

Challenging Confidentiality and Dual Relationships in the
Treatment of Addiction: A Case Study.

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Author Note

Thesis Submitted in Partial Fulfillment of the Requirement
For the Degree of Master of Counselling

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2019 City University of Seattle Victoria, BC

June 2019

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Abstract

This case study explores the question, how does adapting the traditional professional boundaries of confidentiality and dual relationships in the treatment of addictions (by including clients in an ongoing community that practices solidarity, exposure, and psychosocial integration) influence the therapeutic outcome? Framing addiction through the lens of dislocation as per Alexander's Globalization of Addiction (2008), this study looked at the addiction treatment program at Time To Heal Treatment and Workshop Facility, a holistic treatment facility located in Duncan, B.C., Canada.

Keywords: Addiction, psychosocial integration, dislocation, shame, therapeutic community

Acknowledgements

To my business partner, friend, and mentor, Andrew Louisy, I thank you for designing, implementing, and wholeheartedly living the Time To Heal program. I thank you for dedicating countless years of service to the vision of healing and community that we now share.

Thank you, Anna Mae Kanwar and Cheryl Giesbrecht, for keeping me grounded, heartfully connected, and positively focused on success and stability while maintaining a sense of humour. I thank my husband, Jaroslaw Kapela, for making me a better counsellor, challenging me to rise, teaching me what I am capable of, and for the daily gift of choosing to do life with each other and our beautiful children. I thank my parents for instilling me with the values of family and community, and for teaching me to challenge the status quo, think critically, and value life-long learning.

I thank my editor, Corelli Mattice, for being an integral part of my academic success. I appreciate all of the help and brainstorming you and Jai Mills have provided for me on my thesis. I would also like to thank the instructors in the Master of Counselling program, especially my thesis advisor, Dr. Annette Przygoda, for your guidance and encouragement throughout this process, and Dr. Jacqueline Walters for being my faculty reader and for continually inspiring and guiding my love of family systems, curiosity, and questions. I am grateful to have shared this journey of learning and growth with the women of Cohort 14.

Finally, thank you to the staff and community of Time To Heal. I consider myself blessed to belong to such an incredible group of humans striving to heal themselves and each other. I could not have done this research without the survey respondents from Time To Heal. I am especially grateful to Jan Routh, Gloria McArdle, and Jessica Curtis for stepping up and stepping in to keep Time To Heal going and flowing while I've been focused on school.

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Challenging Confidentiality and Dual Relationships in the Treatment of Addictions: A Case Study

Chapter 1: Introduction

Research Question: How does adapting the traditional professional boundaries of confidentiality and dual relationships in the treatment of addictions (by including clients in an ongoing community that practices solidarity, exposure, and psychosocial integration) influence the therapeutic outcome?

Significance

The study will introduce emerging evidence and therapeutic treatments that challenges cherished professional ethical assumptions. Alexander (2008) views addiction as a response to dislocation and a lack of psychosocial integration. As such, then our treatment for addiction must address these problems. “You're not alone, we love you -- has to be at every level of how we respond to addicts, socially, politically and individually” (Hari, 2015). It is possible that the structure of mental health addiction treatment is hindering long-term recovery. I posit that the professional tenets of maintaining confidentiality and avoiding dual relationships as the hallmark of therapeutic treatment obstructs the development of psychosocial integration and inhibits the healing of addiction. If “the opposite of addiction is connection” (Hari, 2015) then connection taking precedence over professional structures in the treatment of addiction arguably would produce better long-term results.

Background

While there is no consensus on the best treatment protocol for addictions in Western therapeutic circles, certain ethical principles are taken for granted as essential, specifically

maintaining confidentiality and avoiding dual relationships. Confidentiality is widely considered to be emblematic of trust and safety in the development and maintenance of a therapeutic alliance (American Psychological Association, 2017; BC Association of Clinical Counsellors, 2014; Perkins, 2018); it is thought to be essential for clients to be able to divulge their secrets within a confidential space, knowing that no one else will ever know their innermost thoughts, feelings, actions, or experiences. This structure puts the therapist in the position of being a secret keeper for numerous clients who will likely never speak to each other, and certainly will never be privy to each other's struggles.

The history of the expectation of confidentiality in psychotherapy came out of doctor/patient privilege in the medical field and was established through a series of American legal cases examining whether specific medical doctors and psychiatrists were justified in disclosing sensitive patient information (Perkins, 2018). Currently, the standards outlined by professional associations that regulate psychotherapy and mental health have specific legal guidelines as to when a therapist has a legal obligation to break confidentiality (American Psychological Association, 2017; BC Association of Clinical Counsellors, 2014; Perkins, 2018). These limits to confidentiality are specifically; if someone is in imminent danger, if there is a suspicion that a child may be being abused or neglected, if a client requests disclosure, or if there are court proceedings that require disclosure (Canadian Counselling and Psychotherapy Association, 2012). In all other circumstances, the therapist is expected to uphold their “fundamental ethical responsibility to take every reasonable precaution to respect and to safeguard their clients' right to confidentiality” (Canadian Counselling and Psychotherapy Association, 2012, p. 7).

The literature on confidentiality primarily outlines problems associated with breaches of confidentiality or challenges in maintaining confidentiality in situations such as group therapy, multi-disciplinary teams, rural settings, and in supervisory/training situations (Liew, 2012; Klontz, 2004). In my understanding, confidentiality and the avoidance of dual relationships are intended to protect the therapist from lawsuits and caregiver burnout, as much as to protect the client.

The “traditional mainstream, majority notions of boundaries are characterized by therapist professional distance, authority, non-reciprocity and anonymity” (Speight, 2007). In the mental health field, dual relationships or multiple relationships refer to a therapist having more than one role of involvement with a client. For example, if a client and therapist both have children who are in the same class, or if a therapist and client have a friendship or business relationship. Dual relationships are generally considered ethically risky and best avoided. The BCACC Code of Ethical Conduct states, “Avoid dual relationships or the perception of a dual relationship in circumstances where the existence of a dual relationship may adversely affect the professional relationship” (BC Association of Clinical Counsellors, 2014).

Problem Statement

Alexander (2008) looks at addiction as a dislocation problem, “experienced as the absence of belonging, identity, meaning, and purpose” (Alexander, 2015), associated with a lack of long-term interpersonal connection and as an adaptation to survive a lack of psychosocial integration. Mainstream Western treatment for addictions often does not adequately address dislocation or long-term psychosocial integration.

Alexander (2008) postulates that the absence of psychosocial integration is excruciating and that individuals continually strive to satisfy both their need for autonomy and their need for social belonging (p. 95). Alexander warns that both “dislocation” and “psychosocial integration” are complex, “multilayered concepts that lose their meaning if they are over-simplified or rigidly operationalized” (Alexander, 2015). In his attempt to summarize psychosocial integration, initially coined by Erik Erikson in his psychosocial theory of development, Alexander described psychosocial integration as the mental state of being and living of people in a well-functioning society who simultaneously feel a sense of belonging and interconnectedness, yet still feel free (Alexander, 2015). I would add that a natural flow between interdependence and independence is an essential component of developing and maintaining healthy psychosocial integration.

Alexander (2008) identifies four different definitions of addiction referred to in Western society ranging from problematic substance use to an obsessive dedication to anything. For this study I will be utilizing Alexander’s third definition which the Globalization of Addiction defines as an “overwhelming involvement with any pursuit whatsoever (including but not limited to drugs or alcohol) that is harmful to the addicted person, to society, or to both” (Alexander, 2008, p. 29).

Much of the dominant discourse surrounding recovery frames addiction as a progressive disease that requires lifelong sobriety to treat. “Once an addict, always an addict” is an actively encouraged sentiment in both medical and recovery circles that align with a 12-step philosophy such as Alcoholics Anonymous (U-Turn Addictions Centre, n.d.). The 2017 Canadian Life in Recovery (LIR) Survey found that 12-step groups were the most common recovery resource used by 91.8% of respondents (McQuaid, et al., 2017). Thus, the relevance of 12-step values and messaging cannot be underestimated. It is essential to note that 12-step programs seek to manage

addiction, not to heal addiction (Alexander, 2008, p. 299). The idea is that once an individual has crossed the line into addiction, “It doesn’t matter how long I’ve been clean. When I use, the drug takes over, 100% of the time. No exceptions. Such is the very nature of being an addict.” (U-Turn Addictions Centre, n.d.).

12-step programs offer peer support and community within the safety and limitations of anonymity. The anonymous nature of 12-step programs can limit broader psychosocial integration as a recovery tool. It is left to the individual. Also, the peer support structure does not provide professional therapeutic guidance. While 12-step group cultures vary, identifying as an addict/alcoholic, and subscribing to the philosophy of the 12-step programs is a requirement, specifically, admitting personal powerlessness over addiction, believing in a power greater than self, and turning life and will over to Higher Power (Alcoholics Anonymous Great Britain, 2018). The lifelong commitment to abstinence can be problematic for 12-step members whose values do not align with that requirement, and it can limit long-term psychosocial integration. “I would like to explore the option of having a glass of wine, but the stigma, fear, and shame the recovery community puts on that is limiting. I find it frustrating that I have to remain ‘in recovery’ to have a support group or friends” (McQuaid, et al., 2017, p. 23). If one decides to explore recovery from addiction outside of abstinence they must leave Alcoholics Anonymous and sacrifice the community support that was attached to Alcoholic Anonymous.

Harm-reduction strategies set more flexible and individually targeted goals that range from eventual abstinence to reduced usage and reduced substance-related problems (Subbaraman & Witbrodt, 2014, p. 2) but still function within the disease model of addiction as an individual problem that requires medical treatment.

McQuaid, et al. (2017) outline how professional addiction programs are funded and designed to provide short-term professional interventions and commonly utilize 12-step peer groups to provide ongoing support after treatment. While many 12-step groups strive to provide long-term peer support the lack of alternatives was named as problematic in the Life in Recovery survey (McQuaid, et al., 2017). Psychosocial integration is not necessarily provided as a key component of professional treatment, rather it is seen as the work of the individual to find ongoing recovery support such as relationships with family and friends, creative expression, spiritual practices, exercise, or online support (McQuaid, et al., 2017). Following Alexander's (2008) reasoning, if one can heal their lack of psychosocial integration and form long-term connections and a sense of belonging that has one feel seen and heard, the addiction should become redundant and no longer problematic.

Purpose

In this study, I will explore an emerging therapeutic model of the treatment of addiction. The model in this study actively and intentionally adapts the traditional professional boundaries of confidentiality and dual relationships in the treatment of addictions by including clients in an ongoing community that offers long term psychosocial integration, solidarity, and an environment of exposure. This case study explores the addiction program at Time To Heal, a holistic treatment facility located in Duncan, B.C., Canada.

Alexander (2008) believes that therapeutic addiction treatments may be individually helpful but that they cannot heal dislocation in an enduring or meaningful way, as

Therapists can provide acceptance and unconditional positive regard during the therapeutic hour, but they cannot create psychosocial integration for the rest of the

week. Achieving psychosocial integration is the project of a lifetime and the product of an enduring community in attunement with an individual (Alexander, 2008, p. 306).

Time To Heal takes a long-term integrated approach to health and considers the physical, emotional, mental and spiritual needs of the client in the development and implementation of treatment protocols. The method includes consideration of the clients' interpersonal relationships with an emphasis on social and familial integration for long-term stability. In my observation, many clients achieve long-term psychosocial integration within the Time To Heal community, heal their family relations, and establish healthy long-term interdependence.

The programs at Time To Heal incorporates group therapy, collaborative therapy teams, training situations, and counselling sessions that include multiple clients simultaneously.

Key services of Time To Heal include:

- Psychoeducational workshops such as the foundational program, 'Recreating Life Patterns', to create guidelines for relational interaction with a focus on long-term stability and behavioural change.
- Acupressure, massage and other forms of bodywork to address physical ailments as well as provide a somatic release for trauma and emotions that are stored in the body memory. Counselling is often combined with acupressure bodywork.
- Detoxification in the form of wet steams, saunas, and natural remedies.
- Bi-weekly community meetings. Meetings are "drop-in" and are open to anyone who desires to participate in a healing community. There is often a great deal of

exposure and laughter while honouring each other's successes and seeking solutions to personal challenges (Kapela, 2018).

- Individual counselling.
- Family counselling.
- Group counselling.
- Combined counselling sessions where two or more clients are “paired up” and share one or more counselling sessions based on their similar struggles, way of operating, or related family of origin issues. I have seen these mini-groups build close friendships as they progress. Combined counselling sessions are also utilized to address interpersonal challenges between clients, avoid triangulation, and hold a client accountable for their actions (especially when involving another client).
- Witnessing occurs when staff, trainees, or other clients are called into a session (either in person or via conference call) to witness a client's process. Witnessing is used to create additional accountability, counteract shame, share perspectives, and create a mirror to better support clients to see themselves.

Time To Heal includes “mirroring” as a foundational premise. Louisy & Kapela (2010) define mirroring as a tool and awareness that empowers an individual to gain perspective on their own behaviours or challenges by witnessing those behaviours or challenges in other people. “Through mirroring we are able to share the experience, see how similar we are, build compassion, and embrace the opportunity to work through our own challenges” (Louisy & Kapela, 2010). Alexander noted that “Psychosocial integration is experienced as a sense of

identity, because stable social relationships provide people with a set of duties and privileges that define who they are in their own minds” (Alexander, 2008, p. 58).

The practice of mirroring encourages clients and staff to share their experiences and their struggles openly. In speaking about his patients in Vancouver’s Downtown Eastside (DTES), Dr. Gabor Mate said, “What they care about is my presence or absence as a human being. They gauge with unerring eye whether I am grounded enough on any given day to coexist with them, to listen to them as persons with feelings, hopes, and aspirations as valid as mine” (Mate, 2008). Exposure, self-disclosure, and group counselling sessions are a regular practice. The concept of exposure encourages both staff and clients to be vulnerable and authentically transparent in how they represent themselves personally and professionally. The goal is to have individuals be consistent in their representation of self, regardless of the situation or interaction. Mirroring and exposure are used as interventions to combat shame, build community, and increase accountability, compassion, humility, and empathy.

Addictions commonly treated at Time To Heal include; alcohol, drugs, cannabis, codependence, sex, pornography, and process addictions such as workaholism, disordered eating, technology, food, love addictions, impulse-control disorders, and risky behaviour addictions (Pinna, et al., 2015).

The addiction program at Time To Heal has a foundational focus on connection, accountability, and long-term psychosocial integration through community building that includes Time To Heal staff and clients, family counselling, and long-term friendship and connection. Dual relationships are a vital component of recovery as clients at Time To Heal develop friendships and comradery within the community and work together as mentors, peer-counsellors, healers, and friends.

Alexander states that,

The best way out of addiction is overcoming dislocation by finding a secure place in a real community. People sometimes work their way out of dislocation by rejoining their previous world of family, friends, and society, with an enhanced appreciation of its importance. Sometimes, however, this familiar world is too fragmented or dysfunctional, and people must create communities with others who have likewise been forced to build their communities anew (Alexander, 2008, p. 340).

