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Distinguishing Between Empathy and Enabling:
Dance/Movement Therapy for Family Members of People with Addiction

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Abstract

This theoretical inquiry investigates the experiences and needs of family members of people with addiction; a group which is rapidly growing in the United States, and one that has been largely neglected by health service providers and medical professionals. With more than 22 million Americans currently addicted to drugs and alcohol (Substance Abuse and Mental Health Services Administration, 2017), and 365 drug-related deaths occurring each day (Sheff, 2013), the scope of family member grief and suffering is immeasurable. Evidence-based research reveals that family members lose touch with their own basic needs and experience high rates of psychological and physical health disorders, and social and financial instability as a result of their loved one's addiction and subsequent stigmatization from the wider culture. Despite the severity and urgency of family member needs and the mounting evidence that their wellness improves their loved one's success in recovery, families have been given little to no therapeutic resources, let alone options. This inquiry concludes with a discussion of the existing resources, which offer conflicting approaches, and the suggestion of dance/movement therapy as an additional therapeutic treatment option that can improve family member coping. It is proposed that a body-based, psychotherapeutic approach would allow family members to notice important distinctions between thoughts and feelings, self and other, and to distinguish between popular addiction theories and individualized needs and preferences amidst the unpredictable course of a loved one's addiction.

Keywords: addiction, empathy, enabling, family, dance/movement therapy

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The addiction epidemic in America is killing its sufferers and traumatizing their families. More than 22 million Americans are currently addicted to drugs and alcohol (Substance Abuse and Mental Health Services Administration, 2017), devastating countless children, parents, grandparents, spouses, partners, siblings and other close family and friends who love them. 365 Americans die each day from drugs, causing immeasurable grief and suffering for those who mourn them (Sheff, 2013). The course of the illness is harrowing and unpredictable, exposing family members to extreme stress which harms their health and threatens family functioning. Desperate to protect their loved one's life, family members become consumed by the symptoms and circumstances of the addiction, abandoning their own needs and well-being along the way. Only 6 percent of people with alcohol addiction and 16 percent with drug addiction receive professional treatment in their lifetime (Roozen, de Waart, & van der Kroft, 2010), leaving family members to serve as untrained caretakers for the duration. Families need professional therapeutic support to gain tools for understanding and coping as they witness and endure an average of 6 to 10 years of active substance use before the person with addiction seeks treatment (Roozen et al., 2010). Families that do cope better are found to be more resilient to the damaging effects of the addiction on their health and well-being, and more successful at getting their loved ones into treatment (Ventura & Bagley, 2017). However, there is little to no clarity within the available literature about what healthy family member coping looks like or entails.

Despite the severity and urgency of family member needs and the mounting evidence that their wellness improves their loved one's success in recovery, families have been largely neglected by health service providers and given little to no therapeutic resources, let alone options. Profound public stigma about addiction and dated theories about the role of the "dysfunctional family" in treatment have contributed to the lack of resources while also ensuring

that families suffer in shame and silence (Ventura & Bagley, 2017). Consequently, family members research what to do on their own and navigate the array of confusing and conflicting approaches without guidance or support. Of these approaches, few acknowledge the need for family members to receive therapeutic treatment. Arguably the most accessible approach, the twelve-step mutual support group, advocates acceptance of powerlessness and surrender to a higher power, while mainstream television has popularized the controversial family intervention approach (Sheff, 2013). The most current research raises concerns about many existing approaches and proposes new ideas, but modern modes lack the accessibility, affordability, and sheer reach of older ones. Physically, mentally, and socially compromised, many families resign themselves to the idea that there is nothing they can do to improve their or their loved one's outlook (Conyers, 2009). To ameliorate the impact of this national crisis, more attention and therapeutic resources need to be directed at families to address their psychological, physical, and social needs, effectively improving their coping, understanding, and healing amidst a loved one's addiction. With treatment, families gain the opportunity to help themselves, and in doing so they improve their loved one's chance for survival and recovery.

To illustrate the experiences and address the needs of family members of people with addiction, it is imperative to first grasp addiction. To many, addiction appears to be a choice and a sheer matter of will. Historically, some experts have perpetuated this notion – insisting that treating addiction as a “medical responsibility” allows the person with addiction to adopt a victim mentality; and suggesting rather that addiction is a “self-esteem illness” (Craford, 1980, p.80-81). For these reasons and more, accepting addiction as a brain disease within the wider culture is still debated, although most medical associations define it as such. Of the 80 percent of adolescents in America who choose to try drugs and alcohol, only 1 in 10 becomes addicted and

develops the chronic disease (Sheff, 2013). This is supported by evidence that about 10 percent of humans carry the genetic and neurological abnormalities that cause them to respond to drugs and alcohol differently than others, making them more susceptible to becoming addicted (Sheff, 2013). This genetic, biological predisposition accounts for about half of the likelihood that a person will become addicted, and the other half is thought to be environmental. Poverty, trauma, media influence, peer pressure, and other environmental factors may contribute to the onset of the disease. Regarding why and how the disease develops and manifests, Sheff asserts that “there are as many permutations as there are people” (Sheff, 2013, p.xxi). The development of addiction has been compared to that of cancer where genetic predisposition and environmental factors conspire, causing the disease to originate in an infinite number of ways, and impacting some people more severely than others. Despite these considerations, people with addiction are often condemned for their symptomatic behavior and shamed for their inability to stop using. A person diagnosed with cancer may have made a choice not to wear sunscreen, but it is unlikely that they will be socially disgraced as a result of their body developing cancer. (Sheff, 2013; see also Conyers, 2009)

Addiction is complexly intertwined with other mental illnesses as two out of every three people with addiction suffers from a co-occurring psychological disorder. Addiction can develop in response to underlying mental illness, it serves to worsen existing mental illness, and it can lead to the development of additional mental illness. For those with co-occurring disorders, 85 percent are shown to have an existing psychological disorder prior to the development of a substance use disorder. Substances are often used to self-medicate amidst the distressing and sometimes frightening symptoms of mental illness. Anxiety disorders, depression, post-traumatic stress disorder, and personality disorders have been found to be the most common mental

illnesses to co-occur alongside addiction. People with dual-diagnoses endure greater stigmatization, are more difficult to treat, and experience a higher rate of relapse than those diagnosed with addiction alone (Conyers, 2009).

Once addicted, the brain endures structural changes in areas that control motivation, reward, and memory. Some of these changes are permanent and others are found to heal with abstinence and treatment. As a result of the various neurological changes, the brain becomes functionally impaired. This diminished cognitive functionality leads to some of the better known, and for families - most confusing, maddening and devastating characteristics of the illness. These include the person's inability to stop using, irrational thinking, lack of impulse control, memory loss, erratic and risky behavior, and anosognosia or the inability to recognize that oneself is ill. "Unlike most other disorders, addiction affects behavior we think of as free will, which is the reason it's more insidious than other illnesses. Radically disordered brains lead to radically altered behavior and impaired thinking" (Sheff, 2013, p.100). On top of these, other psychological and physical symptoms can manifest as a result of the disease like depression, anxiety, mania, sensory impairment, and insomnia, as well as disrupted breathing, digestion, heart rate, and blood pressure. Physiological dependence on certain substances leads to the build-up of tolerance and the danger of physical withdrawal, both of which can lead to sudden death. The body eventually requires the use of the substance to achieve a temporary feeling of normality. When left untreated, addiction progressively worsens over time and is often fatal. It is possible for some people to recover from addiction without treatment, but this is considered to be a phenomenon rather than the norm, and most people require intensive, lifelong treatment to manage and survive the illness. For people with addiction who do receive treatment or achieve abstinence on their own, the predisposition toward addiction never leaves them and they often

spend their entire lives working against relapse. Despite the evidence which proves that addiction is a chronic mental illness requiring treatment, we continue to shame, criminalize, and cast aside its sufferers in our culture. While a diagnosis of heart disease or dementia spurs families and medical professionals to rally toward treatment and healing without hesitation, a diagnosis or recognition of addiction often leads to feelings of shock, shame, and the punishing plea to “just stop.” (Sheff, 2013; see also Conyers, 2009)

