party to share or relieve the tension and stabilize the system. A triangle is more stable than a straight line.

According to Bowen Theory, the triangle is the basic building block of the family emotional system. (Goldberg and Goldberg 1991) The family member that is sucked into any kind of tension in the two-member relationship is usually the most emotionally vulnerable member of the family. If the anxiety level continues to increase, then the system will pull other people. Where there is domestic violence and a chemically dependent offender, the system may triangulate social service agencies, lawyers or even the court system.

If working with the chemically dependent offender's families, professionals are advised to become aware of triangulation. In these family systems, it is routine to find members closely fused and who have low levels of differentiation and high anxiety. Consequently, it is expected there will be intense triangulation in the family system.

Family Projection Process:

Most parents claim that they do not treat any of their children differently than they do the others. Family therapists are aware that this is not accurate. Each child is born at a different time, under different circumstances and in a unique moment in the history of the family. Children who are the focus of their parents' attention usually develop greater fusion than their siblings, have lower levels of self-differentiation, lower abilities to distinguish between thoughts and feelings, and have greater amounts of tension and anxiety. These children are more reactive to stress within the family. Bowen Theory teaches that immature parents pick out the most infantile of their children to play this role. Bowen (1978) called this process family projection process.

This most emotionally vulnerable child is most likely to become triangulated into the parental relationship. This child can triangulate with either parent, but at different times. This child usually reports feelings of confusion, high anxiety, and of being trapped between the parents - both of with whom he has bonded to some greater or lesser degree.

This does not have to happen to just one of the children in the family. The more immature the parents and the greater the stress in the family, the more opportunities there are for triangulation. Children who are victims of the family projection process can be expected to grow up with physical, mental, and emotional problems.

This also explains how addictive disease can be passed down through many generations of the family.

The Emotional Cutoff:

The children, who are not as heavily involved in the family projection process, are not as fused to the family and are better able to distinguish between their thoughts and their feelings. These are the children who can separate from the family either by relocating to a different area or by seeing themselves as emancipated from the family. This is a form of self-deception and denial. Bowen saw emotional cutoff as a flight from unresolved conflicts. (Goldberg and Goldberg, 1991)

Emotional cutoffs happen most often in families where there are high levels of anxiety and stress plus great emotional dependence. Conflicts occur as both the anxiety and the dependence escalate. It may not be obvious immediatly; but in time, the anxiety will become so intense that it becomes unbearable. Emotional cutoff is about distancing ones-self from pain. This distancing might happen emotionally, socially or physically; it is about self-preservation.

Communication in these families is poor, non-directed, and superficial. Bowen (1978). If the parents are emotionally cut off from their parents, there is more likelihood they will be emotionally cut off from their children.

Virginia Satir:

The late Virginia Satir was a pioneer in the family therapy movement. Satir called her work a “process / communication approach”. Two of the basic beliefs of Satir Therapy are that all humans work towards growth and development and that each individual has the resources needed to reach his / her potential. According to Satir, there are three types of factors that influence human development:

- Unchangeable genetic endowment that determines our physical, emotional, and temperamental potential.
- Longitudinal influences: the result of learning acquired in the process of growth, experiences from birth to the present.
- The constant mind-body interaction.

To Satir, the primary triad was the mother, father, and child. From this triad a child gets not only his identity, but also his self-esteem. If the parents have low self-esteem, chances are great that they will pass low self-esteem onto the child. They simply do not know how to pass along high self-esteem. Satir believed that positive self-esteem is the foundation of a healthy family.

In the mind-body connection, people have negative or positive feelings about their different body parts. For instance, a person with a very large nose may take on negative feelings about her/his nose. A person with long, healthy, silk-like hair may have very positive feelings about her hair. Clients are encouraged to become aware of these feelings and learn to use them in a harmonious and integrated manner.

Satir believed that the "self", which is the core of every person, consists of eight separate but interacting parts. These eight parts determine a person's sense of well being. The eight parts are:

- Physical (the body)
- Intellectual (thoughts, facts, left brain activity)
- Emotional (feelings, intuition. right brain activity)
- Sensual (sound, touch, taste, smell)
- Inter-action (I-thou communication between oneself and another)
- Contextual (colors, sound, light, temperature, movement, space, time)
- Nutritional (solids and fluids ingested)
- Spiritual (one's relationship to life's meaning, the soul, the life force)

For Satir, the purpose of family therapy is to build self-esteem, encourage self-worth and to discover and correct communication problems within the family. Satir used terms like "wellness and wholeness" to describe the desired results of family therapy.

Satir's Family and Communication Roles:

A fundamental belief of Satir's approach to family therapy was her belief that most problems in a family system stemmed from faulty or dysfunction communication patterns.

Satir's Family Reconstruction:

Being very experiential and hands on, Satir saw the therapist role as one of entering into the family system and interacting with family members. One of the significant therapeutic techniques she devised was what she called "family reconstruction". The person getting help is called the explorer while a group of people volunteer to participate in another technique called family sculpting. The group of volunteers or family members of the explorer play the roles of the

explorer's family back three generations. The explorer then uses these people to sculpt a painting or representation of what the family looked like in preceding generations. Once placed in the sculpture, the participants report their feelings and emotions. The purpose of the family reconstruction is to assist the explorer in seeing and experiencing family patterns as a means of uncovering and eventually discarding dysfunctional patterns.

In the introduction of her book, The New Peoplemaking, Satir wrote:

> "Over the years I have developed a picture of what human beings living humanly are like. They are people who understand, value, and develop their bodies, finding them beautiful and useful. They are real and honest to and about themselves and others; they are loving and kind to themselves and others. People living humanly are willing to take risk, to be creative, to manifest competence, and to change when the situation calls for it. They find ways to accommodate what is new and different, keeping that part of the old that is still useful and discarding what is not.
>
> When you add all of this up, you have physically healthy, mentally alert, feeling, loving, playful, authentic, creative, productive, responsible human beings. These are people who can stand on their own two feet, love deeply, and fight fairly and effectively. They can be on equally good terms with both their tenderness and their toughness, and can know the difference between them.
>
> The family is the context in which a person with such dimensions develops. And the adults in charge are the peoplemakers." [11]

What Satir describes in the above paragraph is the healthy family and healthy family members. This is a wonderful goal to work towards for both the families of the chemically dependent families and the professional who are working with them.

When the disease of addiction plus criminal behavior stresses a family system, the exact opposite describes the dysfunctional family. These are people who do not understand, value, or develop their bodies. They often see their bodies as ugly and distorted. They are what Bowen called the pseudo self, unable to be real and honest about themselves and others; they are critical and judgmental of themselves and others. They are unwilling to take risk, cannot be creative, and feel incompetent. They are rigid, do not adapt to change, and hold onto resentments of the past. They are angry, hopeless, and feel stuck in their lives with no way out.

Sometimes these families seek help from professionals. It is important for the professional to have a clear picture of where the family is presently and also a

clear picture of where they can be, with a lot of time and work plus help in getting there.

Dysfunctional Roles of Communication:

Satir believed that most family problems arose out of generations of dysfunctional behaviors, particularly in the patterns used to communicate with one another. The interest Satir had in past generations was to identify these patterns in a way that the family with whom she was working, could see and recognize these patterns in their present day functioning and then change them. Satir put great emphasis on how the members of the family communicate with each other and the verbal and non-verbal messages they send out. The dysfunctional patterns were identified by means of family reconstruction, and role-playing demonstrated the communication roles.

