

**Improving Drug Treatment Court Programs: The Development of a Multiple Family
Group Therapy Treatment Manual**

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Abstract

This project was designed to improve drug treatment court program outcomes by creating a systemic approach for substance use disorder treatment. The addressed problem was that a systemic family treatment approach is not generally used in drug treatment court program therapy sessions. The treatment gap for substance use disorder treatment negatively impacts the program participants, their families, and the community. The project purpose was to develop a treatment manual that focuses on a family systems theory approach. A qualitative phenomenological approach was used to interview experienced clinicians who use systemic approaches to treat substance use disorder. Participants responded to the project questions and provided information on what topics, interventions, and resources should be included in the treatment manual. Semi-structured interviews were used to gain new information about the clinicians' experiences treating substance use disorder with systemic approaches. A thematic analysis was used to identify common themes and patterns in the data for the target population and projected therapeutic approach. The analysis results identified themes for the first project question: engagement, sharing, and emotional support, and for the second question: tracking and support. The conclusions were that manualized treatment is effective for substance use disorder, so that the program participants will not have to change clinicians to those who specialize in multifamily group therapy. An additional conclusion is that the approach could be effective for similar disorders and illnesses. A recommendation for future projects is an outcome evaluation of the program after implementing the proposed manual. Another recommendation was that the drug treatment courts should allow first-time offenders into the program and allow assessments for those charged with "intent to sell" for program qualification.

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Section 1: Foundation

In the mental health field, the systemic approach is an evolutionary approach to treating various disorders (Wampler, 2020; Wampler & Patterson, 2020). Some of the disorders include multiple addiction disorders and substance use disorder (SUD). SUD is defined as a family disease and a chronic illness that demands a lifetime of support for lower relapse rates and the best recovery outcomes (Fuchshuber & Unterrainer, 2020). The systemic approach strengthens the resources and tools the clients already possess to alleviate the symptoms affecting their daily functioning. Marriage and family therapy (MFT) focuses on the family as a main systemic resource for treatment, for example, including a romantic partner who may live with the client. Some research has suggested that the family of origin is a common source of increasing mental or emotional health issues (Kirkbride et al., 2024). With the immediate family being the environment of individual daily functioning, family involvement may benefit treatment outcomes (Armoon et al., 2022). However, not enough mental health practices are using the element of a family focus in treatment.

An MFT systemic approach called multifamily group therapy (MFGT) allows families to relate and learn from other families and their members in treatment. The MFGT approach has been shown to be effective for severe and chronic illnesses (Maone et al., 2021) while building and strengthening relational skills. The diagnosis of SUD may be considered a chronic and family disease, and therefore, MFGT is an effective approach for this population (Beaulieu et al., 2021; Birkeland et al., 2021). In addition, SUD recovery relies heavily upon social support; therefore, the addition of peers to MFT may be beneficial to treatment. Treatment for SUD addresses the behavioral aspect as well. Given that most behavior is learned through modeling in childhood (Ajay et al., 2023), some marriage and family therapists (MFTs) rely on the family to

find the root cause of symptoms. By discovering how the symptoms began, more growth in understanding, empathy, and support may occur for SUD clients' long-term recovery needs (Stokes et al., 2018).

The MFGT approach is relevant to SUD treatment because of the diversity considerations of many families that struggle to understand the perspectives and needs of the other members (van Es et al., 2023). Traditional family members were more likely to be of a similar race, culture, and background (Chambers & Gracia, 2021; Inglehart, 2020). Post-modern families, which emerged in the 1970s and have been a growing trend of diversity ever since, are more likely to be bi-racial, blended, and from different backgrounds (Chambers & Gracia, 2021; Inglehart, 2020). A meta-analysis found that MFGT is used in diverse settings to treat multiple issues and populations as well as integrating various modalities and durations (van Es et al., 2023). Through the evolution of society, families have diversified. Therefore, more than ever, families need to work together with their different personal and family beliefs, views, and values.

Diversity is a major factor in MFGT as a post-modern approach in the mental health field (Roué et al., 2021). One example of this is an individualist spouse from a Western culture and a collectivist spouse from an Eastern culture. The individualist spouse may not appreciate the other spouse involving their family of origin in their marital issues, such as conflicting parenting styles or infidelity. Family therapy (FT) welcomes the members to work together on issues while creating boundaries that best fit the clients' needs. If families can learn and understand each other's perspectives, there is more room for empathy and compromise (Smolyaninova et al., 2020). The emphasis on the diverse approach of MFGT focuses on learning as a family and from other families for inspiration, modeling, and relatability. In addition, this approach provides

additional support needed for long-term recovery related to disorders such as SUD. Therefore, introducing other families into therapy further extends their behavioral and social learning (Roué et al., 2021).

The use of the client's family for SUD treatment has been shown to be more effective than individual and peer-involved group therapy (GT) approaches (Lander et al., 2013). In the studies that demonstrate increased efficacy, some show better long-term outcomes due to family support (Maone et al., 2021; Roué et al., 2021). The MFGT approach, like GT but with groups of families as peer involvement, has shown significant success for the SUD population (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). It combines the components of peer relatability and family modeling from the extra interpersonal interactions and social support outside the family (Roué et al., 2021). The use of MFGT in mental health treatment has been growing, as evidenced by many programs worldwide (Shalaby & Agyapong, 2020).

Although not worldwide, a nationwide SUD treatment program, known as drug treatment court (DTC), was implemented in the United States to reduce the incarceration and recidivism rates of those with SUD (Lowenkamp et al., 2005). The DTC goals are for clients to gain and maintain abstinence (Joudrey et al., 2021). However, the needs of people struggling with SUD go beyond these behavioral goals of first-order change. Since addiction is a chronic and family issue, why not treat the family together in DTC programs? By changing the relationship dynamics with MFGT, second-order change may occur for the long-term recovery support this population needs.

Currently, the adult DTC (ADTC) program only offers group and individual therapy sessions (Supreme Court of the State of Florida, 2023). This scholar used the ADTC to compare

recovery outcomes to other DTCs that allow family involvement. Although there are other courts that have adult participants, since the ADTC is the most prominently utilized, the other DTCs will not be discussed in this project. A meta-analysis has shown that DTC programs have improved recidivism rates but found that many of those studies were weak in design (Joudrey et al., 2021). In addition, a persisting issue is that the United States currently is the country with the highest global incarceration rates (Holland et al., 2018).

According to the U.S. Department of Justice, in the year 2020, two-thirds of jail inmates had a substance use-related issue (Denieffe, 2020). These issues include being arrested under the influence, having possession of a substance, or being diagnosed with a SUD. Although a 15-year study of drug court effectiveness showed that recidivism decreased when compared to the probation process, long-term reports for other outcomes are weak and limited (Kearley & Gottfredson, 2020; Lowenkamp et al., 2005). More specifically, the ADTC program outcomes are significantly unknown for the SUD treatment being provided (Gonzales & Ahram, 2025; Joudrey et al., 2021; Lowenkamp et al., 2005). Most who enter rehabilitation or the ADTC program do so individually, but then return home to the same environment that possibly fostered their symptoms (Javed et al., 2020). A major factor related to the U.S. incarceration rates may be that many SUD offenders do not have stable family lives at home. The individual returns to their family homeostasis, where the system desires to maintain the status quo.

Family homeostasis is a subconscious set of rules, roles, characteristics, and behavioral patterns that help maintain balance in a family after an interruption has occurred (Kim & Rose, 2014). Family homeostasis is difficult to change because each member instinctively reverts back to their typical behaviors to maintain stability so that the unit remains intact (Papero, 2024). For example, an adult son returns to the family home after inpatient rehabilitation, but he relapses to

cope with his father's verbal abuse of his mother. He would rather use drugs again and stay in a familiar place rather than moving out to stay sober. In order to effectively change a family's homeostasis, second-order change must occur as well as first-order change (Novak et al., 2023).

The DTC programs show evidence of first-order change through the use of cognitive behavioral therapy (CBT; Joudrey et al., 2021), but this model has very few reports on long-term coping skills for SUD (Roos et al., 2020). The focus of CBT is generally individual-based and does not focus on family involvement in therapy. Therefore, CBT has only been demonstrated to be effective for short-term changes, which does not help the long-term needs, and for the diagnosis of SUD, the individual is highly susceptible to relapse at any point in life (Javed et al., 2020). To sustain change, the addition of family behavioral therapy (FBT), family psychoeducation, communication, support, and their involvement with each other, in and out of therapy, may contribute to the second-order change needed for long-term recovery outcomes related to SUD (Camargo et al., 2023; Novak et al., 2023). However, resources to support outsourced DTC clinicians in implementing treatment and incorporating family involvement remain insufficient (Lloyd Sieger et al., 2021).

Statement of the Problem

The problem addressed in this qualitative project study was that the systemic family treatment approach is not utilized often in DTC programs. Individual and peer group treatment of SUD can be effective; however, research has demonstrated that involving the family in SUD treatment increases the long-term outcomes, which may reduce high incarceration and recidivism rates in the United States (Holland et al., 2018). Those who are impacted by the elevated rates of SUD incarceration are not only the inmate but their families and communities as well (Daley et al., 2018). What should be known about this phenomenon is that many inmates struggling with

SUD and their families, due to incarceration, lose many benefits, including emotional connection, financial stability, and parental obligations (DeHart et al., 2018). Of the U.S. children living in poverty, one in eight has an incarcerated parent (Axelson & Boch, 2019). A potential negative consequence of not addressing this issue is the continuation of draining resources from the SUD offenders' families and communities (Gifford, 2019). According to the National Institute on Drug Abuse (2020), 85% of all inmates are involved in substance use, with 65% diagnosed with SUD and 20% arrested while using a substance. Out of all the adults in the United States with SUD, many have been incarcerated for reasons exacerbated by receiving zero treatment or treatment that does not fit their needs, contributing to relapse and re-offense (National Institute on Drug Abuse [NIDA], 2020; Tsai & Gu, 2019). A gap in the literature related to this project topic is the lack of research linked to the use of MFT for adult SUD offenders. Brinkley-Rubinstein et al. (2018) suggested that the criminal justice system's (CJS's) focus on incarceration rather than rehabilitation, such as medication for drug-addicted offenders, has limited the amount of SUD treatments available in this system (as cited in Grella et al., 2020). Further research is hindered by the controversial opinion of SUD being a crime versus a disease (Center for American Progress Action, 2017). If reoffending rates continue to increase, drug and criminal activity may escalate the levels of harm and hardships for these families and communities (Olagunju et al., 2024; SAMHSA, 2023).

Purpose of the Project

The purpose of this qualitative phenomenological project was to develop the Treatment Manual Draft Proposal (TMDP) that integrates a systemic family treatment approach in the DTC programs. This project helped fill a treatment gap because, in the general population of SUD treatment programs, outside of DTC, 93% use group therapy (SAMHSA, 2021), 60% offer

couples counseling, and 81% use at least one form of family-based intervention (SAMHSA, 2020). The construct of this project was the benefit of using MFGT for SUD treatment. The sample size was aimed to include clinicians from each therapy approach (GT, FT, and MFGT), totaling seven project participants, or until saturation was achieved. Semi-structured interviews were conducted via Zoom to obtain data. A thematic analysis was conducted to find the common themes and patterns in the data for the target population, which consisted of currently practicing registered or licensed clinicians who treat SUD.

Nature of the Project

This project focused on developing the completed TMDP using qualitative phenomenological interviews to explore new information (Bevan, 2014). The descriptive phenomenological design aligned with the current project's problem and purpose statements to fill the treatment gap in the CJS by exploring effective interventions for SUD clients through the use of manualized treatment. Descriptive phenomenology was a better fit for this project than interpretive because this scholar wanted to receive the data objectively (Watson, 2024), then interpret the meaning when compared to the findings of the literature review. This methodology allowed this scholar to gain data from experienced clinicians on the systemic topics, resources, and interventions that current SUD clients received in treatment. The project questions aligned with clinicians' real-life experiences about treating SUD peers and their families to inform the creation of the TMDP intended for the DTC programs.

Methodology

The interviews were conducted virtually for the convenience of the project participants. In the phenomenological approach, interviews typically last about 45 to 60 minutes, depending on the participant, allowing them time to reflect on their responses (Sohn et al., 2017). In-depth

one-on-one interviews were used to collect data. The interviews were conducted virtually with clinicians treating SUD using at least one or a combination of GT, FT, and MFGT. All the semi-structured interviews included the same open-ended questions, with optional additional questions as prompted by the interactions with participants. Using open-ended questions is a more effective approach for thoroughly exploring a topic (DeJonckheere & Vaughn, 2019).

Design

Phenomenology allowed for the extraction of subjective human experiences to aid this scholar in strengthening the TMDP for the DTC programs, where the majority of clients may benefit from a systemic approach. For this descriptive phenomenological design, a limited number of questions was appropriate because the fewer and broader the questions, the more opportunities participants have to expand upon each topic (Bevan, 2014). Exploring new emergent information from the participants was the aim of the interviews to collect rich data. Descriptive phenomenology was used to analyze the results.

Data Collection

The data collection procedure was a semi-structured interview protocol that explored the experiences of SUD clinicians. Experienced clinicians provided information on current and effective treatments, interventions, and outcomes. The common themes were then categorized for a *hermeneutic interpretation*, which is interpreting human experiences, to determine how the systemic treatment of MFGT would benefit this population. The number of various fields of study and the diversity of the participants helped to reduce bias in the data collection phase (Sohn et al., 2017). Additionally, in connection with the literature review findings, hermeneutic phenomenology was used as a collective and subjective reflection in the data analysis (Leigh-Osroosh, 2021). This scholar conducted member checking that addressed the hermeneutic aspect

by sending each interviewee their transcribed data to check for accuracy to strengthen the credibility of the analysis.

Analysis

This scholar used an analysis process to synthesize the systemic approaches and literature findings to create the TMDP. The analysis included the approach of *free imaginative variation*, which shows the topic's essence from different perspectives (Tranberg & Brodin, 2023). This scholar used free imaginative variation in the analysis of the interviews of various clinicians who used several different modality approaches for treating SUD clients. The variation captured the unique perspectives of systemic interventions. Because SUD and crime are closely associated (Karlsson & Håkansson, 2022) and have similar elements of behavior, family conflict, and peer influence, data from clinicians who treat the general population of SUD were adequate for an effective TMDP.

Need for Project

The need for this project is the implementation of MFGT in the DTC programs because the systemic family treatment approach is not utilized often for those SUD offenders. Out of all offenders released from incarceration, 68% reoffend within 3 years (Moore & Eikenberry, 2021). Moore and Eikenberry (2021) reported the necessity to implement an effective treatment approach to address the long-term struggles of this population. One way to address this issue may be to amplify the strategies that are currently working—GT and FT—by combining the approaches with MFGT which has been shown to be effective for long-term outcomes (Maone et al., 2021).

The epistemology of SUD is significantly evidenced in the insecure attachment from childhood family conflicts and peer influence (Lewis, 2020). These two correlating factors are

another reason this approach involves peers and family in the treatment. However, the current DTC treatment does not simultaneously reflect the family of origin and peer influences in treatment. In addition, the literature reported that other countries have lower incarceration rates using open and collaborative treatment (Moses, 2020).

For DTC programs, family involvement in treatment is determined based on child welfare needs controlled by public health systems (Guastaferrero et al., 2020). Therefore, family involvement is only allowed in treatment for child-parent reunification purposes, which is family drug treatment court (FDTC) and to keep the child in the home, which is juvenile drug treatment court (JDTC). Guastaferrero et al. (2020) reported that future research should examine the intervention effects of the reunification process and how these court approaches correlate to reducing relapse and recidivism. According to Guastaferrero et al. (2020), if the CJS and the public health systems collaborate on family involvement efforts, the collaboration may be more effective in encouraging the inclusion of families in treatment. Therefore, the desired situation would be for the two systems to work together to include FT in ADTC programs. Studies have shown that interventions that strengthen interpersonal relationships benefit long-term recovery outcomes (Maone et al., 2021).

Project Questions

PQ1

According to experienced clinicians who treat SUD, what impact does peer and family involvement have on the recovery outcomes of SUD clients?

PQ2

According to experienced clinicians who treat SUD, what elements of systemic treatment (topics, interventions, or resources) need to be included in the treatment manual for SUD offenders?

Theoretical Framework

Systems theory was the guiding framework of this descriptive phenomenological project. Systems thinking started in 347 BC with Aristotle, who explained that “the whole is greater than the sum of its parts” (as cited in Halimi et al., 2020, p. 1). In the 1940s, Ludwig von Bertalanffy applied this notion to human biology, coining the term general systems theory (GST; Friedman & Allen, 2011). Aristotle’s notion of systems thinking and GST are related because the interdisciplinary theory of GST is a complex organization of interactions relating to a larger system (Friedman & Allen, 2011). When GST is effectively applied to a social aspect of mental health for the SUD population, family is a key factor (Chattopadhyay et al., 2022).

Family systems theory (FST) was coined in the 1950s by psychologist Murray Bowen. His theory was derived from GST to help explain working with a closed system, such as a family (Bowen, 1993). FST and GST are related because individuals grow and develop a pattern through the understanding of their family context, and they can apply it when the influences of the larger system of society work to destabilize them (Malik, 2020). In addition, elements from the family communication theory are derivative of GST and FST (Chattopadhyay et al., 2022; Long, 2003; Watson, 2012). Bowen aimed to help explain how families survive in homeostasis (Malvig, 2021) and develop their own unique interaction patterns including familial interaction, differentiation, and triangulation to describe human behavior as a complex social system (Brown,

1999). If there is recognition of a need for further support for individuals facing SUD, the addition of family through MFGT may benefit the SUD client.

This scholar's decision on the topic, population, and approach was guided by systems theory, highlighting the growing evidence of MFGT, an effective systemic approach for the SUD population (Shumway et al., 2022). Systems theory helped this scholar develop the problem statement because current approaches for SUD offenders exclude FST in therapy for the majority of DTC programs. The systemic framework also aligned with the purpose statement by identifying what systemic aspects would be more effective for the SUD offenders' treatment approach. Furthermore, this framework guided the development of the project questions by allowing this scholar to think about which information was needed to inform the clinicians treating the peers and families, and how it was presented in the TMDP. Common systemic themes and patterns of the clinicians' experiences treating SUD clients were examined. Their responses were used to develop an MFGT manual using a systemic approach to serve this population more effectively.