It is important to acknowledge that substance-related problems can range from mild to severe and may impact family life in any number of ways. The *Diagnostic and Statistical Manual of Mental Disorders* (2013), or DSM-5, uses the classifier “substance use disorder”, and it identifies a range of criteria that covers a spectrum of substance-related issues. It is estimated that 25 to 50 percent of people who qualify along this substance use continuum have a severe, chronic disorder (What is addiction?, n.d.). This inquiry will focus on the experiences of families who are impacted by this more severe end of the spectrum, and thus the term “addiction” will be used rather than “substance use disorder”, to distinguish the chronic disease from the range of substance-related problems identified in the DSM-5. This is not to disregard the families that are affected by the gamut of substance use issues, but rather to explore and recognize those whose lives have been critically and irrevocably transformed by the cruelty of addiction. It is these family members for whom treatment is urgently important. Additionally, children affected by the addiction of a parent, sibling, or other loved one are mentioned in this analysis, but it is imperative to distinguish between a child’s needs and experiences compared to those of adult family members. This inquiry does not intend to explore or address circumstances specifically related to children coping with another’s addiction, as this population requires a thorough, dedicated examination all their own.

This paper hopes to investigate the needs of families, but not at the sacrifice of further stigmatizing their loved ones with addiction. Families indeed suffer, not because their loved ones are selfish and immoral, but rather due to their being chronically ill and gravely misunderstood within the wider culture. Mounting evidence shows that addressing family member needs may be one of the best ways to improve outcomes for people with addiction (Foote, Wilkens, Kosanke, & Higgs, 2014). That being said, of course not all families are sources of support for their loved ones, and some family members jeopardize their loved one's recovery due to their own substance misuse or other instability (Sheff, 2013). This investigation will highlight family member experiences and needs as they have been dictated by the literature while assuming that every familial relationship is dynamic, complex, and intrinsically flawed. Additionally, the term "person/people with addiction" will be used in place of "addict/addicts", as the latter can be dehumanizing and surveys show that the negative connotations associated with the term "addict" change how one feels about and treats the person beneath the label (Szalavitz, 2016). That said, some people with addiction prefer to self-identify with the term "addict," and they maintain this right.

Appreciating the impact of the concept of enabling is fundamental to considering the experiences of family members of people with addiction. When family members witness the erratic, harmful behavior of a loved one with active addiction, it is common for them to react or intervene in an attempt to protect themselves, the family at large, or their loved one from danger or emotional pain. These attempts to shield themselves and one another from the painful realities of addiction are considered to be enabling behaviors, because they are thought to foster addiction and allow it to worsen. It is common for family members to feel shocked at the accusation that they have enabled their loved one's addiction since many typical enabling behaviors emerge

from loving, empathic instincts (Pederson, 2007). Enabling is defined as “provid [ing] with the means or opportunity; to make possible, practical, or easy” (Enabling, n.d.). The Betty Ford Foundation outlines eleven characteristics of enabling addiction, including: “protect [ing] the addict from the natural consequences of his behavior, keep [ing] secrets about the addict's behavior from others in order to keep peace, bail [ing] the addict out of trouble (pays debts, fixes tickets, hires lawyers, and provides jobs), avoid [ing] the addict in order to keep peace (out of sight, out of mind)” (Kala, 2016). Popular addiction theories warn families that attempting to control or contain the addiction - whether through over-involvement or sheer denial - protects their loved one from negative consequences and inhibits their internal motivation to change. Families are often encouraged to emotionally detach from the person with addiction and allow them to “hit rock bottom,” or rather, experience the consequences of addiction intensely enough so that they discover the desire to seek help on their own (Szalavitz, 2016). As a result, family members do what they can to educate themselves about avoiding instinctual tendencies to deny or help, sometimes acquiring a paralyzing fear of enabling. Some family members describe feeling too worried to share a laugh or a meal with their loved one, for fear that doing something enjoyable together sends a message of acceptance rather than disapproval (Sheff, 2013). Family members often struggle to distinguish between their loved one and their illness, between natural empathy and harmful enabling. Devastatingly, some family members blame themselves for a loved one's overdose or death, expressing that fear of enabling inhibited them from intervening during a crisis (Sheff, 2013). Some addiction experts caution that detachment and rock-bottom concepts are cruel, instead advising families to take a proactive stance and risk the consequences of enabling to save their loved ones' lives (Foote et al., 2014). Understanding and accepting addiction as a brain disease makes matters more complicated, as family members would

naturally want to do everything in their power to help a loved one recover from illness. Families are tasked with an enormous, confusing moral imperative: to try to improve a situation that is life-threatening for a person that they love, when their very efforts to support can inadvertently cause additional harm. It is suggested that family members require individualized support to help them distinguish between harmful enabling and empathic, helpful intervention (Pederson, 2007).

“Addiction is a family disease” is a saying made popular over the years by experts in the field, and it implies that addiction is both caused and maintained by family dysfunction (Orford, Velleman, Natera, Templeton, & Copello, 2013). This notion emerged from early twelve-step culture as drug and alcohol counselors began “shifting focus from the self-destructive behavior of the alcoholic to the “family system” as the locus of pathology” (Haaken, 1993, p.322). It appears that the initial intent behind broadly labeling families as dysfunctional was to examine family dynamics as they related to the development of alcoholism. Unfortunately, the term “family disease” stuck and has led to an oversimplification and stigmatization of the disease and the role of the family in coping with it (Orford et al., 2013). Despite the negative associations, the adage still carries weight - because regardless of how and why addiction manifests, it bears health-related consequences for the entire family. The profound negative symptoms of addiction cause a ripple effect, strongly impacting those who witness and endure its trajectory. An average of at least five people are directly exposed to the stressful ramifications of any single case of addiction (Hussaarts, Roozen, Meyers, van de Wetering, & McCrady, 2011). A World Health Organization study attempted to calculate the enormity of the ripple more than a decade ago, suggesting that upwards of 100 million people are impacted by a loved one’s addiction worldwide (as cited in Bagley & Ventura, 2017). With 90 percent of sufferers becoming addicted before the age of eighteen (Sheff, 2013) and between 42 and 90 percent of adults with addiction

living at home (Moore, Biegel, & McMahon, 2011), it is clear that a large number of concerned family members are also living with and/or caretaking for their loved ones. Many describe the experience of caretaking as overwhelming, all-consuming, and one which disrupts all aspects of their lives and family functioning (Mokgothu, Du Plessis, & Koen, 2015). Family members have more psychiatric and medical conditions and higher healthcare costs per month than family members of people with other chronic conditions like diabetes and asthma (Weisner, Parthasarathy, Moore, & Mertens, 2009). Family members' overall health and healthcare costs tend to mimic the relative health of the person with addiction, further illustrating the impact of the illness on the entire family. Families that had a loved one making progress in treatment showed improved health and reduced healthcare costs, while families with a loved one who was actively using showed diminished health and increased costs correspondingly. Psychiatric healthcare costs for family members remain higher over the long-term, even when their loved one is doing well in recovery (Weisner et al., 2009). This suggests that mental health issues for affected family members are chronic. This may be due in part to the fact that relapse during addiction recovery is common, causing family members to endure repeated cycles of optimism, disappointment, and defeat (Conyers, 2009). Family members tend to lack the motivation or the energy to care for themselves when the needs of their loved ones are perpetually acuter. Exacerbating family health concerns is the lack of social and professional support they receive, leaving them uninformed and ill-equipped to meet their or their loved ones complex needs (Clark & Drake, 1994).