Satir's was primarily interested in observing the patterns families develop in their attempt to maintain emotional balance. It was her belief that the manner in which families communicated with each other is a strong indication of how members feel about themselves and their self worth. She described dysfunctional communication as incomplete, inaccurate, unclear, indirect, distorted and inappropriate.

Satir saw family members as communicating not only with their words but with body language as well. When describing her communication styles, she would have her clients assume body positions which correlated with the activities she was describing. This also assisted in the clients getting in touch with the feelings accompanying the actions.

Satir contended that under stress, people will communicate in one of five ways:

- The Placator is the people pleaser / approval seeker who appears weak and is always apologizing. This person acts like a doormat. The body position is down on one knee, one arm out stretched to receive the crumbs of life, the other arm is behind the back with an out stretched middle finger. This is a precarious position where one can be knocked over easily. The posture is demeaning, passive, and not empowering. It is a very passive/aggressive stance. The extended hand says "I will do anything, just love me"; and the hand behind the backs says "But I will get even".

- The Blamer is dominating, always finds fault with others, and is very self-righteous and accusatory. The body position is with the index finger consistently pointing at someone else. This gives the illusion of power. The verbal message is "It is all your fault".

- The Super Reasonable is a rigid, intellectual, aloof, and emotionally detached role. The body language is in a lecturing position; arm overhead with index finger pointing up, which easily allows it to fall into the blaming position. The verbal message is "Listen to me. I am always right, and you need to do it my way."

- The Irrelevant person distracts others and is seemingly unable to relate to whatever is happening.

- The Congruent is the person whose body language and verbal messages match. They are effective communicators. They appear real, genuine, expressive, and send forth straight, clear messages. This facilitates the message sent being the message received, which promotes effective communication.

In family therapy, it is generally accepted that dysfunctional families live by at least three dysfunctional rules: don't talk, don't feel, and don't trust. Problems do not get addressed; feelings are either anesthetized or numb; and there is no trust because the chemically dependent family member is predictably unpredictable. These rules help in reinforcing Satir's communication roles. The point of this kind of communication is not to communicate in an attempt to keep the tension and anxiety at low levels. In actuality, the roles increase the discomfit and anxiety in the family system.

Satir was quick to point out that the communication roles described actions and were not labels. Placating, blaming, lecturing, distracting are all verbs describing actions. They are not nouns or labels to put on people

"Satir, a warm, caring, nurturing person, who was also capable of being fearlessly direct, inevitably tried to facilitate straight talk between family members, encouraging them to be congruent in the communications, matching words to feelings to body stance, without qualifications." [11]

At a later time, another family therapist, Sharon Wegscheider-Cruse, borrowed from the communication roles, gave them names and described their function in the dysfunctional family system. (Another Chance-Hope and Health for the Alcoholic Family) These descriptions can give an understanding of the roles family members of the chemically dependent offender may assume:

The Addicted Person:

- This person represents "the problem". They create chaos, are dishonest, aggressive, often irresponsible, blaming, self-centered, and in big time denial; but they do not see themselves this way.

The Chief Enabler:

- This family member represents “control”. They see themselves as victims, have a bad case of “poor me”. They are angry and see themselves as inadequate. They are super responsible, out of touch with their feelings, self-righteous, and in denial. People who take on this role often had one or more parents who were chemically dependent. They have a tendency to marry chemically dependent people.

The Family Hero:

- The hero’s job in the family is to make the family “look good or normal”. They are hard workers, get good grades in school, win awards and in adulthood are usually very successful at what they do. They are workaholic human doings that justify their behaviors by their success. They are often lonely and empty inside.

The Rebel/Scapegoat:

- These people are hostile, defiant and angry. They act out the family pain. Their function is to take the focus off the chemically dependent person. They do not feel a part of the family system and often join gangs or seek lesser companions. They seek negative attention and usually get blamed for whatever goes wrong in the system. They have problems at work or school, poor interpersonal relationship skills, and are extremely lonely. They are at the highest risk in the family to become chemically dependent.

The Lost Child:

- This person makes no waves. They keep out of the line of fire. The Lost Child makes no problems; they try to stay away from family interactions and family life. They are good at becoming invisible. Lost children have little zest for life, sexual identity problems, eating disorders, remain very quiet, and have trouble making decisions.

The Mascot/Clown:

- Seeks attention but is immature, fragile, cute, fun and funny, hyperactive, and has a short attention span. Represents “comic relief” to the family. Clown has many physical complaints and looks for a “hero” to marry in order to be taken care of. The clown usually remains immature.

All members of a family are assigned roles, not just members of dysfunctional families. One role is not superior to another. Roles are about carrying out family functions and maintaining homeostasis and emotional stability. For a family to remain functional all the time, all members would have to maintain their roles and functions continuously. This is not realistic. Life is stressful, family life is particularly stressful. The definition of a dysfunctional family is a family system in pain and under stress from some inside or outside force, resulting in pain, anxiety and tension for family members.

The Significance of Shame, Violence, Abandonment and Post Traumatic Stress Syndrome in Families of Chemically Dependent Offenders:

Shame

Few other family systems experience the emotion of shame more than the families of chemically dependent offenders. There is still a great deal of ignorance about the disease of chemical dependency, resulting in an existing stigma for the victims of the disease and their families. Add this shame to the stigma of incarceration, and these families usually experience an overwhelming sense of shame. Where there is stigma, there is shame; and where there is shame, there are secrets.

What is shame? It is important to distinguish between the feelings of guilt and the emotion of shame. Guilt is the feeling people experience when they do something that they know to be wrong. It is the feeling people get when they violate their own belief or moral code. The guilt message is “I did wrong”. For instance, if one believes sex outside of marriage is wrong, but s/he has many sexual affairs, then s/he will most likely feel guilty. Guilt can be remedied by stopping the activity that provokes the feeling.

The painful message of shame is “I am faulty”. It is a core concept or belief about one’s self or one’s family. It is learned through life experiences and picked up both verbally and non-verbally from the messages a person receives about ones self and to whom they belong. The family message about a member’s worth and how she feels about herself is passed down from generation to generation. Bowen Theory explains this as generations of low levels of differentiation where people are triangulated to lower and lower levels and decreasing ability to react intellectually but, under stress, are driven to react increasingly with emotionally charged anxiety.

The painful feelings that accompany shame are: unacceptable, loser, less than, deficient, disappointed, not enough, inadequate, helpless and not as good as

others. Shame is learned in comparison to others. Since it is learned, it can be unlearned but it takes a great deal of time and effort. Changing our in-grained emotions is an inside game. People often think they can overcome shame by high achievement or success. Ask any hero child who has tried this, they will tell you that success alone is not the answer. It takes a lot of work and therapy to change a core concept about the self; however, it is not impossible.

The cover up for shameful feelings can best be described as shameless behaviors. These behaviors mask the shame and in so doing look like arrogance, grandiosity and narcissism. On the outside these people "appear to have it all together." There is no room for mistakes or weakness, they project that they are invincible. They go it alone and are critical, blaming and judgmental of others.