Significance of the Project

The contribution of this project was the development of a TMDP to better address the needs of SUD offenders using systemic methods with family involvement for the goal of reducing incarceration and recidivism. This project contributes to the field of MFT because researchers and clinicians interested in this systemic treatment method will be able to use the TMDP to influence the treatment of other client populations. The National Drug Court Resource Center (NDCRC) reported that in 2025, out of 4,000 DTC programs, only 406 of the FDTCs and 247 of the JDTCs involved FT (National Treatment Court Resource Center, 2025; U.S. Department of Justice, 2025). Out of all the DTC programs, only 16% involve family in

treatment, yet have the best outcomes (DeVall et al., 2022). Therefore, the importance of adopting FT in all the DTC programs may be pertinent to achieving similar outcomes by reducing dropout rates, relapse, and reoffending.

The impact of the TMDP may be substantial to MFT leaders and practitioners because they will be able to access the clinician-recommended steps of conducting MFGT effectively with SUD clients. Leaders may allow clinicians the use of the manual proposal that may contribute to the literature by providing their expert-informed feedback related to conducting MFGT with the TMDP, specifically for clients at high risk of relapse and reoffending. An article showed that clients with severe depression, a common co-occurring disorder of SUD, MFGT was conducive to preventing relapse (Paganin, 2024). The benefit of addressing the project problem was that families may be encouraged to join DTC programs. This aligns with the findings of Kahyaoğlu et al. (2020) that the more the family attends therapy with the SUD member, the less likely a relapse occurs.

The benefit of producing the TMDP is the addition of peers and family support for long-term recovery, seen as effective for decreasing relapse and recidivism (Maone et al., 2021). Furthermore, this project used theory triangulation to fill the research gap by examining MFGT for long-term SUD recovery outcomes. The triangulation addressed the research and experiences of clinicians who work closely with SUD, using GT, FT, and MFGT. The benefit of answering these project questions made the TMDP more credible and accurate to move toward positive change in the lives of SUD offenders, their families, and communities.

Definitions of Key Terms

Chronic illness

Chronic illness is a long-term health condition that is rarely curable (National Library of Medicine, 2022).

Comorbidity

Comorbidity means having two or more disorders simultaneously or sequentially, with worsening symptoms in one being due to the other (NIDA, 2018).

Co-Occurring Disorder

Co-occurring disorder is most commonly defined as having one or more substance use disorders in combination with one or more mental health disorders (SAMHSA, 2022).

Differentiation

Differentiation is when an individual balances intellectual and emotional functioning, along with intimacy and autonomy within their own family (Bowen, 1993).

DNA

Deoxyribonucleic acid is a genetic molecule that determines a living organism's development and functioning (Bates, 2024).

The Family

In the context of mental health treatment, the family refers to relatives and individuals who have a significant emotional connection with the client (SAMHSA, 2020).

Gene Expression Regulation

Gene expression regulation is the transcribing and translating of a cell to determine which genes are activated or inactivated (Gatta et al., 2021).

Intergenerational

Intergenerational refers to when patterns of interactions or communication in relationships are transmitted from one generation to the next (Sánchez & Díaz, 2020).

Pathology

Pathology is the cause, development, functioning, and history of a disease or diagnosis (Funkhouser, 2020).

RNA

Ribonucleic acid is what can make gene expression regulation possible by transcribing the genes for the cells of an organism (Sen, 2024).

Secondary Disorder

This labeled disorder in an individual develops because of a primary disorder or otherwise would not present symptoms enough to be a diagnosis (Turk, 2006).

Severe Mental Illness (SMI)

Severe mental illness is an impairment or disability in one or more significant life functions due to an emotional, behavioral, or mental disorder (National Institute of Mental Health [NIMH], 2024).

Literature Review

In this literature review, connections found in the literature searches related to systems theory were provided. The connections include a reiteration of the theoretical framework, the projected approach of multifamily group therapy, drug treatment courts, family systems and treatment of SUD, prevalence and etiology of SUD, biological factors contributing to SUD, environmental factors contributing to SUD, current treatments for SUD, and current use of

MFGT. The synthesis of the related existing research was to help balance the project results for the TMDP development.

Theoretical Framework

The theoretical framework for this project was systems theory, which comprises the main concepts: homeostasis and feedback loops. Systems theory is a system that naturally attempts to stay in homeostasis, which is stable and survives whether it is healthy or not (Billman, 2020). Negative feedback loops create stability but do not allow for positive growth for long-term health (Brandman & Meyer, 2008). Alternatively, positive feedback loops make a system unstable in the short-term but allow for long-term growth (Brandman & Meyer, 2008). Systems theory is appropriate for this project because the subjects' long-term improvement is the goal. A systems theory assumption for this project was that it aligns with all social systems possessing the power to develop new characteristics (Valentinov & Hajdu, 2019). The proposition was that the parts of a system are more powerful when they work together instead of separately (Morgaine, 2001), which justifies MFGT use.

Multifamily Group Therapy

The framework used for this project was systems theory that explored the more systemic approach of multifamily group therapy (MFGT) for SUD in drug treatment court programs. The concept of MFGT was developed by Peter Laqueur in 1953 and was first implemented to support families and communication for patients with schizophrenia (Bokoch et al., 2017; van Es et al., 2023). Treatment outcomes of MFGT, along with the combination of group and FT have decreased the social stigma of mental illnesses, increased social support, and enabled clients and their families to learn effectively from other participants about experiences, perspectives, and

treatment success (Depestele, 2018). In addition, MFGT allows a feeling of belonging, shared psychoeducation, and mutual support (Dakof et al., 2015).

MFGT is a systemic approach and is well-evidenced in treating chronic illnesses like SUD and other severe disorders (van Es et al., 2023), often seen in the individuals who enter the CJS. For SUD treatment of the general population, group therapy (GT) is used in 90% of all SUD treatments and is the main focus for most (Wendt & Gone, 2017). Eighty-one percent of SUD treatments use family-based interventions (SAMHSA, 2020), and the National Survey of Substance Abuse Treatment Centers shows that SUD providers use FT in 85% of their programs (Hogue et al., 2022). Therefore, MFGT may be the most effective for the SUD population's multifaceted needs (Berg & Burke, 2023; Joudrey et al., 2021; Sanchezmeier et al., 2002). Using MFGT for SUD has shown that the information received in treatment by the family impacts the SUD client significantly and improves health outcomes for the entire family (Shumway et al., 2022; Ventura & Bagley, 2017). DTC clinicians facilitating MFGT may provide a more expansive approach with a treatment manual in an attempt to improve recidivism.

Existing Framework of MFGT. An existing project that used this framework was a study of MFGT treatment for 794 individuals with severe mental illnesses (SMI). This study found that the approach of sharing issues and solutions with peers and families promotes long-term treatment attendance, which leads to fewer unwanted symptoms and more family cohesion (Maone et al., 2021). In addition, the study found that this approach is feasible for long-term use. A study found that those who receive long-term support or a treatment plan were 23.9% more likely to abstain from or moderately use substances (Beaulieu et al., 2021). Cañas and Estévez (2021) conducted a study on the use of MFGT for 46 adolescents addicted to the internet. The study showed that the benefit of other families in therapy together strengthened communication

through their own intervention work and from observing the other families' work as well. Outcomes included the parents identifying other forms of activities for the teens' needs in replacement of their internet usage habit. In addition, the other families were seen as beneficial supporters, as they showed encouragement and praise for the behavioral changes being made. Cañas and Estévez (2021) also reported these positive effects lasting after the interventions were conducted.

Alternative Framework of Drug Treatment Courts. The alternative frameworks used in the ADTCs are individual therapy and GT, while the JFDTCs and FDTCs use individual therapy and FT. Since these two programs use FT with better outcomes, largely due to the long-term support (DeVall et al., 2022; Maone et al., 2021), this shows reasons that the ADTC approach of the peer group may benefit from the addition of family in treatment. A systematic review covered 19 studies which conducted an alternative framework for the family members of SUD clients, one group having individual therapy and the other received GT, that showed successful outcomes (Rushton et al., 2023). Therefore, with the better outcomes for those who participated in the FT compared to GT in the DTC program and the family members of SUD clients having success with GT, these approaches used simultaneously are appropriate for strengthening the long-term recovery outcomes of the DTC participants and their families. Using the modality of MFGT creates a therapeutic condition where clients have access to a larger system of peers and family in treatment.

The problem statement was guided by systems theory based on the research of utilizing stand-alone individual, group, and FT for individuals with SUD. The use of these therapies separately does not substantially reduce the high rates of long-term SUD offender recidivism (Berg & Burke, 2023). The framework addresses the purpose of this project through fulfilling the

need for more long-term systemic interventions that may be provided by MFGT, which has been shown to be more effective for this population (Shumway et al., 2022), through the TMDP. The systems theory framework exposed the gaps in the literature as well as the treatment, through the project questions, by finding the common systemic themes and patterns of treating SUD to help the DTC participants. The answers to the project questions also helped create a TMDP, systemically, which increases the chance of clinicians effectively implementing an innovative approach (van Es et al., 2023).

Family Therapy

FT is the first of two approaches for a more systemic approach for ADTCs. FT is used in Family DTC (FDTC) and Juvenile DTC (JDTC), which are the most successful of all DTC programs (Bruns et al., 2012; Tabashneck, 2018). The addition of family in therapy increases the likelihood of clients returning to each session (Diamond et al., 2021). Therefore, ADTCs may benefit from adding family in treatment, because failing to attend required sessions may lead to criminal conviction (Tomaz et al., 2023), which has been shown to increase the likelihood of reoffending (Gibbs & Lytle, 2020). Furthermore, FT provides opportunities to mend the existing support system through communication, understanding, and empathy (Markoulakis et al., 2018). In addition, client treatment engagement is motivated by the severity of how their close relationship have been damaged and the continuation of efforts at repairing those relationships (Dillon et al., 2020).

FT is widely effective for troubled teens, such as JDTC participants, and Shumway et al. (2022) suggested that family-based approaches are the most effective treatment for SUD. The general population of adults with SUD may also benefit from this approach because addiction to substances is linked to emotional dysregulation, which prevents growth and maturity (Pisaneschi,

2025). FT, used in the FDTCs and JDTCs, is an evidence-based practice (EBP) that also came from systems theory through building support, relational appreciation, shared activities, and communication (Hogue et al., 2022). FT has been well-defined as a multiple-component approach that includes the use of behavioral therapy (BT). The use of family behavioral therapy (FBT), which may be effective for the population of SUD is widely used for adolescents (Hogue et al., 2022). Therefore, the TMDP includes emotional support interventions for this approach and the SUD population because MFGT is effective using FBT (Reuman et al., 2021).

Group Therapy

The second of the two approaches, GT, is used in ADTCs is the most commonly used systemic approach for SUD in any population (Lo Coco et al., 2019). GT came from systems theory because of the additional support needed for certain mental disorders with a high relapse rate (Shumway et al., 2022). One study found that 40-60% of those in SUD treatment relapse (Vella, 2022). The National Library of Medicine reports that within one year, 85% of individuals with an addiction relapse (Sinha, 2011). GT is a session that includes peers with similar issues and illnesses; GT enables the development of new support systems and is well-established in prisons for SUD offenders (Ezhumalai et al., 2018). A meta-analysis found that GT is effective, but a 17-year follow-up report showed that 50-75% percent of participants failed to remain in recovery (Lo Coco et al., 2019). Integrative approaches for treatment, like FT, may make up for the limitation of long-term recovery of GT for the chronic illness of SUD. Shumway et al. (2022) reported that there is a significant need for family involvement in SUD treatment in GT.

Prevalence and Etiology of SUD

Generally, one in three people will have SUD in their lifetime (McCabe et al., 2022). According to the NIMH (2024), SUD is common in individuals with co-occurring disorders

(COD), mental illnesses (MI), and chronic medical disorders, and vice versa (Fernández-Miranda et al., 2024; Vasilenko et al., 2017). Compared to the general population, individuals who are incarcerated have significantly higher rates of SUD, COD, and SMI (Hedden et al., 2021). Within the population of inmates who have SUD, 70% have a COD (Leach et al., 2022). Relapse susceptibility for SUD is higher when the client has a history of MI (Andersson et al., 2023), which leads to recidivism. Additionally, CODs are more challenging to treat than SUD alone because CODs often differ from client to client (Perry et al., 2019).

Secondary disorders are often the result of the primary disorder but can also co-occur due to chronic stress (Field & Jette, 2007). When considering secondary disorders, it is important to assess whether people are abusing substances to cope with MI symptoms, if the substance abuse created the symptoms of MI, or if individuals clinically have more than one disorder (Tolliver & Anton, 2015). According to the DSM-5, if the MI is not substance-induced, SUD comorbidities include intoxication and withdrawal (American Psychiatric Association [APA], 2013). Therefore, careful assessment must be conducted to ensure clients receive the best treatment for the complexity of their symptoms. The elements of MFGT have been reported to relieve a multitude of COD symptoms for SUD clients (Fernández & Baena, 2021), so the manual proposal includes assessments to identify secondary disorders to ensure the clients are receiving the appropriate and most beneficial treatment (Field & Jette, 2007). Treatment is often more successful when a secondary disorder is identified (McNally et al., 2025).

Along with COD as a major factor of SUD, age is another. In 2018, 18 to 25-year-olds were most likely to abuse drugs and alcohol (American Addiction Centers, 2024). A study conducted from 2015 to 2018 found that individuals over the age of 26 were a rising SUD population (Bouchery, 2021). The average age of DTC participants is 28 to 33 years old (Brown,

2010; Sheeran & Heideman, 2021). Martinelli et al. (2020) reported that the time of sustaining an addiction from initial use is one to five years. The average time of substance use from entering the DTC program was about 14 years (Leach et al., 2022). This aligns with the average age of initial use and the time to develop an SUD significantly enough to develop a severe addiction or relapse, leading to arrests that correlate with the ages seen in DTCs. Based on the age group, family involvement may help reveal the root causes of the young adults entering DTC programs. The average age reported in the literature is reflected in the TMDP by incorporating family engagement interventions.

In addition to age, gender is another factor related to SUD (Alegria et al., 2021). Although SUD prevalence is higher in men, addiction progresses at faster rates for women, making it harder to treat effectively (Fonseca et al., 2021; Vasilenko et al., 2017). Women seek intervention for SUD significantly less often than men because of stigma, being viewed as caregivers to children, and the fear of losing custody (Fonseca et al., 2021; Pinedo et al., 2020). By the time women reach a program option offered by the CJS, their symptoms may have progressed in severity due to persistent poor decision-making and risky behaviors. In addition, females experience more PTSD that involves guilt and shame, making them less likely to disclose past trauma that can perpetuate substance use (Fonseca et al., 2021). Because of disclosing trauma, symptoms can worsen before the benefit of therapy is seen (Fonseca et al., 2021). Women with SUD are more difficult to treat because their withdrawal symptoms are reportedly worse because of cravings caused by the ovarian steroid hormones affecting behavior, such as relapse (Fonseca et al., 2021). MFGT can bring these women and their families together for relatability and support for managing their cravings and withdrawal symptoms. The FDTC

programs serve more women, as assumed by multiple articles referring to the participants as women (Brown, 2001; Gifford et al., 2014).

Participants in the FDTC show better success in completing the program, with a study of 412 participants having only 12% program terminations and only 2% lost custody of their children in the year of 2022 and 2023 (Bruns et al., 2012; Office of the State Courts Administrator, 2024). This may suggest that the family involvement helps with the extensive challenges of recovery for women, which then may be highly beneficial for the ADTC program, which consists of 74% men (Brown, 2010; Marlowe, 2022). A study of 43 programs for women with the goal of reuniting with their children shows that the success rate doubles when family-related services were utilized compared to those who did not (Gifford et al., 2014). Much like the reunification of a parent and child, an SUD offender, who often loses connection with family (Earnshaw, 2020), may benefit from their reunification.

Race has some prevalent connections to SUD, but that variable is lesser known than age and gender (Vasilenko et al., 2017). Ethnic minorities may be underreported for SUD because they are less likely to receive or complete treatment for reasons of language barriers, stigma, and the lack of cultural competencies by clinicians (Pinedo et al., 2020; Slobodin & Crunelle, 2019). Native Americans have the highest rates of SUD and illegal drug-related deaths (Skewes & Blume, 2019). A study of Native Americans found that race-based stress, stretching back from historical trauma and oppression, may prevail as to why this ethnicity is at high risk of SUD (Skewes & Blume, 2019). SUD for Native Americans may also be related to being discriminated against (Afuseh et al., 2020; Skewes & Blume, 2019). Another at-risk ethnicity is Latinas, who report a lack of support when it comes to issues of substance abuse (Pinedo et al., 2020). Not only does the Latina community suffer from a perceived lack of support for SUD treatment from

the cultural stigma, but they are also shown to be untrusting of mental health services (Hernandez, 2024). MFGT may help these and other marginalized populations come together to speak about the challenges and barriers they face when battling their addiction and possible criminal convictions.

Socioeconomic status (SES), along with race, is significantly underreported in medical literature compared to age and gender (Alegria et al., 2021). SES studies related to SUD do not indicate a strong correlation of prevalence. In an article about ADHD and SUD, lower SES individuals were seen to have less access to resources such as education, health insurance, and affordable housing (Slobodin & Crunelle, 2019), which are indicators of the use of poor coping skills, such as substance abuse (Porcaro et al., 2021). Slobodin and Crunelle (2019) also found that individuals with higher SES have more access to prescription drugs such as opioids and stimulants, which leads to an increased risk of developing SUD. When compared to those with higher SES, people with lower SES were offered differentiated treatment, such as pain management, over other highly addictive medications that they may not afford (Damiescu et al., 2021). With the question of high or low SES being more prevalent for SUD, the TMDP includes psychoeducation to reveal the underlying psychological factors of pain needed in addiction recovery.

The root cause of SUD depends on characteristics of the individual (Bradberry & Baunez, 2022). The etiology of SUD develops from a system of genetic and environmental complexities (APA, 2013). The question of nature vs nurture was once controversial when debating the cause of SUD. In the past, people considered addiction solely genetic, but this is still being explored through studies of twins and family history research (Deak & Johnson, 2021). Now, researchers consider that the environment plays an important role in the development of SUD.