The Time To Heal program is designed to foster long-term psychosocial integration by encouraging both previous and new long-term connections. The Time To Heal community actively provides guidelines, encouragement, and support for clients to reconnect and heal relations with their own families.

Operational Definitions

1. **Addiction** - “overwhelming involvement with any pursuit whatsoever (including but not limited to drugs or alcohol) that is harmful to the addicted person, to society, or to both” (Alexander, 2008, p. 29).
2. **Confidentiality** – the ethical assurance that a client’s privacy will be respected and what a client discusses with their service provider (therapist) will not be disclosed or discussed with anyone else without first obtaining the informed consent of the client unless the therapist is faced with a legal duty to disclose information (Taylor, 1989).

3. **Dark** – Louisy & Kapela (2010) define darkness as the shadow we all have. Dark is the hidden entity in us that moves us away from the light. Dark is anything that takes us away from our Heart Spirit or our Highest Self. Dark is often associated with fear (p. 33-34).
4. **Dislocation** – a lack of psychosocial integration due to physical, psychological, or social separation from one’s society, culture, or family (Alexander, 2008, p. 59).
5. **Dual relationships** (or multiple relationships) - a therapist having more than one role of involvement with a client.
6. **Empathy** - Ivey, Pederson, & Ivey, (2001) describe empathy as the ability to perceive a situation from the other person's perspective, to see, hear, and feel the unique world of the other as cited in (Brown B. , 2006).
7. **Exposure** – openly and vulnerably sharing one’s struggles, thoughts, and feelings; existing within the world vulnerably, with an authentic presentation of one’s true self in interactions and relationships (Louisy & Kapela, *Recreating Life Patterns*, 2010, p. 9).
8. **Holarchy** – sometimes referred to as the “opposite of hierarchy”, holarchy refers to relationships in which “different and unequal participants enhance each other and co-creatively make a larger wholeness possible” (Spangler, *A Vision Of Holarchy*, 2008).
The word ‘holon’ originated from the Greek *holos* meaning whole and was coined by systems theorist, Arthur Koestler in 1967, who theorized that a holon is an entity that has distinct integrity and identity at the same time as it is a part of the larger system (Günther, 2013). In a holarchy, each participant is valued and honoured for their differences and their contributions to the whole system naturally and inclusively without regard for rank or position (Spangler, *A Vision Of Holarchy*, 2008).

9. **Light** - Louisy & Kapela (2010) define light as the recognition and awareness that we are all a part of all and universally interconnected. Light is the embodied understanding of spirit and love and is associated with being heart-focused.
10. **Long-term** – in this study long-term is defined as longer than 5-years and viewed in the context of a lifespan.
11. **Mirroring** – a tool and awareness that empowers an individual to gain perspective on their own behaviours or challenges by witnessing those behaviours or challenges in other people and sharing experience, growth, emotions, and moments with other people with a focus on seeing the similarities between self and other (Louisy & Kapela, *Recreating Life Patterns*, 2010, p. 6).
12. **Psychosocial integration** – the sense of identity that develops over a lifespan through stable long-term relationships and interdependence between individual and society in such a way that guides duties, roles, privileges and reconciles both an individual's need for social belonging with their need for individual autonomy and achievement (Alexander, 2008, p. 58).
13. **Shame** - psycho-social-cultural construct involving intensely painful feelings and the belief that one is fundamentally flawed and thus unworthy of love, belonging, acceptance, and connection (Brown, 2009).
14. **Solidarity** - a professional walking alongside a client with close boundaries, a real relationship, and a willingness to be of service in such a way that will make the most significant difference in the client's life (Speight, 2007).
15. **Witnessing** – witnessing occurs when staff, trainees, or other clients are called into a session (either in person or via conference call) to witness a client's process. Witnessing

is used to create additional accountability, counteract shame, share perspectives, and create a mirror to better support clients to see themselves.

Chapter 2: Review of Selected Literature

I selected peer-reviewed articles, journals, and publications on the topics of addictions, psychosocial integration, confidentiality, dual relationships, and shame. I specifically looked at the shame research of Dr. Brené Brown, Erikson's psychosocial theory, and the addictions work of Dr. Bruce Alexander, Dr Gabor Mate, and Therapeutic Communities.

Psychosocial Integration

Erikson's psychosocial theory of development outlines eight stages of development, spanning infancy to death, and the primary crises to be resolved at each stage (McLeod, 2018). Çelik & Ergün (2016) outlined how Erikson's psychosocial theory of development did not see children as passive persons being moulded. Erikson held children as active explorers seeking to control their environment and adapting to the differing conditions of their lives while seeking to "understand the realities of the social world in order to adapt effectively and show a normal pattern of personal growth" (Çelik & Ergün, 2016, p. 21).

Erikson's theory suggests that identity can evolve toward either a positive or negative resolution in each stage of psychosocial development. Positive resolution at each stage would result in the development of hope, will, purpose, competence, fidelity, love, care, and wisdom (McLeod, 2018). Failure to consolidate a healthy and positive identity at any stage of development may create social or relational impairments, insecurities, depression, or psychosocial disconnection (Çelik & Ergün, 2016, p. 22). Negative resolution of the stages

would result in mistrust, shame, guilt, inferiority, role confusion, isolation, stagnation, and despair (McLeod, 2018).

According to Çelik & Ergün (2016), Erikson stressed the importance of culture and society in an individual's development. Erikson noted that children in every culture are taught and guided by older members of society and that the differing ceremonial and ritualistic traditions to mark life transitions help to build both a cultural identity and solidify the development of individual identity. In the stage of identity conflict (12-18 years) an individual may experience extreme conflict if the culture s/he belongs to is marginalized, unacceptable, or oppressed (p. 25). Alexander's addiction theory highlights that in a dislocated society lacking generational and cultural stability, the identity conflict of adolescence may not be resolved. According to Erikson, the work of adolescence is to "search for a sense of self and personal identity, through an intense exploration of personal values, beliefs, and goals" (McLeod, 2018). Success in this stage will lead to fidelity whereas failure to establish a self-identity would result in role confusion or not knowing who they are or where they fit into society (McLeod, 2018).

The Institute for Social Therapy and Research (ISTR) asked the question, how do you make a community healthier, not just individual members of the community? ISTR concluded that a "social therapy is necessary, an approach which treats people not merely as viewers, or even participants, but producers and builders" (Holzman, 1987, p. 106) of community and society.

The function of traditional psychology and psychiatry in North American society was historically focused on adapting people to society as it is. Unfortunately, "the society to which people are being adapted or into which we are being assimilated is racist, classist, homophobic and sexist to its core" (Holzman, 1987, p. 106). Instead of helping people to adjust to an

unhealthy society the ISTR focused on building social environments to address common emotional needs, and break away from societally sanctioned roles, through social therapy and co-creating healthy community (Holzman, 1987, p. 109).

Therapeutic Communities

Nate Azrin, the founder of the Community Reinforcement Approach (CRA) to addiction treatment, believed that altering the living environment to provide positive reinforcement for sobriety from family, friends, work, and community was a necessary component of treatment for alcoholism (Miller, Meyers, & Hiller-Sturmhöfel, 1999). Therapeutic Communities (TC) became a prominent treatment method for addiction in the 1960s in the USA as a response to the heroin crisis (Mullen & Arbiter, 2017). “TCs are a revolution of inclusion in which a healing community nurtures people to become bigger than what wounded them, to leave things better than they found them, to strive to belong to something larger than themselves that contributes to the greater good” (Mullen & Arbiter, 2017, p. 206). Mullen & Arbiter (2017) note that in recent years the mainstream focus for addiction treatment has largely favoured medically assisted treatment and short-term clinical interventions and that ‘community as method’ treatment is primarily used in the criminal justice system.

The term ‘therapeutic community’ is a descriptor of a community where the relationships between the members (including staff) and with the community are utilized for healing purposes and reflected on openly in therapy. (Veale, Gilbert, Wheatley, & Naismith, 2014, p. 286). De Leon (2009) talks about the value of using the community as the method for promoting holistic change. In a TC, the community provides the context of psychosocial interaction, as well as guidelines for behavioural and lifestyle change. There are explicit and implicit boundaries for the

group and social participation. The community helps to assess whether or not members are making positive changes and provides affirmation, encouragement, correction, and guidance to support ongoing growth (De Leon, 2009). As community members advance in their healing, they increase their responsibility and mentorship capacity within the community.

According to De Leon (2009), the general progression through treatment in a TC requires individuals practice exposure, model their learning, mentor and guide new community members, and be challenged on their ability to handle increasing responsibility in different situations and aspects of life. The idea is that the individual will be able to adapt, transfer their learning, and rise to the challenge.

TCs address the whole person, in context. “If I’ve got a whole person, and I’ve got a community, we have the relationship between what I would call a multi-interventional approach, the use of the whole community” (De Leon, 2009). TCs represent one way in which short-term psychosocial integration has been used as a component of addiction recovery.

Dual Relationships

There is an abundance of literature and ethical guidelines regarding how to eliminate or avoid dual or multiple relationships that include warnings of the potential for harm and client exploitation (Campbell & Gordon, 2003; Gottlieb, 1993; BC Association of Clinical Counsellors, 2014; American Psychological Association, 2017). It was believed that any non-professional involvement with a client could lead to a “slippery slope” where innocuous interactions eventually led to exploitive sexual relations (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007).

This historical view developed out of the psychoanalytic and psychodynamic ideas regarding transference, where the therapist was in a hierarchical power position as “expert” and was responsible for carefully mitigating emotional transference and protecting the client (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007). Ethical guidelines were created to define, structure, and limit the therapist/client relationship. Boundaries regarding time limitations, gifts, the location of interactions, touch, self-disclosure, finance, and others were prescribed across the profession (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007). There were warning signs published of role-boundary conflicts that included, “increased self-disclosure to a client; increased anticipation of meeting with a client; a desire to prolong a session with a client; failure to terminate or refer a client; and a desire to please, impress, or punish a client” (Campbell & Gordon, 2003, p. 433).

The literature has since been expanded to acknowledge that dual relationships may be unavoidable in certain therapeutic settings such as when working with a marginalized group or in rural communities (Campbell & Gordon, 2003; Speight 2007). However, it has only been in recent years that there has been a professional discussion regarding the therapeutic benefits of dual relationships. “The current view is that dual relationships, overlapping boundaries, and/or boundary crossings are at a minimum problematic. Rarely are boundary crossings discussed as beneficial, therapeutic, or positive events within therapeutic relationships” (Speight, 2007, p. 137). Speight (2012) highlights how the standard view of professional boundaries to mitigate risk to the client or the therapeutic alliance is a simplistic notion that fails to consider the nuance of culture, relationship, or the complexity, flexibility, and negotiation that can exist in a responsible therapeutic context focused on solidarity (p. 134).

The Emergency Department Violence Intervention Program (EDVIP) in Winnipeg is one such program that focuses on the benefits of building long-term supportive relationships. The staff are on call 24/7 and run to the hospital with the goal of arriving within 15-minutes of receiving the call, and there is value in knowing that there is no cut-off date for service (Goldman, Woodward, & Snider, 2016). EDVIP staff intentionally dress in plain clothes and walk beside their clients, doing what is necessary to help their clients make significant life changes (Goldman, Woodward, & Snider, 2016).

Similarly, in her work with African American women, Speight expressed that in cultures which emphasize close community and familial bonds, aka strong psychosocial integration, that multiple relationships, mixing of roles, therapist self-disclosure, and “socializing at important events together are all seen as normal and expected” (Speight, 2007) and that doing so increases authenticity. She said,

Walking outside with clients, attending special events, seeing clients at church or at community events, sharing food during sessions, giving birthday presents, introducing my family members to clients, receiving gifts, offering rides home, and hugging all became common occurrences within my community-based practice. From a traditional standpoint, these were boundary crossings, actions outside of the standard parameters. Conversely, from a culturally responsive and culturally congruent standpoint all of these actions were well within the normal parameters of my therapeutic relationships (Speight, 2007, p. 142).

Palliative care is another therapeutic environment where the end of life care requires close boundaries and non-traditional responsibilities as a practitioner and the development of warm and effective relationships, often with multiple family members (Rosenberg & Speice, 2013). Speight notes that there is a distinct difference between boundary crossings that are deviations from practice verses boundary violations which are harmful or exploitive to the client and calls for a practice based in solidarity (Speight, 2007). “Solidarity calls for a different kind of professional. One who accompanies their comrade clients through the therapy process with close boundaries and a real relationship” (Speight, 2007). Solidarity asks us to focus on what service will make the biggest difference in someone’s quality of life. There are times when that does not work with office hours or a clinical setting. “She didn't need, need me to talk about how she felt about moving, she needed help moving” (Speight, 2007). From the perspective of psychosocial integration, a community of people helping someone move is far more useful than an isolated therapeutic hour talking about it. An approach based on solidarity and community-building, “makes it possible for people to become emotionally, culturally, and politically empowered in order to take on the task of reorganizing society to meet our needs” (Holzman, 1987, p. 105).

Building a healing community requires a close connection, family bonds, and multiple relationships between clients and therapist. The relational flexibility increases authenticity and helps to provide the best service to clients (Speight, 2007). Building a culturally inclusive healing community that does not subscribe to the dominant cultural norms and expectations of treatment, but meets clients where they are at and works to build long-term connection and spirals of growth is of paramount importance in establishing psychosocial integration. “The creation of culturally inspired therapeutic rituals can offer richness in work with families and support the benefits of connection, belonging, spirituality and acknowledging achievement.

These goals support therapeutic goals related to growth, change and transformation” (Richardson, 2012).

Confidentiality

Searching the topic of confidentiality produces an overwhelming abundance of ethical guidelines, information about how to avoid breaches of confidentiality, and warnings regarding situations where there is a potential for breaches of confidentiality, including in dual relationships (Liew, 2012; American Psychological Association, 2017; BC Association of Clinical Counsellors, 2014; Perkins, 2018; Canadian Counselling and Psychotherapy Association, 2012).

Common therapeutic situations in which confidentiality challenges commonly arise are in collaborative or multi-disciplinary teams, group or family therapy, and in palliative care (Liew, 2012; Rosenberg & Speice, 2013). Professional guidelines regarding confidentiality were not designed with group therapy in mind and when conducting multi-person therapy “the issues of confidentiality surface differently and must be dealt with differently than in traditional dyadic therapy” (Lakin, 1994, p. 346). Group members are not bound by professional ethics codes. Groups are social by nature, and group members may discuss what they have learned or witnessed outside of the group (Klontz, 2004, p. 173). Efficacy of multi-person therapy relies on “the development of trust, that participants will not abuse one another's confidences, that they will try to bear one another's interests in mind, and that they will try to help one another” (Lakin, 1994, p. 347). Discussing guidelines of confidentiality with group members at the beginning of a meeting is a recommended practice (Klontz, 2004, p. 173).