The preferable place to be emotionally is what is called fully human. This is between the polar opposites of being neither shame based or shameless behaviors. This is the goal for shame based family members. The feelings that accompany being fully human are more comfortable. To be fully human is to drop the pretense and get rid of the mask. It is not a need to be perfect, but just to be acceptable. It is being peaceful, forgiving and forgivable, vulnerable and peaceful.

Anger and Violence:

Anger is a common way that people express fear, hurt and frustration. These are the underlying emotions of angry outburst. Two of the primary emotions that addicted people project onto their families are anger and fear. The behavior is blame. The addicted see themselves as victims, feel sorry for themselves and blame others for their mistakes and behavior. The addicted have a very low frustration tolerance.

Anger is a normal and natural emotion. When someone violates a personal boundary it can be expected that there will anger expressed. Violence is when anger is acted out. Violence can range from throwing an object to murder.

There is always anger in a chemically dependent family system and often violence in the chemically dependent offender family. It is critical to assess for the presence of domestic violence. Over half of battering men have alcohol or drug problems.

Children who have an incarcerated parent feel a deep sense of sadness, suffer acute emotional trauma, poor school performance, social stigma, eating and attachment disorders and aggressive behavior. They are five to six times more likely to go to prison than their peers. (Springer, McNeece and Mayfield-Arnold, 2003) Because of the emotional trauma these children and family members usually feel overwhelmed and anxious.[12]

According to Terrance Gorski, alcohol and drugs are readily available in most federal and state prisons. Thus, the chemically dependent continue to drink and use while incarcerated, and they leave prison still addicted and with a renewed criminal mindset. The addiction problems result in poor judgment, poor impulse control and stronger criminal behavior. This is a set up for revolving doors in and out of the prison system.

Gorski states " at least 60% of violent crime to be associated with drug use and most drug users also have problems with alcohol. Addicts commit 15 times as many robberies and 20 times as many burglaries as criminals not on drugs or alcohol." [13]

Approximately 70 percent of America's 1.4 million prisoners have alcohol and drug problems but only 1 percent of federal inmates and 15 percent of state prisoners receive effective treatment.

Alcohol and drug addiction isn't the only problem among the incarcerated. Approximately 70 percent of the chemically dependent criminal offenders also have personality disorders, such as anti-social, narcissistic or borderline personality disorders. This means that from childhood, these individuals have learned to be self centered, focus upon immediate gratification, and discount the rights and feelings of others. These people never learned to respect the law and consistently defy legitimate authority.

What does this mean to the families of the chemically dependent offender? It means they are faced with the prospect of long term chemical dependency in the family. It means that there will be repeated violence and probably repeated and increasingly long term incarcerations with the possibility of not having the offender back as a productive, contributing member of the family or society. It means other family members will have to take over the offender's responsibilities including surviving financially and / or raising children. It means they are going to have to move forward in their lives without any guarantee they can ever depend on the chemically dependent offender. It also means that in many cases, sobriety and recovery are not enough to cause the problem with the offender to get better. There will need to be intense therapy for co-morbid personality disorders or other mental illness.

This sounds very hopeless, but if the family members attend support groups such as Al Anon or Codependent Anonymous, they can get help for themselves regardless of what the chemically dependent offender does with his/her life. Family therapy, if plausible and available, should also be encouraged.

Abandonment:

There are two types of abandonment, emotional and physical. Families of the chemically dependent offender experience both kinds in depth. Emotional abandonment is perhaps the most confusing and difficult to identify. The perpetrator can be physically present but emotionally unavailable or abusive. They can have a physical presence, but in all other ways are not available to other family members.

In the case of the incarcerated offender, they cannot be present in the physical sense and if they are available emotionally it is from a distance physically and infrequently.

Children who are abandoned have holes in their souls. They feel like the problems in the family are because they have done something wrong and caused a parent to leave, drink or use alcohol. They are set up to be both chemically dependent and offenders at an early age.

Trauma, Traumatic Stress and Post Traumatic Stress Syndrome

It is safe to say, that the chemically dependent people and their families experience trauma. It is safer to say that the families of chemically dependent offenders experience trauma tenfold. They live under a cloud of trauma and get stuck in it, often without resolution for their lifetime.

The dictionary defines trauma as “an emotional shock that creates substantial and lasting damage to the psychological development of the individual, generally leading to neurosis.” [14]

In his book, Walking The Tiger, Peter A. Levine describes the human organism as more than the sum of the parts. Webster defines an organism as “a complex structure of interdependent and subordinate elements whose relations and properties are largely determined by the functions of the whole”. Levine states “body and mind, primitive instincts, emotions, intellect and spirituality all need to be considered together in studying the organism. The vehicle through which we experience ourselves is the ‘felt sense’. The felt sense is the medium through which we experience the fullness of sensation and knowledge about ourselves.” [15]

Humans, who have lived with acute or long-term trauma, as in the case of chemical dependency, learn not to talk, learn not to feel and learn not to trust. In other words, there is a disconnect whereby the “felt sense” cannot be experienced; leaving an empty, sad and joyless existence. Recovery from the

trauma slowly allows the "felt sense" to return, allowing the victims of trauma to again experience the fullness and joys of life.

There is a difference between Traumatic Stress Syndrome and Post Traumatic Stress Syndrome. (Springer, McNeece and Arnold, 2006) Traumatic Stress Syndrome is trauma that may be ongoing and that is happening now; as in the case of the family members of chemically dependent offenders. For example, when children are traumatized, that is very much in the present. When they are adults and out of the traumatic family system, but they still carry the pain of the trauma, it becomes posttraumatic stress syndrome. For instance, this can be said about adult children of alcoholics.

The criteria for diagnosis for Posttraumatic Stress Disorder, according to DSM IV, is as follows:

a. The person has been exposed to a traumatic event in which both of the following were present:

- The person experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

- The person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.

- Recurrent, distressing dreams of the event. **Note** In children these may be frightening dreams without recognizable content.

- Acting or feeling as if the traumatic event were recurring (including a sense of reliving the experience, illusions, hallucinations and disassociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma specific reenactment may occur.

- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

- Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of generalized responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- Efforts to avoid activities, place, or people that arouse recollection of the trauma.
- Inability to recall an important aspect of the trauma
- Markedly diminished interest of participation in significant activities
- Feelings of detachment or estrangement from others
- Restricted range of affect (unable to have loving feelings)
- Sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- Difficulty falling or staying asleep
- Difficulty concentrating
- Hyper vigilance
- Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Codependency and the Families of Chemically Dependent Offenders

Two major characteristics of the families of the chemically dependent are codependency and the inability to set personal boundaries. Families of the

chemically dependent offender experience a type of forced codependency because of the incarceration of the alcoholic/addict. They are forced to assume the responsibilities of the member who is incarcerated.

A major difference between families of the chemically dependent non-offender and the chemically dependent offender is that the families of offenders do not have as many choices due to the incarceration. Nevertheless, they still suffer from codependency and can be helped to regain their lives and their right of choice without remaining victims of the chemically dependent and the incarceration. Professionals working with these families need to learn to recognize codependency.

What Is Codependency

Codependency is an over used, confusing and vague concept. If you give one hundred blind men an elephant to feel, you will get one hundred relevant but different descriptions. The same would be true if you asked one hundred people to define codependency. The purpose of this section of the course is to assist professionals in gaining a working understanding of codependency.