Understanding etiology is critical in prevention and treatment (Deak & Johnson, 2021). As with every illness, there is more to learn about biological versus environmental factors and the combination of those factors in the systemic disorder process.

Biological Factors Contributing to SUD

Substance use disorder is a neurobiological disorder that affects the brain's reward center (Christensen et al., 2023). SUD develops when the substances desensitize the reward system for everyday activities such as hydrating, eating, bathing, social activities, and other survival needs (Wise & Robble, 2020). Most psychoactive drugs signal the dopamine receptors to activate the feelings of pleasure in the reward system of the brain, which affects the individual's mood, cognition, perception, and emotions (Lustig, 2018). Lustig (2018) explained that researchers claim addiction can be caused by a dysfunctional prefrontal cortex when the stress hormone called cortisol is overactive. When the brain is chronically stressed, it causes a constant need for dopamine release to feel the reward (Lustig, 2018).

Once a substance is introduced into the body, the drive to provide the physiological reward intensifies (Christensen et al., 2023). The person then finds what they think is needed to cope with the dysfunction. In addition, when a person is exposed to certain stimuli, the response mechanism develops a habit that inhibits healthy conscious thoughts or healthy neural pathways (Lüscher et al., 2020). Not only does the body develop an addiction, but the conscious thoughts reinforce the SUD (Lustig, 2018). Furthermore, the neurological brain sectors related to decision-making, judgment, and memory change. The change in the brain from addiction over time leads to neuron death, which causes the permanent loss of brain function (Lustig, 2018). This loss of brain function may suggest why it further exacerbates the addiction by hindering decision-making (Lüscher et al., 2020). By adding peers and family support, the encouragement,

inspiration, and motivation to engage in treatment may reduce the additional chronic stressors such as facing treatment alone, relational conflict, and the threat of criminal punishment.

Heredity

Due to these multiple factors, the best form of predicting SUD and overdose may be through a multi-faceted approach that incorporates biological, environmental, and family history factors of substance abuse assessments. According to the DSM-5, SUD has been evidenced as a hereditary disease (APA, 2013). A meta-analysis found that the brain carries inherited genetically correlated psychiatric disorders in those with problematic alcohol use, which strongly predicts SUD (Du et al., 2022). In a study of 13,840 parents with SUD, the authors found that children with SUD parents had high rates of SUD themselves, in addition to comorbid disorders such as SMI and chronic pain disorders (Li et al., 2022). Although there are many contributing factors related to SUD that can lead to a person being in the CJS, science has shown evidence linking SUD with sequential generations. Therefore, starting treatment with the entire family may give therapists more answers to how to create long-term recovery plans.

Genetics

Substance abuse and stress can cause long-term DNA and RNA changes through the gene expression regulation, determined by genetic background and environmental factors (Gatta et al., 2021). Although genes do not change, epigenetics regulates which genes become active or inactive due to an individual's environment, as a factor (Sartor, 2019). Although biology is not systemic in the sense of psychotherapy, it is critical within the addiction system as a component of etiology. Gatta et al. (2021) considered substance use, as another factor, such as alcohol as a stressor to the gene expression. Therefore, with a susceptibility to addiction in genes and an initial or prolonged substance exposure, there is a high risk for the development of a SUD (Barr

et al., 2022). The DTC programs may benefit from family involvement because family members with similar gene expression can receive help for a current addiction, increase their awareness of its impact, or prevent an addiction within themselves.

Environmental Factors Contributing to SUD

Although a person's genetics has been determined to be one of two contributing factors for developing mental disorders, like SUD (Deak & Johnson, 2021), various elements of the environment play an important role in the systemic development of an individual's SUD (Barr et al., 2022). These statements suggest that since an individual can develop SUD from a genetic predisposition or environmental factors, the combination of both puts a person at greater risk. Multigenerational behavior modeling patterns are part of a dysfunction etiology tested on rodents and humans (Goldberg & Gould, 2019). Goldberg and Gould (2019) found that drug use exposure is tied to anxiety-related behavior that is passed down to each generation of children. However, all psychopathologies, such as SUD, PTSD, and ADHD, seem to possess some origins in a family system dysfunction (Zagefka et al., 2021). A disorder like SUD is strongly connected to family dysfunction because of caregiver modeling and parental factors. A significant factor for the intergenerational transmission of developing SUD is parental separation (Blake et al., 2024; Bruns et al., 2012). The FDTC program uses FT, with parent-child reunification as the main goal, and has the highest success outcomes, as stated by the National Association of Drug Court Professionals (Bruns et al., 2012; Marlowe, 2022). If the ADTCs incorporate FT in treatment, the cycle of negative intergenerational transmission may be broken, helping these families stay together in healthier households.

Capaldi et al. (2018) studied three generations of a family struggling with SUD and found that parental behaviors, the environment of usage, and accessibility played a part in an

individual's initial drug use. If children witness one or more parents using substances to cope, the children are more likely to mimic the substance use behavior, thinking it can help them feel better, too, which can begin an addiction (Capaldi et al., 2018; Trucco, 2020). Lack of adult supervision accompanied by negative peer influence can also increase the risk for developing SUD (Capaldi et al., 2018; Li et al., 2022; Trucco, 2020). Family involvement, in the form of MFGT, may prevent further substance use by encouraging more adult supervision, the awareness of peer influence, and connections made with other families. To reach these goals, the TMDP provides clinicians with information about parental interventions.

Parental Conflict and Single Parenting. As negative behaviors can be passed down from generation to generation, parental stress, parental SUD, and the dynamics of the family play a role in developing disorders as well. A study of 5,887 adolescents with SUD showed a correlation between them coming from single-parent households and parental substance abuse (Essau & de la Torre-Luque, 2021; Ramsewak et al., 2020). Parental challenges and lack of additional caregiver supervision may be contributing factors that lead to SUD use in minors (Trucco, 2020). A single parent has less time to observe or obtain knowledge about the friends that the child associates with that may lead to prevention issues. Trucco (2020) claimed that negative peer influence, either witnessing their friends actively using or the attitude of acceptance, are strong indicators of initial substance use, especially among adolescents. Though the majority of DTC participants are 18 or older, adolescent research is significant because the emotional maturity level of an individual with SUD is often underdeveloped (Pisaneschi, 2025). The stunted maturity level from a teenager to young adult with a substance addiction may be reflected in the adults in the DTC programs. Through observations, interviews, a review hearing and a thorough analysis, the DTC officials consider the participants as children that grow into

functional adults upon completion, deeming a family framework essential for SUD treatment (Gordon, 2018).

Trauma and PTSD. Post-traumatic stress disorder (PTSD) is a significant environmental factor because it develops from traumatic events where a person is in immediate threat of harm, or a constant and consistent sense of threat (Pinho et al., 2024). They do not actually have to be in harm's way to experience PTSD from an event, they may be witnesses to the event happening to someone close to them, hearing about it, or repeated exposure to the extreme aftermath of a traumatic event (Marx et al., 2023). Of individuals diagnosed with long-term PTSD, 57.7% have some form of long-term SUD (Simpson et al., 2021). Examples of the most frequently reported traumatic events that lead to PTSD are natural disasters, war, torture, bereavement, terminal illness diagnosis, serious accidents, sexual or physical assault, and childhood abuse (Du et al., 2022). Childhood trauma, compared to adulthood trauma, is a more significant factor in being diagnosed with PTSD as well as an indicator of the severity of the symptoms (Hawn et al., 2019). Hawn et al. (2019) also found that having PTSD puts an individual at greater risk for SUD. The TMDP resulting from this project includes interventions for the clinicians to address specific traumatic experiences related to substance use and abuse.

SAMHSA (2023) reported that PTSD symptoms seem to overlap with the symptoms of anxiety and depression, putting them at greater risk for developing SUD, especially when in combination with other biological and environmental factors. In terms of the etiology of SUD, there are many gaps with both major factors and limitations that emerge from the literature, requiring more systemic research on SUD. Simpson et al. (2021) conducted a meta-analysis of 3,247 SUD clients with PTSD. This analysis report claimed that manualized SUD treatment is more beneficial for substance use outcomes. Developing a TMDP using family interventions

may help guide individual trauma sharing, seen to increase the perspectives of others (Winter et al., 2022). In turn, building understanding and empathy is needed in recovery for the growth and maintenance of long-term support.

Current Treatments for SUD

Ray et al. (2020) reported that the most commonly used EBP treatment for SUD is CBT. Although CBT is the most widely used treatment for SUD, a meta-analysis of 30 studies found that in combination with pharmacotherapy, CBT did not lead to a difference in outcomes compared to other EBP behavioral therapies with the same combination of pharmacotherapy (Ray et al., 2020; Rosenthal et al., 2022). The efficacy of the combined treatments was examined by the frequency and quantity of substance use after treatment during follow-up reports. The efficacy measurements are pertinent to what may cause reoffending after completion of the DTC program. The Department Of Family Medicine and Community Health reports that the ADTC program has four main approaches for long-term recovery, consisting of CBT, relapse prevention, aftercare, and substance abuse treatment (López et al., 2021). Yet, these individualized treatments do not include their family or medication to help support the recovery maintenance, among many other aspects. Therefore, using MFGT may be more effective for the DTC participants because it allows additional forms of interventions such as psychoeducation, CBT, and assertive community treatment (Chow et al., 2010) to better target the participants' specific needs.

Clinicians' hesitation with conducting individual, family, or group therapies separately instead of MFGT may be the perceived intimidation of a large group. Schaefer (2008) mentioned that if therapists are trained in techniques like intensification and enactments, the challenge of various dynamics may not be as difficult. The author gives an example of high loyalty levels that

SUD members commonly have towards family, but if this aspect is challenged by another family, the group can escalate (Schaefer, 2008). However, if the dynamics of a group are combative, the therapists can use those techniques in a treatment manual to de-escalate conflict. Another factor for clinician resistance to facilitating MFGT is if they are only trained in one of the therapy approaches, FT, or GT. They may feel underqualified in certain situations, such as in co-therapy, which may consist of two or three different therapists (Gouveia et al., 2025). A lack of training may be overcome when there is an effective manual to guide them. Therefore, the manual proposal may enhance and expand SUD treatment for the DTC programs to benefit a large therapy group.

Participants' issues include social stigma, family not wanting to be around the SUD client because of abuse and not wanting other families to know their deeper issues (Tambling et al., 2022). However, clinicians trained in the MFGT approach have been known to reach out to clients and their families to combat their irrational fears towards the approach (Schaefer, 2008). Diversity training is another tactic to help engage family members with different cultural views and beliefs. Saleem et al. (2021) claimed that when a group shares diverse viewpoints, the participants not only learn about others, but they also learn more about themselves. MFGT is commonly used in intensive outpatient and residential facilities (SAMHSA, 2020). Therefore, using this extensive approach with possibly resistant family members, a thorough TMDP should be more effective for the DTC clients and their clinicians, as opposed to the individualized treatments.

Current Use of MFGT

MFGT is an evidence-based intervention for populations with chronic disorders and severe mental illnesses (SMI) and their families, including psychoeducation and behavioral

therapy (Stuart & Schlosser, 2009). Along with SUD, the most common mental health conditions MFGT is used for are eating disorders and schizophrenia, as well as anxiety and depression (Shumway et al., 2022; van Es et al., 2023). MFGT is not used in the DTC programs but is used in many psychiatric hospitals, private SUD practices, and school systems (Roué et al., 2021; SAMHSA, 2020). Although, there is more literature for the effectiveness of MFGT for clinical practice compared to schools, another popular setting for this approach (Whittles, 2020), family involvement in therapy for SUD is still an underutilized tool for many populations (Dopp et al., 2022; Ventura & Bagley, 2017).

When facilitating MFGT, a major component allowing clinicians to conduct the approach is the family members' participation. For that reason, the TMDP includes a recommendation that the provider must reach out to the family, stressing the significance of their attendance for better recovery outcomes. Kelty and Wakabayashi (2020) conducted a study on educators engaging families for their children to discuss the importance of their involvement. Kelty and Wakabayashi (2020) reported that the engagement increases their social experience, which predicts the students' motivation, cognition, impulse control, attention, self-confidence, and socio-emotional skills. The hope is that the SUD clients will have the same outcomes. If family members still refuse, risk harm, or are unavailable to be involved in therapy, the SUD individual can participate alone while still receiving the benefit of MFGT. In a study of 794 individuals participating in MFGT, 180 were the identified client with no family members. The results showed that the high attendance rate was long-term, spanning over a four-year period (Maone et al., 2021). Therefore, the DTC officials will likely not be concerned with any lack of family participation.

Studies on the use of MFGT have shown positive outcomes, including reductions in relapse, drop-out rates, and anxiety (Roué et al., 2021). In addition, studies have shown it improves counseling retention, social functioning, and family resilience (Rosenblum et al., 2017; van Es et al., 2023). A study on first-time juvenile offenders participating in MFGT showed evidence that the interventions were more effective than traditional probation when measuring recidivism (Quinn & Van Dyke, 2004). With these factors pertaining to the clinicians who will be using the TMDP to address these factors, a study of 24 MFGT sessions showed that the clinicians who adhered to a step-by-step manual scored over a 70% success rate (Sanchezmeier et al., 2002). Skarbø and Balmbra (2020) claimed that the more therapists in an MFGT session, the better the therapeutic outcomes, but in another article, the claim was that two therapists are preferred (Paganin, 2024). Having more than one therapist with different training to provide more innovative interventions, may find that a TMDP can fill the treatment gaps. Therefore, the TMDP can be utilized interchangeably for all DTC program clinicians for treatment collaboration.

Literature Review Summary

The key points discussed in the literature review were family systems and SUD treatment, SUD prevalence and etiology, biological factors such as heredity and genetics, environmental factors such as parental conflict and single parenting, trauma and PTSD, and current SUD treatment trends. The outcome of this project connects the DTC participants with the predictors and interventions of MFGT, such as age, gender, race, and SES, as well as PTSD, parental factors, and childhood trauma. With all these elements, the presented literature supports the idea that MFGT may be a possible adjunct tool to decrease the SUD offender recidivism rates in the US.

The elements in the literature that support the need for the current project include the use of family in DTC therapy to increase client engagement and decrease drop-out rates, relapse, and recidivism (Marlowe, 2022). In addition, the literature shows a need for peers and family inclusion for SUD treatment because parent and peer influences impact the likelihood of SUD development (Meulewaeter et al., 2022). MFGT may combat the challenges of additional chronic stressors of the participants, including possible criminal conviction that leads to family separation, loss of employment, and many other factors that exacerbate SUD symptoms (McHugo et al., 2021). Interviews consisted of experienced clinicians who work closely with the key elements of SUD, GT, FT, and MFGT. The semi-structured interview questions were used to discover new factors related to each modality to help the innovative approach of MFGT for DTC participants. The data analysis and prior research conducted may benefit not only the clients themselves, but also their families and communities.

Ethical Assurances

This project received approval from the university's Institutional Review Board (IRB) prior to any data collection. The risk to participants was minimal because the interviews were not about the clinicians directly and was not held in-person. A relevant ethical issue was licensure legitimacy. Therefore, this scholar screened the participants' clinical hours and modalities used to treat SUD before the interview and identified their titles and practices on official websites. A potential problem of compensation for the clinicians' time was considered to ensure they were not participating for the reward only. This concern was addressed by reviewing similar projects and studies for compensation determination. Details of compensation reasoning are discussed in Section 2.

Other important ethical factors related to a research project were consent and confidentiality. Consent was achieved by providing written and verbal agreements to participants (Appendix C). Since the project has a low risk of ethical violations, this scholar provided a verbal highlight of the consent form that the participants previously received with the prescreening document. The verbal agreements were obtained before recording the interviews to ensure the awareness of the consent terms. Participants can benefit from verbal agreements because the process highlights the critical parts, and it has been found that participants often do not read the written version (Xu et al., 2020). Confidentiality for the participants was achieved by using numerical labels instead of actual names. Anonymity for any clients discussed was included in the agreement that the participants would not share details that could directly link the information to any individual. The data was securely stored in accordance with IRB requirements. Zoom was the videoconferencing software utilized for the interviews, which includes the HIPAA-compliance plan approved by the U.S. Department of Health and Human Services (McGill & Fiddler, 2021). During the interview, earbuds were used to ensure the information was only heard by this scholar. The encrypted data was saved through the platform with password access known only by the researcher. As the agreement stated, once the data was analyzed, it was deleted. Confidentiality of the interviewees' identities and data is essential for ethical and legal considerations of any research project (Kang & Hwang, 2021).

The role of this scholar in the proposed project was building rapport, maintaining professionalism, providing a safe space, and upholding the ethical standards of working with human participants. The relevant issues were preventing bias, awareness of personal and professional experiences, and strategies to avoid these factors from affecting the analysis. The possible biases may be a non-diverse group of participants and this scholar's personal and

professional experiences and knowledge resulting in leading the participants through the questions in the interview. Avoiding bias related to the participants was achieved through a nationwide search from multiple types of practices surrounding this project topic. To avoid leading questions, this scholar used an alignment tool prior to the interviews and reviewing the question structure with the project committee.

This scholar's personal experiences with the factors of topic, problem, or context were that a family member was negatively affected by a CJS failure to provide appropriate SUD treatment. This scholar's professional experiences with these factors relate to working in an addiction treatment center that used MFGT for the SUD population. The strategy that was used to prevent these biases and experiences from influencing the analysis or findings was maintaining awareness by periodically referring back to a reflexive journal while literature searching and interviewing. This helped to ensure this scholar's perspectives did not skew interpretations of the data or the information included in the TMDP. This awareness helped create the TMDP in the best interest of the project population, rather than what this scholar thinks works from biased findings and interpretation of the results of the interviews.

Summary

The first key point discussed in the foundational section was the problem of high rates of recidivism for the SUD population. The purpose of developing a standardized TMDP was to improve the current DTC programs to reduce recidivism further. Interviews were structured and conducted in order to answer the project questions related to program efficacy and content. There is a need for improvement in current treatments as indicated by the analysis of previous scholarly articles (Marlowe, 2022). The systems theory framework explained why the qualitative method and descriptive phenomenological design fit this project and showed how it can significantly

contribute to the literature and improvements to the practice of MFGT for SUD offender treatment. All of these factors contributed to the ethical implementation of this project with the goal of creating a program that may better serve this population.