According to Wegscheider-Cruse et al. (1990) “the dynamic of group therapy helps to get beneath the denial as a person responds emotionally to the work of another group member. It is difficult for cognitive blocking to persist in one person when emotional healing is taking place in other group members” (Klontz, 2004, p. 174). This example of mirroring is a valuable therapeutic tool utilized at Time To Heal. In multi-person therapy, therapists are unable to predict the course of therapy or the reactions and responses group members may have to each other or whether individual members will maintain the confidence of the other members (Lakin, 1994). However, the goal of confidentiality is still maintained, whereas at Time To Heal confidentiality is not necessarily held as the primary ethical tenet.

There is a strong professional assumption that confidentiality must be maintained and that failure to do so is always a violation of the client. However, the ethical codes fail to capture the “complexities of the overlapping, and sometimes competing, demands of caring for multiple members of a family and for how a... practice might transform when caring for someone at the end of life and across care settings inherent to the end-of-life process” (Rosenberg & Speice, 2013, p. 83). Maintaining confidentiality in end of life care can be complex and controversial. While ethical guidelines are clear, situations may occur in which “there are concerns that others might be harmed as a result of their ignorance, or when rigid adherence to confidentiality is perceived by relatives as being obstructive or antagonistic” (Draper, 2005, p. 57).

In considering psychosocial integration, one of the features of small rural communities is that “people are known in family, social, and historical context. Individuals are known not simply by the work they do or where they live but also by their family legacy in the community” (Campbell & Gordon, 2003). I think that while small-town gossip can certainly be challenging, there is also longevity in close communities that locate individuals across a lifespan and makes

psychosocial integration possible. However, in the therapeutic world, the golden cow is privacy and the promise that no one outside of the therapy room will ever know your secrets or your shames.

Shame

Brown (2009) outlined shame as a psycho-social-cultural construct involving intensely painful feelings and the belief that one is fundamentally flawed and thus unworthy of love, belonging, acceptance, and connection. Helen Block Lewis (1971) described how “shame involves a global negative feeling about the self in response to some misdeed or shortcoming, whereas guilt is a negative feeling about the specific event, rather than about the self” (Dearing, Stuewig, & Tangney, 2005, p. 1393). For example, a person experiencing shame might think, “I’m a loser” where someone experiencing guilt would think, “I messed up”. In shame, the focus is on the defective self and often results in impaired empathy and interpersonal challenges (Dearing, Stuewig, & Tangney, 2005, p. 1393). Jean Baker Miller and Irene Stiver (1995) noted that shame has people “become so fearful of engaging others because of past neglects, humiliations, and violations...we begin to keep important parts of our experience out of connection. We do not feel safe enough to more fully represent ourselves in relational encounters” (Hartling, Rosen, Walker, & Jordan, 2000, p. 1).

Shame is a commonly associated trigger of relapse (Dearing, Stuewig, & Tangney, 2005) and is associated with feelings of fear, blame, and disconnection (Brown B. , Connections A 12-Session Psychoeducational Shame-Resilience Curriculum, 2009). “Shaming serves to disconnect people from themselves, from their real feelings, and from others. It also serves to silence and isolate people” (Hartling, Rosen, Walker, & Jordan, 2000, p. 10). Mason

(1991) discovered that it is not a specific occurrence that creates shame. It is the secrecy surrounding the event, the family myths obscuring facts and the denial of pain, that on some level are intended to protect individuals, that create shame. This results in unresolved grief, denial, and addictions (p. 178). The behaviour of shame avoidance cultivates an environment of denial. In shame, the self is “flawed, inadequate, unworthy, and defective. Shame erodes the possibility of relating intimately with others. It destroys the capacity to trust oneself as well as others. As shamed, one not only expects failure but behaves in a way that brings it about” (Sabatino, 1999, p. 3).

When one believes that there are secrets they carry that have the potential to make them unlovable, disposable, or untouchable if anyone were to know the truth, keeping the secret becomes a poisonous quest that erodes vulnerability and connection. “Intending to protect themselves and their children from this pain, parents create family myths and obscure the actual sources of pain, which are passed on and cause unresolved grief, denial, addictions and an ongoing sense of shame” (Mason, 1991, p. 178). Secret-keeping can morph into an obsession to control the presentation of an acceptable role or mask developed to distract others from noticing spirals of shame and addiction (Mason, 1991, p. 183).

Brene Brown’s (2006) shame-resilience theory emphasizes that shame is a universal human emotion that everyone experiences. “Shame resilience is best conceptualized as a continuum, with shame, fear, blame, and disconnection anchoring one end, and empathy, courage, compassion, and connection anchoring the other end” (Brown B. , 2009, p. 5). Brown discovered that strategies to combat shame, while varied, can be characterized as “being with others who have had similar experiences” or “talking with people who've been there.” (Brown B. , 2006, p. 44). Hartling, Rosen, Walker & Jordan (2000) identified five specific relational

practices that can help to heal shame; 1. Listening and responding to shine a light on reality, 2. Mutual empathy, 3. Authenticity, 4. Movement towards mutuality, and 5. Humour (p. 2).

Psychotherapy and counselling were rarely identified as helpful. I propose that the professional construct of confidentiality creates an environment of confession rather than of connection that reinforces a hierarchy of professional and client rather than an egalitarian empathetic connection. Shaming or humiliating interactions can thrive in hierarchical relations where there is a power imbalance. In “moving toward mutuality, we are moving away from the power-over dynamics” (Hartling, Rosen, Walker, & Jordan, 2000, p. 2). Talbot (1995) stated that “Even in the best of therapeutic circumstances, it is inherently shaming for patients to reveal weaknesses to a therapist” (Brown B. , 2006, p. 44).

Dearing, Steuwig, & Tangney (2005) and Brown (2006) found that guilt is positively correlated with accountability, enhanced empathy and constructive responses to anger. “Guilt-prone individuals are inclined to take responsibility for their actions, rather than to deflect blame onto others or onto elements of the situation” (Tangney, Wagner, Fletcher, & Gramzow, 1992). Thus, the elimination of shame is integral to the fostering of connection and establishing psychosocial integration.

Brown (2009) outlined how shame resilience is determined by one’s ability to “recognize (1) shame and our specific triggers, (2) our level of critical awareness, (3) our willingness to reach out to others, and (4) our ability to speak shame” (Brown B. , 2009, p. 5). Shame-resilience theory suggests that empathetic connection, openly exposing feelings of shame instead of holding secrets, and connecting with people who have been through similar experiences is essential (Brown, 2006 & 2009). The courage required to speak shame out loud requires sharing

vulnerabilities openly. “Courage is about bringing oneself more fully into connection. It involves finding out that you’re not alone” (Hartling, Rosen, Walker, & Jordan, 2000, p. 12).

Exposing shame is in direct conflict with the standard structure of Western psychotherapy where the therapist becomes the secret-keeper for multiple clients who never interact with each other. There is no exposure outside of the confidential therapy room. While the therapist would hopefully express empathy for the client, I think the structure of the interaction inadvertently reinforces the idea that what is being shared in therapy is shameful as it must be kept confidential and private.

Chapter 3: Methodology

This chapter will provide a comprehensive description of the methodology used in the study and will include a description of the research design and rationale for doing a mixed-mode case study of Time To Heal. I will describe the factors considered in designing the research to ethical standards. Finally, I will outline the process I utilized for data collection, interpretation and analysis.

The hypothesis for this study is that including clients in an ongoing community that practices solidarity and exposure to re-establish psychosocial integration is essential in the long-term healing of addiction. The null hypothesis is that clients participating in a community that practices exposure and solidarity is irrelevant to their recovery from addiction.

Research Approach and Rationale

In my observation, the vast majority of Time To Heal clients have struggled with addiction by Alexander’s definition. Doing a mixed-mode case study of Time To Heal’s addiction

recovery program allowed for an in-depth investigation into the “holistic and meaningful characteristics of real-life events” (Yin, 2003, p. 2). My interest is primarily in the contextual data of “how” and “why” the Time To Heal addiction program has the results it does. It is essential that the research methods allow for the collection of real-life context, experience, and diverse variables (Yin, 2003).

Alexander’s dislocation theory of addiction is a well-formulated and well-researched theory that has a “clear set of propositions as well as circumstances within which the propositions are believed to be true” (Yin, 2003, p. 40) which align with Time To Heal’s philosophy. This single-case design is an opportunity to examine what the long-term results are of an addiction program specifically designed to address dislocation and psychosocial integration.

Alexander’s (2008) propositions include:

- Addiction is an adaptive response to dislocation.
- Dislocation is excruciating.
- Social bonds and connection are essential human needs.
- Dislocation is a universal consequence of globalization, colonialism, and the free-market society.
- Psychosocial integration is essential to avoiding or recovering from addiction.
- Recovery from addiction requires long-term psychosocial integration.
- Psychosocial integration requires a social change that extends beyond the treatment of the “individual addict”.

Addiction is operationalized as an “overwhelming involvement with any pursuit whatsoever (including but not limited to drugs or alcohol) that is harmful to the addicted person, to society, or to both” (Alexander, 2008, p. 29).

Mixed-Mode Case Study

I chose a mixed-mode survey design. I collected both quantitative and qualitative data which allowed for a more comprehensive data set describing both individual experiences as well as numerical data regarding the types and frequency of addictions and recovery. For example, by collecting quantitative data, I was able to assess how many respondents had an addiction to alcohol at the beginning of their work with Time To Heal and compare it with how many respondents currently have an addiction to alcohol. The qualitative data allowed me to gain an understanding of the impact of alcohol on an individual’s life and the contextual factors, experiences, insights, and complexity of the individual’s relationship with addiction. Having both data sets allowed for an analysis of recovery, both in looking at recovery statistics from specific addictions, as well as whether individuals feel “recovered” from addiction and what that means to them. I think the qualitative and quantitative data sets substantiate each other and provide useful contextual and comparative information that I would be unable to assess from only one set of data.

Overview of Research Procedures

I utilized a volunteer research assistant as an intermediary between myself and the respondents. She creates resources for Time To Heal staff and clients but is not involved in the day-to-day activities and has no official role or influence in Time To Heal. Professionally, she

collected and quantified data in a corporate setting for human resources. The research assistant sent out the invitations and posted the link to the online survey on social media. Informed consent was obtained through the initial survey questions and was collected anonymously.

In the invitation, I was transparent about my role as a City University student researcher as well as my role as a co-owner and counsellor at Time To Heal. I made explicitly clear that neither I nor, my business partner, Andrew Louisy will have access to any information about who has or has not responded and that their choice to participate or not will have no impact on the services they receive at Time To Heal. I made clear that I will not know, at any point in time, who the clients are, current or former, who have chosen to participate in the survey and I will not have any client identifying information. Instructions were explicitly clear to respondents to not include any identifying information such names or descriptions of themselves or other clients. I made clear that access to the raw data collected would be limited to myself and the research assistant. No other counsellors or staff at Time To Heal will ever have access to the raw data collected. Survey results will be kept confidential and secure.

Researcher Stance

I am cognizant of the conflict of interest and potential for bias in this study. I do not hold an objective stance of Time To Heal. I have been a co-owner of Time To Heal for 8-years. It is my primary source of income. I personally believe in the efficacy of the programs. Results from the study have the potential to improve Time To Heal, in which I have a vested interest. Results also have the potential to influence my approach with clients in the future at Time To Heal. Time To Heal will benefit from recommendations that emerge from this study.

I had specific thoughts that the results of this study would positively show that the Time To Heal program is effective in helping people recover from addiction and dislocation. It is essential that I remain humbly open and willing to be proven wrong or receive feedback that conflicts with my perceptions.

During the research design process, I did perception checks with four trusted friends who are familiar with the inner workings of Time To Heal. I brainstormed with them how best to design the questions in order to invite both positive and negative feedback. One of the assumptions that was revealed during my perception checks was that I have information about the Time To Heal program design and the intentions of the practitioners that may not be known by the clients. For example, I know that the Time To Heal staff intend to work in solidarity with the clients. However, I do not know if the clients feel solidarity from the Time To Heal staff.

Research Design

The survey consisted of 38 quantitative questions and 8 qualitative questions. The quantitative questions assessed basic demographic information, current and former addictions, and whether the respondent had participated in specific Time To Heal programs or protocols, such as whether the respondent had interacted with Time To Heal staff in social situations outside of the clinic or developed friendships with other clients. Respondents were given the option to skip any question other than the consent forms.

The qualitative questions included:

1. Describe the problem or challenge you had. Talk about specifically what you were struggling with, what it looked like and felt like, and what led to the decision to start working with Time To Heal.

2. Outline the specific results and benefits you achieved through your work with Time To Heal.
3. Outline specific challenges, difficulties, or aspects of the Time To Heal program that did NOT work for you.
4. Describe your experience of solidarity at Time To Heal.
5. Describe how Time To Heal's protocol around confidentiality and exposure has influenced your recovery from addiction?
6. Describe how Time To Heal's protocol regarding dual relations has influenced your recovery from addiction?
7. Describe how the Time To Heal community has influenced your recovery from addiction?
8. Optional: Is there any other information or feedback you would like to include?

Recruitment

An invitation to participate in an anonymous online survey was emailed to all current and former clients of Time To Heal for whom email information was on file. I did this to avoid influencing or having direct contact with clients and preferential selection of respondents. Current and former clients who do not receive emails from Time To Heal or do not use a computer were not recruited. It is possible that the email was filtered into junk mail in some cases and the recipient may not have received the invitation. Former clients who have ceased communication with Time To Heal and had previously requested to be removed from email communications were not recruited. Permission to utilize the Time To Heal client database was obtained from Time To Heal co-owners, Andrew Louisy and myself. The invitation to complete the survey was posted on

the Time To Heal Facebook page and in the Time To Heal community Facebook group. Instant messages were sent out to the Time To Heal message groups by the research assistant.

Instrumentation

The survey was conducted through Survey Monkey, an encrypted online service that allowed for anonymous data collection. Due to my role as a co-owner and counsellor at Time To Heal, it was essential that respondents knew that I would not have any identifying information. I used an anonymous survey in order to minimize my influence on the data received and avoid influencing respondents. I strived to formulate questions in such a way to invite balanced and objective responses that include critique. Informed consent was embedded at the beginning of the survey. Respondents were given the option to skip any questions other than the consent forms. A copy of the survey is attached in Appendix A.

Data Collection and Storage

Data collected was stored online in Survey Monkey. Once the survey was closed the research assistant exported the data and blacked out any data that could potentially identify a specific respondent before transferring the data to me. The research assistant deleted all survey data from her computer once the data was transferred to me. Downloaded data was stored password protected on my private computer. No identifying information such as IP or email addresses were collected. Printed data was securely stored in my personal files. No one else had access to the printed data. All print data pertaining to this study will be shredded once this paper is complete. Electronic data pertaining to this study will be disposed of after 5-years.

Data Analysis

The data collected from quantitative questions were reported and compiled in graphs and percentages. I conducted a thematic analysis of the qualitative data collected as related to psychosocial integration through dual relationships, community, solidarity, and exposure in the treatment of addiction. “A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p. 82). A thematic analysis allowed me to isolate key themes that emerged from the data that captured the nuance and commonality of experiences in the healing of addiction.