Family members often serve as untrained, inexperienced caretakers during their loved one's addiction and potential recovery process. Caretaking for a person with addiction can involve significant financial burden and dedication of time and energy (Mokgothu et al., 2015).

Family members may contribute to or cover treatment bills as well as provide fundamental resources like food, clothing, and rent (Clark & Drake, 1994). Other economic costs to families may include money given naively that is used to obtain substances, money or property that is stolen to obtain substances, family member loss of employment due to stress or caretaking duties, and resultant healthcare costs for the rest of the family. For some people with addiction, family support is the only thing preventing them from homelessness. One study found that average caretaking costs for a concerned family member were \$25,000 annually (Orford, et al., 2013). Another found that about half of family members provide financial support to their loved ones with active addiction or have daily contact with them (Bagley & Ventura, 2017). Family members have been found to spend 16 additional hours doing activities such as cooking and cleaning for every two weeks of caretaking for their loved one (Clark & Drake, 1994). For adults with addiction, parents are the most common caretakers, but as parents age, their physical and financial ability to do so diminishes (Moore et al., 2011). As addiction worsens over time, families become exhausted and discouraged, and this trend has been linked to an increase in hospitalizations for corresponding loved ones (Clark & Drake, 1994). Fear of enabling causes some family members to withhold financial or other support, for fear that their contribution is helping to sustain the addiction. Recovery from addiction is rarely quick or smooth, often involving relapse, multiple hospitalizations, and various attempts at different courses of treatment for the person with addiction. After receiving acute care, patients are frequently discharged home and might wait weeks or months in between the next stages of their treatment. In other instances, families must provide life-sustaining care as professional services are too expensive, inaccessible, or are found to offer inadequate care (Mokgothu et al., 2015). Of the 3.4 million adolescents with addiction, only 10% enter treatment each year and of those, nearly 50%

relapse within six months of discharge (Kirby, 2015). Families find that caring for a person with addiction requires substantial time, energy, and resilience as loved ones require close monitoring and long-term caretaking.

The persistence of addiction and its harmful symptoms can lead affected family members to live in heightened emotional states for months or years at a time, leaving them at high risk for developing chronic psychological conditions (Gethin, Trimingham, Chang, & Farrell, 2016). “Living with an addict is inherently traumatic; those who do often feel as if they’re living in a war zone, because they’re dealing with someone out of control, irrational, and threatening, who is self-destructing before their eyes – and this is someone they love” (Sheff, 2013, p.109). As a group, families display large rates of depression, anxiety, low self-esteem, adjustment disorder, substance misuse, and post-traumatic stress disorder (Roozen et al., 2010). The health and well-being of these family members have been compared to others who have endured persistent adversity, such as those who have encountered war or long-term unemployment (Pons, Barron, & Guijarro, 2016). Families in the midst of a loved one’s addiction frequently experience a range of negative emotions such as anger, resentment, frustration, regret, helplessness, embarrassment, failure, and despair (Gethin et al., 2016). Many live in a state of persistent fear due to their increased risk for verbal and physical abuse, especially considering that more than half of all violent incidents, including child abuse and rape, are substance-related (Sheff, 2013). Adding to this fear is their loved one’s increased risk of criminal involvement, accidents, injuries, and premature death (Bagley & Ventura, 2017). Denial, guilt, and obsessive thoughts and actions are common as family members grapple with, feel responsible for, or attempt to control their loved one’s symptoms and behavior (Gethin et al., 2016). Family members may struggle to regulate their own emotions, possibly becoming verbally or physically aggressive toward the person with

addiction. It is common for family members to beg, plead with, or even threaten their loved ones to change their behavior and seek help. Intensely expressed emotions by family members toward their loved ones have been found to contribute to relapse for the person with addiction (Moore et al., 2011). Self-blame and shame alienate families physically and psychologically from their loved one, from other family members, and from society more generally. Shame that endures can contribute to depression, eating disorders, bullying, suicide, and increased family violence (Brown, 2007).

One of the hallmark features of caring for a person with addiction is excessive, unrelenting worry (Sheff, 2013). Worrying is a natural response to extreme circumstances, and for family members who feel essentially powerless, actively worrying can feel like the only way to express their love and concern. Families struggle to seek enjoyment or a better quality of life for themselves as these attempts can increase feelings of guilt (Orford et al., 2013). Public stigmatization of people with addiction and their families contributes to feelings of disgrace and failure, causing some members to withdraw socially (Gethin et al., 2016). Disappointment, loss, and preparatory grief plague families as they come to terms with expectations they once held for their loved one and cope with the persistent threat of overdose or death (Chapman, 1997). All of these complicated emotions and mental health issues make coping difficult for family members and impinge upon every aspect of life, including the fulfillment of basic needs like sleeping, eating, and exercising. As a result, family members may find it difficult to perform at their jobs, to nurture relationships, and to maintain healthy family functioning overall (Sheff, 2013). Together these stressors and psychological symptoms manifest for some as immobilizing panic or chronic stress, and may ultimately lead to a host of physical health problems. High utilization of healthcare services and increased costs reveal that family members of people with addiction

are at high risk for chronic medical conditions in addition to psychological ones (Ray, Mertens, & Weisner, 2007). They suffer from insomnia, anemia, hypertension, asthma, migraines, and gastrointestinal issues (Orford et al., 2013). Family members have a higher prevalence of congestive heart failure, ischaemic heart disease, diabetes, and hepatitis C (Orford et al., 2013). As a result of their increased risk for domestic abuse, they have higher rates of injury and premature death (Gethin et al., 2016). Hospitalization rates for children of people with addiction have been 24% higher than for children in similar groups without an addicted loved one (Ray et al., 2007).

Living with and caring for a person with addiction can increase interpersonal conflict among family members and disrupt family roles and functioning (Perlmutter, 1992). New evidence challenges the outdated notion that family dysfunction is the definitive cause of addiction, suggesting rather that family disruption is often a normal response to the extreme circumstances of the illness (Bagley & Ventura, 2017). The addiction transforms the sufferer, leaving them unrecognizable to their family members who respond to the changes in any number of ways. The presence of addiction can damage trust, intimacy, comfort, and a family's shared goals. A family in crisis can be traumatic for every member that is involved. Children that have a parent with addiction who is not receiving treatment are more susceptible to violence and neglect and are more likely to develop addiction themselves (Orford et al., 2013). Older children are sometimes forced to care for younger children, or children find themselves disciplining parents with addiction as familial roles shift in response to the presence of the disease. As family members become collectively invested in "solving the problem" of addiction, they may discover that other familial relationships are neglected (Chapman, 1997). Family members worry excessively not only about the health of their loved one but about the current and future

functioning of the family unit. Families often withdraw from the larger community in an effort to contain or conceal the disrupted dynamics (Bernheim & Lehman, 1985). Family members might guilt or shame their loved ones in a desperate attempt to convey their hurt and convince the person to change (Foote et al., 2014). Tension and hurt between members and the person with addiction can potentially trigger continued substance use or relapse. When familial relationships are strengthened with treatment, people with addiction are more likely to succeed in recovery, and adolescents within the family are less likely to develop addiction (Sheff, 2013). Family involvement in both their own and their loved one's treatment has been found to be one of the most protective and preventative factors in facing addiction.