Section 2: Methodology and Design

A qualitative methodology was chosen because it allows an in-depth exploration of clinicians' experiences that may benefit SUD treatment as well as the development of the systemic TMDP for the DTC program. This scholar found new information about aspects of systemic SUD methods for groups of families in treatment. The problem addressed by this qualitative project is the lack of systemic family treatment in DTC programs. The purpose of this qualitative phenomenological project was to develop a manual that integrates a more systemic approach in treatment programs for SUD offenders. This section covers the Design and Method, Population and Sample, Instrumentation, Goals and Objectives, Procedures, Data Collection and Analysis, Assumptions, Limitations, and Delimitations. The chosen methodology was a descriptive phenomenology design using semi-structured interviews. The following section includes the details outlining the methodology and design chosen for this project.

Design and Method

The qualitative design for this project was descriptive phenomenology. In the early 1900s, Edmund Husserl developed phenomenology to understand an occurrence through participants' lived experiences (Sokolowski, 2000). Husserl later, in 1970, publicized the use of phenomenology in research (as cited in Karter, 2019). Amedeo Giorgi created descriptive phenomenology in the early 1970s, using Husserl's foundational design and adapted it from a philosophical focus to a psychological focus of how the data is analyzed (as cited in Karter, 2019). This design was appropriate for the stated problem because it allowed feedback from current clinicians about possible issues using systemic approaches with the SUD population to help in the development of systemic family treatment TMDP. The results may allow this scholar to better understand why the DTC programs do not incorporate peers and family into therapy for

the DTC programs and identify topics, interventions, or resources that can be included in a TMDP to enhance the benefit of MFGT for this population. Using phenomenology, this scholar described and categorized the emerging themes and patterns of the clinicians' experiences conducting the systemic approaches for SUD clients. This scholar examined the data collected on how clinicians treat SUD and what systemic interventions they see as most effective. This design aligns with the purpose of this project because it explores the subjective human experiences of conducting SUD treatment to develop a TMDP that focuses on using the MFGT systemic approach. Phenomenology allowed this scholar to examine the clinicians' experiences and outcomes of multiple SUD subpopulations.

Using a phenomenological approach allowed this scholar to address their biases or other biases encountered in the project through techniques that recognize personal positionality. This scholar identified and made mental notes on personal beliefs, values, expectations, and perceptions about the topic and population to increase awareness and subjectivity while conducting a project. There was an awareness of this scholar's own family contributions, if they were to be engaged in this implementation, and how that can differ from the families of the SUD population in the current and future DTC programs. Another awareness was the short-term experience of interning at an addiction center using MFGT. While avoiding bias, the proposed project findings provide new insights for improving SUD offender treatment.

Several alternative designs were explored. The first alternative design considered was grounded theory, which uses the participants' experiences (Cullen & Brennan, 2021). However, given that the goal of this project was not creating a new theory but instead exploring a combination of existing theories (i.e., MFGT, GT, and FT) to find what works best for treating SUD, grounded theory was ultimately not selected. The second optional design was ethnographic

research, which focuses on cultural similarities. Although shared views of experiences may have benefitted this project, the focus was on treatment, not cultural immersion. SUD users have certain cultural similarities, but the literature does not reveal a need for exploration of cultural similarities over the relational benefits in treatment (Bufford & Lappan, 2023). Descriptive phenomenology was considered because it focuses on the participants' meaning of the phenomenon. However, this project does not include personal or social experiences in congruence with the scholar's thoughts or feelings (Gill, 2020), because this scholar was not experienced enough with the topic or population focused on in this project. Therefore, descriptive phenomenology was the most effective for this project because it collects the perspectives and experiences of those using the methods and interventions to develop a more focused systemic TMDP for SUD offenders.

Alternative methods reviewed for this project include program evaluation, focus groups, and direct observation. According to the U.S. Department of Education, program evaluation examines the outcomes of an implemented project to determine future direction, correction, or termination (Stewart et al., 2021). Another method considered was a focus group that would have been less time-consuming than individual interviews, but it likely would not have provided the in-depth data needed to answer the research questions (Akyıldız & Ahmed, 2021; Rabiee, 2004). Direct observation of clinical sessions was not selected because it would exclude clinicians' thoughts and feelings about their experiences. The design and method of phenomenological interviewing was ultimately selected over these alternative options because there was no existing data on the use of MFGT in the DTC program, in-depth data was necessary, and this project needed to extract the experience of many sessions.

Population and Sample

The target population of this project was actively working clinicians who treat SUD. According to the US Bureau of Labor Statistics, 76,000 MFTs were in the US workforce in 2023 (US Bureau of Labor Statistics, 2024). The reason MFTs were not the sole targeted population was that this project looked solely for clinician experience with treating SUD systemically. Therefore, mental health counselors, professional counselors, and SUD counselors were also accepted for this project because they are qualified to work with groups and families in treatment. In addition, there were 449,800 substance abuse, behavioral disorder, and mental health counselors employed in 2024 (U.S. Bureau of Labor Statistics, 2025). Not including licensed professional counselors (LPCs) and clinical social workers (CSWs) who may also treat SUD, these numbers give an estimate of 525,800 clinicians for the population of this project.

The sample of this project consisted of seven current clinicians with a minimum of three years of experience conducting SUD treatment with any combination of the approaches GT, FT, and MFGT in the US, and provided that it involved at least one of the two forms of FT. The decision to focus on the population of clinicians with at least three years of experience was based on the possibility of treating substance use disorders and clients varying in ages, cultures, backgrounds, and other demographics. The more experience a therapist has, the more knowledge they may have of treatment outcome variations. Additionally, the longer a therapist practices, the lower the client dropout rates (Goldberg et al., 2016; Roos & Werbart, 2013). Participants must have maintained at least a 20-hours per week position with 50% or more client treatment involving group, family, or multifamily group sessions. Clinicians could be from private practices, community-based non-profit organizations, government agencies, hospitals, or sole proprietors.

The above factors made the target population more likely to yield a sample of participants who could provide the appropriate and rich data to answer the interview questions that may contribute to the TMDP creation. The data collected from the participants addressed challenges that less experienced clinicians may have when conducting MFGT with DTC clients. Additionally, the participants provided more valuable information about manualized treatment to benefit the creation of the TMDP. Finally, the participants selected from this population provided answers about the project questions that were informed by their years of experience treating SUD or using MFGT. Newer DTC clinicians would not have been as aware of treatment considerations.

The sample size was seven participants, from each of the three systemic modalities (GT, FT, and MFGT), with the minimum expectation of including a form of FT. The goal achieved was selecting participants from the three systemic treatment modalities who work in settings such as inpatient, outpatient, intensive outpatient, and telehealth. Selecting clinicians who practice using one or more of the three modalities and who work in varied treatment settings increased the likelihood of collecting the experience of clinicians who treat various subpopulations of SUD clients and their families.

A reason the clinician participants were not required to have experience with solely SUD offenders was that the prevalence of CODs is common among both the general population of SUD and criminal offenders (Proctor et al., 2019). Therefore, the project participants treating the general population of SUD still addressed the problem of DTC clients' complex co-occurring symptoms not being treated with the systemic approaches. The participants had experience working with COD symptoms that addressed the purpose of creating a manualized treatment

approach. In addition, the participants also had the expertise to reveal what peers and families can contribute to the therapeutic treatment for the DTC clients.

The sampling strategies used for this project were criterion sampling or purposeful sampling, commonly used for qualitative research (Denny & Weckesser, 2022), which allows participants to have similarities and differences (Denieffe, 2020). This sampling strategy was appropriate for this project because the participants must have a shared experience (Denny & Weckesser, 2022) of treating SUD and diverse feedback on using the different modalities (GT, FT, and MFGT) that shape their unique perspectives. Bartholomew et al. (2021) found that it is adequate in descriptive phenomenology projects to have between five and 25 participants. Once the interviews were completed, the data were analyzed with the goal of saturation, which was achieved after seven interviews.

Saturation is when no new information emerges to answer the project questions (Buckley, 2022), and when responses become repetitive enough to bring no additional insight to a project (DeJonckheere & Vaughn, 2019; Denny & Weckesser, 2022). This scholar achieved saturation after a significant amount of repeated key terms were obtained, and only minimal new information was being received. Last for the data collection process, the asymptote level was checked, which is the scholar's judgement of new information being no longer presented or contributing to the interviewing process (Buckley, 2022; DeJonckheere & Vaughn, 2019). For qualitative research projects, reaching saturation strengthens the validity and reliability of the results (Frechette et al., 2020). After the interview process was complete, this scholar watched the recorded interviews and thoroughly read the transcripts a multitude of times for a rigorous review.

Recruitment strategies for this project were social media posts (Appendix A) in the American Association for Marriage and Family Therapy (AAMFT), American Counseling Association (ACA), public mental health practitioner group pages on Facebook, and LinkedIn. All interviewees were from the AAMFT site that provided their contact information. The scholar individually emailed the recruitment post to each clinician with the appropriate titles such as LMFT, MFT, LPC, and CSW.

The initial recruitment incentive, of no monetary value, was the contribution each clinician could make to improve SUD treatment by participating in the interview. Resnik (2015) explained that significant incentives can cause a participant to falsely claim the project criteria, which may impact the responses given. However, after one month of no qualified clinicians being interested, the scholar offered a \$35 Amazon gift card as an incentive. The U.S. Bureau of Labor Statistics (2024) reported that the average hourly wage for MFTs is \$33.04. Therefore, the monetary value of \$35 was chosen because this scholar was recruiting experienced clinicians. The selection process was determined by this scholar's recruitment commitment and the clinicians' willingness to participate.

Materials and Instrumentation

The primary data collection instrument for this project was an open-ended, semi-structured individual interview using an interview protocol (Appendix D). Interviews are an effective approach for qualitative research to gain knowledge of a selected topic (Islam & Aldaihani, 2022). Interviews were semi-structured to allow the progression of emergent information as well as follow-up questions. An open-ended semi-structured protocol was a practical approach allowing for an in-depth exploration of new information (DeJonckheere & Vaughn, 2019). This method aligns with the project questions because it extracts the clinicians'

real-life experiences and perspectives on systemic treatment methods for the SUD population. The information from interviews was to address DTC clients' systemic needs to involve peers and families in therapy for the proposed TMDP. This scholar demonstrated the trustworthiness of this project through credibility, transferability, confirmability, and dependability (NU, 2025).

Credibility

The interview questionnaire (Appendix D) consisted of structured, unstructured, and follow-up questions, which this scholar used to investigate the information further. To build credibility, the same questions were presented in the same sequence for each interviewee. Roberts (2020) claimed that a limited number of structured questions was deemed appropriate for a phenomenological project because the fewer and broader the questions, the more opportunities there are for participants to expand on new and pertinent information, their experiences treating SUD systemically, which allows the data to take shape independently, without bias. In addition, fewer questions may increase the chance for more effective listening. Active listening consists of silence from the scholar as a form of respect for the participant, allowing more attention to the interviewees' behaviors, emotions, and possible inconsistencies (Roberts, 2020).

The participants were informed that the interview length was 60 minutes, but could be less, depending on their responses. The time range of each interview was between 38 and 47 minutes. Hysong et al. (2013) claimed that one hour is a preferred time estimate for qualitative interviews, but that the strict length of an hour is the main reason for invitation rejections, and is why this scholar added that it could be less to increase the chances of interested clinicians. Jamshed (2014) found that 30 minutes is a suitable minimum time for open-ended, semi-structured, in-depth interviews and is more amenable to recruitment goals. On the other hand, a

study found that Zoom interviews had a limit of one hour with fewer recruitment issues (Gray et al., 2020). For credibility, permitting an entire hour with each participant, through Zoom, allowed for the in-depth exploration of the experiences treating SUD to construct the TMDP. The deeper the exploration of information, the more credibility a project possesses (Ahmed, 2024).

Transferability

Transferability may be strengthened through a thick description of collected experiences and sources that can interpret the relational and behavioral meaning of a phenomenon (Drisko, 2025). For this project, participants were given the information about their interpretations of the treatment of many clients. The interview contained nonspecific questions for any demographic of the clinician or client being treated. This scholar also conducted literature searches from various sources and interviewed clinicians nationwide from different systemic treatment modalities. The goal was to collect opinions and experiences of systemic treatment for the general population of SUD and the use of systemic approaches. Therefore, the questions are transferable to other samples and settings of clinicians conducting other systemic approaches for many subpopulations in SUD treatment. Lastly, the TMDP is interchangeable for all subpopulations of SUD clients and clinicians.

Confirmability

The scholar's non-verbal cues allowed the interviewees to speak freely without interruption yet guide them toward new information or away from irrelevant information (Kallio et al., 2016). For example, a form of nodding indicated to the participant that this scholar already knows the information or raising eyebrows and leaning forward can indicate that this scholar wanted to know more. Participants' non-verbal communication, that can include tone, pitch,

volume and pauses suggested, in some of the interviews, the need to use follow-up questions. The use of non-verbal cues are why the interviews were requested to be audio and video recorded to seek signs of bias that may have weakened the confirmability. Sholokhova et al. (2022) stated that attention to non-verbal cues strengthens the trustworthiness of a project. Verbal cues with similar outcomes are effective when paired with nonverbal cues received (Kallio et al., 2016). These methods can enhance the richness of the data.

Dependability

The two methods of strengthening the consistency of this project included an *audit inquiry* by this scholar's NU committee and IRB board members. An audit inquiry involves consistent, rigorous feedback as weekly reviews (Lim, 2024). The NU committee reviewed the resources used for this project and checked for the accuracy of the source and what this scholar reported on each. Another form of stability used was the triangulation of the literature review findings with the interview data to prevent bias in the results (Lim, 2024). Triangulation is the use of multiple data sources and approaches to help a scholar validate their results (Bans-Akutey & Tiimub, 2021), which is discussed later in this project.

Project Goals and Objectives

The main goal of this project was to improve the systemic treatment for the SUD population. This goal was an attempt to increase positive recovery outcomes in hopes of reducing incarceration and recidivism rates. The rationale for implementing a more systemic treatment in the DTC programs was the increasing evidence related to the effectiveness of peer and family support in SUD recovery (López et al., 2021; McCrady & Flanagan, 2021). MFGT provides additional support compared to the current stand-alone FT approach (Stuart & Schlosser, 2009), which may increase DTC client success rates. Additionally, Fendrich and

LeBel (2023) suggested that improving treatment outcomes can be created through increased support (specifically group support) and may lower the risk of program violations for younger adults. Adding multiple SUD families as a group to therapy may increase the support to the individual and their family systems compared to a group made up solely of peers. MFGT may assist in the effort to reduce violations that lead to criminal convictions (Gibbs & Lytle, 2020; Tomaz et al., 2023), thus potentially lowering the incarceration and recidivism rates that are disturbingly high in the US.

The main objective of this project was to collect clinicians' experiences to inform the creation of the TMDP that may help enhance client treatment in DTCs. The TMDP, resulting from this project, is a step-by-step process on how to conduct MFGT for SUD clients. The TMDP will ultimately be a softcover book and also available as an eBook of approximately 25 pages. The creation was inspired by a GT Practice Planner (Paleg & Jongsma, 2015). The interview questions aligned with the collected content by asking for the most effective interventions to add to the clients' actionable steps in the TMDP. This scholar used the data analysis to create the TMDP by synthesizing which actionable steps were best to add by examining common themes and patterns in connection to the related literature.

The basis of this draft proposal development was reviewing current Treatment Planners for group, adult addiction therapy. The format for the TMDP, similar to the Practice Planners, starts with Area of Concern, Long-term Goals, Short-term Goals, and a list of Therapeutic Interventions. The interventions were organized into a chart of what the individual and family want to practice, with the corresponding actions the group members need to accomplish. After the list, there is room for personal notes to make modified versions of the interventions. Last,

there are examples of diagnoses linked to those who commonly experience the Area of Concern with room to note diagnoses that the clinician has seen as a pattern of concern.

The information obtained from the clinicians' expertise helped create the steps of effective interventions and techniques necessary to conduct MFGT. The rationale for creating a manualized treatment for SUD clients was that it will help produce positive outcomes (Hogue et al., 2022). Therefore, it is hoped that DTC officials will be more likely to approve the implementation of MFGT in 100% of the programs. The DTC programs with family as a part of treatment have more successful outcomes (Tabashneck, 2018). However, 84% of participants do not receive the benefits of FT in DTC programs (DeVall et al., 2022).

Project Procedures

This project data was collected through semi-structured interviews via online videoconferencing software (i.e., Zoom) with experienced clinicians who shared their experiences treating the SUD population using GT, FT, and MFGT. Online interviewing was a practical option for nationwide sample selection. Online interviewing eliminates time constraints for travel or scheduling (Gray et al., 2020). In addition, online conditions enhanced the dependability of this project (Kallio et al., 2016). In other words, a replicated interview can be conducted efficiently to collect data by other scholars wishing to create a similar TMDP (Kynge et al., 2020). For example, each interview was conducted in the scholar's residence, using a green screen with a neutral background to avoid a varying or distracting environment and an ethernet connection to prevent interruptions, allowing for consistency in the data collection process. Although the interviewees' conditions cannot be controlled before or during an interview, a future scholar replicating this process will be able to collect data in the same manner as was done in this project.

The first and second steps involved personal and core questions. The first step when collecting data was asking the warm-up questions, which were more participant-specific or unrelated to the topic but were necessary to build rapport with the interviewee (Oerther, 2021). An example of a warm-up question was, “Did you experience any difficulty connecting to Zoom?” In this way, a scholar may build a rapport of caring as well as helping the following interviewees if there is a connection challenge. The second step was asking structured questions that relate to the main topic of conducting treatment, the SUD population, and the participants’ experience using systemic modalities. Each data-finding interview question started with the six journalism queries, what, who, where, when, how, or why, to evoke descriptive responses (Naz et al., 2022).