During the data analysis, it was essential that I consistently did perception checks with trusted colleagues and continually reflected on my own assumptions and experiences in order to ensure that I was analyzing themes emerging from the data without imposing my own presuppositions. In order to assess the relevance of each specific piece of data to emerging themes, I reviewed the data sets as a whole. I repeated this process numerous times.

As I was addressing a specific research question, I conducted a theoretical thematic analysis of the data collected through open-coding. I utilized theoretical mapping rather than inductive coding. I modified the codes throughout the coding process to describe the patterns in the data, and “coded each segment of data that was relevant to or captured something interesting about (the) research question” (Maguire & Delahunt, 2017, p. 3355).

Braun & Clarke (2006) point out that prevalence may vary significantly between themes captured in the data. In focusing specifically on themes related to dual relationships and confidentiality, one critique is that my analysis does not do justice to rich descriptions of the

overall data. (Braun & Clarke, 2006). There are themes from the data that go beyond the scope of this project and therefore were absent from the final analysis.

Chapter 4: Results

The invitation to participate in an anonymous online survey was sent out to 552 current and former clients of Time To Heal. The survey was open from October 2, 2018, until January 7, 2019. There were 50 completed responses and 8 partial responses from the email invitation. The invitation was also posted on the Time To Heal Facebook page and in the Time To Heal community Facebook group. 15 survey responses were collected via social media. In total, 73 people responded to the survey.

Saturation, originating from Glaser and Strauss's (1967) grounded theory, occurs when adding additional respondents does not elicit new information, insights or perspectives (Creswell, 2014). "Data saturation is an important concept as it addresses whether such a theory-based interview study is likely to have achieved an adequate sample for content validity" (Francis, et al., 2010, p. 1230). In a deductive approach, such as this case study, "saturation may refer to the extent to which pre-determined codes or themes are adequately represented in the data" (Saunders, et al., 2018, p. 1898). The data collected in this study showed both diverse and overlapping data related to each aspect of the research question.

While there is no set research rule for achieving saturation, the general recommendations vary between researchers and research designs. Morse (1994) recommended a sample of 30-50 for ethnographic or grounded theory studies, while Creswell (1998) suggested 20-30 participants (Statistics Solutions, n.d.). Full survey data was collected from 26 respondents with most qualitative questions being answered by 30 respondents.

43 respondents identified as female. 20 respondents identified as male. 12 respondents declined to identify gender. 8% of the respondents said they were 18-26 years old. 51.6% of the respondents said they were between the ages of 27- 40. 35.5% said they were between 41-65 years old. 5% of respondents said they were 65+.

16 respondents reported receiving treatment from Time To Heal ranging from 1 session to 6 months. 16 respondents reported receiving treatment from Time To Heal for 1-7 years. 3 respondents reported receiving treatment from Time To Heal staff for 10-20 years.

74% of respondents (45 people) have had more than 3 healing or counselling sessions with Time To Heal staff. 45% of respondents (27 people) identified as current clients. 30% (18 people) identified as former clients.

Using Alexander's (2008) definition of addiction, "an overwhelming involvement with any pursuit whatsoever that is harmful to the addicted person, to society, or to both". 75% of respondents (46 people) reported that they have had challenges with addiction. Survey respondents represent an accurate sample of the Time To Heal client base.

Why Time To Heal?

Respondents were asked to describe their presenting problem, what were you specifically struggling with and what led to your decision to start working with Time To Heal? The data shows that Time To Heal clients were desperate for holistic healing in multiple aspects of their lives. They commonly present with an overall feeling of life spiraling out of control, broken relationships, a multitude of behavioural and substance addictions, physical, emotional and mental health problems, and struggles to function in daily life.

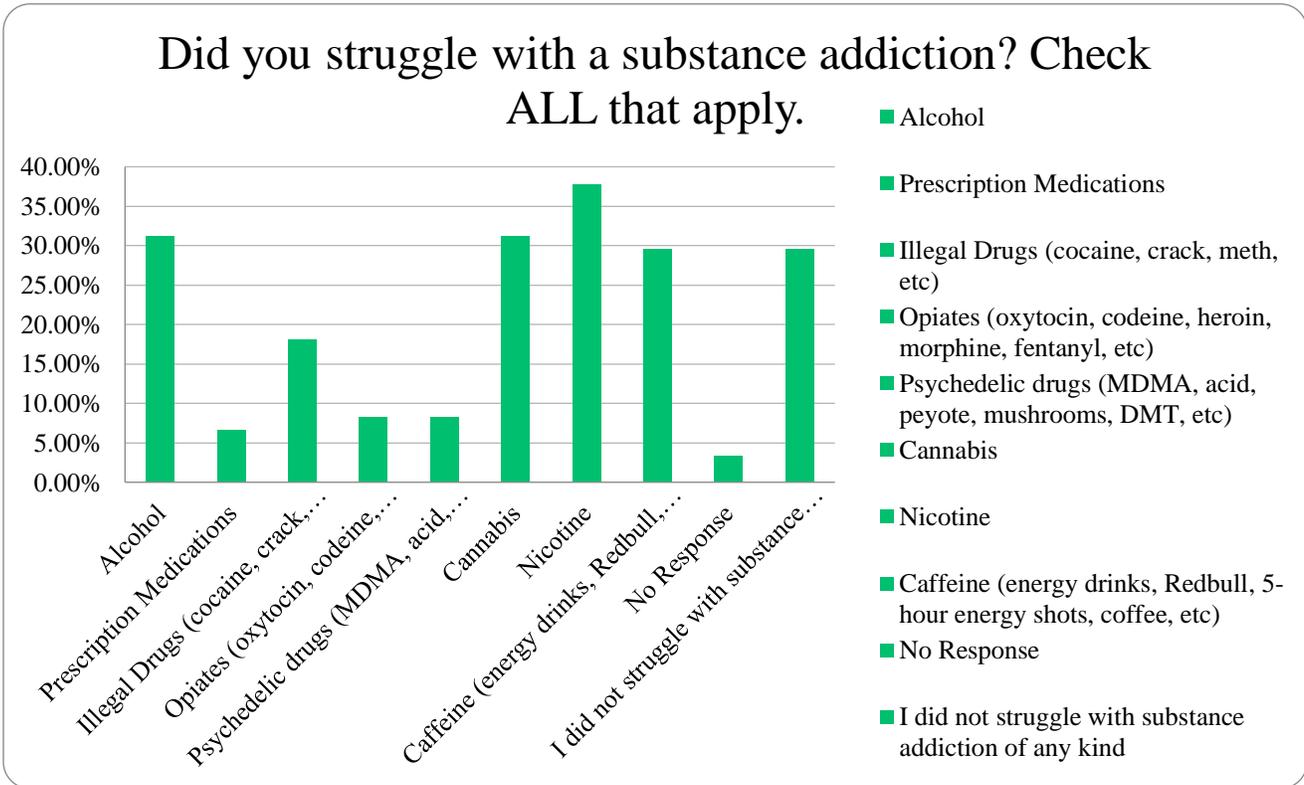
In essence, clients initiate treatment with Time To Heal when they are in a dislocation free fall, “experienced as the absence of belonging, identity, meaning, and purpose” (Alexander, 2015). This free fall was expressed through responses such as; “*I was very lost in all aspects of life*”, “*My life was spiraling out of control*”, “*losing my mind*”, “*everything I didn't want was waiting for me right around the corner and I didn't know what to do*”, “*I was lost and struggling to find self and stability*”, “*I really wanted to get better but didn't know how*”, and an “*overwhelming sense of helplessness*”. Suicidal ideation was common, as was depression or low mood, PTSD, and grief.

Relationship problems were listed by 19 respondents, including 4 people who were in the midst of a marital separation when they started working with Time To Heal. Emotional issues reported that were destructive to relationships included; anger, misogyny, arrogance, ego, narcissism, insanity, and being verbally abusive. A negative relationship with self was evidenced in a “*lack of self-love*”, self-doubt, self-sabotage, neurotic behaviours, disordered eating, low self-worth and self-esteem, body dysmorphia, “*self-created crisis*”, and being “*bent on self-destruction*”. One respondent reported a dissociative personality disorder.

Substance misuse (including prescription medications) was reported as a specific concern by 11 respondents.

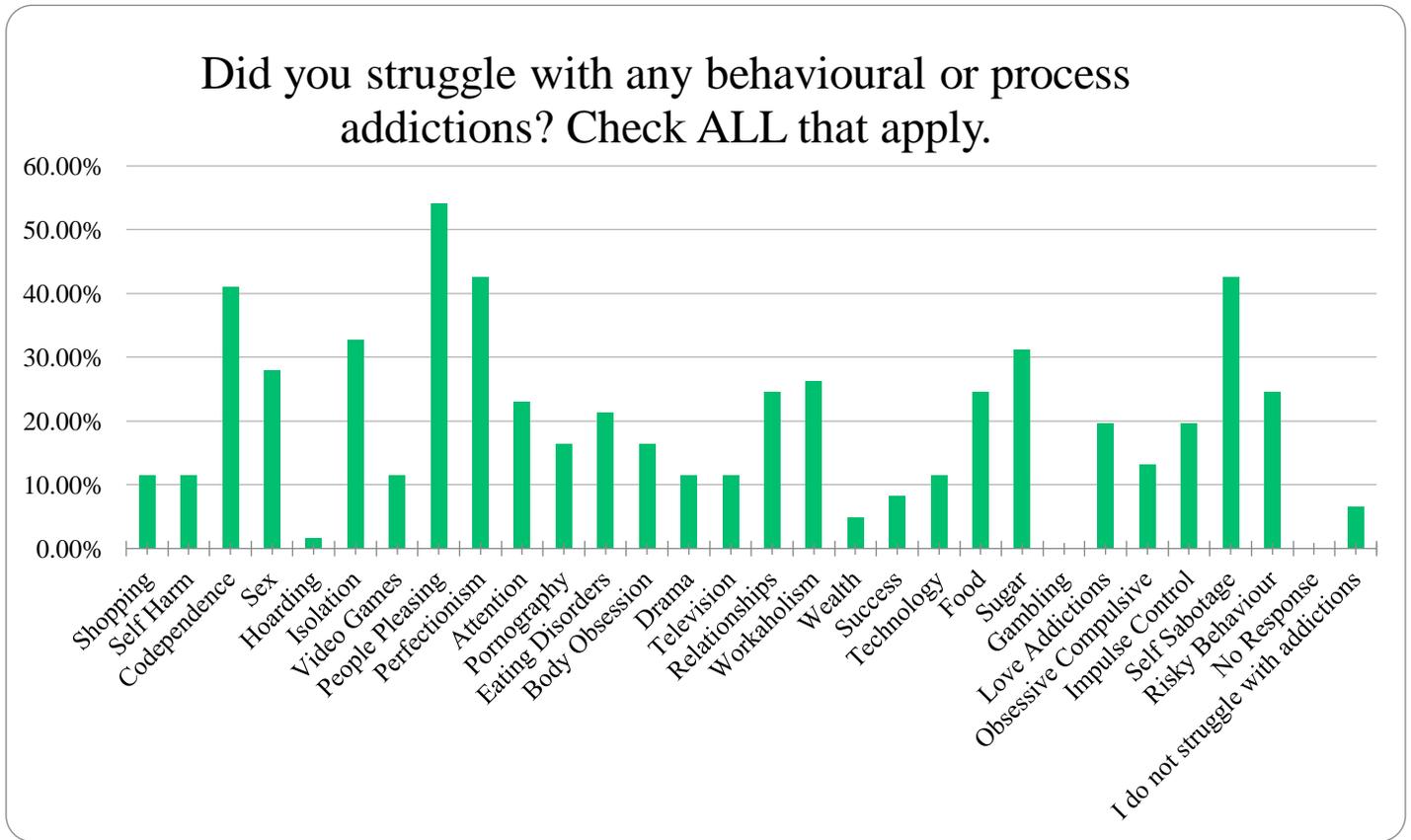
An “*inability to cope with daily life*” was reported in struggles such as financial and career problems, semi-homelessness, hoarding, and physical health issues such as chronic pain. Time To Heal offers physical treatments. A desire for physical healing and the physical health results achieved were mentioned numerous times but went beyond the scope of this paper.

Substance Addictions



Nicotine (23), cannabis (19), alcohol (19), caffeine (18), and illegal drugs (11) were the most commonly reported substance addictions. Opiates (5), psychedelics (5), and prescription meds (4) were also identified. 18 respondents said they did not struggle with substance addictions.

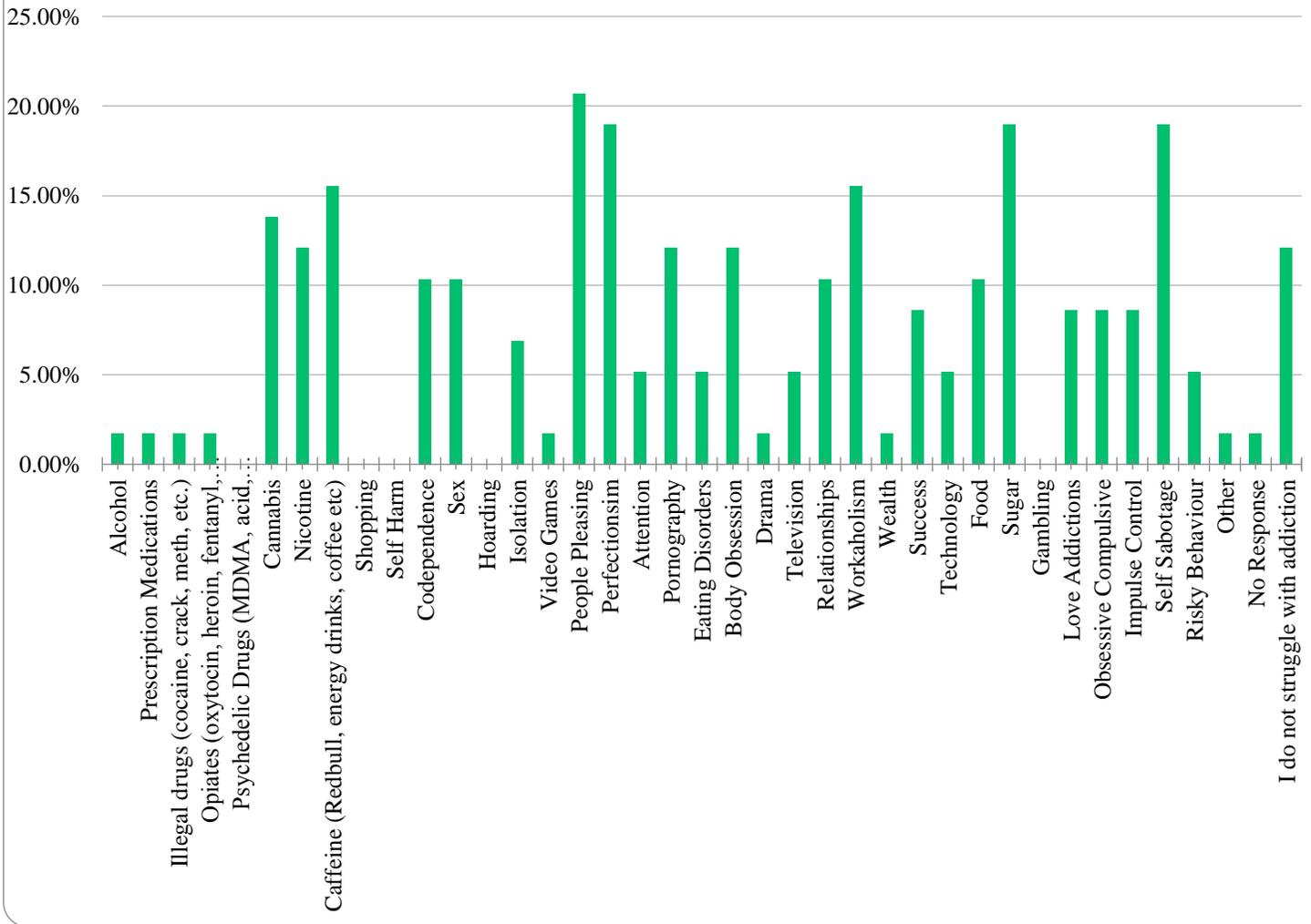
Process Addictions



When asked about behavioural or process addictions the most commonly reported addictive behaviours were; people pleasing (33), self-sabotage (26), perfectionism (26), codependence (25), isolation (20), sugar (19), sex (17), workaholism (16), food (15), risky behaviour (15), relationships (15), attention (14), eating disorders (13), impulse control (12), love addictions (12), pornography (10), and body obsession (10). Self-harm, shopping, technology, video games, drama, success, and obsessive compulsive behaviours were identified as problematic for 5-8 respondents.