One could say that the roots of the codependency movement had its start early in the recovery movement. The wives of the founders of Alcoholics Anonymous, Lois Wilson and Anne Smith, saw that their husbands were getting help and getting better. These two women recognized that they too were in need of help and founded what is now known as Al Anon.

Lois Wilson, in her book, Lois Remembers, describes what today would be called her codependent behavior: “After Bill sobered up, it was a great blow to realize he did not need me in the way he had before. My primary aim in life, helping Bill achieve sobriety, had been canceled out, and I had not yet found anything to take its place. Slowly, I recognized that because I had not been able to “cure” Bill of his alcoholism, I resented the fact that someone else had done so, and I was jealous of his new found friends. Little by little I saw that my ego had been nourished during his drinking years by the important roles I had to fill: mother, nurse, breadwinner and decision maker…. I also saw that I had been self-righteous and smug, thinking I was doing for Bill all that any wife could do. I have come to believe that self-righteousness is the worst of sins.” [16]

What Lois describes as her feelings, beliefs and attitudes is a great example of what Bowen Theory later called under-functioning/ over-functioning. It is also a great description of the symptoms of codependency, which will be reviewed later in this section.

Lois' writings were about the early days of Alcoholics Anonymous and Al Anon, which began in the late 1930s and early 1940s. It is in the 1960s and 1970s that codependency and the codependency movement has it roots.

A simple definition of codependency is when a person wakes up in the morning and puts a thermometer in some other person's mouth to determine how the person holding the thermometer feels. In other words, when how one person feels is contingent upon how another person feels. With codependency the focus is increasingly upon another person. The over-functioning increasingly takes over the responsibilities of the under-functioning, and the focus and attention are on the under-functioning person. In terms of addiction, the chemically dependent under-functions while the spouse or other family members over-function.

Codependency is a Relationship Disorder:

Bowen Theory would explain codependency as the result of two people with low levels of self-differentiation entering into a relationship. The operative words are "two people." Codependency cannot exist in a vacuum, it always occurs in relationship to another person who is experiencing some kind of impairment.

Addictive systems are just one way people develop codependency. Anytime there is a major internal or external stressor in a family system, be it addiction, mental illness, poverty, racism or long- term physical illness, there is a ripe opportunity for codependency. For the families of chemically dependent offenders, there is somewhat forced codependency because of the incarceration.

The dictionary defines dependency as "a state of being influenced, or controlled by something else." In the case of codependency, it is someone else. The dynamic is the addict/alcoholic, increasingly and progressively, becomes dependent upon some mood-altering chemical and simultaneously becomes more and more impaired. As the impairment progresses, the codependent becomes increasingly focused on the addicted person. One might even say, addicted to the chemically dependent person and their behaviors. Indeed, codependency results in a relationship disorder where at least two people fuse in unhealthy ways in an attempt to become whole.

Is Codependency A Disease?

The answer to this question is yes and no. The answer is 'no' in the most restrictive sense of the word. There is no known evidence that we are born with a "codependency gene." It is an acquired or learned set of behaviors, attitudes and beliefs that a person develops when they are in a relationship with an impaired or under-functioning person.

Because of the generational aspects of family dysfunction, people are born into codependency, but are not born with it. Families that have experienced generational hardships, stress and pain often accept codependence as normal and continue to hand down these attitudes, behaviors and beliefs generation to generation.

Codependency can be considered an illness because people get sick and can even die from the stress and pain of living with dysfunction. In the case of the addict / codependent relationship, the codependent exhibits progressive, predictable symptoms just like those of the chemically dependent.

Why Is Codependency Harmful?

Like addiction and criminal behavior, codependency has a recurring, repetitive nature. Children of alcoholics/addicts tend to be addicted or enter into relationships with an addicted person. Without help or treatment, children of alcoholics/addicts are comfortable in their role as the codependent, adapt to the dysfunction and enter into multiple relationships with chemically dependent people. These people tend to never find a life of their own and live their lives through others, rarely finding wholeness, peace and satisfaction in their own lives.

Codependency is a disease in the sense that it has symptoms, is a stress related occurrence and as such can kill people who have it. Many adult children of alcoholics can provide a list of stress related physical illnesses such as general anxiety disorder, migraines, stomach ulcers, irritable bowel syndrome and/or emotional disorders such as various kinds of depression, they have experienced as a result of growing up in chemically dependent families. With the stress of having a family member incarcerated, the psychosomatic symptoms multiply. These illnesses can occur for many years, even after the chemically dependent person is dead or out of their lives Over time, these illnesses become chronic disorders that, if left unresolved or untreated, can cause these people to become very sick or die. Regretfully, often just the symptoms of these illnesses are treated without ever getting to the root cause, which is codependency.

Just as alcoholism and other drug addictions have a predictable pattern of progression from beginning to middle to late stages, so does the disorder known as codependency. As the chemically dependent person's addiction spins out of control, the lives of the codependents become increasingly unmanageable as they attempt to control the uncontrollable.

How does one "catch" codependency?

We learn codependency by growing up in a family system that practices unhealthy attitudes, behaviors and beliefs about themselves, their family and

their world. Besides having low levels of self-differentiation, families of the chemically dependent offenders have few, if any, skills to identify and express feelings. They act out their feelings impulsively and reactively, and the feelings are most often anger and frustration.

Because of the addiction, family members, particularly children, learn they cannot trust the people they should be able to trust the most. What they do learn is to not feel, don't talk and don't trust. They learn how to look good and feel bad. They wear masks to avoid allowing others to see their vulnerability and pain. They feel responsible for what is happening to the family. They believe if they just try harder, they can fix the problem.

The saddest message they get about themselves is that they are not worthy human beings. The universal feeling among the chemically dependent and the people who love them is "I am not enough". They have immense fear of failure that often freezes them into doing nothing and taking no risk. Since they and their thoughts and opinions are not respected, they learn they are not worthy of respect, so they don't respect themselves or others.

Being emotionally and physically abandoned, which are the realities of families of chemically dependent offenders, they abandon themselves in many ways, such as becoming dependent on alcohol, other drugs, work, sex, food, gambling or other people.

They will try most anything to fill the void and emptiness they experience. Since they have been abandoned and they abandon themselves, they cannot be available to others, so they abandon them too.

<u>What is a Dysfunctional Family?</u>

The phrase dysfunctional family is not a derogatory term, neither is it a criticism or a judgmental statement. It is used to describe an unbalanced family system operating under stress and in pain; a family system with an inability to communicate with each other at a feeling level.

This situation results in replacing safety, security and nurture with shaming, blaming and attacking. It is a family system where the parents are not acting like adult parents and children are not allowed to be children.

A dysfunctional family is not about being rich or poor or ethnicity. It is about stress and pain and the messages people get about whom they are. Like any other addiction, codependency is universal and cuts across all socioeconomic, ethnic or cultural groups.

What are the results of Codependency?

Codependents are externally focused people. Having little or no clue who they are, they identify with the externals of life. They learn to be outwardly directed. Ask them who they are and they tell you their name, where they live, who their family is, and what they do for a living. They define themselves with externals because there is little or no sense of the true or inner self. They are constantly taking cues from the outside about how to behave, act and feel. Having lived with uncertain and unpredictable circumstances, codependents have tremendous fear of change and are usually willing to put up with the inappropriate actions of others, even to the point of death.