The role that stigma plays in family member suffering cannot be underestimated. The stigmatization of addiction intensifies guilt and shame while keeping families quiet, embarrassed, fearful, and reluctant to seek help. Addiction is widely misunderstood as a moral failing and sheer lack of will rather than a complicated chronic illness (Sheff, 2013). As a nation, we have declared a "war" on drugs, which has effectively criminalized and ostracized those suffering from the disease of addiction (Conyers, 2009). People with addiction are branded, pitied, and rejected by the larger culture. They are stripped of their complex humanity and carelessly labeled as criminals, vagrants, and junkies (Sheff, 2013). Correspondingly, their families are blamed for contributing to the addiction and assumed to be dysfunctional (Orford et al., 2013). This stigmatization has pushed families into the shadows and convinced them to suppress and conceal their troubles, sometimes even from one another. Stigma has also contributed to the absence of families from evidence-based research, and to their neglect by health service providers (Bagley & Ventura, 2017). When family members are acknowledged in the literature, it is often to question and criticize their character rather than to investigate their

experiences and evaluate their needs (Moore et al., 2011). Assuming the family to be the cause and perpetuator of addiction undermines the complexity of the disease and leads to harmful stereotyping of family members (Bagley & Ventura, 2017; Moore et al., 2011; Orford et al., 2013). Parents of people with addiction are harshly misjudged as incompetent and failing their children, while spouses may be stereotyped as dangerous codependents. Family members are thought of as mere weak enablers, ambivalent bystanders, or as cruelly abandoning the person with addiction (Orford et al., 2013). These accusations, whether real or imagined, increase family member responsibility, guilt, and anxiety while reinforcing secrecy and shame. Family members might participate in periods of denial, both conscious and unconscious, as protection against public perception and to defend the reputation of the addict. They may avoid social interaction for fear of being confronted with questions about their loved one and the difficult feelings that arise as a result (Bernheim & Lehman, 1985). Families should be encouraged to come out of hiding so that they can receive the support and services they so desperately require, and yet many professionals remain deeply influenced by outdated theories and underlying cultural stigma (Bagley & Ventura, 2017; Moore et al., 2011; Orford et al., 2013).

It is not surprising that the punitive attitude toward addiction in America has not only criminalized its sufferers but also effectively demeaned and punished their family members (Bagley & Ventura, 2017). Medical professionals have been known to refuse or avoid working with people with addiction and their families, due to their problems seeming too challenging or unpleasant (Knopf, 2016; Chapman, 1997). This seems counterintuitive as family members often show readiness to receive treatment before their loved ones, and are therefore more equipped to support and motivate the person with addiction into treatment (Knopf, 2016). Families attempting to care for loved ones with other types of chronic illness have historically been

supported by healthcare systems and encouraged in their caretaking duties, while families of people with addiction are completely ignored or left with unanswered questions (Moore et al., 2011). Obsolete policies within rehabs, hospitals, and other treatment facilities seem to disregard the evidence that family involvement increases recovery odds, as they continue to restrict phone use and limit visiting hours (Bagley & Ventura, 2017). It has been suggested that some medical professionals work to deliberately exclude the family from their loved one due to beliefs that family member involvement is destructive to recovery. Parents of adolescents in one treatment facility were completely excluded from having contact with their children or being sufficiently informed about treatment practices, despite their paying for the services (Kirby et al., 2015). Confidentiality laws often restrict families from obtaining any information about their loved one's status during acute hospitalization or quality of care during long-term treatment (Kirby et al., 2015). Family members may be stereotyped and subjected to condescending, skeptical attitudes from staff. Families are rarely given adequate psychoeducation about addiction and its treatment, let alone about its impact on their health or options for family member treatment (Ventura & Bagley, 2017). Family members are biologically wired to care for their loved one, and this tendency should be encouraged, supported, and guided rather than questioned and suppressed.

The entire field of addiction has struggled to find ways to effectively meet the needs of tormented family members (Ventura & Bagley, 2017). Family member well-being is intricately connected to that of the person with addiction and families are often motivated to seek personal treatment only as a means of supporting their loved one (Foote, 2014). As a result, many of the resources available to families focus on teaching members new ways to behave and respond to the person with addiction to avoid a crisis. These resources include books, support groups,

family-based interventions, and modes of therapeutic treatment. However, analyses of the current resources reveal that there are not enough options available or accessible to family members, and many modes lack empirical support (Gethin et al., 2016). Families are rarely provided with information about the discrepancies between various modes of treatment, such as the differences between peer support groups and professional treatment or evidence-based approaches (Ventura & Bagley, 2017). Few resources are offered on the basis that family members require therapeutic treatment of their own. When considering all of the options that do exist for family members, each puts forth different, often conflicting approaches. Some resources warn family members that following other methods could have dangerous, perhaps fatal consequences for their loved ones (Szalavitz, 2016). Families must not only choose between various courses of treatment for themselves but also determine which of these will best help them to keep their loved one alive. Choosing and distinguishing between courses of treatment contributes to family member responsibility and stress.

Families are most commonly directed toward Al-Anon and other similar mutual support groups as a resource for coping and connecting with peers (Timko, Laudet, & Moos, 2014). Al-Anon, Nar-Anon, Alateen, Adult Children of Alcoholics and others are offshoots of Alcoholics Anonymous and were created using the same twelve-step format and acceptance of the disease model, but seek to meet the needs of “concerned others” coping with a loved one’s addiction. Al-Anon and others are the most readily accessible resource for family members, with meetings available nationwide on a walk-in basis, and with no dues or fees required to attend. The majority of addiction treatment is twelve-step based, and medical professionals often encourage family members to seek similar mutual support groups in correlation with their loved one’s care (Sheff, 2013). These groups accept the “addiction is a family disease” concept, implying that

families help to maintain the addiction as a result of dysfunction (Roth, FAGPA, FASAM, & Tan, 2008). Attending members are encouraged to change dysfunctional behavior by accepting Al-Anon's premise that they are powerless over addiction and should let go of the attempt to control their loved one, surrendering instead to a "higher power." Consequently, the goal of Al-Anon attendance is not to impact change upon the person with addiction, but rather to address family member coping regardless of the recovery status of their loved one (Timko et al., 2014). Belief in God is not a requirement to attend, but members may find relief, comfort, and hope in the spiritual foundation of the group. Meetings are peer-run, allowing family members to connect with others who share their experiences to decrease family member isolation and shame. There is limited empirical evidence regarding the efficacy of Al-Anon, although interviews with long-term members and member surveys suggest that regular attendance can decrease stress and improve relationships between attending members and their loved ones (Richter, Chatterji, & Pierce, 2008). Al-Anon puts forth suggestions for family coping which include detachment from alcoholism, increasing awareness of enabling behaviors, and understanding the concept of codependency. These and other teachings have been categorized within the addiction field as components of a "tough love" approach, and have grown more controversial in recent years (Szalavitz, 2016). Families are encouraged to "detach with love" or set firm, non-negotiable boundaries with their loved one, including not engaging with them when they are under the influence of a substance. Family members are warned that their interactions with their loved one may be enabling addictive behavior, and are thus encouraged to be cautious in offering money, transportation, housing, or in keeping regular contact. The concept of codependency is popular in twelve-step culture and it purports that many concerned others are unhealthily attached to their loved ones and might be naively feeding the addiction through denying its severity and engaging

in dangerous enabling behaviors (Sheff, 2013). Family members are thus encouraged to accept their codependency, to acknowledge the severity of the addiction, to detach with love from the addiction, to not enable the addiction, and to surrender their control to “a Power greater than ourselves” (Roth et al., 2008, p.410). The idea that their loved ones with addiction must “hit rock bottom” to become motivated enough to receive treatment is also supported by the twelve-step community (Little, 2005). In Al-Anon meetings, these and other tough love concepts are not communicated by licensed professionals, but rather they are conveyed via peer-to-peer sharing. Some experts in the field caution that these concepts and others may harm the person with addiction or lead to their death, arguing instead that the family has a duty to take action and motivate their loved one toward change (Knopf, 2016). Al-Anon and the like are intended to improve family member functioning regardless of whether their loved one is seeking treatment or engaging in recovery. This has caused researchers to question whether family members might benefit more from an approach which ultimately intends to engage their loved one in treatment (Kirby et al., 2015)