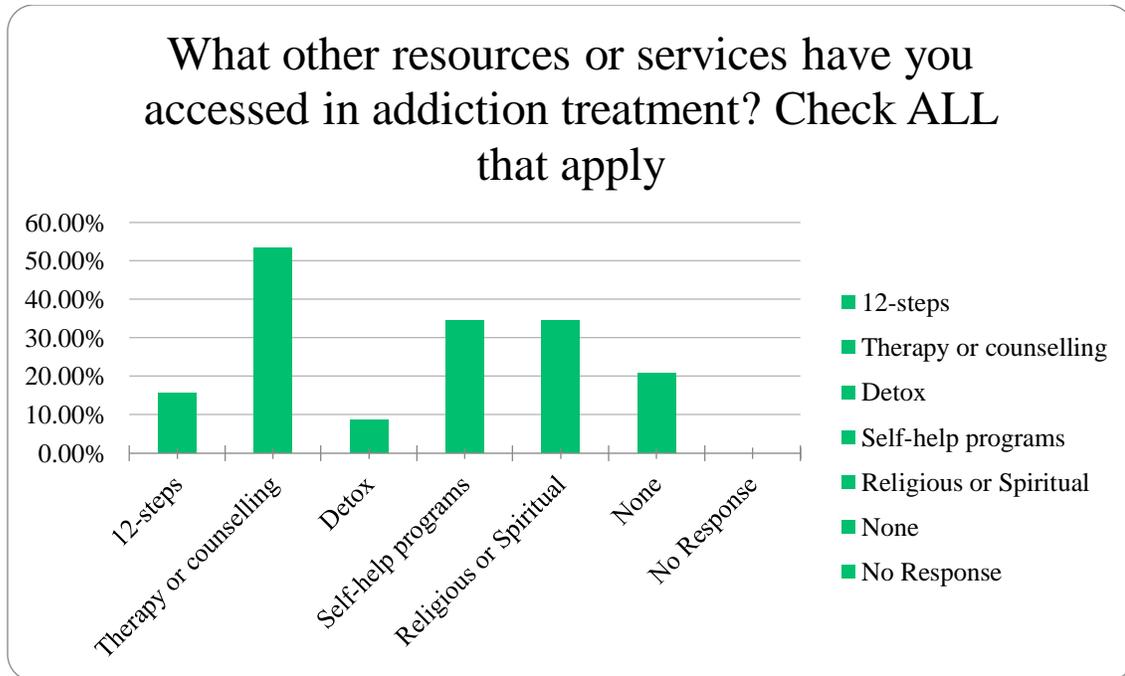
Current Addictions

What addiction(s) are you CURRENTLY struggling with? Check ALL that apply:



The most common addictions respondents reported currently struggling with are; people pleasing (12), perfectionism (11), sugar (11), self-sabotage (11), caffeine (9), workaholism (9), cannabis (8), nicotine (7), and pornography (7).

The most significant changes were reported in; people pleasing dropped from 33 to 12, self-sabotage dropped from 26 to 11, perfectionism dropped from 26 to 11, alcohol dropped from 19 to 1, illegal drugs from 11 to 1, codependence dropped from 25 to 6, risky behaviour dropped from 15 to 3. Overall, recovery from was reported for 78% of the substance addictions and 62% of the process addictions.



Medical interventions, willpower, and cranial sacral massage were each listed by one respondent.

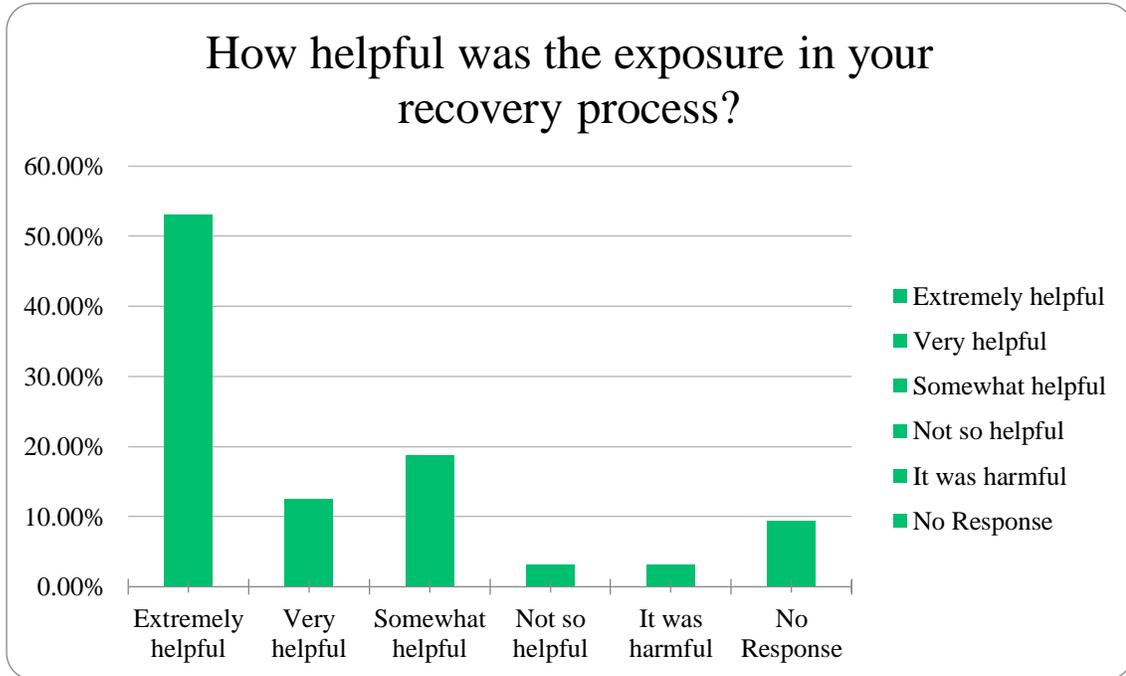
Theme: Exposed

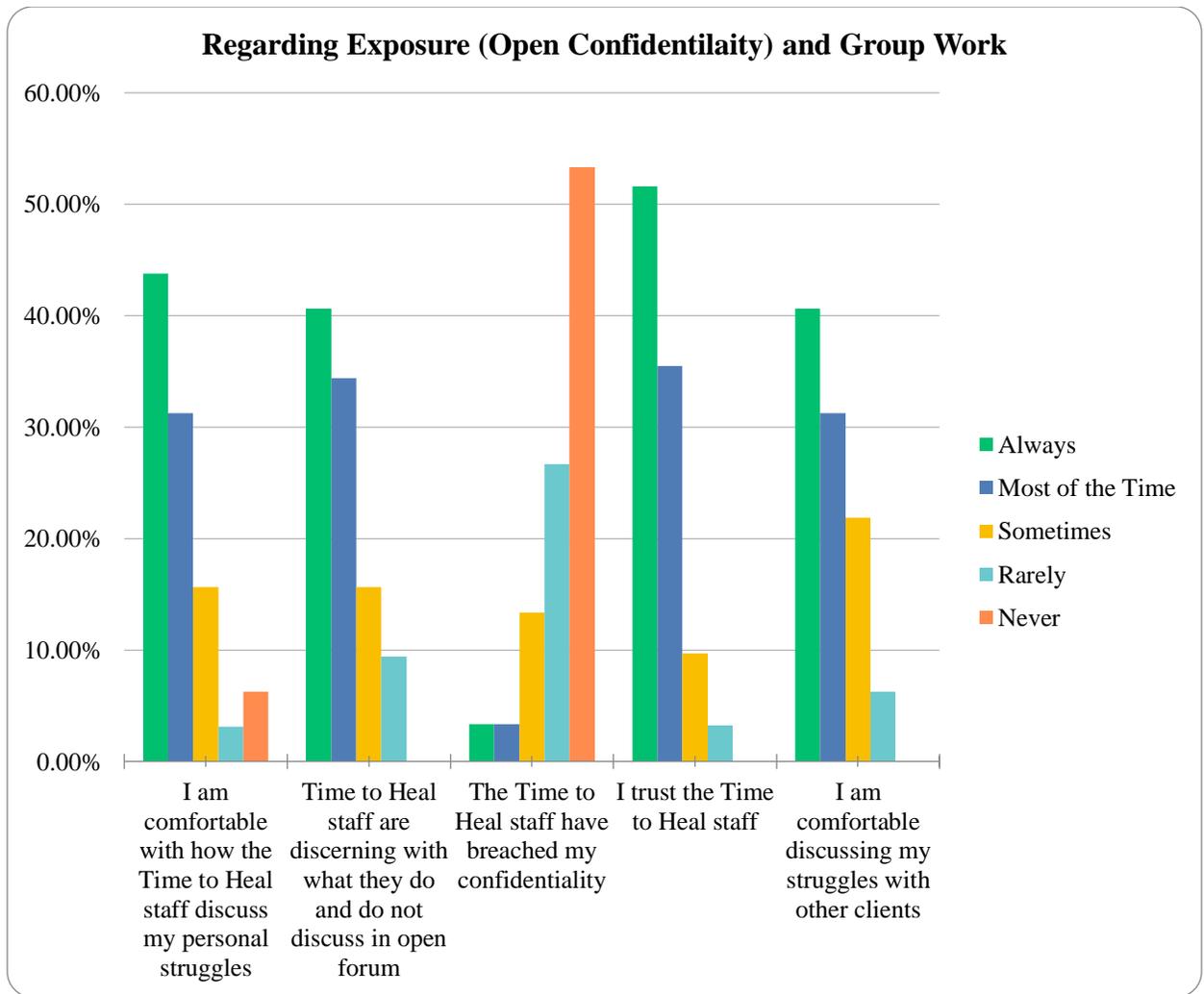
How does adapting the traditional professional boundaries of confidentiality influence the therapeutic outcome? The concept of exposure encourages community members, including staff, to be vulnerable and authentically transparent in how they represent themselves personally and professionally. The goal of exposure is to have individuals be stable in self-acceptance without shame or judgement. Over 80% of respondents claimed to have participated in exposure (open-confidentiality) in the form of public acknowledgment, self-exposure, or paired or group counselling at Time To Heal. 66.67% of respondents said they had had their growth and success publicly acknowledged by the Time To Heal community. The data showed that the level of exposure and authenticity commonly experienced was at times disconcerting, but overall 25/26 respondents said exposure was positive, beneficial, and affirming. 2/32 respondents listed the open confidentiality protocol as problematic and associated with breaches of trust or confidentiality, *“There is a specific emphasis on transparency in Time To Heal, and that has made it difficult for me to deal with all the issues I have. Because I am never sure what information is getting shared around I don’t feel I can get full healing because there are things within my relationship that I do not feel comfortable with a group of people knowing.”*

Respondents talked about how the atmosphere of exposure and openness created a non-judgmental environment in which personal struggles were openly known and discussed between community members. The lack of secrecy fostered acceptance, humility, and was an equalizer between community members and staff. *“It was a relief to be part of a community where everyone’s dark was exposed, including mine.”*

The data showed the benefits of exposure to include; self-acceptance (74.19%), not feeling alone (67.74%), building connection (64.52%), and releasing shame (58.06 %). The

exposure “helped me (to) have more compassion for my own and others’ struggles; able to laugh more about pitfalls and relapses, not to take things seriously enough to actually sabotage myself.”





Theme: Belonging

How does including clients in an ongoing community that practices solidarity and psychosocial integration influence the therapeutic outcome? The theme of belonging emerged as respondents talked about being seen and known, connecting authentically and vulnerably, and feeling loved and accepted. 81% of respondents said they have interacted with Time To Heal staff on a personal level. 78% claim to have developed friendships with Time To Heal staff and 66% said they had developed friendships with other Time To Heal clients. Life-long friendships between community members were mentioned as well as deep and meaningful connections. “I

have a whole community of people I can call almost any time, created the stability, connection, and hope necessary for recovery.” One former client said they still maintain friendships within the Time To Heal community. Respondents affirmed that the community support created an antidote to addiction and the structure of long-term psychosocial integration, stability, and a sense of security that the community would be there when needed or desired. Many respondents credited the community as an integral component of recovery from addiction.