The third and fourth steps consisted of unstructured and open-ended questions. The third step was asking follow-up questions to evoke more in-depth and emotional responses as well as concrete responses (Kallio et al., 2016). Follow-up questions were unscripted questions used to clarify, expand, or redirect the participants’ responses (Alirezai & Latifnejad Roudsari, 2020; Kallio et al., 2016). These were optional questions chosen based on how each participant responded. The fourth step was asking wrap-up questions which allowed for any additional information the participants may have wanted to include (Oerther, 2021). For example, “Is there anything else you would like to add?”

Any additional information the participants added after the interview was sent via email. Likewise, the additional questions this scholar asked after the interviews were emailed to participants and returned to this scholar for documentation. Because data collection and analysis can occur simultaneously, as long as the information was received before the analysis was complete, the addition was allowed in the project findings (Fetters et al., 2013). Each

participant's additional information was documented as an attachment to their original transcripts.

Data Collection and Analysis

After each interview, this scholar transcribed the data, thoroughly read the transcript, watched the recording, and coded the data for analysis. The process used for coding the data, called thematic analysis, is the method of identifying and analyzing common patterns and themes (Braun & Clarke, 2022). A *theme* is essential information linked to the project questions and is identified as a pattern in the data that creates meaning (Braun & Clarke, 2022). Braun and Clarke (2022) suggested that the steps of thematic analysis start with the rigorous review of interview transcripts and recordings, finding codes, collating the codes into themes, reviewing the themes in connection to the codes by categorizing them, naming the themes with a clear description, and extracting examples of each theme to relate back to the project questions. The data collection and analysis answered the project questions through triangulation to fill the treatment gap in DTC programs.

Moreover, literature review findings were triangulated with interview data to help ensure the credibility and reliability of the analysis. Triangulation validates the results of a project through the literature findings to guide a scholar toward the most effective implementation route (Bans-Akutey & Tiimub, 2021). Triangulation assisted the scholar to answer the project questions and create the TMDP by correlating the multiple sources of clinicians interviewed and literature findings (Bans-Akutey & Tiimub, 2021). The scholar's role in triangulation efforts reduces the scholar's bias and builds validity and quality for a comprehensive analysis (Merriam & Tisdell, 2015).

Assumptions

The first assumption was that the participants were invested in the topic. The second was that the participants were open and forthright in their responses with limited bias or personal agendas. Another assumption was that participants provided adequate responses to the questions; providing enough rich data to use in the creation of the TMDP. The rationale was that by completing the vetting process, each participant met the prescreening questionnaire criteria of expertise needed to respond to the questions for this project (Appendix B). A failure to screen the participants can result in inaccurate results that may cause conflicting situations (Mykolenko, 2024), such as terminating an interview early for lack of appropriate information.

Limitations

There were two limitations presented here, along with how they were mitigated. The first limitation was that the sample of seven participants may not have equally represented each clinician's three modality types. Three clinicians used MFGT to treat their SUD clients, and four used GT and FT. A strategy to mitigate a possible misrepresentation of information about all three modalities was to examine the results for skewed information and incorporating the literature findings to balance the representation of modalities. The second limitation involved limited access to the ADTC program outcome details. To navigate the gap in the literature findings, this scholar used the findings of other DTC programs to triangulate the interview data. Not triangulating research reduces the reliability and validity of a project, allowing potential bias results (Bans-Akutey & Tiimub, 2021).

Delimitations

The following four delimitations were chosen to strengthen the data relevant to this project. The first delimitation was that the interviewees did not include those with less than three

years of experience treating SUD. The rationale for this delimitation was that those who have seen more clients will provide this scholar with more information on the use of FT. This data enhances the TMDP and will help novice therapists using MFGT since training in FT may be limited for the outsourced DTC clinicians (Zoellner et al., 2011). The second delimitation was that participants were exclusively clinicians with at least half their therapy hours being systemic treatment experience. The proposed approach of MFGT is systemic, involving groups of families in treatment, so the sample of participants had to include those with experience with GT and FT. The recruitment method was another delimitation; participants were only gathered online, and therapists with specific expertise or experiences were excluded. Online recruitment was chosen because of project time constraints and the convenience of obtaining a sample. Last, the number of participants was limited because the primary focus of this project was for foundational findings, not generalization.

This scholar's delimitation decisions reflect the literature, framework, problem, purpose, and questions of this project. This scholar's delimitation choices relate to the existing literature and the systemic framework by selecting participants linked to the current practice of SUD treatment from various systemic EBP approaches. Although the benefits of MFT and MFGT are becoming more apparent for treating addiction, scholarly literature does not explain why MFGT is not commonly used to treat DTC clients. Rossman et al. (2011) reported that about half of the adults in the CJS treatment courts are parents and there is a growing interest in FT for these individuals (as cited in Lloyd Sieger et al., 2021, p. 3). Therefore, through the semi-structured interviews, the current project explored some of the barriers to implementing MFT and MFGT with DTC clients. Given the in-depth and complex nature of systemic practice and the nature of qualitative methods, the goal of nine participants was considered adequate for the proposed

project. These delimitations also addressed the problem statement by selecting experienced clinicians who currently use the systemic approaches that helped this scholar discover the benefits of using MFT and MFGT for all DTC clients. All delimitation decisions related to the purpose statement were made because descriptions of interventions aligned for DTC clients enabled this scholar to create a TMDP that may be used by most outsourced clinicians. Project questions were answered by delimitation decisions since clinicians with an appropriate amount of experience treating peers and families of SUD clients with effective interventions were targeted to obtain rich data.

Summary

The key points in this section were the project methodology of descriptive phenomenology design, which involved conducting semi-structured interviews with seven therapists to create a systemic TMDP for the DTC programs. This section further explained the process of interviewing as well as collecting and analyzing the data. This scholar also included the assumptions about vetting potential participants on the topic of interest, the limitations of this project, the lack of ADTC outcome details, the delimitations of participants' years spent in practice, the scholar's recruitment style, and the number of seven participants interviewed for this project. The findings are discussed in the following section, as well as addressing the trustworthiness of information gathered, which includes credibility, transferability, dependability, and confirmability. These factors were explained to show the efforts of maintaining accuracy, generalizability, ability to replicate, and preventing bias in this project.

Section 3: Findings, Implications, and Recommendations

This qualitative phenomenological project aimed to develop a systemic Treatment Manual Draft Proposal (TMDP) for the approach of multifamily group therapy (MFGT) in drug treatment court (DTC) programs. This scholar used the data collection and analysis to answer the project questions through triangulation of the interview data, literature review, and theoretical framework. These findings will be used to strengthen the current treatment approach used for the DTC program therapy treatment. The systemic TMDP is intended to reduce incarceration and recidivism for the substance use disorder (SUD) individuals in the CJS diversion program. This section provides evidence of data trustworthiness, results of the data pertaining to the two project questions, interpretation of the results in connection to the literature review and theoretical framework, action plan for the interpretation, recommendations for further applied practices, and recommendations for future projects utilizing these findings.

Findings by Each Project Question

This scholar identified and addressed four trustworthiness factors: credibility, transferability, dependability, and confirmability (National University, 2025). These factors strengthened this project's internal and external validity, reliability, and objectivity. NU (2025) stated that credibility is to show the accuracy and representation of the data, transferability to show the applicability of the findings, dependability to show that the procedure of the project is replicable, and confirmability to show documentation and bias prevention measures.

The first factor, credibility, was established through member checking and triangulation. Member checking occurred when participants were sent their verbatim transcripts after the interview for accuracy review (Soysal & Türkmen, 2024). Two of the seven participants made corrections, and the other five reported being satisfied with the transcription. Triangulation and

synthesis were accomplished by finding connections between interview data and literature review findings concerning project questions (Bans-Akutey & Tiimub, 2021; Lim, 2024). Common themes and patterns were developed through the coding of commonly mentioned words and phrases in the interviews. These themes were then word-searched in the literature review to locate connections to the project questions. Member checking and triangulation were used to ensure credibility and internal validity (Soysal & Türkmen, 2024). The findings represented the project questions and, ultimately, the accuracy of the TMDP.

Transferability of the data was established through the thick description of various demographics of interviewees and for the client population (see Table 1). The demographics included race, gender, age, clinical experience hours, modalities, and license or registration type. Participants' input provided multiple perspectives of experience treating the SUD population to answer the project questions. The transferability of data to help other client populations was evidenced in the literature review that SUD treatment is similar to treatment for other long-term illnesses, including schizophrenia, chronic pain, and other forms of addiction (Fernández-Miranda et al., 2024). Therefore, other scholars can use this data to create a systemic manual for other client populations that require long-term support. The thick description of the data relating to the context of the topic creates an effective way to interpret the transcripts using the literature review findings to answer the project questions (Drisko, 2025).

Dependability was established through the NU project committee's review of this scholar's data collection procedure, analysis, synthesis, and triangulation process. Each element in this project procedure has been well organized and documented by this scholar. Using the method of interviews for data collection allows other scholars to repeat this process of gaining relevant data because it is one of the most common forms of qualitative data collection (Denny &

Weckesser, 2022). The phenomenological design allows other scholars to repeat this process of gaining rich data from the experiences of others, which was a useful form of obtaining data while benefiting from the expertise of those who are in relevant fields of practice. The organized documentation of these procedures provides reliable, in-depth descriptions of how this scholar answered the project questions (Deterding & Waters, 2021).

Confirmability was established by this scholar through the rigorous review of the interview transcripts while having bias awareness. The rigorous review involved reading and word-searching each transcript many times to ensure that the responses were accurate to what the participants were conveying in the interviews (Rowlands, 2021). The review was well documented as an audit trail, identifying the codes and themes in the analysis to answer the project questions (Ahmed, 2024). A tactic of reducing bias was that this scholar did not share the level of experience as the participants working with the client population or the modalities surrounding the interview and project questions. Though this scholar did have some experience of these aspects, the questions were asked with the awareness of possible bias and mindfulness of curiosity, versus trying to confirm what was previously experienced. Therefore, bracketing was unnecessary to reduce scholarly bias in this case because the data were not scrutinized from prior knowledge or experience. Scholars with less experience in their project topic may have less potential bias (Baldwin et al., 2022). In addition, although the interviewees' side of communication was audio only, this scholar was on video for them to see. Therefore, this scholar's awareness of non-verbal cues may have reduced the interviewees' response bias (Chitac et al., 2024).

The overall project goal guided the creation of project questions and the interview questions. The goal of this project was to develop a systemically focused TMPD for SUD, using

the themes found in the interview data in triangulation with the findings of the literature review. Data from the seven interviews identified the five themes of engagement, emotional support, sharing, tracking patterns, and social support. The first project question produced the themes of engagement, emotional support, and sharing, while the second was tracking patterns and social support. The first three interview questions were intended to answer the first project question, and the last three were focused on answering the second. The results of the data collection for each of the two project questions are summarized in Tables 1 and 2.

Most participants had similar levels of experience treating SUD systemically. Years treating SUD ranged from 4 to 10 years, with an average of 6.5 years. The clinician participants reported using a variety of systemic treatment modalities (see Table 1). The participants' therapy hours ranged from 25 to 40 hours per week, for an average of 32 hours per week. Of those therapy hours, systemically focused therapy hours ranged from 15 to 30, with an average of 24.5 hours per week. These results showed that the criteria surpassed the minimum requirements as individuals and as a sample. Therefore, the clinician participants' experience was enough to provide the rich data needed to answer the project questions.

Table 1*Participant Demographics*

Name	Race	Age	Gender	Modality	Therapy hours / systemic hours	License type
Participant 1	African American	39	Female	MFGT*	30/15	MHC
Participant 2	African American	38	Female	GT & FT	35/25	LPC
Participant 3	African American	30	Female	GT & FT	30/20	CSW
Participant 4	African American	40	Female	GT & FT	30/15	LMFT**
Participant 5	American Indian	30	Male	GT & FT	32/16	LMFT
Participant 6	Asian American	32	Female	GT, FT, & MFGT	40/30	LMFT & CSAC***
Participant 7	Hispanic American	42	Male	GT, FT, & MFGT	25/19	LMFT

*Multifamily group therapy. **Licensed marriage and family therapy. ***Certified substance abuse counselor

Project Question 1

According to experienced clinicians who treat SUD, what impact does peer and family involvement have on the recovery outcomes of SUD clients?

Table 2*Themes of Project Question 1*

Theme	Codes	Triangulation
1. Engagement	Communication Listening Quality time Conflict	The use of family in therapy increases client engagement, which decreases drop-out rates, relapse, and recidivism (Marlowe, 2022).
2. Emotional Support	Understanding Empathy Encouragement Validation	The addition of other families in treatment was seen as a beneficial support by showing encouragement and praise for the behavioral changes being made (Cañas & Estévez, 2021).
3. Sharing	Boundaries Contributions Family dynamics Cultural sensitivity Safety Relating	Sharing issues and solutions with peers and families promotes the long-term treatment attendance that leads to symptom relief and family cohesion (Maone et al., 2021).

The steps used to analyze the data to answer the first project question were finding key terms, creating the themes, and reviewing the themes. This scholar generated the themes and codes using the first three interview questions relating to peer and family involvement in treatment. The keywords that were repeated the most included communication, boundaries, and understanding. The next step was categorizing the codes into main themes according to the purpose of answering the first project question. Those themes were engagement, sharing, and emotional support. These themes were chosen because they coincided with the codes in the transcripts and the systemic aspects of the literature review. The last step was the review of the themes, which resulted in, for peers: motivation, personal experiences, and celebrating milestones; for family: belonging, trauma sharing, understanding, and empathy; for MFGT: and families, inspiration, creating a safe space without judgment, validation, and encouragement.

The participants' experiences with the first three interview questions were about their professional perspective, social dynamics, personal context, and cultural differences. The participants' momentum of information sharing was productive because they all had a significant amount of experience conducting systemic treatment. They all reported that when they have a larger therapy group, they have a co-therapist to help manage the clients. As leaders, with the knowledge of this scholar's credentials and the purpose of this project, they all used terms relevant for reporting the effective peer and family skills. Last, the forms all stated that the interviews were to be video recorded through Zoom, but the consent form detailed that participants could disable the video function at any time. Therefore, this knowledge of an option led all of the participants to choose only audio recordings of themselves.

Theme 1: Client Engagement. Most participants conveyed the importance of engagement in and out of treatment sessions between peers and family. Two participants expressed the significance of communication, and one spoke about quality time together. Participant 7 stated, "Family contributions and consistent participation in SUD sessions are very meaningful." Participant 1 quoted, "I tell the members to engage in family trips, regular physical activities, or something to relax together that improves the mood between them." Participant 2 explained, "During session breaks, I told them to have lunch together to communicate and get to know each other." These responses link to the codes of engaging with each other, reducing conflict, open communication, and active listening within all modalities of treatment.

Theme 2: Emotional Support. Almost all the participants expressed the importance of emotional support. Participants 4, 5, and 6 all said something similar to this agreed quote: "Teaching the clients active listening to promote emotional support through an understanding of perspectives gives the clients encouragement to help them stay motivated and engaged in their

recovery.” The other participants related to the theme by mentioning, “the importance of group and family members’ validating and encouraging each other to build emotional support for the SUD clients.” These statements are related to the code of understanding each other’s perspectives, which promotes empathy that allows family members to give the long-term emotional support needed for SUD recovery (Winter et al., 2022).

Theme 3: Therapy Sharing. All the participants stated the importance of sharing during GT, FT, and MFGT treatment sessions. Participant 3 said, “I encourage participants during introductions to share their goals, which helps establish a sense of connection.” This participant also talked about the importance of trauma sharing with the family because it promotes relating, understanding, and empathy. Along with the clients’ disclosing trauma, participants said, “Addressing secondary disorders of CODs (anxiety, depression, and PTSD) is beneficial for clients and family members as well.” Four participants declared that “cultural awareness (i.e., cultural matching between the therapist and clients as well as between the clients in group therapy) builds relatability to avoid possible racial tension.” A few participants expressed that “knowing the boundaries and cultural awareness of the clients helps the clinician navigate multiple family dynamics in MFGT.” These quotes relate to connecting, disclosing, and CODs by clients contributing their stories to promote feelings of safety and calm for those who have social anxiety.

Project Question 2

According to experienced clinicians who treat SUD, what elements of systemic treatment (topics, interventions, or resources) need to be included in the TMDP for SUD offenders?

Table 3*Themes of Project Question 2*

Theme	Codes	Triangulation
4. Tracking Patterns	Triggers Relapse prevention Coping Patterns	Because of how SUD affects the brain, decision-making, judgment, and memory changes (Lüscher et al., 2020; Lustig, 2018).
5. Social Support	Peer specialist Support group Sharing Motivation Community	Treatment outcomes of MFGT have decreased the social stigma of MI, increased social support, and enabled the clients to learn effectively from other perspectives (Depestele, 2018).

The steps used to analyze the data to answer the second project question were finding key terms, creating the themes, and reviewing the themes. This scholar generated the themes and codes using the last three interview questions relating to topics, interventions, and resources in the TMDP. The keywords that were repeated the most included coping, relapse, and motivation. The next step was categorizing the codes into main themes according to the purpose of the TMDP. Those themes were tracking and support. This scholar generated these themes through the participants' responses to the last three questions. Because they coincided with the codes in the transcripts and the treatment aspects of the literature review, these themes were selected. For topics, communication patterns were expressed; for interventions, exploring triggers; for resources, a CBT manual guide was suggested. The last step was the review of the themes that resulted in, for topics, building a support network; for interventions, peer specialist involvement; for resources, local support groups.

A thick description of the participants' experience with the last three questions was about their professional perspective, social dynamic, and personal context. The participants'

professional perspectives were similar because all the participants had conducted SUD treatment. Each participant reported that when a client relapses, they address it through non-judgment using empathy; the social dynamic of non-authoritative therapy works best for these clinicians. For example, all the participants expressed what one quoted, “MFGT creates a breakthrough in understanding and empathy because clients can often feel truly seen and supported for the first time, not just by therapists but by their peers and family members. This emotional validation reduces shame or feelings of being judged and increases motivation. It also enhances their commitment to recovery because they are being viewed as not the problem, the disorder is.” Lastly, the various license types did not create outliers in the data.