Are only Family Members Codependent?

Absolutely not! Most alcoholic and addicts had codependent beliefs, attitudes and behaviors prior to becoming emotionally and physically addicted to alcohol and other drugs. Timmen Cermack, M.D., in his 1986 book titled, Diagnosing and Treating Codependency, had the following to say about the connection between chemical dependency and codependency:

"Substance abuse is consistent with the personality structure of the codependent…..codependents exhibit a wide range of compulsions, and the use of alcohol or drugs fall into this category. Traditionally, however, the codependent who compulsively uses chemicals in the service of denial is diagnosed as chemically dependent. This is as it should be; when chemical dependency is present, it must be treated as the primary issue. But it cannot be seen as the only issue. Once the chemical dependency has been broken, the codependency remains; left untreated it acts as a barrier to long term sobriety." [17]

We now know that underneath chemical dependency lies a true codependent, especially those who grew up in addicted family systems. For these chemically dependent people, they first learned to give their power away to others, then the chemicals. Lack of power is truly their dilemma.

A Definition of Codependency

Codependency is a relationship disorder that makes people sick and can even cause death! Codependents live other people's lives while neglecting their own. It is most commonly learned in dysfunctional families where safety, security and nurturing is replaced with shaming, blaming, attacking and feelings are not important. Because they are dependent upon others for their happiness, they are always at the mercy of others and therefore, see themselves as victims.

Relationship Dependency

Because they cannot over-function unless they are in a relationship with someone who under-functions, they are also on the look out for someone who will allow them to over-function. They feel threatened if the under-functioning person attempts to recover or gain a sense of self. Their role is being diminished. The significance of this is that a codependent will, usually unknowingly, sabotage the attempts for another to gain a sense of self and take on their responsibilities.

Codependents have high expectations that another person will make them feel needed and complete. When this does not happen, they are either off to find the next victim - similar to the way the alcoholic/addict finds the next drink or drug - or they work to keep the dependent person more dependent upon them. Some become sex and love addicts, who are drawn to the excitement of the new relationship and "falling in love." Once the newness of the relationship wears off and they find that the person not a perfect match, they are off to the next encounter.

Over Caretaking:

Codependents are the ultimate caretakers. They are like a flashing neon sign, looking for someone who "needs" them. They know what is best for everyone else while allowing their lives to go down the tube. When they find an under-functioning alcoholic/addict, the glove fits the hand. Ultimately, they tire of being the caregiver, feel unappreciated and become victims.

Codependents frequently enter the helping professions, such as doctors, nurses, counselors, teachers and ministers. They particularly like the ministry for then they can speak for God.

Like the alcoholic/addict, if codependents do not get help, they are doomed to keep repeating these self-defeating behaviors. What codependents learn about relationships as a child, they bring into their adult relationships.

There is a great line from the Woody Allen movie *Crimes and Misdemeanors* that explains the repeating, self-defeating pattern. To paraphrase: 'There is a strange paradox that when we fall in love we try to re-find those people from our past, who caused us great pain, and expect our new lovers to undo the pain from the past'.

People Pleasing:

Codependents depend on others for their self worth to the point of placating or becoming a doormat. They cannot be true to themselves or others because there

is no self. Driven by their fear of abandonment, they tell others what they think they want to hear and are always fearful they will make someone else angry. Over time, they resent this role, become angry and become the perpetrator.

Approval Seeking:

Since codependents have little or no self-esteem, they consistently seek outside validation. Hoping for validation, understanding and love, they habitually end sentences with "you know". Their mantra is "I will do anything, just love and accept me, you know."

Controllers:

Codependents feel powerless and out of control. They tenaciously hold on to the idea they can control everyone and everything. Always trying to control others or situations over which they have no control, they stay angry and frustrated. They live by the creed of "I am only o.k. if you are o.k." Codependents are emotionally invested in controlling others, so they can feel powerful and good about themselves. Since the addict and the codependent cannot function without the other, there is need; but, in addition, there is usually a power struggle and the relationship is filled with conflict.

Enablers/Disablers:

Enabling, or disabling, is repeatedly doing for another person what they should and could be doing for themselves. The enabled person either allows this to happen by doing nothing for themselves or rebels against it. In effect, enabling creates an emotional cripple and always prolongs the addiction, but never stops it. Since their world is dependent upon the welfare of the alcoholic/addict, codependents feel extreme pressure to "fix" the problem without considering that they do not have the power to do so.

Rescuing:

Rescuing is not allowing another person to experience the pain or consequences of their actions and behaviors - it is a great way for the codependent to stay in control. Codependents bail them out of jail, and pay their legal fees and other bills. This is extremely detrimental to the alcoholic/addict because pain is a major motivator for the addicted. If the alcoholic/addict knows they that will be rescued from whatever trouble they get into, then they will continue the dysfunctional behaviors.

Denial:

With any of the addiction or behavioral illnesses, there is always denial. Denial can serve a real purpose. It allows sudden trauma to be taken in at a rate that is not completely overwhelming. The problem is when denial becomes a chief survival mechanism. Then, it is easy to get stuck in denial and never deal in reality.

A very good definition of denial is: “It is easy not to see that which we don’t want to believe.”

Boundaries

Codependence is about giving power away. Boundary setting is about taking power back. Learning to maintain healthy boundaries is a major skill to learn on the road to recovery.

Families of chemically dependent offenders are either what is called enmeshed or detached or possibly somewhere in between. Enmeshment means family members are so entwined that there is no individual separation. It is difficult to determine where one person leaves off and another begins. This is a family system that has little experience with boundaries. The enmeshed family may look like they are close and caring; however, enmeshment is really about control and feels suffocating. An enmeshed family is a closed society, leaving or bringing new people into the system is not welcomed.

A detached family system is where family members are so far removed from each other that there are little or no interactions. These family members have a poor sense of self because there has been no sense of comparison or a family to nurture them. These are people with rather lost souls and little sense of direction in their lives.

The healthy family is on a continuum somewhere between the two polar extremes. These family members are sufficiently grounded and have a healthy sense of self. Each has their own comfortable space. They can come together and be emotionally close and separate without fear of permanent loss or abandonment. There are clear demarcations where one individual starts and leave. It is an open system. Members can safely leave the system and return at a later date and new family members through marriage or birth are readily welcomed into the family. This is a family system that has healthy boundaries.

What is a Boundary?

A boundary is a limit a person sets with others in order to practice self-care. It is an action requiring self-respect. It informs others about how they are to be treated. It can be set with respect and firmness. It is never a threat, but an action one is willing to enforce.

Boundaries are often confused with threats. A threat is a manipulation that is employed in an attempt to get some one else to change their behavior. A boundary is what one does to take care of his/her self, regardless of what the other person does. A boundary differs from a threat in that a motivation behind a threat is to get another person to change their behaviors. A boundary is about initiating change to your life.

Where codependence is a problem, boundary setting is a big part of the solution. Codependence is about giving power away to others; boundary setting is about taking it back.

It is difficult to set boundaries for the following reasons:

- Healthy boundaries are not modeled in dysfunctional homes.
- Codependents have to guess at what normal is and thus, learn unhealthy ways to take care of themselves.
- Setting boundaries is the exact opposite of codependent needing to people please and approval seek.
- Setting boundaries requires letting go of control and the outcomes.
- It is taking a risk and it is therefore fearful
- It requires being true to yourself and valuing yourself enough to believe you have the right and obligation to protect yourself and to be treated with dignity.