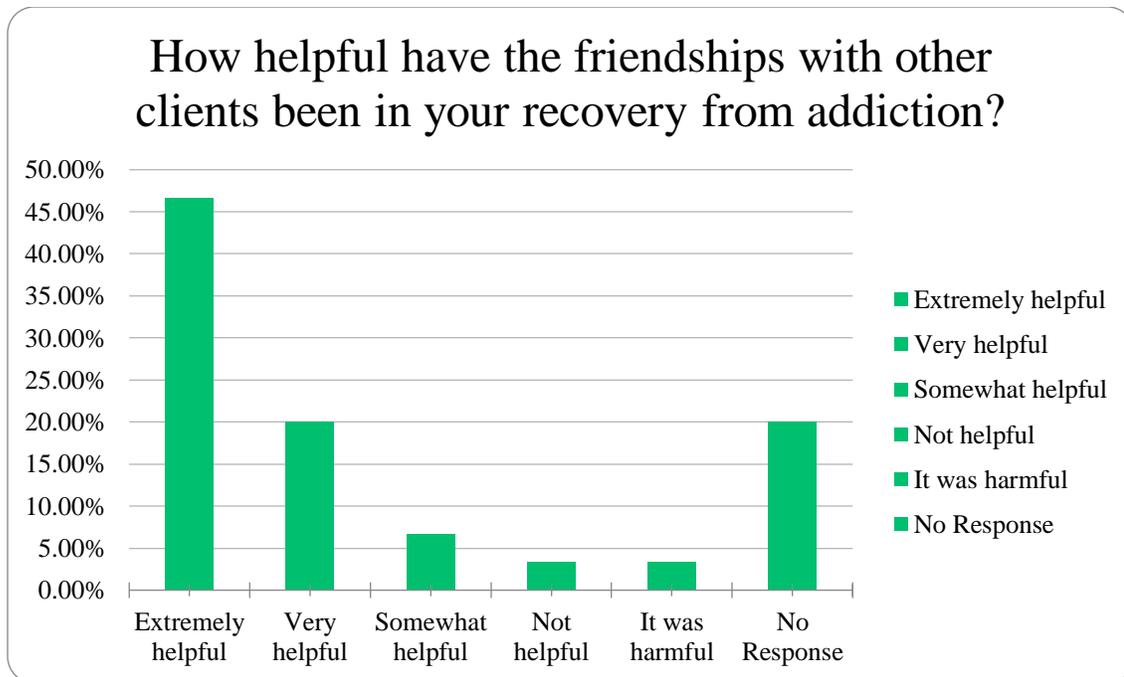
Addictions are created to numb pain; created from all of pain's myriad causes and forms, which twist us into grotesque parodies of human beings. This community provided a safe, irreverent, out-of-the-box, creative and supportive space to begin unpacking & exploring all of those causes and forms, and how they affected myself and others, with non-judgment and enough laughter and compassion to begin the process of learning what it is to be human; how to learn, grow and then thrive in healthier ways than that I was exposed to, or had modeled to me throughout my life. I am grateful.

One aspect of the sense of belonging that emerged was the investment and growth individuals made in the community to enhance their own healing. 20 respondents said they had spent personal time helping Time To Heal community members and 21 respondents said other community members had spent time helping them. Feeling accepted and authentically valued inspired community members to continue building friendships based on continual growth and striving to be better, thus reinforcing their own investment in the psychosocial community integration. The *“Time To Heal community has become the backbone of my stability. The*

community is a large part of where I invest my energy and love. If I become destabilized I will reach out to the Time To Heal community to restabilize. They are essential.” The benefits of friendships and community support supported by the data include; building connection (79.31%), self-acceptance (72.41%), not feeling alone (72.41%), and releasing shame (65.52 %).

Releasing shame was found to be a key benefit of the Time To Heal program. Releasing shame was most often claimed as a benefit of the friendships and community support (65.52%) and of exposure (58.06%). Respondents shared how learning that their struggles were not unique fed compassion for self and other and that the elimination of “*keeping secrets behind closed doors*” assisted in the sense of belonging, acceptance, and letting go of shame.

I built a new understanding of what self-acceptance meant by exposing my actions/behaviours/words to others who accepted me for who I am. Being able to share openly diffused any hold that shame or guilt held on my situation. I was locked in a cage of shame and guilt. I had been taught that shame and guilt meant I was a good girl and that both were required for me to get through a day feeling like I could belong. It was perverse. Having open confidentiality made me feel like we were all in this together. We are all one. I am not alone. If someone else who thought like me and acted like me could be loved and accepted, then maybe I could be too.



Theme: Solidarity

Solidarity: a professional walking alongside a client with close boundaries, a real relationship, and a willingness to be of service in such a way that will make the biggest difference in the client’s life, was considered to be trust-building, life-saving, affirming, and overall positive by 26/29 respondents, *“There is no other community that I know of that is there for me any time I really require them to be.”*

On the critical side, one respondent said, *“Solidarity is a strong word to be used for what I felt at Time To Heal. Sometimes I felt close other times I felt confused. It doesn’t feel like a real relationship.”* Another respondent said the transparency led to confusion between personal and professional boundaries when reaching out for connection and support. However, most respondents expressed gratitude for the staff’s willingness to go above and beyond the call of duty. *“The ability to call Andrew and/or Erin at any time has allowed me to get guidance during the exact moments of struggle. This has allowed me to change patterns in real time, creating*

real, lasting change in my life.” “Outside of conventional norms they made themselves available pretty much 24/7.”

Theme: Holarchy

Having a window into each other’s struggles, including those of staff and trainees, eliminated perceptions of hierarchy and put “*us all on a human level rather than a pedestal*” while empowering both client and counsellor to strive for growth. “*It helped me see everyone as human – no pedestals – which in turn helped me accept my own self.*”

One of the premises of a holarchy is that each person has both something unique to offer and something to learn in any given interaction (Spangler, A Vision Of Holarchy, 2008). This mentorship relationship was expressed in the data as, “*the client becomes the teacher, they speak from experience*”, and respondents talked about how they were able to learn from witnessing the personal struggles of staff and other community members. “*To see into the personal lives of the professionals at Time To Heal allows me as a client to see the example they set of how to navigate through struggle; to watch them walk the talk.*” The positive responses regarding exposure emphasized the value of positive role modelling when faced with challenges that felt daunting or making changes that were outside of the client’s previous experience and frame of reference,

I had NO IDEA how to act in society with healthy boundaries. I was completely clueless. I learn by mimicking others. Monkey see, monkey do. I watched other healthy people set and hold boundaries, then tried doing it myself. I needed to see the skills in action in order to imagine myself being able to do them as well.

Personal struggles were commonly known among community members and this open equalizing between clients, staff, and trainees empowered respondents to learn from each other. *“Sharing my struggles and growth helps others to rise and see that it is worth the effort to work through the pain and learn acceptance.”* New clients benefited from the experiences shared by long-term clients. However, one respondent said, *“Trainees are sometimes just trainees.”* The nature of community members growing as mentors or trainees, while still working through their own healing, was named as problematic by 3 respondents. On the one hand, the mentorship relationship allowed new clients to learn from their predecessors, on the other hand, the personal struggles and opinions of trainees or community members could overpower or hijack a client’s session and lead to confusion or hurt. *“It has its own weaknesses; especially from other clients and sometimes staff who are still working on their own issues.”*

According to Spangler (2008), a holarchy can feel inaccurately chaotic due to negotiation and openness being the guiding factors of organization and decision making instead of position or authority. *“In a holarchy, order and integration are co-created in the moment at the boundaries between people; rules are often made up in the moment based on the conditions and requirements of the unique relationships that are present at the time”* (Spangler, A Vision Of Holarchy, 2008). The in-the-flow reassessment and adjustment of boundaries based on the Time To Heal staff’s assessment of community member needs at the moment was named as challenging by one respondent who said it contributed to *“(mis)perceptions of inequalities, favouritism between clients”*. On the other hand, respondents also named the in-the-flow adjustment as indicative of Time To Heal staff’s willingness to *“go beyond standard work hours*

to support me, they were accessible whenever needed. At the same time, they modelled what it looked like to express open hearted, healthy boundaries.”

The group involvement and nature of having community members able to influence each other *“can require a lot of interpersonal awareness and impulse-control, which I still can lack at times. I consider these interactions essential, but they require great sensitivity to avoid inadvertent harm to another. Requires a delicate balancing”*. As a holarchy *“is the co-creation together of a relationship in which new perspectives and insights emerge for everyone concerned”* (Spangler, A Vision Of Holarchy, 2008), community members learned to see others as mirrors of self and in that interconnectedness the holarchy would enhance the stability and growth of the individual community members. The concept of mirroring showed up in the data as empowering respondents to develop humility, forgiveness, and self-acceptance. *“Hearing other clients struggle and being able to help in their recovery made it easier to see my personal truth and be humble”*.

The data showed that respondents were successfully able to transfer their learning into reconnection with their family. Family healing was commonly reported as community members grew as mentors in the community and in their own families. *“Each of us that has been healed has brought that into the lives of our siblings and parents, we have utilized the program to heal our own broken families. The effect on our children is remarkable.”* Some respondents reported that their family members noticed their changes and chose to attend Time To Heal as clients. The respondents stated that learning how to interact in a healthy way with healthy boundaries and forgiveness empowered them to model new ways of interacting with their families and transform their familial connections.

Theme: Accountability

How does adapting the traditional professional boundaries of dual relationships influence the therapeutic outcome? The theme of accountability showed up repetitively, especially regarding dual relationships. One respondent said that dual relationships created accountability “because I may be able to fake my life and choices to staff, but I cannot fake my life and choices to friends”. Respondents talked about how authenticity and exposure created an atmosphere of accountability and their involvement in the community meant that community members were witness to the choices they were making in their personal lives. In a traditional Western counselling setup, the therapist would primarily receive information from the client about their choices and behaviours. Whereas at Time To Heal, the community involvement meant that the staff would receive information about a client’s choices and behaviours by witnessing their personal lives and the interactions between community members.

*I go (to a Western therapist) when I need reassurance that my sh**ty patterns are serving me. I did this for 10-years and didn't see results that lasted. Time To Heal isn't like that. They won't let you feed the broken record to them. They will ask hard-hitting questions and get up in your business. This is the only way to make a change, in my opinion.*

Admittedly, it can take some getting used to but the outcome is worth it all.

The data showed the benefits of social and personal dual relationships to include; building connection (62.07%), self-acceptance (58.62%), not feeling alone (55.17%), and releasing shame (44.83 %).

Theme: Recreating Life Patterns

Of 60 respondents, 43 indicated that they had completed Workshop 1: Recreating Life Patterns, the foundational course of the Time To Heal program. 17 respondents said they had not taken Workshop 1. The remaining respondents declined to answer. Data was collected regarding attendance at drop-in support groups “Sunday Meetings” and Workshop 2 but was not found to be relevant to the research question and not reported.

The data showed that graduates of Workshop 1 were more involved and invested in aspects of the Time To Heal program that included dual relationships, community psychosocial integration, and exposure. These concepts are explained in detail in the Recreating Life Patterns course. All but 2 of the respondents who completed the qualitative survey questions were graduates of Recreating Life Patterns. Thus, the qualitative data collected was overwhelmingly representative of respondents who have completed Recreating Life Patterns.

Qualitative respondents commonly used the language taught in Recreating Life Patterns when they spoke about their life changes. The ability to see their dark patterns, utilize self-awareness tools, and make positive choices to change their lives was a common theme. Respondents talked about having an awareness of their light and dark and developing the ability to shift their behaviours to be in alignment with their highest self and their heart desires. They reported gaining insight into their intentions and motives, identifying the root causes of destructive patterns, and specifically letting go of sabotage behaviours. I learned “*clarity on my behaviours, choices, motives, and intentions. Clarity on how I why getting in my own way, therefore empowering me to stop it.*”

Theme: Critiques

Financial transactions were listed by four respondents as a critique of Time To Heal, specifically regarding accessibility due to private practice billing, staff disorganization and miscommunication, and a lack of transparency regarding sliding scale rates.

Four respondents said that Time To Heal felt cliquy and overly favours their specific program and language, *“I felt too great an emphasis at times on having to comply with TTH’s ‘language’ and ‘program’ to fit in and/or be accepted, and sometimes even being treated. However, a willingness to communicate usually resolved these dilemmas.”* Two respondents expressed a personal issue with Time To Heal co-owner, Andrew Louisy.

Disorganization in business operations, a lack of resources, and staff limitations was the most commonly reported critique. *“It is hard to watch the staff struggle with resources. While I know this is part of what works for me, as they spend a lot of time and energy on me, and I simply try to be honourable as possible in it, I wish I had a more clear picture to make decisions within.”* Some respondents expressed a wish that Time To Heal was more organized and operated more in alignment with Western health care facilities.

The urgent care protocol at Time To Heal often has appointments rescheduled to triage mental health emergencies and the *“In-the-Flow model of treatments can cause scheduling disruptions and can be quite challenging”*. The changing and rescheduling of appointments was named as a critique, and one respondent said that *“service providers (were) unable/unwilling to consistently meet committed service offerings.”*

Theme: New Life

There was a consistent theme of gratitude for a new life expressed that encompassed vast improvement in multiple aspects of respondents' overall wellbeing and daily lives. These improvements included; better mental health, positive self-acceptance, improved careers, better relationships, emotional stability, recovery from addictions, improved physical health, connection to faith and community, clarity in decision making, and living in alignment with their heart's desires. *"Honestly, I just have extreme gratitude for Time To Heal. I used to feel like I was falling down a pit with no bottom. Now I feel secure, brave, confident, empathetic, and grateful for and in the life I have created for myself (with a lot of help and support from those around me)".* Respondents listed finding self-worth and self-love and finding the courage to follow their dreams.

Living free from addictions was specifically named as a result of their work with Time To Heal by 14 respondents, *"They never judged or pressured me to quit my addictions, they empowered me to see who I was beyond them. As I grew to see who I truly was and feel safe to be vulnerable, my addictions began to no longer serve me and with Time To Heal's continuing support I was able to move past many of them."*

Respondents also said that while the results were remarkable, achieving them was hard. *"As a client you really have to have the desire to heal. Now that I have made it through it's difficult to say that any part did not work for me, the fact of the matter is that the program was a resounding success it was just very difficult."*

Chapter 5: Discussion

The National Institute of Drug Abuse (2016) claims that addiction treatment reduces drug use by 40 to 60 percent. In this study, recovery from was reported for 78% of the substance addictions and 62% of the process addictions. In this case study, including clients in an ongoing community that practices solidarity, exposure, and psychosocial integration was shown to be positively transformative, especially for community members who found themselves in a dislocation freefall. “The best way out of addiction is overcoming dislocation by finding a secure place in a real community” (Alexander, 2008, p. 340) and Time To Heal provides an opportunity for individuals to integrate into a real community. Over 65% of the respondents in this study found their relationships, exposure, and investments of time and care in each other to be very or extremely helpful in their recovery. This casts doubt on the assumed necessity and efficacy of maintaining confidentiality and avoiding dual relationships in the treatment of addictions.

Exposure

Time To Heal uses the community as a therapeutic method. I believe that the exposure, mirroring, and dual relationships at Time To Heal create a therapeutic environment that is similar to Therapeutic Communities (TC) in a way that does not require residential care and does not have an official end date of treatment. As Time To Heal is a private outpatient facility with a focus on long-term psychosocial integration, the personal connections between community members can and do continue indefinitely.

“It is the desire to obtain security from belonging to a group that encourages individuals to change their behaviour” (Veale, Gilbert, Wheatley, & Naismith, 2014, p. 288). However, holding the space of inclusive belonging while simultaneously challenging individuals to make

significant changes without inadvertently demanding conformity is challenging (Veale, Gilbert, Wheatley, & Naismith, 2014) and did show up in the critiques of the Time To Heal program.

While the majority of the respondents in this study named the community interactions and support as beneficial, the data showed there is room for improvement in communications with clients about the structure, design, and flow of the Time To Heal addiction program.

