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Citation: White, W. (1983). Healing ourselves: Taking care of the treatment family. *Focus on Alcohol and Drug Issues*, 6(4), 4-31. Posted at www.williamwhitepapers.com

Healing Ourselves: Taking Care of the Treatment Family

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George Pollack once noted that “a science, in order to remain vital and renewed is obligated to apply its principles and methodologies to itself whenever possible.” We can do no less by applying our growing knowledge of the chemically dependent family to the relationship dynamics between staff in chemical dependency programs.

The Organizational Family

We will begin by conceptualizing the staff of the chemical dependency program as an organizational family system, assuming many family dynamics are replicated in the organization systems. The organizational family system often contains the same kind of triangulations, projections, taboos, ghosts, scapegoats, double-bind communications, etc. seen in the family system.

Nearly all of us replicate at least one aspect of family culture in shaping our treatment programs. This family atmosphere, which can produce the climate of safety and intimacy so important to successful treatment, can also have its darker side. As in the chemically dependent family, our organizational family can get

twisted and strained into a pattern that disrupts the health of all concerned. This disruption in the organizational family can radically alter the quality of services to clients and produce emotional casualties among organizational family members.

Incest in the Organizational Family

We have observed for many years how the chemically dependent family closes itself off from the outside world as family members individually and collectively adapt to the illness. Organizational families in the alcohol and drug abuse field have a similar tendency to become progressively closed systems. The closure of the organizational family is marked by dynamics remarkably similar to those described in cases of consummated incest within families. These incestuous dynamics take a variety of forms, but broadly include stages in the life of a staff-group marked by members meeting an increasing number of their personal, professional, and social and sexual needs within the boundaries of the staff-group. This closure process occurs slowly over a number of years and inevitably produces extreme

program disruption and staff casualties.

The professional closure of the organizational family is marked by the following: (1) the organization of the program around a rigid belief system; (2) reduced professional contact with outside resources; (3) the homogenization of staff, e.g. values, life styles, etc.; (4) the scapegoating and/or extrusion of staff who challenge tenets of the belief system; (5) excessive demands for time and emotional commitment to the program, and (6) a progressive breakdown in the boundaries between the professional and personal lives of staff. This closure eventually produces a high level of boredom, deterioration in program morale, and sense of being trapped (since there is no guilt-free way out of the closed system). As staff members begin to experience a loss of faith in program ideology, the stage is set for increased interpersonal conflict between staff, the scapegoating of organizational leaders, and a contagion of staff turnover.

During the early stage of professional closure, staff may be spending an increasing amount of social time away from work with other staff. Work has become all consuming. Non-work social relationships decrease as the world of the organizational family draws tighter and tighter. As intimacy barriers are broken down, an increasing amount of staff time is spent on the personal and interpersonal problems of staff and their significant others. Spouses may be sacrificed (with the blessing of the organizational family), rather than compromise one's emotional/time commitment to the organizational family.

As the professional and social closure continues, it is perhaps inevitable that staff work to meet sexual needs within the boundaries of the organizational family. The development of problematic sexual relationships between staff marks the violation of the final intimacy barrier within the organizational family.

The stages of professional, social and sexual closure are integrally linked and their development overlaps in time. During the final stages of this closure we see the replacement of direct communications with gossip and rumor, the splintering of the

organizational family into diads and triads (a process similar to what Bateson has described in families as "the infinite dance of shifting coalitions"), and primitive struggles for status and power. In its most extreme form, this closure is broken by a high percentage of staff being extruded or choosing to leave when the emotional tension gets too excessive. (The latter cases are remarkably similar to the dynamics noted in adolescent runaways from disturbed family systems.) The organizational family cuts off sources of outside replenishment, while escalating interpersonal conflict and personal and professional stress for organizational family members.

Organizational Family Roles

In addition to the broad organizational processes, the health of individual members in both the nuclear and organizational family depends on the role expectations and role conditions placed on each member. In a study of relapse among recovering alcoholics working in alcoholism programs, this author identified 10 role stress conditions in the work environment that were associated with the incidence of relapse. These same conditions can produce a wide range of maladaptive behaviors among organizational family members. These role stress conditions included:

- **Role/Person Mismatch:** the incongruency between: (1) an individual's knowledge and skill level and the skills required to perform tasks of a given role; (2) an individual's level of stress tolerance and the level of stress endemic to a particular role; (3) an individual's style of stress management and the methods of stress management officially and informally sanctioned within an organization.
- **Role Conflict:** incongruous demands and expectations from two or more simultaneously held roles.
- **Role Integrity Conflict:** conflict between one's personal values and values inherent in the work milieu.

- **Role Ambiguity:** inadequate knowledge of: (1) role expectations; (2) task priorities; (3) methods for task completion; (4) accountability structure; and (5) rewards and punishments.
- **Insufficient Role Feedback:** the non availability of regular information on: (1) the adequacy of role performance; (2) the methods of improving performance; and (3) the adequacy of adjustment to work milieu.
- **Role Overload:** excessive and unrealistic expectations regarding quantity and/or quality of work to be completed within given time frames.
- **Role Assignment Misplacements:** the misplacement of staff with excellent skills in interior organizational positions into boundary positions where their skills may be insufficient for the job to be done there.
- **Role Connectedness Problems:** one's degree of isolation or overconnectedness to other members of the organization.
- **Role Deprivation:** the sudden or gradual removal of all significant responsibilities from an individual—forced retirement on the job.
- **Role Termination:** failure to provide permissions, procedures, and processes to allow members guilt-free exit from the organization.

We have much in our growing knowledge of roles in the chemically dependent family that can be applied to our organizational families. Is it possible in our constant emotional contact with the alcoholic and the addict that we adapt roles as staff similar to those seen in family members? Do we see the overfunctioning/underfunctioning roles in the alcoholic family mirrored in our own program staff? Can we see the family heroes, enablers, scapegoats, etc. in our own organizational family?

The Casualties

The emotional turmoil of the

incestuous organizational system and the role stressors many of us work under produce a high toll of human casualties within our field. One does not have to look far to see the stress-related health problems among staff: the self-medication with psychoactive substances (let's include nicotine and caffeine here!); the loss of emotional control; the maladaptive attitudes of cynicism; grandiosity, or hopelessness; and the disruptions in relationships, e.g. emotional distancing from clients, increased problems in intimate relationships away from work, etc.

By failing to understand the dynamics within our own organizational families that contribute to this casualty process, we continue to blame the victims.

Our casualties (and I particularly include the relapse of recovering staff) receive less respect, less concern, and less understanding than would be given any client who entered our program. Once extruded, they become the pariahs and untouchables of our field, and those of us remaining continue myopically to believe what happened to them could not happen to us.

The Challenge

The challenge before us is to boldly apply to ourselves the growing knowledge of family dynamics that is emerging in our field. As our skills grow in healing the chemically dependent family, we must also learn how to promote health, and when necessary, heal the wounds within the organizational family.

As we have confronted the stigma that forces the closure of the chemically dependent family, we must confront those forces in our own programs that influence us to build walls rather than bridges. In a period where we are expected to continually do more for less, we must examine the changing role conditions under which our profession is expected to work.

Perhaps the ultimate challenge is the recognition that the major force shaping quality of care is not found in forms and procedures, but in the health and vitality of the organizational family charged with introducing people to the recovery process.