Theme 4: Tracking Patterns. Most participants spoke about the importance of tracking patterns to prevent a relapse. The participants in the project stated that “the client and therapist were to identify and manage dysfunctional patterns and triggers to prevent a relapse” and “after a relapse, they had to collectively as a family and therapist figure out what went wrong and what could be done differently to avoid another relapse.” Participant 1 detailed that “identifying coping strategies that effectively support clients’ stress management is important.” An example was about a family that liked going on trips and having family dinners in the past, when they were happy. Therefore, these types of activities were set as therapy assignments. The input relates to the codes of identifying triggers and disrupting patterns, preventing relapse, and re-strategizing the coping skills and support.

Theme 5: Social Support. All the participants stated that “social support is necessary for GT and MFGT.” They expressed, “For GT, supporting peers through friendships and inviting peer specialists to speak to the group and connect with newer clients to provide them additional

support, inspiration, and motivation.” Most participants also recommended the clients to attend support groups outside of therapy together as a family or peer connections. Participant 4 detailed,

There was a client I saw who was ashamed about his IV drug use and refused the traditional treatment groups initially. However, after connecting with a peer specialist who shared a similar history, this client became visibly relaxed, and I could see that the social support of relating was the key. He started opening up and eventually felt safe enough to attend a local support group of AA meetings.

These responses link to the code of motivation, along with most participants finding that community support resources were important to the clients’ recovery as well.

Evaluation of the Outcomes

Engagement was a theme spoken about by participants and connected to the existing literature and systems theory, which helped answer the first project question. A few participants spoke about engagement for all modalities in the form of “check-ins for group and family members who miss attendance to ensure they know the importance of returning to treatment.” Increased engagement promotes a decrease in drop-out rates, relapses, and recidivism (Marlowe, 2022). All but one participant expressed the importance of repairing conflict. The others verbalized, “The repair allows more open communication to engage with one another because the solutions create a safe place to return to treatment.” Treatment engagement may be measured by the client’s close relationship repair needs and efforts to mend the family bond (Dillon et al., 2020).

To continue the theme of engagement, several participants mentioned that “the therapy groups praising and celebrating milestones for the members increases the emotional support needed for long-term SUD recovery.” Cañas and Estévez (2021) stated that the addition of other

families was seen as beneficial support by showing encouragement and praise for the behavioral changes being made, and reported these positive effects lasting after the interventions were conducted. Blair and Raver (2015) conducted a review finding that individuals who had SUD from their adolescent years to adulthood lack emotional maturity (judgment-making, long-term goal projection, and impulse control; as cited in Pisaneschi, 2025). In 2003, Farrington stated that early substance use leads to poor emotional regulation, family functioning, and impulse control that make the chance of an individual ending up in the CJS greater (as cited in Pisaneschi, 2025).

These factors related to emotional maturity, early substance use, and developing an addiction into adulthood may affect treatment attendance. Because emotional maturity predicts impulse control, a common problem with SUD, the inspiration to show up for treatment may deter clients from relapse. From a study of students, Kelty and Wakabayashi (2020) reported that engagement increases their social experience, which predicts the students' motivation, cognition, impulse control, attention, self-confidence, and socio-emotional skills.

Emotional support was repeatedly expressed by the participants as critical. This connects to the existing literature and the systemic theory that helped answer the first project question involving peers and families. One participant expressed, "The added support of family in treatment tends to help DTC participants for long-term SUD recovery needs, motivates attending treatment, and helps reduce the stress of the pending criminal punishment." Another participant commented, "Additional families in treatment are seen as a beneficial support by showing encouragement and praise for the behavioral changes being made." In turn, building the family's empathy towards the SUD client strengthens the emotional support they can provide. Cañas and Estévez (2021) reported these positive effects lasting after the interventions were conducted.

Gaining emotional support starts with communication interventions that lead to a better understanding of each other's perspectives; this allows family members to feel empathy for the SUD client (Metaxa et al., 2025). FT provides opportunities to mend the existing support system through communication, understanding, and empathy (Markoulakis et al., 2018). Building understanding and empathy is needed in recovery for the growth and maintenance of long-term support (Winter et al., 2022).

Sharing was discussed by all participants as important and connected to the existing literature and the systemic theory by answering the first project question involving peers and families. Many participants mentioned that "there is a benefit of the clients' peers having the same cultural backgrounds in GT." However, they also said that "having a treatment based on different cultural backgrounds would be very helpful for MFGT because of the number of clients in a session." Therefore, considering the literature findings of using MFGT interventions (i.e., psychoeducation, CBT, and assertive community treatment), this approach is effective to treat diverse groups (Chow et al., 2010). Saleem et al. (2021) claimed that, when a diverse group shares viewpoints, the participants learn not only about others but also about themselves. Many participants stated that "family involvement is very important, so sharing in FT and MFGT promotes long-term treatment attendance, which increases recovery outcomes." An existing project that uses this framework is a study of MFGT treatment for 794 individuals with severe mental illnesses (SMI) (Maone et al., 2021). This study found that the approach of being able to share issues and solutions with other peers and families promotes long-term treatment attendance, which leads to fewer unwanted symptoms and more family cohesion.

Tracking in relation to relapse prevention was discussed extensively by the participants, which connects to the existing literature and the systems theory that helps answer the second

project question that involves topics, interventions, and resources. A large part of CBT is tracking behavior and identifying triggers, so with the addition of family tracking and support as a form of aftercare, which was mentioned by the participants, and SUD treatment, it increases the chance of long-term recovery (McKay, 2021). The Department of Family Medicine and Community Health reports that the ADTC program has four main approaches for long-term recovery, consisting of CBT, relapse prevention, aftercare, and substance abuse treatment (López et al., 2021). Many participants voiced, “Psychoeducation is important for the families of SUD.” One mentioned that “substance use affects the brain, which decreases understanding of behavior to promote the empathy needed for long-term support.” Lüscher et al. (2020) stated that when an individual is exposed to particular stimuli (i.e., drugs or alcohol), the response mechanism fosters a habit that hinders healthy neural pathways and conscious thoughts. This loss of brain function may imply why it further intensifies the addiction by impeding logical decision-making (Lüscher et al., 2020).

Social support in relation to motivation was expressed significantly by the participants. Motivation connects to the existing literature and systems theory, helping to answer the second project question that involves topics, interventions, and resources. Many participants revealed that “the more the peers (especially for those who have anxiety disorders) witnessed others opening up to the group, the more likely they were to feel safe enough to also open up about what was happening for them.” Studies on the use of MFGT have shown positive outcomes, including reductions in relapse, drop-out rates, and anxiety (Roué et al., 2021). Participants also said that “the SUD clients may be more likely to engage in treatment with the encouragement, inspiration, and motivation from the additional support of peers and families.” MFGT studies have shown that this treatment approach improves counseling retention, social functioning, and

family resilience (Rosenblum et al., 2017; van Es et al., 2023). Because negative peer and parental influences in early childhood are often foundational factors of SUD development, it is beneficial for peers and family to be included in SUD treatment as part of the solution (Meulewaeter et al., 2022).

Observations Regarding this Project

A factor that could have influenced the interpretation of the results included variations of the clinicians' therapy modalities regarding the first project question. Because not all clinicians conducted therapy using MFGT, there may have been a misinterpretation of questions relating to MFGT only. Some participants did not have experience using MFGT to appropriately respond to the third interview question regarding MFGT use only. Instead, they were asked what skills they thought peers and family need in treatment based on their experiences of treatment using GT and FT separately. Therefore, the interpretation may lack the aspects of treating a large group consisting of multiple families.

Another influencing factor of this scholar's interpretation is the participants' current use of treatment manuals when addressing the results of the second project question. For the last three interview questions, it was assumed that all the participants did not use treatment manuals for their therapy sessions. The responses for what the participants thought should be included in the TMDP are not differentiated between who may be referring to the use of personal manuals or from a possibly less biased perspective from those who are unfamiliar with the use of a manual to treat their clients. Therefore, the interpretation may have been influenced by the participants using a treatment manual and those who may have been referring to the use of manuals that address only GT or FT, not MFGT.

In the context of this project, the results of the data addressed the project problem, purpose, literature review, and theoretical framework. The results showing the benefit of additional support in therapy address the project problem of a lack of a systemic family modality in DTC treatment programs. The value of results addressed the project purpose by providing MFGT goals, objectives, and interventions in the manual for the DTC's outsourced therapists who currently conduct GT and FT separately. The benefit of MFGT for SUD therapy addressed the existing literature by having multiple sources linked to what the participants said about how peers and families contribute to recovery outcomes. The systemic framework relates to the foundation of family therapy, the studies of current use, and the interview data about MFGT benefits for the SUD population.

These results are consistent with existing research and theory. The data collected from the clinicians provide further evidence that supports the potential benefit of addressing secondary disorders in SUD treatment (Field & Jette, 2007; McNally et al., 2025). Within the literature, the common occurrence of CODs (anxiety, depression, and PTSD) with SUD, as well as a family history of addiction (intergenerational trauma and genetics), brought to light the need for information about this to be included in the TMDP to better fit the needs of the SUD clients. CODs are more challenging to treat than SUD because CODs can differ from client to client (Perry et al., 2019). The use of MFGT has been reported to alleviate a multitude of COD symptoms for SUD clients (Fernández & Baena, 2021). Therefore, this provides a compelling reason why MFGT is the projected modality for the TMDP that covers a multitude of secondary diagnoses.

A potential explanation for the divergent results of diversity may be addressing treatment tactics that are less complicated compared to what could be more beneficial long-term. Although

most participants expressed that the same cultural background for clients and therapists is more impactful in terms of relatability and connecting, the literature says that MFGT is effective for diverse groups (van Es et al., 2023). Therefore, this scholar included information and interventions related to diverse clients in the TMDP to cover possible diverse settings in a DTC program, compared to clinicians in private practice who can choose their clientele.

Action Plan

This project revealed that MFGT may be a valuable approach to the CJS; therefore, the next step will be to present the TMDP to DTC officials. The presentation will show the benefit of the MFGT and how the manual may aid outsourced clinicians in incorporating the approach into their practice. If this proposal is denied, feedback will be requested to revise the TMDP, then subsequent presentations will be conducted until all efforts are exhausted. After this draft TMDP is completed, this scholar will practice presenting it to the DTC officials. In addition, further research will be conducted to determine what the officials deem effective for treatment and implementation factors. This systemic TMDP will also be presented to other SUD organizations, programs, and clinicians treating similar disorders and illnesses. Systemic interventions for a multitude of disorders and illnesses have grown in popularity over the past 25 years (Carr, 2025).

Rather than creating a finalized TMDP, a draft proposal will be adequate to present to the DTC officials for their approval and to address financial concerns. The officials do not need to see in-depth intervention steps, but they can review which types of goals, objectives, and interventions are intended for the final draft. Moreover, these government officials may want to see how this change in the DTC treatment will not negatively impact their budget. Co-therapists may be acquired from outsourced practices, and sessions could be conducted via video conferencing to keep costs down. There will be no monetary expenditures because no other

therapists will need to be hired. This scholar has a grant proposal draft stating the projected savings, but it has not been updated for review at this point in time.

Additional future actions include using the TMDP outline to fully complete a final draft. DTC officials include judges, prosecutors, defense attorneys, treatment providers, probation officers, and members of law enforcement who work for the government. Therefore, the TMDP must go through a chain of command to be approved. Whether or not the DTC approves the MFGT implementation immediately, this systemic TMDP will be revised for the general population of SUD and other disorders and presented to other organizations in the future. Lastly, if the initial TMDP presentation is denied due to funding concerns, this scholar will update and revise the grant proposal to show the potential savings the government may benefit from due to the MFGT approach implementation.

Implications and Recommendations for Practice

Findings may be applied to practice through encouraging systemic treatment for other disorders. The systemic treatment of MFGT may also be used for disorders of any addiction, as well as chronic or severe illnesses or disorders. MFGT is an evidence-based intervention, including psychoeducation and behavioral therapy (Stuart & Schlosser, 2009), for populations with chronic disorders and SMIs and their families. Treatment practices outside the DTC program for MFGT are effective in treating SUD, eating disorders, schizophrenia, chronic pain disorders such as fibromyalgia and rheumatoid arthritis, as well as anxiety and depression (Shumway et al., 2022; van Es et al., 2023). In turn, these disorders are similar to SUD because they are chronic, share risk factors, affect the brain, and have a high risk of relapse. Therefore, an implication can be that the MFGT TMDP may be applied to various similar medical and mental treatment practices.

The findings can be applied to practice through the use of the systemic manualized treatment. The future use of the manual may allow the outsourced clinicians of the DTC program to keep their clients. For example, instead of changing the SUD participants' clinician to one who specializes in MFGT, they can simply use the content of the manual proposal and add a co-therapist to assist in facilitating the group, as discussed by the project participants. This way, the rapport between the client and therapist remains intact. The majority of DTC programs that use GT will invite the clients' family members, and the DTC programs that use FT will introduce multiple families to sessions. The manual proposal can also help other clinicians of any specialty modify their approaches; allowing clinicians to incorporate the TMDP in therapy to allow transition from a GT or FT to an MFGT. Simpson et al. (2021) reported that manualized SUD treatment is more beneficial for substance use recovery outcomes, even for SUD clients with PTSD. Therefore, the use of the manual for SUD treatment may be more effective and convenient for the DTC's outsourced clinicians.

Recommendations for Future Projects/Research

To build on the findings of this project, future scholars may conduct further research, such as interviews with more clinicians, interviews with the DTC participants and their families, and seek clinician feedback on the use of the manual. Further research on this topic may reveal evidence of MFGT being effective for other disorders and situations. Additional clinician interviews may further expand on the interventions in the manual for more effective treatment as a new edition. Interviewing the intended SUD clientele and their families about the DTC program may allow a different perspective for improving the manual and the implications of this project. Lastly, gaining the clinicians' feedback on their use of the manual may allow the opportunity to create newer editions.

Given the limitations of the sample size and demographics, this scholar will discuss how future scholars can improve upon this project. Future scholars can improve this project by recruiting a larger sample size of clinicians who use MFGT as their approach to treating SUD. In addition, this may allow a larger variation of demographics that may increase the number of perspectives to reduce possible biased responses. A future scholar may produce more diverse results by purposefully selecting clinicians with diverse characteristics.

Future projects can consist of program evaluations, program treatment timing, and participant qualification. Outcome evaluations can compare the DTC program outcomes before and after the implementation of the MFGT treatment manual. Another project may be the attempt to accept SUD offenders into the DTC program at their first substance offense as opposed to waiting until they are facing serious incarceration time as a prison divergent program. This tactic may prevent substance abuse progression and recidivism. Quinn and Van Dyke (2004) found that first-time juvenile offenders who participated in MFGT had lower recidivism rates compared to those who underwent traditional probation, which indicates that the systemic treatment is likely more effective. The final future project recommendation is that all DTC locations allow an assessment of SUD for program qualifications of CJS offenders who are charged with “intent to sell,” which the DTC program does not allow currently, according to the Supreme Court of the State of Florida (2023). These types of projects may build more evidence on the use of MFGT, improving SUD recovery outcomes, family members’ mental health, recidivism, and many other factors that play a part in the systems of a family unit, community, and society.

Conclusions

This project was focused on developing a systemic TMDP for SUD offenders to address the lack of family involvement in the DTC program treatment. The desired outcome is to reduce SUD recidivism in the US and keep families who are struggling with SUD intact. A takeaway is that manualized treatment can be a benefit of not having to change therapists when changing modalities in a program similar to DTC. What this scholar gained from the outcomes of this project was that social and emotional support is significantly beneficial to SUD client outcomes, and when clients are treated in a larger group, communication, understanding, and empathy lead to support for their families and their long-term recovery needs. The findings of this project relate to previous research and practice through the studies of individuals with similar disorders and illnesses who may benefit from the use of MFGT more effectively for their long-term recovery, as well as the recovery outcomes of the FDTC and JDTC programs. This project strengthens the evidence of those reports, studies, and other research projects by correlating the findings and bringing novel ideas to improve SUD outcomes and recidivism. The action plan of completing and presenting the treatment manual to the DTC officials and learning the process it must go through to be implemented is being practiced through the presentation/defense. The implications of the commonality of COD with SUD are important to address when conducting treatment, and the practicality of manualized treatment for outsourced clinicians of the program is beneficial. The recommendations suggest that future research and projects might be outcome evaluations after MFGT is implemented, the DTC allowing first-time offenders in the program, and assessing for secondary disorders to better fit the needs of the participants. In addition, future scholars can interview a larger sample of clinicians, interview the DTC participants, and analyze feedback from the clinicians who use this treatment manual. Although further research and

scholarly projects will benefit the SUD population, this MFGT treatment manual is an innovation that may benefit other populations and the effectiveness of clinicians conducting a systemic approach for chronic and severe disorders and illnesses.

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Appendices

Appendix A: Recruitment Post

Appendix B: Pre-screening Questionnaire

Appendix C: Consent Form

Appendix D: Interview Questions

Appendix E: Treatment Manual Draft Proposal

Appendix A

Recruitment Post

My name is **Lauren Goss** and I am a doctoral candidate at National University. I am conducting a research study to implement a more systemic approach in the Drug Treatments Court (DTCs) programs by sharing your experiences about the elements and impact of peers and families in SUD treatment.

I am recruiting individuals who meet all of these criteria:

- You are age 18 or older
- You have at least three years of experience treating substance use disorder.
- You are currently a practicing registered or licensed clinician with a minimum of 20 hours per week and 50% of clients being treated as groups, family and/or multifamily group sessions.

If you decide to participate in this study, you will be asked to do the following activities:

1. Participate in a 1:1 online interview over Zoom for 60 minutes
2. Review your interview transcript via email for 10-15 minutes

During these activities, you will be asked questions about:

- Your age, race, gender, and disability
- Your experience conducting group therapy, family therapy and/or multifamily group therapy with substance use disorder clients.

If you are interested in participating in this study or have questions, please contact me at lauren.goss1986@gmail.com or 407-853-2503.

Thank you for considering participating in this voluntary research!

Lauren Goss, RMFT

Appendix B

Pre-screening Questionnaire

Thank you for your interest in participating!

Screening Questionnaire:

1. Age:
2. Race:
3. Gender:
4. Ethnicity:
5. Disability:
6. License type:
7. Years of treating substance use disorder:
8. Hours of therapy sessions each week:
9. Hours of sessions in the form of group, family, and multifamily group each week:
10. Email address and phone number:

In addition, please read the consent form attached to this email because you will be requested to give a verbal agreement before the interview recording starts. Any pre-screening data from participants who do not meet eligibility criteria will be immediately deleted. Let me know if you have any questions about the pre-screening questionnaire, consent form, or participation.