Learning to self-regulate, tolerate, and communicate intense emotions is a necessity of healing and can be learned through exposure, however, “the way in which exposure is conducted and in particular the audience on whom it impacts need careful thought. Experienced therapists know this of course, but it is poorly researched and articulated in the literature” (Veale, Gilbert, Wheatley, & Naismith, 2014, p. 289). 25/26 respondents said that exposure was positive, beneficial and affirming. This indicates that Time To Heal has developed a method for guiding exposure with discernment and safety.

In a community setting, there is no way to ensure that community members do not talk about each other. However, Time To Heal staff make the time to mediate, support, and intervene in interactions between community members outside of office hours in order to maintain the group integrity and values of non-judgment, communication, acceptance, and unconditional positive regard (Rogers, 2007). This is often done through conference calls and was confirmed by the data.

Exposure requires vulnerably being seen as imperfect and struggling, and the willingness to be publicly humble and guided to make a change. In my experience, it can be scary and trigger shame, emotional responses, and the fear of being judged. I think the fact that 75% of the respondents reported that they are always or mostly comfortable exposing and trust the discernment of the staff in what is publicly exposed shows extraordinary courage. Respondents

talked about finding self-acceptance and being freed from shame and guilt as a result of the non-judgmental acceptance mirrored to them by the community, thus creating a safe foundation for psychosocial integration and authentic relationships.

Vulnerability

If one's caregivers do not provide unconditional love, a child may develop behaviours such as people-pleasing, codependence, and perfectionism in order to secure connection, earn love, and prove worthiness (Adler, 2008; Brown, 2010). In this study, the recovery rates of those specific behaviours were; people pleasing 64%, codependence 76%, perfectionism 58%.

The fear of not being good enough, of not being worthy of love and belonging, is excruciating (Alexander, 2008). The other most significant recoveries reported were self-sabotage 58%, and risky behaviour 80%. I think that these behaviours represent a pendulum swing of the same longing for connection. Once an individual gives up or accepts the belief that there is nothing they can do to be 'good enough' or worthy, sabotage and risky behaviour show up along with the attitude of, 'what does it matter anyhow?' Unfortunately, in my experience, the choices made from the belief that one's life is irrelevant often carry shame. Shame is inexplicably attached to the fear of disconnection and comes with the question, "Is there something about me that, if other people know it or see it, that I won't be worthy of connection?" (Brown B. , The power of vulnerability, 2010).

The nature of exposure directly challenges shame tapes as clients discover that their darkest most shameful secrets, experiences, and flaws are unrelated to their worthiness of connection and belonging. According to shame-resilience theory, the antidote to shame is empathy, courage, compassion, and connection (Brown B. , 2009, p. 5), all of which showed up

in the data as integral benefits of the Time To Heal addiction program. I agree that our job is to say, “you're imperfect, and you're wired for struggle, but you are worthy of love and belonging” (Brown B. , 2010).

In my view, the belief that one is not worthy of love and belonging is a symptom of dislocation and an extremely common pattern of thinking attached to addictions. Young (1999) describes filters as enduring patterns of thinking that develop in childhood, reinforce themselves throughout an individual’s life and experiences, and create the filter through which one views the world. One of the accountability concepts taught in the Time To Heal program, as outlined by Louisy & Kapela (2011), involves the awareness that when one is filtering information and experiences through past hurts, numbing, and avoidance of vulnerability, it is nearly impossible to assess a situation accurately. A filter can be like wearing incorrect prescription glasses. Even when something is happening right in front of you, it is blurry.

Unfortunately, it is impossible to selectively numb emotion. When one says,

Here's the bad stuff. Here's vulnerability, here's grief, here's shame, here's fear, here's disappointment. I don't want to feel these. I'm going to have a couple of beers and a banana nut muffin. You can't numb those hard feelings without numbing the other affects, our emotions. You cannot selectively numb... when we numb those, we numb joy, we numb gratitude, we numb happiness (Brown B. , 2010).

The numbing that Brown (2010) refers to of “I don’t want to feel that” is a common filter and showed up in the data as depression, feeling lost, a lack of hope, suicidal ideation, and could

be summed up as, *“addiction for me has always been about a lack of seeing myself clearly in acceptance with gratitude”*.

Time To Heal teaches tools for clients to examine and rework their own filters by seeing how the information they receive can be skewed, how their processing of information may be based on past experiences, and how the actions they choose may be patterned responses designed to avoid vulnerability and pain (Louisy & Kapela, 2011). *“I broke down past destructive behaviours by finding the root causes of those behaviours and learning to shift them into more healthy behavioural patterns.”*

Respondents expressed an acceptance of vulnerability and openness to a connection as part of the benefits of the Time To Heal program, *“that level of authenticity and realness meant I was genuinely safe to access the vulnerability that is essential to healing.”* Brown (2010) found that whole-hearted people embrace vulnerability and have the courage to tell their story, the good, the bad, and the ugly with their whole heart and without shame or fear. This was expressed in the data as,

When you expose your “dark” it holds no power over you. What is left is raw vulnerability which is the best place to find yourself, the best place to begin to heal. All the trappings of our ego are removed. It is the place of acceptance. It is important to note that group sessions are nonjudgmental, it is a safe place to expose.

Brown noted that the whole-hearted had connection, psychosocial integration, and practiced compassion for the imperfect nature of themselves and others as a result of

authenticity. “They were willing to let go of who they thought they should be in order to be who they were” (Brown B. , 2010).

Brown (2010) discovered that people who have a strong sense of worthiness, love and belonging believe that they are worthy of love and belonging while being imperfect. I believe that the community integration respondents found through the Time To Heal addiction program guided and supported them to make a fundamental shift in their core sense of worthiness and was expressed in responses such as, “*I learned to love and value who I am*”, “*I really like myself*”, and “*I feel secure, brave, confident, empathetic, and grateful*”.

Holarchy

Community members regularly witness to the personal struggles of staff, and the data indicated that the staff exposure helped to eliminate hierarchy, judgment, and the idea that anyone was better than anyone else. Witnessing how staff or community mentors navigated their own struggles provided role modelling and shone a light on ideas for solutions or ways of interacting that were totally foreign to newer clients. I find that when one is locked into repetitive patterns of interaction, it can be hard to imagine something different. Having a window into someone else’s process can be transformative and generative in bringing in new information and ideas.

The idea that “*the client becomes the teacher*” emphasizes a structure of growth and continual advancement and learning. What individuals are able to offer each other is encouraged and acknowledged. However, it can be complex and requires careful supervision of community members to ensure that the modelling and information offered is consistent with the individual’s context, values, and goals. Community members may not have all of the information about a

situation or an individual, especially when it has been discerned by the staff and individual to keep specific information confidential.

It requires the staff maintain extraordinary discernment and communication in order to guide a community mentor to offer support to a client, while keeping the mentor accountable to their own struggles and blind spots, ensuring the safety and growth of the client, and allowing for the natural flow of interactions, mirroring, and relationships without attempting to control anyone involved in the situation.

In my experience, standard therapeutic boundaries allow for clarity of roles, responsibilities, and consistency of expectations. The nature of a holarchy can feel chaotic as boundaries, parameters, and guidelines are organized and reorganized in the moment to meet the specific needs of specific community members (Spangler, A Vision Of Holarchy, 2008).

The lines are terribly blurred between a personal relationship and being a client. I often felt frustrated that it felt like I had friends in the people that I associated with at Time To Heal but if I had a personal issue I could not call and talk to anyone unless if I booked a professional appointment. Though I understand this is a business I don't feel that it should be advertised as being so open and loving when there's a price tag put on everything.

This quote highlights a significant challenge of the holarchic structure of Time To Heal. There have been clients who, through much hard work and dedication, have progressed from clients to community mentors then apprentices, and finally into the staff. Confusion has arisen during those transitions as community members struggle to adjust to each other's changing roles

and responsibilities. As friends, a community member may call another community member for support. However, when one of them transitions into training and working at Time To Heal there comes the point when calling the staff member at home for advice and support becomes seeking free counselling instead of a friendship connection. Community members at times avoid reaching out to staff or community mentors who will hold them accountable and may instead reach out to community members who will support their struggle.

The protocol for staff members is to assess in the moment when the shift happens from a friendly connection into counselling and to verbalize it and ask the client if they want a phone counselling session in the moment, and to discuss the billing for it, or to recommend booking an appointment during office hours. As evidenced by the above quote, there have been struggles and ruptures to the therapeutic relationship during these interactions as both clients and staff learn to navigate the changing relationships.

The financial aspect of Time To Heal being a private business is relevant. Currently, Time To Heal receives zero external funding, and all revenue comes through direct client billing. If Time To Heal were funded through mental health resources, the costs of services would be separated from its relationship to therapeutic care. The necessity of having direct conversations about billing, especially in moments of personal challenge, can become a barrier, trigger an emotional response, and may skew the results of this study and of therapeutic care. On the other hand, Time To Heal's ability to create its own protocols of care may be compromised if it were limited by funder requirements.

The opportunity for community members to seek support outside of office hours is one of the ways in which Time To Heal staff go above and beyond the call of standard practice and requires a high level of discernment, communication, boundaries, and flexibility. Gratitude for

this service was named in the data as respondents talked about how valuable it was to be able to seek support in the moment of struggle rather than having to wait for their next appointment.

There are also Workshop Study Groups and Sunday Meetings offered as avenues of support for minimal fees. There is also a community Facebook group and community chats that connect community members to support each other. All of these resources are monitored by Time To Heal staff to ensure a focus on growth and healthy interaction.

Time To Heal staff are willing to offer some support without billing on a regular basis as a way of extending grace and commitment to community health. This does decrease the overall revenue of the business and care must be taken to balance the needs of the clients with the needs of the staff and maintain the integrity Time To Heal as a business with staff to support and bills to pay. One way Time To Heal attempts to remedy the financial challenge is by offering monthly membership programs that include out of office phone counselling and support as part of the monthly fee.

Therapeutic Community

Therapeutic Communities (TC) represent one practice where community connection and exposure are used as a therapeutic method. 70.1% of Life in Recovery (LIR) respondents described therapeutic communities as “very important” to their recovery (McQuaid, et al., 2017, p. 21). Veale, Gilbert, Wheatley, & Naismith (2014) suggest that traditional therapeutic communities (including those used in criminal justice) could be improved by fostering safety through an attachment lens that cultivates compassion, avoids shaming, and encourages positive reinforcement of acts of courage. Borrowing ideas from restorative justice, they suggest discernment whereby conflict is resolved through “very small groups with only members

involved in a conflict to discuss the issues compassionately and reduce the risk of shame... rather than involving the whole community” (Veale, Gilbert, Wheatley, & Naismith, 2014, p. 291). This recommendation is in alignment with Time To Heal’s practice and is supported by the data.

Mutual helping is an important way to change patterns of interaction and regulate emotions, and one of the therapeutic benefits of a group is the “opportunities to be validated and supported by others and also opportunities to be valuing and supporting of others... This process of reciprocity can be central to a sense of belonging, affiliation and change” (Veale, Gilbert, Wheatley, & Naismith, 2014, p. 295). 20 respondents said they had spent personal time helping Time To Heal community members and 21 respondents said other community members had spent time helping them. The reciprocity of mutual helping and support was found to be a key factor for community members developing a sense of belonging, security, and provided the structure, opportunity, and guidelines for long-term psychosocial integration.

In this study, viewing the opposite of addiction as connection (Hari, 2015) and framing connection as the treatment priority contributed to the creation of enduring friendships, hope, community integration, and gratitude for a life free from addiction.

Veale, Gilbert, Wheatley, & Naismith (2014) hypothesize that when compassionate values and goals are carefully explained, including an evolutionary understanding of physiological threat responses, a context for change can be placed at the heart of a community in a way that is different from standard TC approaches (p.298). These six recommendations put forth by Veale, Gilbert, Wheatley, & Naismith (2014) for the 3rd generation of therapeutic communities are present in the Time To Heal addiction program as shown in the data. Further research is required to test the application of these protocols in other facilities and populations.

Veale, Gilbert, Wheatley, & Naismith (2014) suggest that TCs should;

1. Create and provide a secure attachment base and safe haven, so that community members are empowered to enhance their ability to manage distress and discomfort. The TC culture should model being attentive to each other's needs in a non-judgmental, respectful, compassionate, empathetic and kind way.
2. From this established place of safety, community members would be encouraged to be courageous in their personal growth and lean into painful or challenging moments in ways that are consistent with their personal values and therapeutic goals.
3. Encourage community members to support each other in achieving their therapeutic goals and be sensitive and attentive to the challenges individuals face, empowering community members to strengthen community by supporting each other and "respond to acts of courage in others and provide compassionate ways of understanding the source, nature and ways of resolving and being honest about conflicts" (Veale, Gilbert, Wheatley, & Naismith, 2014, p. 298). Acts of courage may include "being honest, doing vulnerable disclosures, being authentic, discussing losses, discussing values and what the person stands for, taking risks, confronting difficult situations or doing exposure" (Veale, Gilbert, Wheatley, & Naismith, 2014, p. 298).
4. Community members should have self-awareness of their personal patterns and challenges and openly share with the community how their interpersonal behavioural patterns show up, thus arming community members with the awareness and tools to help the individual change the pattern.

5. In encouraging authentic caring and connection, community members can reach out and support each other within and outside of the bounds of formal structures, meetings, and facilities. “There would be an option for calling ‘crisis meetings’ when a member can obtain support from others. Members of nonresidential TCs can phone or visit another member of the community so long as this can be carried out safely and with mutual benefit and awareness by the staff” (Veale, Gilbert, Wheatley, & Naismith, 2014, p. 299).
6. Of importance is the requirement that “staff need to feel supported and safe with themselves and preferably are affiliative with each other. Staff who have not resolved conflicts among themselves are not in a position to provide safe and affiliative environments. Furthermore, staff need to model being authentic, fully present, compassionate and caring with colleagues and members” (Veale, Gilbert, Wheatley, & Naismith, 2014, p. 299).

The development of personal accountability showed up in the data. I propose that the structure of the Time To Heal program made it difficult to hide or lie while the unconditional positive regard, acceptance, and non-judgment made it safe to be accountable. I think openly acknowledging one’s mistakes and imperfections and learning that it does not make one unlovable or unacceptable is healing. At the same time, the level of accountability, exposure, attention to relationship, and willingness to communicate that was recommended by Veale, Gilbert, Wheatley, & Naismith (2014) can be challenging. “*The fact of the matter is that the program was a resounding success it was just very difficult.*” ‘It was hard’ showed up numerous times in the data and I believe this reflects the complexity and holistic nature of the Time To

Heal program. It is hard to be accountable in all aspects of life. It is hard to be challenged on your struggles and unhealthy behaviours, especially in front of people. It is hard to be publicly exposed. The Time To Heal addiction program is challenging for both clients and staff.