In What Areas Are Boundaries Usually Violated?

Physically:

All people have a need for personal space. If physical boundaries have been violated in the past, these people will have need for more space than others. If people have a close personal, intimate relationship with someone they know, the space requirements will not be so guarded. A physical violation has occurred any time people have entered your personal space without permission. If violence happens to the body, then obviously a boundary violation has taken place.

Violence can happened in any family system and happens somewhat routinely in families of the chemically dependent offender.

Emotionally:

Emotional violation is when a person is yelled at, degraded, cursed, and called profane names. It also happens when someone has intentionally hurt another person's feelings. Emotional violation is to be expected in the family system where there is chemical dependency.

Fiscally:

Alcoholics and addicts are often in need of money and rely on family members to give it to them. Codependents feel guilty and ashamed when they cannot do so. If they continue to do so, they often feel angry, but keep supporting the addiction anyway. Every person has a right to their own finances and the choices they make as to how they want to use them. The addicted will use anger, force and intimidation to get money, and these tactics are boundary violations.

Sexually:

Every person, assuming they are of legal age of consent, has a right to grant or withhold sexual contacts or acts. Whenever there is inappropriate touching, force or pressure put on another person for sex, there is a boundary invasion. For children under the age of consent, any form of sexual contact, with or without permission, is justifiably a criminal offense.

When the criminally dependent offender has been a sexual perpetrator, professionals should be diligent about evaluating family members for sexual abuse. It has been estimated that 90% of women seeking treatment for chemical dependency have in some manner experienced sexual abuse. The figures for men are not available, but could be expected to be high.

Spiritually:

Every adult person has a right to find their own path to personal spirituality. There is such a thing as religious addiction. Each person should be allowed to practice their own faith, but not at the expense of others.

<u>What is the Process of Setting Boundaries?</u>

Boundary setting is a process leading to action one takes to protect and maintain their physical, fiscal, emotional, sexual and spiritual safety and comfort. The process happens as follows:

The Boundary Violation:

The process is initiated when another person or persons literally or figuratively "step over the line." It is a violation of personal space, a thoughtless disrespect of feelings and emotions, a disrespectful act or an illegal infraction of a person's rights.

Physical boundary violations range from another person standing uncomfortably or inappropriately close to actual assault.

Fiscal Violations may be as subtle as manipulating a person to give them their money or possessions to out right robbery.

Emotional Violations occur when one is yelled at, cursed, demeaned or in any way made to feel badly about his / herself. Emotional abuse is a severe type of torture.

Sexual Violations are when a person forces his / herself upon another person. This ranges from touching private parts of the body to rape. A sexual violation has occurred with a person has turned down a sexual proposition and the perpetrator uses persuasion in an attempt to get the other person to give in. A person needs only to say "no" one time, otherwise it is considered being pressured to consent.

Spiritual Violations are when someone uses pressure, preaches or frightens another in an attempt to get that person to accept his / her concept of a higher power.

Awareness of Boundary Violations:

There are two major responses to boundary violations. The first is a startled response when something unplanned or unexpected happens such as being cut off in traffic to an outright accident. A weapon being drawn is another example. This response is immediate and clearly noticeable.

The other is a kind of boundary violation is more long term; it happens over a period of time and is less recognizable. At best, it takes a longer period of time and intense therapy to be uncovered. This is particularly true when there has been childhood neglect, abandonment and abuse. This type of boundary violation is more subtle. An example is when a child is given inappropriate or burdensome responsibilities that are not age appropriate. Such children are clinically referred to as "parentified children"; which is a nice way of saying the child never had a carefree childhood because they had to perform as adults at an early age. Children from dysfunctional families have a difficult time acknowledging this kind of abuse and abandonment as a boundary violation

even in their adulthood. They would rather defend and rationalize the behavior than admit they have been abused by a loved one.

Identifying or Expressing Feelings about Boundary Violations:

Since anger is the most common expression of fear and hurt, it is also the most common response to boundary violations. Codependents have problems expressing their anger, hurt and resentments. Consequently, many people get stuck at this stage of the process and walk around, sometimes for years, with resentments. Resentment is held-on-to anger and hurt. People stuck in this stage lead lives of frustration and usually see themselves as victims who are at the mercy of other people for their happiness. Again, codependents often attempt to intellectualize and justify the boundary violation.

Taking Actions to set Boundaries:

Setting boundaries is about self-care. It is an action a person takes to protect his/herself from further harm. It is not a threat. A threat carries with it an expectation that another person has to change their behaviors. Setting a boundary is giving another person notice that the boundary setter is going to change his or her behavior. Boundary setting is about setting limits and teaching others to respect your space and boundaries. One should never set a boundary unless s/he is willing to follow through with the consequences should the boundary be violated again.

An example of setting a boundary with a chemically dependent offender might be the family member's unwillingness to live with alcohol and other drug use or criminal behaviors. The boundary setting family member must then determine what action s/he will take to enforce the boundary limits and conditions.

Learning How to Set Boundaries:

If a person moves beyond feelings to taking actions, then they are ready to learn the necessary skills of boundary setting. The good new is that it is a skill and can be learned. This is a skill that is used to replace codependent behaviors such as people pleasing, approval seeking and over care taking.

Codependency is about behaviors, attitudes and beliefs that facilitate giving personal power away. Boundary setting is about learning the tools to take back personal power.

When setting a boundary with another person, it is a good idea to role-play setting the boundary with a neutral third person. This takes some of the anxiety out of setting the boundary. It also allows the boundary setter to practice what

needs to be said. It is a good idea to request the third party to give feedback as to what they are hearing and feeling. Always point out that boundary setting is about changing the boundary setter's behavior, not other people's behavior.

Through boundary setting, family members start to find their true, inner selves. They learn to respect themselves and teach others how to respect them. Most importantly they learn to stop abandoning themselves through alcohol and other drug use. Where there is an emerging true self, the opposite of Bowen's pseudo self, there is the possibility of finding and maintaining a healthy, rewarding and loving relationship with another person.

As a professional working with families of chemically dependent offenders, the most valuable therapeutic tool to be employed is to teach family members how to set boundaries. Empowering family members to set boundaries, allows families to start dealing with reality instead of denial and false assumptions.

The Family In Recovery

The best thing professionals who are working with families of the chemically dependent offender can do is to recommend recovery programs for all family members. Addiction is a family problem, and recovery can be a family solution. On going programs such as Al Anon, Codependency Anonymous and Families Anonymous are cost-free 12 step programs. Individual and group therapy is also advised. Community Family Centers often provide cost-effective therapy groups and counseling, particularly in metropolitan areas. Self –help groups can easily be found in any area of the country by going to the internet for www.**alcoholics-anonymous**.org; www.al-anon.alateen.org, or www.codependents.org For family therapy, check with community based mental health authority.

It is very important to remind family members that even when the chemically dependent family member is in recovery, remaining abstinent, and is paroled, there is a long period of family reconstruction ahead. There is also the ongoing possibility of relapse and returning to incarceration. Thus, family members need ongoing support and recovery. Without support and recovery, family members will remain unchanged. The possibility of relapse increases for the chemically dependent offender when the family system is the same as when they were incarcerated.