Thank you,

Lauren Goss, RMFTI

National University Doctoral Candidate

Appendix C

Consent Form

My name is Lauren Goss, and I am a doctoral candidate at National University. I hold a role as a Registered Marriage and Family Therapist Intern as a sole proprietor. I'm asking you to take part in a research study for an applied doctoral project to implement a more systemic approach in the Drug Treatments Court programs by sharing your experiences about the elements and impact of peers and families in SUD treatment.

The name of this research is "Improving Drug Treatment Court Programs: The Development of a Multiple Family Group Therapy Treatment Manual."

You may participate in this research if you meet all of the following criteria:

- You are age 18 or older
- You have at least three-years of experience treating substance use disorder.
- You are currently a practicing clinician with a minimum of 20 hours per week and 50% of clients being treated as groups, family and/or multifamily group sessions.

I hope to obtain nine participants for this project.

Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

If you agree to be in this study, you will be asked to do the following activities:

1. Participate in a 1:1 online interview over Zoom for 60 minutes
2. Review your interview transcript via email for 10-15 minutes

During these activities, you will be asked questions about:

- Your age, gender, race, and disability
- Your experience conducting group therapy, family therapy and/or multifamily group therapy with substance use disorder clients.

Risks: A breach of confidentiality on the clients of the participants. There are minimal foreseeable risks or discomforts associated with this research. You can still skip any question you do not wish to answer, skip any activity, or stop participation at any time.

To prevent a possible risk, the participants are asked to keep the details of their clients to a minimum. This may reduce the risk of the interviewer discovering the identity of their clients.

Benefits: If you participate, there are no direct benefits to you. This research may increase the body of knowledge in the subject area of this research.

Recording: I would like to video-record your responses with Zoom during the interview. You can disable the video function of the online meeting platform at any time.

Mandated Reporting: My professional role outside of NU requires me to report suspicion of child or elderly abuse, suspicion of possible harm to self or others, and committed crimes to the appropriate authorities.

Confidentiality: I will keep the records of this study private and take reasonable measures to protect the security of all your personal information. In any report I make public, I will not include any information that will make it possible to identify you. Confidentiality for the participants will be achieved by using numerical labels instead of actual names. Once the data is analyzed, it will be deleted.

Taking part is voluntary: Participation in this study is completely voluntary. You may quit at any time.

If you have questions: Please ask any questions you have now. If you have questions later, you may contact me at lauren.goss1986@gmail.com or at 407-853-2503.

If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) via email at irb@nu.edu

Appendix D

Interview Questions

Warm-up Questions:

1. Hi, how are you?
2. Did you get connected okay?
3. Do you have any questions before we start?

Structured Questions:

1. In your experience, what peer skills effectively improve SUD client recovery outcomes?
2. From your experience, how can the family contribute to improving SUD client recovery outcomes? For example: support, interventions, skills, etc.
3. From your perspective, what are the most important aspects of peer and family involvement regarding SUD client recovery outcomes?
4. What systemic topics should be included in an SUD Treatment Manual?
5. What systemic interventions should be included in an SUD Treatment Manual?
6. What systemic resources should be included in an SUD Treatment Manual?

Wrap-up Question:

Is there anything else you want to address on this topic?

Appendix E
Treatment Manual Draft

Cover

Title: Multi-Family Group Therapy for Substance Use Disorder Offenders



Signature Logo:

This manual features:

- Stated treatment goals, objectives, and interventions
- Presenting issues corresponding to the interventions
- Steps to create the unique treatment plans for the clients
- Additional space to develop modified plans

Author: Lauren Rae Goss

Editor:

Publisher:

Formalities

Official credentials

Quotes of inspiration and foundation:

“Do it before you don’t because if you don’t you won’t.” -Lauren Goss-

“The whole is greater than the sum of its parts.” -Aristotle-

Acknowledgements: My wife and family members

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Preface

Substance use disorder definition: a family disease and a chronic illness that demands a lifetime of support for lower relapse rates and the best recovery outcomes (Fuchshuber & Unterrainer, 2020).

Purpose of this Manual

The purpose of this scholar's qualitative phenomenological project was to develop this treatment manual that integrates a systemic family treatment approach in the Drug Treatment Court (DTC) programs. The project helped fill a treatment gap because, of the general population of substance use disorder (SUD) treatment programs, outside of DTC, 93% use group therapy, 60% offer couples counseling, and 81% use at least one form of family-based intervention (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). The construct of the project was the benefit of using multifamily group therapy (MFGT) for SUD treatment. The sample size was seven clinicians that conducted therapy using at least one or a combination of the approaches group therapy (GT), family therapy (FT), and MFGT. Semi-structured interviews were conducted via Zoom to obtain data. A thematic analysis was conducted to find the common themes and patterns in the data for the target population, which consisted of currently practicing registered or licensed clinicians who have a significant amount of experience treating SUD systemically.

Significance of this Manual

The contribution of the project was the development of this treatment manual to better address the needs of SUD offenders using systemic methods with family involvement for the goal of reducing incarceration and recidivism. The project contributes to the field of MFT because researchers and clinicians interested in this systemic treatment method will be able to use this manual to influence the treatment of other client populations. The National Drug Court Resource Center (NDCRC) reported that in 2025, out of 4,000 DTC programs only 406 of the Family DTCs (FDTCs) and 247 of the Juvenile DTCs (JDTCs) involved FT (National Treatment Court Resource Center, 2025; U.S. Department of Justice, 2025). Out of all the DTC programs, only 16% involve family in treatment, yet have the best outcomes (DeVall et al., 2022). Therefore, the importance of adopting FT in all the DTC programs may be pertinent to achieve similar outcomes by reducing rates of dropout, relapse, and reoffending.

The impact of this treatment manual may be substantial to marriage and family therapy (MFT) leaders and practitioners because they will be able to access the clinician-recommended steps of conducting MFGT effectively with SUD clients. Leaders may allow clinicians the use of this manual that may contribute to the literature by providing their expert-informed feedback related to conducting MFGT with this manual, specifically for clients at high risk of relapse and reoffending. The work of Paganin (2024) demonstrated that clients with severe depression, a common co-occurring disorder of SUD, MFGT was conducive to preventing relapse. The benefit of addressing the project problem is that families may be encouraged to join DTC programs. This aligns with the findings of Kahyaoğlu et al. (2020) that the more the family attends therapy with the SUD member, the less likely a relapse is to occur.

The benefit of producing this treatment manual is the addition of peers and family support for long-term recovery, seen as effective for decreasing relapse and recidivism (Maone et al., 2021). Furthermore, the project used theory triangulation to fill the research gap by examining MFGT for long-term SUD recovery outcomes. The triangulation addressed the research and experiences of clinicians who worked closely with SUD, using GT, FT, and MFGT. The benefit of answering the project questions made this manual more credible and accurate to move toward positive change in the lives of SUD offenders, their families, and communities.

Foundational Theories

Systems theory was the guiding framework of this descriptive phenomenological project. Systems thinking started in 347 BC with Aristotle, who explained that “the whole is greater than the sum of its parts” (as cited in Halimi et al., 2020, p. 1). In the 1940s, Ludwig von Bertalanffy applied this notion to human biology, coining the term general systems theory (GST) (Friedman & Allen, 2011). Aristotle’s notion of systems thinking and GST are related because the interdisciplinary theory of GST is a complex organization of interactions relating to a larger system (Friedman & Allen, 2011). When GST is effectively applied to a social aspect of mental health for the SUD population, family is a key factor (Chattopadhyay et al., 2022).

Family systems theory (FST) was coined in the 1950s by psychologist Murray Bowen (Malvig, 2021). His theory was derived from GST to help explain working with a closed system, such as a family. FST and GST are related because individuals grow and develop a pattern through the understanding of their family context, and they can apply it when the influences of the larger system of society work to destabilize them (Malik, 2020). In addition, elements from the family communication theory are derivative of GST and FST (Chattopadhyay et al., 2022; Long, 2003; Watson, 2012). Bowen’s aim was to help explain how families survive in homeostasis (Malvig, 2021) and develop their own unique interaction patterns including familial interaction, differentiation, and triangulation to describe human behavior as a complex social system (Brown, 1999). If there is recognition of a need for further support for individuals facing SUD, the addition of peers and family through MFGT may benefit the SUD client.

This scholar's decision on the topic, population, and approach was guided by systems theory, which highlights the growing evidence of MFGT, an effective systemic approach for the SUD population (Shumway et al., 2022). Systems theory helped this scholar develop the problem statement because current approaches for SUD offenders, exclude FST in therapy for the majority of DTC programs. The systemic framework also aligned with the purpose statement by identifying what systemic aspects would be more effective for the SUD offenders' treatment approach. Furthermore, this framework informed the development of the project questions by identifying the types of information needed to support clinicians working with peers and families, and by guiding how that information could be effectively presented in this manual. Common systemic themes and patterns of the clinicians' experiences treating SUD clients were examined. Their responses were used to develop this manual using a systemic approach to serve this population more effectively.

Structure of MFGT Sessions

Client selection for groups: It is up to the clinician to determine exclusion criteria that will be used to select participants for their group treatment practice.

Exclusion criteria: These are determined by the clinician.

Average duration of treatment: 52 weeks (Gouveia et al., 2025; Lowenkamp et al., 2005)

Average duration of session time: 90 minutes weekly (Maone et al., 2021)

Average group size: 8-12 clients or 4-6 families (Gouveia et al., 2025)

Number of therapists: 2 or 3 therapists (Gouveia et al., 2025; Maone et al., 2021)

All the participants in the project reported that, when they have a larger therapy group, they add a co-therapist to help manage the clients. Co-therapists may be acquired from outsourced practices, and sessions could be conducted via video conferencing to keep costs down.

Skarbø and Balmbra (2020) claimed that the more therapists in an MFGT session, the better the therapeutic outcomes, but in another article, the claim was that two therapists are preferred (Paganin, 2024).

Family involvement details:

When facilitating MFGT, a major component allowing clinicians to conduct the approach is the family members' participation. For that reason, the TMDP includes that the provider must reach out to the family stressing the significance of their attendance for better recovery outcomes. Kelty and Wakabayashi (2020) conducted a study on educators engaging families for their children to discuss the importance of their involvement. Kelty and Wakabayashi (2020)

reported that the engagement increases their social experience, which predicts the students' motivation, cognition, impulse control, attention, self-confidence, and socio-emotional skills. The hope is that the SUD clients will have the same outcomes. If family members still refuse, risk harm, or are unavailable to be involved in therapy, the SUD individual can participate alone while still receiving the benefit of MFGT. In a study of 794 individuals participating in MFGT, 180 were the identified client with no family members. The results showed that the high attendance rate was long-term, spanning over a four-year period (Maone et al., 2021).

Treatment Manual Development

Step 1: Discussion choice

The initial assessment of the clinicians' observation of client group sharing will indicate a primary issue for discussion. This is based on the significance of each group member's being able to gain motivation for attendance and engagement from a selected topic.

*The project data showed a lot of success in the clients sharing and none about a simple voting system when selecting a presenting issue for session work.

Step 2: Psychoeducation of defining the issues

Many project participants voiced, "Psychoeducation is important for the families of SUD."

Psychoeducation for SUD clients and their families is beneficial because it helps the clients' understanding, engagement, and the use of the information is the main goal for this approach in treatment (Camargo et al., 2023). In addition, MFGT allows a feeling of belonging, shared psychoeducation, and mutual support (Dakof et al., 2015).

SUD: Brain and Body

Substance use disorder is a neurobiological disorder that affects the brain's reward center (Christensen et al., 2023). SUD develops when the substances desensitize the reward system for normal activities such as hydrating, eating, bathing, social activities, and other survival needs (Wise & Robble, 2020). Most mind-altering drugs signal the dopamine receptors to activate the feelings of pleasure in the reward system of the brain, which affect the individual's mood, cognition, perception, and emotions (Lustig, 2018). Furthermore, researchers claim that addiction can be caused by a dysfunctional prefrontal cortex when the stress hormone called cortisol is overactive. When the brain is chronically stressed, (i.e. financial, family, or medical issues) it causes a constant need for dopamine release to feel the reward (Lustig, 2018).

Once a substance is introduced into the body, the drive to provide the physiological reward intensifies (Christensen et al., 2023). The person then finds what they think is needed (i.e. cocaine, opioids, or alcohol) to cope with stress. In addition, when a person is exposed to certain

substances, the response mechanism develops a habit that inhibits healthy conscious thoughts (Lüscher et al., 2020). Not only does the body develop an addiction, but the conscious thoughts reinforce the SUD (Lustig, 2018). Furthermore, the neurological brain sectors related to decision-making, judgment, and memory, change. The change in the brain from the addiction over time leads to neuron death, which causes the permanent loss of brain function (Lustig, 2018). This loss of brain function may suggest why it further exacerbates the addiction by hindering decision-making (Lüscher et al., 2020).

*Through the addition of peers and family support, the encouragement, inspiration, and motivation to engage in treatment may reduce the additional chronic stressors such as facing treatment alone, relational conflict, and the threat of criminal punishment.

SUD: Family Factors

Although a person's genetics have been determined to be one of two contributing factors for developing mental disorders, like SUD (Deak & Johnson, 2021), various elements of the environment play an important role in the systemic development of an individual's SUD (Barr et al., 2022). These statements suggest that since an individual can develop SUD from a genetic predisposition or environmental factors, the combination of both puts a person at greater risk. Multigenerational behavior modeling patterns are part of a dysfunction etiology tested on rodents and humans (Goldberg & Gould, 2019). Goldberg and Gould (2019) found that drug use exposure is tied to anxiety-related behavior that is passed down to each generation of children. However, all psychopathologies, such as SUD, PTSD, and ADHD, seem to possess some origins in a family system dysfunction (Zagefka et al., 2021). A disorder like SUD is strongly connected to family dysfunction because of caregiver modeling and parental factors. A significant factor for the intergenerational transmission of developing SUD is parental separation (Blake et al., 2024).

*The FDTC program uses FT, with parent-child reunification as the main goal, and has the highest success outcomes, as stated by the National Association of Drug Court Professionals (Marlowe, 2022). If the ADTCs incorporate FT in treatment, the cycle of negative intergenerational transmission may be broken, helping these families stay together in healthier households.

SUD: Influential Factors

Capaldi et al. (2018) studied three generations of a family struggling with SUD and found that parental behaviors, the environment of usage, and accessibility played a part in an individual's initial drug use. If children witness one or more parent using substances to cope, the children are more likely to mimic the substance use behavior thinking it can help them feel better too, which can begin an addiction (Capaldi et al., 2018; Trucco, 2020). Lack of adult supervision accompanied with negative peer influence can also increase the risk for developing SUD (Capaldi et al., 2018; Li et al., 2022; Trucco, 2020).

*Family involvement, in the form of MFGT, may prevent further substance use by encouraging more adult supervision, the awareness of peer influence, and connections made with other families.

SUD: Trauma and PTSD Factors

Post-traumatic stress disorder (PTSD) is a significant environmental factor because it develops from traumatic events where a person is in immediate threat of harm, or a constant and consistent sense of threat (Pinho et al., 2024). They do not actually have to be in harm's way to experience PTSD from an event, they may be witnesses to the event happening to someone close to them, hearing about it, or repeated exposure to the extreme aftermath of a traumatic event (Marx et al., 2023). Of individuals diagnosed with long-term PTSD, 57.7% have some form of long-term SUD (Simpson et al., 2021). Examples of the most frequently reported traumatic events that lead to PTSD are natural disasters, war, torture, bereavement, terminal illness diagnosis, serious accidents, sexual or physical assault, and childhood abuse (Du et al., 2022). Childhood trauma, compared to adulthood trauma, is a more significant factor in being diagnosed with PTSD as well as an indicator of the severity of the symptoms (Hawn et al., 2019). Hawn et al. (2019) also found that having PTSD puts an individual at greater risk for SUD.

SAMHSA (2023) reported that PTSD symptoms seem to overlap with the symptoms of anxiety and depression, putting them at greater risk for developing SUD, especially when in combination with other biological and environmental factors. In terms of the etiology of SUD, there are many gaps with both major factors and limitations that emerge from the literature, requiring more systemic research on SUD. Simpson et al. (2021) conducted a meta-analysis of 3,247 SUD clients with PTSD. This analysis claimed that manualized SUD treatment is more beneficial for substance use outcomes. Developing a TMDP using family interventions may help guide individual trauma sharing, which is seen to influence positively the perspectives of their family members (Winter et al., 2022). In turn, building understanding and empathy is needed in recovery for the growth and maintenance of long-term support.

Step 3: Creating long-term goals

Clients can state one or more overall goals, but if they struggle, the clinician may use solution-focused brief therapy interventions, such as the miracle question.

Goal examples:

- Gaining and maintaining employment, custody of children, and sobriety
- Strengthening and maintaining relationships
- Starting a career or an academic degree

Miracle question examples:

If a miracle happened while you were asleep, you woke up tomorrow, and all your issues were gone...

- ...what would you notice first?
- ...what would you do first?
- ...what would be different?
- ...how would others be different?

*The information the client expresses helps in identifying their goals and the actionable activities they can engage in to feel better, as opposed to waiting to feel better in order to accomplish those tasks (Wioldy & Razzaq, 2024). This intervention may help the client step away from their issues and envision a brighter future for inspiration, motivation, and hope.

Step 4: Creating short-term objectives

Have the client list a couple of measurable actions to achieve each long-term goal; if they struggle, refer back to the miracle question responses.

Objective examples:

- Completing and submitting job applications
- Practicing the therapeutic interventions outside of sessions
- Researching career opportunities, educational degrees, or vocational programs

Step 5: Creating interventions

- Clinicians help the clients reach their short-term goals with at least one intervention per objective.
- Intervention examples are listed below for the clinicians use, inspiration, and modification.

Step 6: Verifying inclusion criteria

- Using the DSM-5 and the assessment form below, clinician must compare the clients' behavioral, cognitive, emotional, and interpersonal symptoms to verify an SUD diagnosis or any significant secondary disorder.
- If a DTC participant does not have any family to attend treatment, they can join individually to share, observe, and learn from the work of the other families to practice the interventions in their own family and close friend circle. Maone et al. (2021) reported that a study of almost 800 clients, 180 were in MFGT alone, showed that the long-term

attendance was significant despite the large amount of those who participated without family members. This may suggest that the other families were enough to motivate them to keep coming back.