While Al-Anon posits that family members ought to decrease their involvement with the person with addiction, to protect against enabling and codependency, other family treatment approaches insist that family member involvement is vital to the recovery of their loved one (Knopf, 2016). Some of these approaches do not offer the family treatment per se, but rather suggest that successfully motivating their loved ones into recovery will naturally relieve family stress and improve relationships. The Johnson Institute Intervention and similar approaches including those portrayed on the popular television show “Intervention,” utilize the family as a tool in convincing the person with addiction to attend treatment through a planned confrontation. Families might rehearse the confrontation with a trained interventionist, but 70 percent of

families who prepare for an intervention do not follow through with it (Miller, Meyers, & Tonigan, 1999). Of the small percentage of families who do complete a formal intervention, it has been found that their loved ones were more likely to relapse than those who entered treatment through other means (Kirby et al., 2015). Some experts illustrate the cruelty of this approach which may include inviting the person with addiction to a “surprise party,” then forcing them to endure as family members convey their anger and disappointment, or place blame upon their loved one (Little, 2005). This approach can have deleterious outcomes, causing a loved one to become defensive or increasing their sense of guilt and shame, thus furthering their propensity to use and ultimately devastating the family further (Szalavitz, 2016). The popularity of the television show has contributed to public stigmatization of addiction as family members are filmed reading lists of all the “horrible things” their loved one may have done (Little, 2005, p. 53). Family members discouraged by the expense of a formal intervention may attempt to facilitate a confrontation without a trained interventionist, increasing the risk for the traumatization of everyone involved. This approach does not provide the family with tools for coping before, during, or after the intervention is completed (Kirby et al., 2015). Other family-involved modes utilize the family less confrontationally to engage their loved ones in treatment, including The Unilateral Family Approach, The Pressure to Change Approach, and The Community Reinforcement and Family Training (CRAFT) program, among others (Kirby et al., 2015). CRAFT operates on the premise that family members can effectively coerce their loved ones into treatment if they simultaneously tend to their own needs. This program teaches family members Motivational Interviewing and Cognitive Behavioral techniques to support their healthy coping and to effect positive change in their loved one’s attitude toward treatment (Foote et al., 2014).

CRAFT intends to do essentially the opposite of Al-Anon. Families are taught to empower themselves and their family member with addiction, rather than to accept powerlessness and wait for a loved one to hit rock bottom. This approach has been found to increase family member's sense of choice in comparison to twelve-step or intervention strategies, which suggest adherence to particular guidelines (Miller et al., 1999). CRAFT proves to be the most effective approach in terms of successfully motivating loved ones into treatment, and family member well-being has been empirically shown to improve as a result (Knopf, 2016; Kirby et al, 2015; Little, 2005). While each of these family-involved treatment options has been found to decrease family member distress initially, long-term studies have not been utilized to test whether the impacts on family functioning are durable over time (O'Farrell & Fals-Stewart, 2001). Additionally, the availability, affordability, and efficacy of these resources are questionable. The Johnson Institute Intervention and other formal intervention approaches can be expensive, and an interventionist-trained counselor should be present to facilitate the encounter safely (Sheff, 2013). The Unilateral Family Approach is considered to be intensive, requiring the commitment of family members for up to six months of weekly sessions (O'Farrell & Fals-Stewart, 2001). The Pressure to Change and CRAFT approaches are more widely available in that their methods can be learned through manuals, books, and videos, both by therapists hoping to offer the treatment and family members hoping to apply it (O'Farrell & Fals-Stewart, 2001). The CRAFT program has arguably the most evidence-based support for families motivating persons with addiction into treatment, but there is less research regarding the efficacy of the program in meeting family member needs independent of their loved ones treatment status.

A final category of treatment available to families exists on the premise that family members are not only vital to their loved one's recovery but that recovery includes treatment of

the family together in family-based therapy. Family Systems Therapy, Behavioral Couples Therapy and other family-involved therapies often include both the person with addiction and one or more of their family members in long-brief or long-term therapy guided by a trained professional (Gleeson, 1991). Some family therapy approaches accept the hypothesis that addiction is a family disease and work to acknowledge and change dysfunctional patterns among members (Chapman, 1997; Crafoord, 1980). Family members are thought of as parts of a whole, so that a shift in one member is thought to change the relative functioning of the rest. Family roles and boundaries may change or become impaired in response to the illness, and interactions that are not improved may hinder the recovery of the person with addiction (Sheff, 2013). Family therapy proposes to help members improve communication, focusing on interactional rather than individual issues (O'Farrell & Fals-Stewart, 2001). Behavioral Couples Therapy (BCT) is a family-involved approach which seeks to treat the person with addiction and their partner or spouse to both support abstinent behavior and improve relationship functioning. Family members and their loved one work together to identify and decrease triggering or enabling behaviors while agreeing to refrain from discussing past substance use outside of therapy sessions. BCT has been shown to improve relationships and decrease domestic violence among partners (O'Farrell & Fals-Stewart, 2001). Despite the popularity of family therapy during the last quarter of the 20th century, there is limited evidence supporting its efficacy overall (as cited in O'Farrell & Fals-Stewart, 2001). This mode can be expensive and often requires the long-term commitment of multiple family members (Chapman, 1997). A meta-analysis of family-involved treatments found that a major challenge to applying these methods is that they are not easily adopted by the treatment community (O'Farrell & Fals-Stewart, 2001). Unlike peer-support groups or manual-based resources, family-involved treatment is less readily available to family members in need.

Additionally, these modes are limiting in that they require the participation and commitment of the person with addiction (O'Farrell & Fals-Stewart, 2001).

The existing literature mostly fails to acknowledge the impact of various cultural considerations, including ethnicity, race, gender, age, and socioeconomic status, when evaluating family member experiences and needs. The meta-analysis of family-involved treatment acknowledges that the majority of evidence was collected from studies of white, male patients (O'Farrell & Fals-stewart, 2001). One study suggests that current resources for family members often require access to specialist services that are largely unavailable to a wide variety of socio-cultural settings (Orford et al., 2013). An analysis of twelve-step peer-support groups argues that the program endorses predominantly white, middle-class ideals and undermines the "important strategies in survival for poor women and women of color" (Haaken, 1993, p.339). Here it is also suggested that twelve-step groups historically pathologize the behavior of women more severely than that of men. Medical service providers and treatment professionals cannot effectively meet a wider array of family member needs without first considering and evaluating the various cultural implications of current circumstances and resources.