Dr. Stephanie Brown conducted a developmental model for the chemically dependent family in recovery. She calls the first five years of family recovery the "period of transition". This is for the conventional alcoholic family. When there is the added stress of long-term abandonment and incarceration, it is reasonable to extend the time of transition for the families of the chemically dependent family. "The erosion of denial is an incremental process. It begins during drinking and

moves people to abstinence. But it is not over. The challenge of denial and all distorted think continues long into recovery." [18].

A Fictional Story about the family of a Chemically Dependent Offender

Dick and Jane marry at an early age. For the first couple of years, they live in a kind of marital bliss. Both are working and there is adequate money for them to live comfortably and enjoy some short vacations, dinner out and entertainment. Jane was aware that Dick drank alcohol more than she would like, but she was sure that after they had children, he would not drink as much. She was also sure she would be able to control the amounts and when he drank. Dick's drinking reminded her of how her Dad drank; but her Dad was an alcoholic, and she was sure Dick was not!

After they had been married a year and one-half, Jane announced to Dick that she was pregnant. They were both elated and scared at the same time. Jane, being an adult child of an alcoholic with a low level of self- differentiation, felt very insecure about being a mother. Not only did she not have any experience with taking care of an infant, the full time responsibility of child raising overwhelmed her. This would mean that she will have to stop working, and their income will be significantly reduced.

Dick was resentful towards Jane because he left birth control responsibilities up to her. He blamed her for the fact that she was pregnant, and he was going to have to work two jobs, since they now had to move because there was not room for a baby in their present location.

Dick reacted to the anxiety by drinking more. Jane expressed her anxiety by nagging Dick about his drinking, which she saw was happening more frequently and more often.

In time, little Susie was born. Where there had been two, now there were three. Jane had given up her job; and Dick, an insurance salesmen, had taken a part time job as a bookkeeper for a manufacturing company. Even working two jobs, money was scarce.

After Susie was born, Jane devoted her attention and focus on the baby and away from Dick, who felt lonely, angry, unappreciated and resentful. Increasingly, Dick found comfort in alcohol and had started secretly using cocaine and meth-amphetamine. Feeling unappreciated, lonely and unloved, Dick started stopping off at a late night strip club, where he met Angel. Dick began an extramarital affair with Angel, who he felt understood, appreciated and loved him.

Jane was increasingly nagging Dick for money, for drinking too much and for coming home late, if at all. The cost of supporting his alcohol, cocaine, meth addiction, and Angel had become very expensive. He never had enough money. Dick came up with what he saw as a sure-safe plan to embezzle money from the manufacturing plant. He was certain he would not get caught.

As Dick's drug addiction progressed, so did his expenses. Dick began to embezzle more money and take greater risks. With continued use of cocaine and meth-amphetamine, Dick had developed a sexual addiction and was gambling away most of the money he embezzled plus large amounts of his salary.

In the meantime, Jane had became less and less interested in herself. She spent her time focusing on Susie, who now was nine years old, and attempting to control Dick's drinking and drug use. She no longer had any time for herself. In effect, she was living her life though Susie while abandoning her life to Dick's addiction.

As the tension and anxiety grew in the family, Susie became Jane's confidant. Jane would constantly tell Susie her troubles and demean Dick to his daughter, even telling Susie her Dad did not love them, stating he only loved alcohol, drugs, gambling and sex with other women. Adults would often comment to Jane about how adult Susie was. Jane would beam with pride and say that Susie was her only reason to live. Dick and Jane no longer had a civil word to say to each other. The atmosphere in the home was heavy with tension and anxiety. Sometimes the anger and tension would escalate to the point that Dick would strike Jane and blacken her eyes.

Susie was trying hard to keep the screaming and fighting from happening. She attempted to be the peacekeeper and was frustrated because any thing she tried did not work. She started to see herself as worthless and hopelessly ineffective. At school she would put on a happy face and try to act as if everything at home was just fine. She was really feeling very afraid, trapped between her mother and her father and lonely because she had no one in whom to confide. She was careful not to make any friends as she did not want anyone to come to their house and observe what was happening. She loved her Dad but could not understand why he did not stop drinking and fighting with her mother. Sometimes, she thought her mother must be right, that he did not love them. She had to be brave for her mother, who needed her protection. Even though she was only nine, she had to be the adult in the family.

One evening, the local Sheriff came to their home and arrested Dick for embezzlement and hauled him off to the local jail. The next morning there was a front-page picture of Dick in handcuffs being taken to jail, along with a lead story about Dick's years of embezzlement. Ultimately, Dick was charged with

embezzlement of $500,000, possession of illegal substances, and domestic violence.

Dick and Jane did not have money for an attorney, so a local attorney was assigned to Dick's case by the courts. When the case was tried, Dick was found guilty on all counts. Dick was sentenced to 15 years in a minimum-security prison and a mandate to repay all of the stolen money upon his release. He was also mandated to attend education courses on alcohol and drug addiction, 12 step meetings, and anger management classes while incarcerated. Jane was referred to the local domestic violence agency in their community.

Jane had become the sole income provider and had to work two jobs to pay the bills for the household. Susie worked part time after school in an ice cream shop, where she met Joe, who was a nineteen year old man. They started secretly dating. Joe used alcohol and meth. In time Susie started using with Joe. By the time she was 17, she found out that she was pregnant. She and Joe used together for a year. After the baby was born, Joe was convicted for armed robbery, and Joe was incarcerated in a State Prison. Susie was left to support their baby.

Course Summary:

There is a tremendous need to treat both chemically dependent offenders and their families. The number of family members in need of education and treatment is staggering – well into the millions. Criminal justice providers and chemical dependency counselors can learn to recognize the symptoms and dynamics of this family illness of addiction and repeat criminal incarceration.

Even if the professionals simply provide referral for treatment, it is important that they have some tools to evaluate what the family members need. There are many family theorists and their suggested therapies. For the purpose of this course, there has been some examination of two family theories and approaches to therapy, the late Dr. Murray Bowen and the late Virginia Satir. These were chosen because of their applicability and adaptability to the families of the chemically dependent offenders.

Bowen saw all family dysfunction as stemming from generations of poorly differentiated family members, who did not have the ability to separate feelings and intellect; and who, consequently, reacted impulsively and emotionally to stress. Bowen saw all problems arising in the present and generational family systems. Conversely, he believed that problems in the family could be fixed by helping clients to find differentiation and to resolve all past and present problems. When it comes to chemical dependency, it is important to note that Dr. Bowen did not have modern day knowledge of chemical dependency as a relapsing brain disease.

Satir, on the other hand, believed in generational dysfunction, but was much more focused in the here and now. She believed that most family dysfunction has its origin in the communication patterns among family members. To illustrate this she devised the dysfunctional communication pattern of the placatory, the blamer, the super reasonable and the distracter.

The family of the chemically dependent offenders has all the pain and stressful dynamics of the families in the general population, only much more. For these families there is more pain, more stress, more shame, more guilt, more abandonment, more anger, more hopelessness, more stress, more post traumatic stress syndrome, and relapse has more serious consequences because it often leads to re-incarceration.

Codependency and lack of boundary setting skills are primary problems for the families of the chemically dependent offenders. Codependency results in a relationship disorder where an over-functioning person is in a relationship with and under-functioning person. Both have a lack of positive self esteem and are seeking fulfillment through the other person. Codependency is giving personal power away to another person. Both the addicted person and the family members usually have codependent behaviors, beliefs and attitudes.