- If a client has worsening symptoms of severe disorders, such as schizophrenia or delusional disorder, they should be assessed for severity and risk level to ensure the safety of themselves, the therapists, and the other clients.
- If the client is assessed as unsafe, they can be referred for treatment elsewhere until the symptoms decrease enough to function safely in the therapy group again.
- Referral sources for these circumstances may be found in the recommendations section below.

Examples of SUD symptoms from the DSM-5:

- Amount and frequency of use increased more than expected
- Many failed attempts to quit or reduce usage
- Continued use despite the fact that it is negatively impacting many aspects of their life

Examples of common secondary disorders of SUD from the DSM-5:

- Psychotic - Bipolar - Anxiety - OCD - Depression - Other addictions

*Using the DSM-5, clinicians must diagnose a severity level of the disorder to ensure they do not need inpatient care, detox, or medication assisted treatment (MAT) to prevent harm.

Session Layout

These steps are aimed at strengthening group rapport, knowledge, cohesion, agreement, social experience, relatability, and the practice clients need to build a bond and grow together.

1. Select a topic of the presenting issue based on the initial group sharing.
2. Read the explanation of the topic to the group for agreement on the session work.
3. Decide on an overall goal as it pertains to the group's assessment.
4. Find at least one objective to focus on for the session.
5. Figure out which members of the group that will start each intervention.
6. Have the clients share their thoughts and feelings about the work.
7. Have the clients share how they relate to each clients' thoughts and feelings.
8. Assign therapy homework related to the work done in the session.

Final Note

There are many intervention options to choose from or modify for each unique client, family, and group. This treatment manual aims to spark a clinician's creativity when treating clients, allowing for new ideas for the goals, objectives, and interventions.

Areas of Focus

*These topics are based on the collective suggestions of the project participants in relation to the findings from the literature review of the project.

Communication patterns: Defensiveness and misinterpretation avoidance and building a stronger bond.

All the participants in the project stated the importance of sharing during MFGT treatment sessions. A participant said, "I encourage participants during introductions to share their goals which helps establish a sense of connection."

Cultural: Social stigma and race-based stress

An at-risk ethnicity is Latinas, who report a lack of support when it comes to issues of substance abuse (Pinedo et al., 2020). Not only does the Latina community suffer from a perceived lack of support for SUD treatment from the cultural stigma, but they are also shown to be untrusting of mental health services (Hernandez, 2024). MFGT may help this population and other marginalized populations such as Native Americans, come together to speak about the challenges and barriers they face when battling their addiction and possible criminal convictions. Treatment outcomes of MFGT have decreased the social stigma of MI, increased social support, and enabled the clients to learn effectively from other perspectives (Depestele, 2018).

Most participants in the project expressed that "the same cultural background for clients and therapists is more impactful in terms of relatability and connecting in their peer group therapy," which this scholar interprets this as a short-term benefit to recovery. However, the literature says that MFGT is effective for diverse groups (van Es et al., 2023), which is interpreted as a long-term benefit that the SUD clients and their families need. Therefore, an overall idea would be, if the client is resistant to treatment and groups, that matching the therapist and a peer specialist's cultural background to the client in the beginning would promote the motivation to keep attending and that the diversity of the group itself will give the client the tools and knowledge needed for the long-term benefits.

Relapse: Chronic disorder relapse prevention, self-awareness, and tracking patterns

Relapse susceptibility for SUD is higher when the client has a history of MI (Andersson et al., 2023), which leads to recidivism.

*There are many mentions of relapse in the significance section of this manual.

Trauma: Intergenerational trauma sharing and PTSD sharing

Winter et al. (2022) reported that family interventions may help guide individual trauma sharing, seen to increase the clarity of the perspectives of others.

A participant in the project also spoke about the importance of trauma sharing with the family because it promotes relating, understanding, and empathy. Along with the clients' disclosing trauma, participants mentioned that "addressing PTSD is beneficial for clients and family members as well."

Support: Peer specialist for clients who are unmotivated and encourage group members to connect outside of therapy

Participants in the project mentioned the benefit of using a peer specialist. One in particular detailed, "There was a client I saw who was ashamed about his IV drug use and refused the traditional treatment groups initially. However, after connecting with a peer specialist who shared a similar history, this client became visibly relaxed, and I could see that the social support of relating was the key. He started opening up and eventually felt safe enough to attend a local support group of AA meetings."

Conflict : Cool down tactics: punching a pillow and intensification tactics

Schaefer (2008) mentioned that if therapists are trained in techniques like intensification and enactments, the challenge of various dynamics may not be as difficult.

Boundaries: Enabling, cultural awareness, and family dynamics equality

Participants in the project quoted, "Knowing the boundaries and cultural awareness of the clients helps the clinician navigate multiple family dynamics in MFGT by clients contributing their stories to promote feelings of safety and calm for those who have social anxiety."

A particular project participant expressed that "a family feared the client would relapse if they upset her, so they avoided confrontation by essentially paying for the abuse of another person." Despite the SUD client not working, the family made excuses for her. The interviewee stated, "this enabling allowed her to avoid facing consequences and hindered her motivation for change and the family became exhausted and resentful."

Psychoeducation: SUD, COD, anxiety, and depression

MFGT is an evidenced-based intervention, including psychoeducation and behavioral therapy (Stuart & Schlosser, 2009), for populations with chronic disorders and SMIs and their families.

Many participants in the project expressed that “psychoeducation being important for the families of SUD.” One in particular mentioned how substance use affects the brain for the understanding of behavior to promote the empathy needed for long-term support.

*Two blank pages for other topics

Objectives

*These objectives are based on the collective suggestions of the project participants in relation to the findings from the literature review of the project.

Engagement: Connects with interventions of psychoeducation, peer specialists, and the SMART model

Sharing: At the beginning and end of each session

Emotional support: Connects with interventions of psychodrama, IMAGO Therapy, and the CRAFT and TBRI models

Tracking: Connects with interventions of family behavioral therapy (FBT), genogram, and triggers identification

Social support: After sharing they tell the group how they can relate

*Two blank pages for other objectives

Interventions

*These interventions are based on the collective suggestions of the project participants in relation to the findings from the literature review of the project.

1. Psychoeducation

*Discuss the section earlier addressing the biology to each new client and the rest of the group; hearing it again will help them remember the information.

- SUD and the high prevalence of CODs (Fernández-Miranda et al., 2024), such as anxiety, depression, PTSD, and other common disorders

Therefore, using MFGT may be more effective for the DTC participants because it allows additional forms of interventions such as psychoeducation, CBT, and assertive community treatment (Chow et al., 2010) to better target the participants’ specific needs.

2. Psychodrama

*Can be conducted verbally or physically

*Consists of a warm-up, action, de-role, and share

- Role reversal: A protagonist acting as the other member for a new perspective of their own behavior
- Empty chair: Client speaks to an imaginary person or a representation of themselves to address and solve internal issues
- Doubling: A client or therapist stands with their hand on the shoulder of the selected client and acts as that person physically, but speaks the words that they think that person is afraid to say out loud. The selected person then confirms, denies, or modifies what is being said. The outcome is to help the clients find a sense of self while strengthening their emotional expression.
- Mirroring: one or more group members act out as a protagonist in front of the group for the protagonist to recognize their own behavior

A couple of project participants stated that they have the clients practice boundary setting communication using psychodrama role play by coaching them on stating clear and loving boundaries.

Another participant of the project expressed that “they would conduct boundary intervention to repair conversations for validation, apologies, and reconnecting after a rupture.” Their example was a parent role play saying that they didn’t understand their struggle before working on this intervention and they are doing better. The clients practice this intervention as a nonphysical, verbal role play and that it is just as effective as the physical approach, especially when considering the safety and trauma sensitivity of the group members.

3. FBT

- CBT reframing: Identify the negative thoughts, change how valid they are or evidence of why they are not rational, and then find replacement thoughts to use instead; for example, a positive mantra
- Exposure therapy: An example would be that a group member is afraid to tell their spouse certain information about themselves, like being currently pregnant. The therapist will assist them to reveal smaller pieces of information to test the reaction to make the client more comfortable to divulge more intense information. The sequential increase will likely make them more comfortable with disclosing the pregnancy for both parties.
- Mindfulness-Based Relapse Prevention (MBRP): Assigning and conducting meditations, breathing techniques and nature walking; SOBER Breathing Space: stop, observe, breath, expand, and respond; practicing self-awareness such as active-listening skills and personal care

One project participant quoted that “I incorporate several mindfulness-based family interventions across the group, family, and MFGT sessions to support clients with SUD and use grounding exercises, mindful listening, and mindful movements.”

Acceptance and Commitment Therapy (ACT): Embracing difficult feelings; separating irrational thoughts from facts; staying in the present moment as opposed to dwelling on the past or future; observing thoughts and feelings; noting the values that they want in life to replace the unwanted thoughts and feelings that drive their behavior; making goals and the steps to achieve them; and how to avoid or overcome hurdles

4. IMAGO therapy technics

- Mirror: One person speaks and then the other repeats what they heard for confirmation.
- Validate: Once everything is understood, they can validate what was expressed, but not necessarily agree.
- Empathize: When the understanding is reached the speaker must talk about the past situations that may explain why they feel the way they do. Once the present and past are understood and validated, the chance of empathy may occur. When the empathy is voiced to the speaker, conflict on the topic usually dissipates.

One participant of the project mentioned that “a form of self-disclosure, listening, and learning allows an individual to truly hear the client’s struggles without judgment and validates their feelings, even if not agreeing with their actions, it's about you are saying that they validate their point.”

Several project participants said that “teaching the clients active listening to promote emotional support through an understanding of perspectives gives the clients encouragement to help them stay motivated and engaged in their recovery.”

5. Genogram

- Draw structure with family members
- Note family events (i.e. marriage, divorce, or adoption)
- Note disorders or illnesses
- Note relationship strengths and factors
- Share and discuss

Several participants in the project said, “Family mapping visually represents the current family structure of their boundaries, called a genogram” and “It is a technique that shows the family across generations to identify the patterns of their relationships, mental health, and major life events. They also stated that “it is often most useful early in treatment.”

6. Peer specialist

- Find a relatable peer that has a successful recovery
- Introduce them as a potential mentor
- Instruct them to share their story

All the project participants stated that “social support is necessary for GT and MFGT.” They also expressed, “For GT, supporting peers through friendships and inviting peer specialists to speak to the group and connect with newer clients to provide them additional support, inspiration, and motivation.”

7. Trigger identification

- Instruct the client and family to identify unwanted behavior
- Find the patterns where the behavior continues
- Figure out ways to avoid or reduce the occurrence

A large part of CBT is tracking behavior and identifying triggers, so with the addition of family tracking and support as a form of aftercare, which was mentioned by the project participants, and SUD treatment, it increases the chance of long-term recovery (McKay, 2021).

The participants in the project stated that “the client and therapist were to identify and manage dysfunctional patterns and triggers to prevent a relapse” and “after a relapse, they had to collectively as a family and therapist figure out what went wrong and what could be done differently to avoid another relapse.”

8. CRAFT model

- Community Reinforcement and Family Training (CRAFT)
- Empower the concerns of the family members

9. TBRI model

- Trust-Based Relational Intervention (TRBI)
- Connecting, empowering, and correcting family members

10. SMART model

- Specific, Measurable, Achievable, Relevant, and Time-bound (SMART)
- Setting goals

*Four blank pages for other interventions

Assessments

Mental Health Screening Form III:

*Identifying secondary disorders of CODs in relation to the primary, SUD

*This form can be printed or electronically filled out by the therapist or client:

<https://www.forensiccounselor.org/images/file/MHSF%20III.pdf>

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According to Carroll and McGinley, (2000):

The Mental Health Screening Form-III (MHSF-III) was initially designed as a rough screening device for clients seeking admission to substance abuse treatment programs.

Each MHSF-III question is answered either “yes” or “no.” All questions reflect the respondent’s **entire life history**; therefore all questions begin with the phrase “Have you ever...”

The **preferred** mode of administration is for staff members to read each item to the respondent and get their “yes” and “no” responses. The MHSF-III can also be given directly to clients for them to complete, providing they have sufficient reading skills (Carroll & McGinley, 2000).

Often, treatment is more successful when a secondary disorder is identified (McNally et al., 2025).

Canva:

*A family history genogram of disorders and illnesses is a useful tool to track hereditary patterns and psychological factors that may impact the relationships (Canva, 2025), in order to find solutions.

*The genogram can be handwritten or made through the link below:

<https://www.canva.com/graphs/genograms/> © 2025 All Rights Reserved, Canva®

In the link:

There is a white board with options of tables, shapes, lines, text, drawing tools, and sticky notes.

According to Canva (2025):

Genograms come in different types, each with its own purpose and benefits. Here are some of them:

- **Family genogram:** A family genogram displays up to three generations of a family. It's used to track a person's ethnicity or ancestry.
- **Emotional genogram:** An emotional genogram provides insights into whether a relationship is close, distant, conflicted, or even abusive between family members.
- **Relationship genogram:** A relationship genogram determines how individuals are related to one another. It covers marriages, committed or casual relationships, divorces, separations, and cohabitations.
- **Medical genogram:** A medical genogram is handy when understanding a family's medical history. It's used for tracing diseases in the family and identifying carriers of certain genes (Canva, 2025).

*Completing genograms are easier with the family present because, collectively, they will know and remember more about the whole family.

SUD: Co-Occurring Disorders

Generally, one in three people will have SUD in their lifetime (McCabe et al., 2022). According to the National Institute of Mental Health (2024), SUD is common in individuals with co-occurring disorders (COD), mental illnesses (MI), and chronic medical disorders (Vasilenko et al., 2017). Compared to the general population, individuals who are incarcerated have significantly higher rates of SUD, COD, and SMI (Hedden et al., 2021). Within the population of inmates who have SUD, 70% have a COD (Leach et al., 2022). Relapse susceptibility for SUD is higher when the client has a history of MI (Andersson et al., 2023), which leads to recidivism. Additionally, CODs are more challenging to treat than SUD alone because CODs often differ from client to client (Perry et al., 2019).

Secondary disorders are often the result of the primary disorder but can also co-occur due to chronic stress (Field & Jette, 2007). When considering secondary disorders, it is important to assess whether people are abusing substances to cope with MI symptoms, if the substance abuse created the symptoms of MI, or if individuals clinically have more than one disorder (Tolliver & Anton, 2015). According to the DSM-5, if the MI is not substance-induced, SUD comorbidities include intoxication and withdrawal (American Psychiatric Association, 2013). Therefore, careful assessment must be conducted to ensure clients receive the best treatment for the complexity of their symptoms. The elements of MFGT have been reported to relieve a multitude of COD symptoms for SUD clients (National Institute of Mental Health, 2020), and identifying secondary disorders help ensure the clients are receiving the appropriate and most beneficial treatment (Field & Jette, 2007).

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Resource Suggestions

*These resource suggestions are based on the collective suggestions of the project participants in relation to the findings from the literature review of the project.

Psychoeducation

SAMHSA's recorded webinars (Addressing SUD): <https://tinyurl.com/53wvf2jf>

NAADAC Free Webinar Series (Peer recovery support): <https://tinyurl.com/yerz9erw>

Community

Volunteering – United Against Poverty Orlando: <https://uporlando.org>

Address: 150 W. Michigan St., Orlando, FL 32806

Phone: 407-650-0774

Detox Center

Sunrise Detox Orlando: <https://www.sunrisedetoxorlando.com>

Address: 2431 Sand Lake Rd. Orlando, FL 32809

Phone: 407-305-4029

Crisis Care

AdventHealth Orlando – Behavioral Health Care: <https://bit.ly/3JfQOXJ>

Address: 601 E. Rollins St. Orlando, FL 32803

407-303-5600

Legal

NAMI Greater Orlando: <https://www.legalsurvivalguide.org/substance-use-law/>

Vocational

Florida's Division of Vocational Rehabilitation (DVR): <https://rehabworks.org>

Address: 3191 Maguire Blvd. #244, Orlando, FL 32803 Unit 12C

Phone: 407-204-7630

Employment

Essential Staffing Solutions – Orlando: <https://esolutionspm.com>

Address: 300 S. Orange Ave. #1000 Orlando, FL 32801

Phone: 844-437-7562

Shelter

One Heart for Women and Children: <https://helponeheart.org>

Address: 2040 N. Rio Grande Ave., Orlando, FL 32804

Phone: 407-233-4718

Orlando Union Rescue Mission: <https://ourm.org/>

Address: 1521 W. Washington Street, Orlando, FL 32805

Phone: 407-422-4855

Medical Clinic

Aspire Health Partners – Medication Assisted Treatment (MAT): <https://bit.ly/45DZbUB>

Address: 100 West Columbia Ave. Orlando, FL 32806

Phone: (407) 875-3700

Support Groups

Winter Park Group: <https://bit.ly/4fGsJW6>

Address: 5407 Lake Howell Rd., Winter Park, FL 32792

Phone: 407-260-5408

Eastside Club House AA: 2017 N. Goldenrod Rd., Orlando, FL 32807

Al-Anon/Alateen Orlando: 407-265-7334

Food Pantries

Community Food and Outreach Center: 150 W. Michigan Street

The Salvation Army – Orlando: 400 W. Colonial Drive

Second Harvest Food Bank of Central Florida: 411 Mercy Dr. Orlando, FL 32805

Clothing

Out of the Closet – Orlando: <https://outofthecloset.org>

Address: 1349 N. Mills Ave, Orlando, FL 32803

Phone: 407-583-4916

Assessments

Addiction Severity Index (ASI): <https://bit.ly/41sCqSj>

Drug Abuse Screening Test (DAST): <http://bit.ly/4fFpA8Y>

Crisis Hotline Numbers

Suicide and Crisis Lifeline: 988

SAMHSA: 800-662-HELP (4357)

Cultural Information

Drug Cultures and the Culture of Recovery (NIH):

<https://www.ncbi.nlm.nih.gov/books/NBK248421/>

*Two blank pages for other resources

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