One major reason for the lack of resources available to families is that treatment tends to be expensive, exclusive, and specialized. Families experiencing poverty are found to suffer the most as they are essentially stuck with the most affordable option available (Sheff, 2013). Accessibility is perhaps the primary benefit of twelve-step support groups which are admission-free, peer-run, and abundant worldwide. The CRAFT approach has been published in a book and videos are accessible online that feature professional counselors teaching the methodology. The self-help and psychology sections of bookstores offer a variety of literature for families, much of it based on the twelve-steps, which is intended to teach and encourage family members of people

with addiction to follow particular guidelines and programs. While these resources are accessible and may be useful, they offer inconsistent recommendations to family members (Miller et al., 1999). Al-Anon advocates that family members detach from their loved one while warning that enabling could have devastating consequences. CRAFT suggests a different tactic, encouraging family members to use motivational techniques to impact change in their loved one's behavior and convince them to seek treatment. The Intervention approach advocates confrontation and encourages families to accept responsibility for inspiring change in their loved ones. Many of the other available resources make similar right versus wrong arguments about what families ought to do. Unfortunately for families, the reality that addiction presents appear far more complex. Furthermore, it is worth questioning whether concepts that are taught in a video, read in a book, or relayed by peers can be sufficiently defined and applied by family members amidst the chaos of addiction. Personal accounts from family members convey the fear invoked as a result of ill-defined terms like enabling, rock-bottom, and codependency (Sheff, 2013). Each distinct approach proposes to improve outcomes for family members and their loved ones, further illustrating the conundrum with which family members are presented.

Conflict between various approaches may be common in any treatment endeavor, but unfortunately for families of people with addiction - one approach compared to another can appear to mean the difference between life and death. Without a complex understanding of concepts like enabling and accepting powerlessness, family members may find it difficult to distinguish between their feelings and those dictated by popular beliefs (Moore et al., 2011). Many family-involved treatment modes exist as a means to motivate the person with addiction into treatment, suggesting that family members will naturally improve as a result of their loved one's recovery (Foote et al., 2014). This notion implies that addiction treatment is linear, when in

reality it is a chronic, progressive illness which often involves relapse and requires lifelong maintenance (Ventura & Bagley, 2017). Along the way, family members often develop their own chronic physical and mental illnesses while continuing to endure the social stressors of caretaking or witnessing addiction (Orford et al., 2013). Family members who have lost loved ones to sudden overdose or the slow deterioration and eventual death of untreated addiction may spend years coping with guilt, loss, and grief (Sheff, 2013). Family members are deserving of treatment that honors the immeasurable, permanent impact that addiction has had on their lives. They would benefit from a therapeutic treatment mode that improves their mind-body connection to bring awareness to their physical, psychological, and spiritual needs (Perlmutter, 1992). They need support in navigating stigma while demystifying and clarifying commonly held beliefs about the family's role in addiction (Ventura & Bagley, 2017). They require ample space and time to express and process the myriad difficult feelings that come with the territory of loving a person with addiction while exploring their preferences for coping (Gethin et al., 2016). Finally, family members are deserving of treatment that is neither bound to their loved one's treatment status nor negligent of the fact that family members can influence and empower their loved ones who are suffering.

Dance/movement therapy is a psychotherapeutic approach which is based in the body and acknowledges that bodily experience and movement behavior are inextricably linked to thought and emotion (Roberts, 2016). The American Dance Therapy Association defines dance/movement therapy as "the psychotherapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual" ("FAQs: What is dance/movement therapy?", para. 1). A basic tenant of therapy more generally is the idea that human beings have not only biological, but psychological and social needs that contribute to survival (Chaiklin &

Wengrower, 2016). Dance/movement therapy is an intrinsically holistic approach, recognizing that body, mind, and spirit are equally significant components of psychotherapeutic treatment. Dance/movement therapists are specially equipped to support individuals in increasing bodily awareness to cope better with the negative effects of stress, to learn to self-regulate during heightened emotional states, and to bring attention to one's physical, mental, social, and emotional needs (Shafir, 2016). Dance/movement therapy adopts a post-modern (Fischman, 2016), culturally-curious approach, disputing the notion that there is one truth or a single picture of health and rather accepting that there are many diverse and ever-changing ways of achieving well-being (Caldwell, 2013). Dance/movement therapy also employs a person-centered approach, ensuring that the client is an active participant in collaboration with the therapist throughout treatment, rather than a mere recipient of prescriptive care (Hill, 2016).

Dance/movement therapy is uniquely equipped to address the needs of families coping with the addiction of a loved one. It can serve as an additional therapeutic resource for a growing population of family members and concerned others who remain underserved, despite the positive correlation between their health and the health of the person with addiction. Family members have been largely ignored within the larger field of addiction, but the existing literature proves that they are sufficiently compromised emotionally, cognitively, physically, and socially as a result of their loved one's suffering. For family members of people with addiction, the interaction between the biological, psychological, and social becomes disrupted through encountering complex biopsychosocial stressors like stigma, shame, guilt, denial, stress, loss, anger, and isolation. A meta-analysis of the psychological health benefits of dance/movement therapy found that it is effective in improving mood, well-being, and overall quality of life while decreasing depression and anxiety (Koch, Kunz, Lykou, & Cruz, 2014). Unfortunately, the

whole of the field of dance/movement therapy has neglected to acknowledge family members of people with addiction despite their likely benefit from a holistic, body-based therapeutic approach.

Discussion

Evidence-based research that evaluates how best to meet the needs of families impacted by the addiction of a loved one is sparse. Evidence-based research that examines currently available resources and their efficacy is similarly lacking. Researchers have highlighted the need for more evidenced-based study, to better evaluate existing modes, while advocating that new options be created to meet the growing need (Ventura & Bagley, 2017; Orford et al., 2013). In reviewing what exists, it appears that the most widely accessible and popular resources have attempted to address the experiences of families by reducing their problems into categorical concepts. Assuring family members of their codependent, enabling nature has allowed many experts to treat them somewhat prescriptively - suggesting emotional detachment or motivational techniques as problem-solving, pain-reducing fixes. Additionally, while popular peer-support groups have been shown to be helpful in reducing isolation and providing spiritual sustenance, “repeated cathartic self-disclosure at 12-step meetings, while therapeutic, may not necessarily ensure that deep personal change is taking place” (Lawlor, 2016, p.109). While these formats and suggested solutions have been constructed to meet the demands of a vast and growing epidemic as quickly and easily as possible, they undermine the more complex, long-term needs of this population. While family members may feel drawn to resources with quick and promising solutions, the evidence of their maladaptive coping behaviors and overall ill health suggests that the available options are inadequate. Additionally, the course of addiction has been compared to that of a marathon rather than a sprint – suggesting that the progressiveness and the chronicity of

the illness requires family member resilience, far beyond a mere quick fix (Foote, et al., 2014). Family members of people with addiction would benefit from a mode of treatment which honors and accepts that each and every experience of addiction is unique, complex, unpredictable, and worthy of person-centered care.