Boundary setting is a skill that can be learned. It is a means of gaining or regaining personal power. It leads to the exact opposite of codependency. By setting limits with others, codependents learn to respect and protect themselves. This is a practice in becoming the differentiated, healthy self.

Footnotes

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[4] Texas Commission on Alcohol and Drug Abuse, *Substance Abuse and Crime in Texas,* by Jane Carlisle Maxwell (Austin, Texas, November 1998) p.7

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Appendix A: Post Test and Evaluation for *Working with Families of Chemically Dependent Criminal Justice Offenders*

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in any **one** of the following manners:

1. *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.

   To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. , which is the final step in the process. Once you submit the evaluation, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

   If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

   OR

2. *Submit your test by mail using the answer sheet found at the end of this package.* First, complete the cover page that will identify the course and provide us with the information that will be included in your Certificate of Completion. Then, answer each of the questions by selecting the best response available and marking your answers on the sheet. The final step is to complete the course evaluation (most certifying bodies require a course evaluation before certificates of completion can be issued). Once completed, mail the information, answer and evaluation sheets to this address:

   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

   Once we receive your exam and evaluation sheets, we will grade your test and notify you of the results.

   If successful, you will be able to access your Certificate of Completion and print it. Access your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Certificate' and you will be presented with a download of your Certificate of Completion that you may save / and or print. If you would rather have your Certificate of Completion mailed to you, please let us know when you mail your exam and evaluation sheets; or contact us at ceumatrix@ceumatrix.com or 800.421.4609.

   If you do not obtain the required 80% score, we will provide you with feedback and instructions for retesting.

   OR

3. *Submit your test by fax.* Simply follow the instructions above, but rather than mailing your sheets, fax them to us at **((512) 863-2231**.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. If an offender is convicted of two or more offenses while under the influence of alcohol or other drugs, they are classified as chemically dependent?
   a. True
   b. False

2. Texas has the highest per capita incarceration numbers in the country?
   a. True
   b. False

3. All family units has major characteristics which are:
   a. organizational roles
   b. interaction
   c. interdependence
   d. stability
   e. all of the above

4. The concept of mutual interdependence illustrates:
   a. everyone is dependent on everyone else
   b. there must be give and take in relationships
   c. any action by one family members affects all members

5. To Bowen, undifferentiated family ego mass means families interact with each other on an intellectual level:
   a. True
   b. False

6. Chemically Dependent People usually fall into what range on self differentiation scale?
   a. 0-25
   b. 25-50
   c. 50-75
   d. 75-100

7. In an alcoholic/addict relationship, it is easier to get:
   a. the under-functional person to perform at a higher level
   b. the over-functioning person to perform at lower levels

8. A victim of domestic violence should always be referred to Al Anon?
   a. True
   b. False

9. In a highly stressed relationship, triangulation is an attempt to bring in a third party to share the anxiety?
   a. True
   b. False

10. By way of the family projection process, children of the chemically dependent offender often grow up with:
   a. physical problems
   b. mental problems
   c. emotional problems
   d. all of the above

11. Satir believed the purposes of family therapy is to:
   a. build self esteem
   b. encourage self worth
   c. discover and correct communication problems
   d.. all the above

12. It is better to be shameless than shameful?
   a. True
   b. False

13. Levine's "felt sense" indicates that we are more than flesh and bones, but also spiritual, intellectual and emotional?
   a. True
   b. False

14. What percentage of chemically dependent offenders also have personality disorders?
   a. 50%
   b. 75%
   c. 25%
   d. 70%

15. Children of chemically dependent offenders get physically and emotionally abandoned, learn to abandon themselves and in turn abandon others?
   a. True
   b. False

16. In the fictional story, Jane showed symptoms of being:
   a. adult child of an alcoholic
   b. codependent
   c. high self differentiation
   d. Both A & B

17. Susie is an example of:
    a. triangulation
    b. family ego mass
    c. emotional cut off

18. Jane should have been referred to Al Anon instead of the domestic violence agency?
    a. True
    b. False

19. The family story of Dick, Jane and Susie illustrates:
    a. low self differentiation
    b. Poor family ego mass
    c. Relapse and Recidivism
    d. All the above

20. Codependency is about giving your power away to others, boundary setting is about gaining or regaining your power?
    a. True
    b. False

Fax/Mail Answer Sheet

CEU Matrix - The Institute for Addiction and Criminal Justice Studies

Test results for the course "Working with Families of Chemically Dependent Criminal Justice Offenders

If you submit your test results online, you do not need to return this form.

Name*:_____

(* Please print your name as you want it to appear on your certificate)

Address: _____

City: _____

State: _____

Zip Code: _____

Social Security #*: _____

(*Most certifying bodies require a personal identification number of some sort – last 4 digits or License is perfect.)

Phone Number: _____

Fax Number: _____

E-mail Address: _____

On the following sheet, mark your answers clearly. Once you have completed the test, please return this sheet and the answer sheet in ***one*** of the following ways:

1. Fax your answer sheets to the following phone number: **(512) 863-2231**. This fax machine is available 24 hours per day. **OR**

2. Send the answer sheet to:
   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

You will receive notification of your score within 48 business hours of our receipt of the answer sheet. If you do not pass the exam, you will receive instructions at that time.

Name: _____

Course: <u>Working with Families of Chemically Dependent Criminal Justice Offenders</u>

1. [A] [B] [C] [D] [E]
2. [A] [B] [C] [D] [E]
3. [A] [B] [C] [D] [E]
4. [A] [B] [C] [D] [E]
5. [A] [B] [C] [D] [E]
6. [A] [B] [C] [D] [E]
7. [A] [B] [C] [D] [E]
8. [A] [B] [C] [D] [E]
9. [A] [B] [C] [D] [E]
10. [A] [B] [C] [D] [E]
11. [A] [B] [C] [D] [E]
12. [A] [B] [C] [D] [E]
13. [A] [B] [C] [D] [E]
14. [A] [B] [C] [D] [E]
15. [A] [B] [C] [D] [E]
16. [A] [B] [C] [D] [E]
17. [A] [B] [C] [D] [E]
18. [A] [B] [C] [D] [E]
19. [A] [B] [C] [D] [E]
20. [A] [B] [C] [D] [E]

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. Then, if mailing or faxing your test results, return this form along with your answer sheet for processing. **If you submit your evaluation online, you do not need to return this form.**

NAME:_____

COURSE TITLE: Working with Families of Chemically Dependent Criminal Justice Offenders

DATE:_____

COURSE CONTENT		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

_____

COURSE MECHANICS		
Course materials were well organized	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Materials were received in a timely manner	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Cost of course was reasonable	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
OVERALL RATING		
I give this distance learning course an overall rating of:	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
FEEDBACK		
How did you hear about CEU Matrix?	☐ Web Search Engine ☐ Mailing ☐ Telephone Contact ☐ E-mail posting ☐ Other Linkage ☐ FMS Advertisement ☐ Other: _____	
What I liked BEST about this course:		
I would suggest the following IMPROVEMENTS:		
Please tell us how long it took you to complete the course, post-test and evaluation:	_____ minutes were spent on this course.	
Other COMMENTS:		