The complexity of interactions at Time To Heal can be challenging. There is multi-dimensional accountability required at all times. Staff must simultaneously address individual struggles, interpersonal dynamics between community members, and urgent mental health issues while being mindful of the short-term and long-term consequences of action and inaction for both individual community members and the integrity of the larger community. At the same time, both staff and community members have responsibilities in their own families and relationships outside of Time To Heal. It is hard.

Alexander (2008) suggested that the best way to recover from addiction was to find a secure place in an authentic and enduring community. He noted that while some people are able to reintegrate into their previous connections with family and friends, others must create a new community to escape dislocation and dysfunction (p. 340). The results from this study showed that Time To Heal community members were successfully able to transfer what they learned at Time To Heal into their familial relationships with the result of ripples of healing through their families and their lives. I posit that community members learn accountability and leadership at Time To Heal and with the skills learned, they develop the confidence to lean into vulnerability and discomfort in their families in order to create systemic change.

It is possible that the complexity of the relationships between community members and the difficulty of the program prepares clients to take on the challenge of healing their own family relationships with acceptance, non-judgment, and the secure knowledge that they have enduring support and connection. They know that Time To Heal ‘has their back’.

Recommendations

Overall, the critiques that arose from the data indicate gaps in communication. Moving forward, I would recommend Time To Heal develop clear written guidelines that are discussed with all new clients and periodically revisited with existing clients regarding the following;

1. The use of community as a method and the nature and structure of the community, including written consent forms that outline the purpose of exposure and dual relationships. Consent forms and confidentiality agreements should accurately reflect what can be anticipated as a participant in a holarchic therapeutic community.
2. The general structure and progression of community responsibility that is available, including what the roles, requirements, and limitations are for community members, mentors, apprentices, and staff. The written material should also outline what qualifications or behaviours are necessary in order for a community member to be given more responsibility in the community as well as what the apprenticeship training program entails.
3. Payment and fee structures, sliding scales, and monthly programs should be transparent and consistent. This material should explicitly outline what services are available as a courtesy for clients, what services require billing, and what services are available as community support. This material should explain the nature and purpose of communications and boundaries regarding financial transactions and what a client can anticipate.

Staff willingness to go above and beyond, even when not receiving payment, stretches staff resources and capacity. Time To Heal does not currently receive external funding, and staff

members often sacrifice time and money to ensure the health and stability of a client. As a private facility, Time To Heal has been limited in its ability to grow due to staff and financial barriers. At the same time, Time To Heal has been free to operate without answering to external funders. Moving forward, some of the critiques and concerns expressed in the data could be remedied by increasing staff resources and supports, including seeking external funding sources so long as they do not detract from the integrity of the Time To Heal program.

Limitations

As Time To Heal is a private clinic, clients generally must have the financial means to pay for treatments. There is a community service aspect to Time To Heal, and there are numerous clients who have received treatment for nominal or no fees. However, as Time To Heal receives no funding or third-party billing, it does limit the demographic of clients who access services. There are no mandated clients.

Time To Heal is located in Duncan, BC, Canada on Vancouver Island and its clients are a general representation of the population demographics. Approximately 80% of Time To Heal clients identify as White. 10% identify as First Nations, Metis, or Indigenous. The remainder identifies as Black, Caribbean, Chinese-Canadian, South Asian, Indo-Canadian, or other. Approximately 70% of the clients at Time To Heal identify as female.

It is plausible that former clients who did not experience benefits from their sessions at Time To Heal would not feel inclined to participate in the survey. This has the potential to skew the data towards favourable respondents. Recruitment for the survey was limited to current and former clients who are engaged in online communication with Time To Heal in the form of reading emails or social media posts. Clients who do not use a computer were not recruited.

The vast majority of the respondents have completed the Recreating Life Patterns workshop which includes significant written exercises. There is a literacy requirement of the program that could be a barrier for some people. Adaptations to the Recreating Life Patterns program that address literacy and culture could make the Time To Heal program more accessible.

As a co-owner and clinician at Time To Heal I am privy to the inner workings of the facility, and I carry with me my personal and professional experiences, thoughts, and biases. External research conducted on the Time To Heal program may reveal different data.

As a specific case example of a specific program accessed by a narrow demographic of clients, the findings of this study are limited in their ability to be generalized to the greater public. Further research would be required to look at the possible benefits of adapting confidentiality and dual relationships in the treatment of addiction in other situations.

Concluding Thoughts

Speight's (2007) work on solidarity emphasizes the importance of assessing and honouring the differences between deviations from standard practice that enhance healing and connection versus boundary violations that are harmful or exploitive. "Solidarity calls for close boundaries and a real relationship" (Speight, 2007) and is consistent with the practice and protocol at Time To Heal. There is a narrative in the mental health field that says dual relationships are impossible to conduct in a healthy way. However, the results from this study indicate that dual relationships can be integral to developing enduring psychosocial integration.

Multiple relationships, mixing of roles, therapist self-disclosure, and "socializing at important events together are all seen as normal and expected" (Speight, 2007) in a community

that is founded on the values of authenticity and long-term connection. When a real friendship is developed naturally within a community of people who have walked alongside each other while striving to heal and recreate their lives, it makes sense to join in celebrations of success such as weddings and parties. In this context, a wedding is not only a celebration of two people coming together it is also a celebration of healing, changing family patterns, years of hard work, and the result of facing oneself in the mirror with courage, humility, determination, and accountability. Of course, the community members are overjoyed to witness, affirm, and share in the celebration!

I think that replicating the Time To Heal program would be challenging and rewarding. The level of exposure and role modelling that the staff are required to maintain is a tall order. The staff have all healed from significant familial, addictive, and societal struggles and carry with them the experiences of existing in marginalized communities. It takes courage to vulnerably share one's journeys of trauma, pain, addictions, and stigmatization. The ability to navigate the intersectional challenges and hold a big picture awareness of both individual and community needs, with a focus on long-term psychosocial integration, while being personally exposed, requires extraordinary long-term training.

The Time To Heal addiction program would not be appropriate for individuals who have a binding confidentiality contract that is relevant to their personal struggles or who have personal or professional expectations of confidentiality as the only way to be professional. Individuals who are not ready to look at themselves or embark on a holistic life change are unlikely to tolerate the discomfort inherent in the Time To Heal program.

The Time To Heal addiction programs seems most suited for individuals who find themselves in a dislocation freefall, have a history of dysfunctional, broken, or abusive families

of origin, who desperately want a new life and freedom from their addictions, and have a bone-deep knowing that change is the only option. Aside from freedom from addictions, a long-term benefit of the Time To Heal program is community psychosocial integration. Thus, the program is most suited for individuals who are seeking psychosocial integration through community connection and family healing.

The Time To Heal approach was not designed as a brief short-term therapy, but rather focuses on recreating foundational life patterns through long-term psychosocial integration and community support. In this sense, the Time To Heal addiction program is significantly different from standard mental health approaches and occupies a space in between Western therapy, spiritual communities, 12-step groups, and residential treatment programs.

Alexander (2008) noted that while a therapist provides unconditional positive regard and acceptance during session, the therapeutic relationship is isolated and disconnected from the rest of the client's life and that "achieving psychosocial integration is the project of a lifetime and the product of an enduring community in attunement with an individual" (Alexander, 2008, p. 306). At Time To Heal, the therapeutic relationship is one component of an enduring community. I think the combination of professional therapeutic support and community integration offered at Time To Heal creates long-term wraparound care with authenticity and guides the development of genuine healthy connection. "You're not alone, we love you -- has to be at every level of how we respond to addicts, socially, politically and individually" (Hari, 2015). At Time To Heal, it is.

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Appendix A: Survey Questions

Writer's note: In ensure ongoing consent and voluntary participation each question had a "no response" option. Qualitative questions are highlighted in **RED**.

To maintain anonymity and confidentiality please do NOT include information or descriptions that could potentially identify yourself or other clients.

For the purpose of this survey, addiction is defined by Alexander (2008) as an **"overwhelming involvement with any pursuit whatsoever (including but not limited to drugs or alcohol) that is harmful to the addicted person, to society, or to both"** Please use this definition when considering the survey questions.

Demographic Info:

- Gender: Male, Female, Other _____
- Age: 18-27, 28-40, 41-65, 65+

Qualifying and locating questions

- Did you struggle with a substance addiction to alcohol, prescription medications, illegal drugs, cannabis, nicotine, other psychoactive substances (explain)? Check ALL that apply.
- Did you struggle with any behavioural or process addictions? shopping, self-harm, codependence, sex, hoarding, isolation, video games, people-pleasing, perfectionism, attention, pornography, eating disorders, body obsession, drama, television, relationships, workaholism, wealth, success, technology, food, sugar, gambling, love addictions, obsessive-compulsive, impulse-control, self-sabotage, risky behaviour, or other (explain). Check ALL that apply:

- What addiction(s) are you CURRENTLY struggling with? Check ALL that apply: alcohol, prescription medications, illegal drugs, cannabis, nicotine, other psychoactive substances (explain), shopping, self-harm, codependence, sex, hoarding, isolation, video games, people-pleasing, perfectionism, attention, pornography, eating disorders, body obsession, drama, television, relationships, workaholism, wealth, success, technology, food, sugar, gambling, love addictions, obsessive-compulsive, impulse-control, self-sabotage, risky behaviour, or other (explain)
- Have you had 3 or more healing or counselling sessions at Time To Heal?
- Are you a current or former client?
- Current: How long have you been working with Time To Heal?
- Former: How long did you work with Time To Heal?
- Have you completed the Recreating Life Patterns course? (workshop 1) (Y/N)
- Have you completed the Developing Willpower in Transition course? (workshop 2) (Y/N)
- Have you attended Sunday Meetings? If YES, how often? (1-4 per month, 6-10 per year, 1-5 per year, less than 1 per year)
- What other resources or services have you accessed in addiction treatment? (12-step, therapy, detox, self-help programs, religious or spiritual, Other)

Overall Experience

- Describe the problem or challenge you had. Talk about specifically what you were struggling with, what it looked like and felt like, and what led to the decision to start working with Time To Heal
- Outline the specific results and benefits you achieved through your work with Time To Heal
- Outline specific challenges, difficulties, or aspects of the Time To Heal program that did NOT work for you.

Solidarity refers to a professional walking alongside a client with close boundaries, a real relationship, and a willingness to be of service in such a way that will make the biggest difference in the client's life.

- Describe your experience of solidarity at Time To Heal.

A counselling "session" at Time To Heal refers to any conversation or treatment longer than 10 minutes that addressed personal challenges or situations.

Confidentiality:

- Have you participated in counselling where your session was combined with another client's, or where another client was brought into your session? (Other than immediate family members) (Y/N)
- Have you participated in group counselling sessions? (multiple clients having a session together) (Y/N)

- Have you participated in conference phone counselling that included multiple Time To Heal staff members? (Y/N)
- Have you participated in conference phone counselling that included other clients as well as Time To Heal staff? (Y/N)
- Have you had Time To Heal staff publicly acknowledge your specific struggles and growth in front of other clients? (sharing some personal information) (Y/N)
- Have you publicly exposed your specific struggles with other clients? (Y/N)

If YES to any of the above...

- How helpful was the exposure in your recovery process (Very helpful, somewhat helpful, neutral, Not helpful, harmful)?
- What do you feel the sharing/exposure helped with? (Nothing, releasing shame, building connection, feeling not alone, self-acceptance, other).
- I am comfortable with how the TTH staff discuss my personal struggles (Always, most of the time, sometimes, rarely, never)
- TTH staff are discerning with what they do and do not discuss in open forum (Always, most of the time, sometimes, rarely, never)
- The TTH staff have breached my confidentiality (Always, most of the time, sometimes, rarely, never)
- I trust the TTH staff (Always, most of the time, sometimes, rarely, never)
- I am comfortable discussing my struggles with other clients (Always, most of the time, sometimes, rarely, never)

Confidentiality Protocol

Time To Heal staff create the space for clients to share their lived experience in a non-judgmental environment based in exposure and authenticity. Time To Heal staff conduct an ongoing assessment of what is best for all clients present or involved, their families, and the community as a whole. Staff members collaborate and communicate with each other to discern what exposures and shared experiences are appropriate and necessary to enhance the long-term healing path of the client, while being cognizant of what is necessary to not inadvertently co-sign on denials or duality. Time To Heal staff prioritize respecting the integrity and privacy of the client while exposing and mirroring to guide the release of shame, denials, and duality. Mirroring is a tool and awareness that empowers an individual to gain perspective on their own behaviours or challenges by witnessing those behaviours or challenges in other people. Self-disclosure is encouraged in community as a method of mirroring and building connection. Once a client has released shame and healed from a specific exposure the example may be used (with permission) as a teaching tool in community with other clients.

- Describe how Time To Heal's protocol around confidentiality and exposure has influenced your recovery from addiction?

Dual Relationships

- Have you interacted with Time To Heal staff members in social, personal or casual settings outside of Time To Heal functions? (Y/N)
- Would you consider any Time To Heal staff members to be your friends? (Y/N)

- Have you invited Time To Heal staff members to personal functions (weddings, parties, dinners, etc.) (Y/N)
- Have you attended personal functions of Time To Heal staff members (weddings, baby showers, parties, dinners) other than Time To Heal functions? (Y/N)

If YES to any of the above...

- How helpful has the social and personal interactions with TTH staff been in your recovery from addiction (Very helpful, somewhat helpful, neutral, Not helpful, harmful)?
- What do you feel the consequences are of the social and personal interactions (Nothing, releasing shame, building connection, feeling not alone, self-acceptance, other).

Dual Relationship Protocol:

Personal and social relationships are a natural component of co-creating a long-term integrated community. Time To Heal staff do an ongoing assessment of what is best for the client, the client's family, the staff member, and the community as a whole. Staff members collaborate and communicate with each other to discern what boundaries and interactions are appropriate and necessary to enhance the long-term healing path of the client while simultaneously maintaining the staff member's stability, safety, and comfort. All staff are required to model a high standard of authenticity, exposure, and willingness to grow in all of their interactions, personal and professional. Staff, trainees, and long-term clients are held accountable for the ripple of consequence due to their actions, inactions, intentions, and words.

- Describe how Time To Heal's protocol regarding dual relations has influenced your recovery from addiction?

Community (psychosocial integration)

- Have you developed friendships outside of Time To Heal with other Time To Heal clients? (Y/N)
- Have you participated in or volunteered for the Time To Heal community? (Y/N)
- Have you spent personal time helping another Time To Heal client? (Y/N)
- Have other Time To Heal clients spent personal time helping you? (Y/N)
- Have you been publicly acknowledged by Time To Heal community in your growth and success? (Y/N)

If YES to any of the above...

- How helpful have the friendships with other clients been in your recovery from addiction (Very helpful, somewhat helpful, neutral, Not helpful, harmful)?
- What do you feel the impact has been on your life from the Time To Heal friendships and community support? (Nothing, releasing shame, building connection, feeling not alone, self-acceptance, other).
- Describe how the Time To Heal community has influenced your recovery from addiction?
- Optional: Is there any other information or feedback you would like to include?