While there is no existing literature regarding the use of dance/movement therapy as a possible treatment approach for family members, the literature illustrates family suffering quite clearly, thus providing many clues about how to possibly address family member needs. Some of the overarching concerns for family members include dealing with the various negative impacts of chronic stress, becoming disconnected from oneself and one's needs, struggling to distinguish between popular addiction concepts, and poorly coping with the progressiveness and chronicity of their loved one's illness. It is suggested that dance/movement therapy can address these particular concerns and help families to integrate therapeutic progress into their lives as they continue to cope with the unknown circumstances of addiction. With dance/movement therapy, family members can address symptoms of stress and emotional overarousal by learning practical skills for healthy emotion regulation and relaxation. Dance/movement therapy supports healthy self-regulation by increasing self-awareness, allowing participants to reconnect to personal needs while accessing and processing difficult feelings. Treatment options which increase family member choice rather than provide strict recommendations have been found to allow family members to more successfully support their loved one's chances for recovery (Miller et al., 1999). A dance/movement therapy approach acknowledges the inherent complexity and uniqueness of each experience (Fischman, 2016). As such, family members would be given the opportunity to examine the complexity, or rather the grey areas of their particular circumstances, to effectively make choices based on their own experiences and needs. By exploring the various

grey areas – between extremes of empathy and enabling, self and other, body and mind – family members can find a flexible middle ground that suits their particular circumstances. With the therapeutic goals of increasing healthy emotion regulation and resilience, gaining a better awareness of needs and a more secure sense of self, and expanding choice and the ability to distinguish preferences, family members might translate therapeutic discoveries into their lives - to more effectively cope and to better support their loved ones during the long course of addiction and potential recovery.

Family members coping with the addiction of a loved one have likely experienced some negative emotional, psychological, and somatic symptoms, and these can potentially spur them toward seeking treatment. The use of a body-based approach is appropriate for meeting a wide range of needs (Koch et al., 2014), as members are encouraged to return to their body as both an anchor and a guide (Caldwell, 2004). The dance/movement therapist is trained to attune and adapt to a wide range of mental, physical, and emotional experiences present in any moment - exhibiting empathy and modeling acceptance throughout (Fischman, 2016). It is likely that family members seeking treatment have experienced some manifestations of chronic stress in their bodies as a result of witnessing or trying to control the deterioration of a loved one's body due to addiction. The disease of addiction ravages the bodies, minds, and spirits of its sufferers leaving them unrecognizable and extremely difficult to reach. As family members bear witness to the progressive decline of their loved ones, they too are transformed in body, mind, and spirit (Perlmutter, 1992). People with addiction are essentially cut off from bodily sensation and access to emotion as a result of their mind-body connection becoming impaired through the use of drugs and alcohol (Sanchez, 2012). Family members find themselves desperate to repair this damage and control the progression of the addiction, often begging, pleading, bargaining with, or even

threatening their loved one to stop using. In this way, families become addicted to their loved one's addiction, losing touch with their physical, mental, and emotional needs in an effort to restore these connections in their loved ones (Sheff, 2013). Family members develop maladaptive coping mechanisms like denial, causing them to dissociate and withdraw emotionally, or over-involvement, causing them to experience emotional hyperarousal and stress (Gethin et al., 2016). This disconnection from themselves combined with the inability to effect change in their loved one contributes to family members' feelings of helplessness and low self-esteem. Additionally, many family members serve as untrained caretakers for their loved ones with addiction and find that home environments and family functioning becomes disrupted as a result. Dance/movement therapy theory puts forth that "an understanding of the self is incomplete without self-regulation, that is, knowing how the self maintains control over itself and makes the adaptations necessary to feel harmony in its environment" (Seoane, 2016, p.23). The ability to self-regulate emotions is necessary for healthy psychological functioning, while an inability to self-regulate can cause physical damage to the nervous system (Seoane, 2016). According to these suggestions, improving emotion regulation for family members can allow them to reclaim a sense of agency and control within themselves while adapting more effectively and healthily amidst the uncontrollable circumstances of addiction.

Dance/movement therapy follows with current neurophysiological findings which show that emotions are the result of bodily responses that are communicated to the brain (Shafir, 2016). The process of emotion regulation might be thought of as one's efforts to deliberately control physiological sensations and motor behaviors in order to modulate emotional disturbance (Shafir, 2016). Dance/movement therapy increases mindful awareness of bodily sensation and physical behavior in support of healthy modulation (Sanchez, 2012). Bringing attention to the

immediacy of the body through mindfully acknowledging breath, heartbeat, or body temperature has been found to improve emotion regulation - disrupting obsessive thought patterns and increasing a sense of trust within oneself (Danielsson & Rosburg, 2015). This practice of returning to the physical body can increase one's ability to access internal resources while releasing control over circumstances outside oneself. By heightening nonjudgmental awareness of the body, one can avoid becoming overly attached to or dissociated from their felt experience - a skill that family members can explore within themselves and later practice in relationship with their loved one. If members become emotionally dysregulated with increased awareness of self during a session, the dance/movement therapist is there to offer opportunities for adapting that can further expand family members' repertoire of coping skills. The therapist might encourage participants to utilize self-applied touch or to notice and adjust posture, both of which have the potential to improve emotion regulation and relationship to self. Warming up the body with guided self-applied touch can reduce anxiety, relieve physical tension, and provide an option for self-care (Seaone, 2016). Practicing self-care has been found to improve mood, build tolerance amidst distress, and improve emotional resilience toward better overall health (Foote et al., 2014). Additionally, releasing bodily tension is necessary to increase receptiveness toward deeper therapeutic work throughout a given session (Levy, 1988). Posture and physical movement are also found to continuously impact mood and self-esteem. By recognizing motor patterns and posture, participants of dance/movement therapy are encouraged to notice connections between their bodies and their feelings, while discovering options for physical expression that might feel more personally satisfying (Shafir, 2016). For family members, gaining access to more desirable feelings through movement can provide another tool for coping, while reminding family members that they are worthy of pleasurable experience despite difficult

circumstances. As family members work to shift their experience of felt emotions in the present moment, they can also begin to consider and question how they express these feelings to others. Living with or witnessing a loved one suffering from addiction can result in harmful miscommunication between family members. When one is able to improve management of their emotional arousal, they can become more adept at communicating their feelings in the presence of others (Milliken, 2008). Modulating movement can allow one to slow down reactivity to outside circumstances, decreasing impulsivity and allowing for the exploration of new ways to respond to stimuli (Biondo, 2017). Increasing self-regulation and awareness, and expanding physical expression, can help family members to access internal resources while building communication skills and emotional tolerance for inevitable future stress outside of sessions.

According to neurophysiology, bodily responses communicate information to the brain through a process of activating unconscious emotions, which correspond to conscious feelings (Shafir, 2016). While emotion regulation is necessary for coping with conscious feelings that arise, it can also give greater access to unconscious emotions that need to be addressed and processed. Dance/movement therapy theory posits that the expansion of movement repertoire can lead directly to an expansion in the range of emotional access and expression (Fischman, 2016). By bringing attention to their bodies, participants of dance/movement therapy are able to improve self-awareness - getting in touch not only with the physical but also the emotional aspects of themselves. Once a more regulated, receptive state is achieved on a body level, family members may discover more nuanced feelings beneath their typical stress and worry. These may include shame, guilt, disappointment, loss, anger, sadness, and hopelessness. Family members have been found to bury their feelings as the needs and feelings of their loved ones become a priority or in an attempt to avoid the painful feelings associated with the addiction. For family

members of people with addiction, “a major source of conflict lies between the part of the self that has been unconsciously dedicated to adapting to the needs of others and the less developed part of the self, which holds the real, but often repressed, thoughts and feelings” (Lawlor, p.111, 1995). If deeper needs and feelings are not acknowledged and brought into awareness, it is assumed that family members will continue to suffer by unconsciously repeating maladaptive behaviors. Additionally, stigma and shame cause families to conceal their feelings from others, whether to protect their loved one or themselves from possible judgment and discrimination. Concealing aspects of oneself to avoid stigmatization requires considerable mental energy and can lead to intrusive thoughts and psychological distress (Roberts, 2016). Dance/movement therapy “offers a laboratory in which adaptive or maladaptive behaviors are brought to awareness, in which the demands of the self and those of the dominant culture are embodied, amplified, nurtured, or challenged” (as cited in Rogers, 2016). By bringing awareness to present feelings and unconscious emotions, family members might combat cultural stigma while exploring a healthy balance between their own and their loved ones needs.

Dance/movement therapy relies on nonverbal exploration, expression and communication as a way of accessing and processing repressed emotions that may be too difficult to access or too complex to express verbally (Roberts, 2016). A major benefit of a body-based approach to therapeutic treatment is that as clients explore unconscious feelings, they do so from a conscious viewpoint - that is, the awareness of the physical body (Chodorow, 1991). This process is thought to improve the mind-body connection because it allows clients to hold “the tension of the opposites,” or rather, the seemingly opposed aspects of thought and feeling, fantasy and reality (Chodorow, p.37, 1991). Family members have been found to cope by disconnecting thoughts from painful feelings, and maintaining bodily awareness while experiencing difficult

feelings may be challenging. However, through the containment of the therapeutic environment and by exploring creatively (Chodorow, 1991), clients of dance/movement therapy can learn to withstand discomfort and increase emotional resilience (Seoane, 2016). Dance/movement therapists utilize structure, improvisation, and creative movement interventions to support clients in exploring playfully and imaginatively (Levy, 1998). Through creative, imaginative exploration, meaningful symbolic expression is able to occur and be processed (Chodorow, 1991). As unconscious feelings surface and are expressed and processed, clients can begin to explore new and other adaptive ways of coping (Shafir, 2016), gaining a sense of empowerment and deepening trust in oneself (Dulicai, 2016). For family members who feel powerless over their loved one's addiction and disempowered within the wider culture, dance/movement therapy can invigorate feelings of empowerment to combat guilt, shame, and other difficult emotions. As self-awareness improves through acknowledging and addressing thoughts and feelings, family members can gain greater self-trust and improve self-esteem. With increased self-esteem, family members improve their capacity to cope with stigma and advocate for themselves and their loved ones within the wider culture.

By increasing self-awareness, family members also work to gain clarity about their own needs, discerning between popular beliefs and their own preferences. Dance/movement therapy employs an enactive approach toward person-centered care, suggesting that "each individual knows the world through his own actions. This occurs at the same time that he co-creates the worlds in which he lives, generating his everyday life. By this process the person transforms himself and his world" (Fischman, 2016). Through a collaborative relationship with the dance/movement therapist, a client can integrate therapeutic discoveries into their day-to-day lives in a way that is meaningful to them. Families have been found to struggle with adapting to

the extreme circumstances of addiction, and are often forced to cope through a series of harsh missteps and subsequent trial-and-error. Family members

do their best to adapt. They try to protect the addict, they try to discipline the addict, they try to reason with the addict, they try to compromise with the addict. All of these are reasonable and rational coping responses under normal circumstances. When these techniques don't work, they try them again and they try them more intensely. . . after years of being alternatively disappointed and terrorized and feeling encouraged, the behaviors become more extreme and in some cases really distorted and maladaptive - and also damaging to the addict. (as cited in Sheff, 2013, p.109)

Attempts by some professionals and experts to address this conundrum have led to the popular and often conflicting approaches to family member treatment. In order to navigate through popular concepts, and to avoid accepting too much or not enough responsibility for their loved one's behavior - family members would benefit from supportive therapeutic treatment. With dance/movement therapy, structured and creative movement interventions are used as "the vehicles by which the client organizes, expresses, and clarifies conflicting thoughts and feelings" (Lawlor, 1995, p.111). By exploring popular beliefs creatively and on a body-level, family members can more accurately identify and clarify their own needs and beliefs. Supporting family members in their enactive process, that is, of co-creating with their environment, is to work against the belief that there is one truth or correct way to navigate addiction. Rather, clients of dance/movement therapy are encouraged to work toward navigating complexity and accepting that the truth is "diverse, partial, implying different perspectives that undergo a continuous transformation" (Fischman, 2016). Rather than succumbing to sheer powerlessness or taking

complete responsibility for motivating their loved one to change, family members can work toward integrating both extremes into an adaptable truth with which they can live.

As family members improve their ability to tolerate complexity and distinguish preferences, they will inevitably confront core issues of empathy and enabling. Most of the available resources provide strict instructions and guidelines to family members about how to avoid enabling their loved one. In the CRAFT method, family members are trained in eight “basic behavior management strategies,” which include training the family member in “ceasing ineffective negative communication while simultaneously facilitating the delivery of appropriate consequences” (Kirby et al., 2015, p.159). These strategies and others put forth by different programs, operate on the premise that family members can learn and employ quick tactics to effectively handle addiction. The use of these strategies, while shown to be useful for motivating loved ones into treatment, seems to imply the emotional detachment of family members. It is implied that family members ought to set their feelings and needs aside when interacting with their loved one with addiction. Of the eight strategies put forth by CRAFT, only one considers the needs of concerned family members, and this strategy is implemented last. Twelve-step support groups suggest a different form of emotional detachment, proposing that family members restrict or cease involvement with their loved one to avoid enabling or increasing hurt. These tactics seem to disregard the emotional significance of enabling, which has been thought to emerge from family member empathy (Pederson, 2007). Meanwhile, dance/movement therapy acknowledges that empathy is a neurophysiological process stimulated by recognizing the emotional and expressive behavior of another (Payne, 2017). Neuroscience studies have shown that mirror neurons in the brain enable “one to perceive the action, emotion, or sensation of another as if she were performing that action or experiencing that emotion herself” (as cited in

Payne, 2017, p.171). These action-oriented, emotional responses interact with one's personal felt history, and together this creates one's subjective perception of another's experience (Payne, 2017). Witnessing the addiction of a loved one is, therefore, a visceral, emotional experience, and one that cannot be easily categorized, detached from, or compartmentalized. The concept of mirror neurons perhaps illustrates more clearly how and why family members become unhealthily consumed with their loved one's addiction and fall into patterns of enabling. Since enabling is thought to emerge from the family member's love for the person with addiction, it should not be forbidden, but rather examined to distinguish between an empathic expression and its possible negative consequences. It is understandably difficult for family members to reconcile conflicting actions and feelings, as their attempts to help often cause harm, and feelings of empathy coexist with anger and disappointment. However, in order to diminish their own suffering and cope more effectively with the circumstances of addiction, family members must work to acknowledge past and present actions and feelings, even when these inevitably cause pain (Foote et al., 2014). Dance/movement therapy utilizes nonverbal expression and communication to honor and explore the complex interplay between the actions and emotions that create one's subjective reality. Working with a dance/movement therapist on a nonverbal level can allow clients to access spontaneous expression, improve communication skills, increase awareness of others, and contribute to a sense of belonging (Payne, 2017). Dance/movement therapists hone the ability to access and utilize empathy within their own body, to nurture and repair these neurobiological processes in their clients (Biondo, 2017). Through the use of dance/movement therapy, family members can gain a new awareness of the interplay between mind and body, between action and feeling, between the experiences within oneself and those of another. As family members work to make distinctions between extremes and discover a

tolerable middle ground, they may reconcile love with hurt, hope with sorrow, empathy with enabling. By attending to their own needs with therapeutic treatment, family members improve their ability to effectively support the survival and recovery of their loved one.

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