

**Substance Abuse Treatment
and Family Therapy
(Revised)
Part 1**

Contents

Chapter 1—Substance Abuse Treatment and Family Therapy	1
Overview.....	1
Introduction.....	1
What Is a Family?.....	2
What Is Family Therapy?.....	4
Family Therapy in Substance Abuse Treatment.....	8
Goals of This TIP.....	18
Chapter 2—Impact of Substance Abuse on Families	21
Overview.....	21
Introduction.....	21
Families With a Member Who Abuses Substances.....	23
Other Treatment Issues.....	28
Chapter 3—Approaches to Therapy	31
Overview.....	31
Differences in Theory and Practice.....	31
Family Therapy for Substance Abuse Counselors.....	49
Substance Abuse Treatment for Family Therapists.....	64

1 Substance Abuse Treatment and Family Therapy

In This Chapter...

- Introduction
- What Is a Family?
- What Is Family Therapy?
- Family Therapy in Substance Abuse Treatment
- Goals of This TIP

Overview

This chapter introduces the changing definition of “family,” the concept of family in the United States, and the family as an ecosystem within the larger context of society. The chapter discusses the evolution of family therapy as a component of substance abuse treatment, outlines primary models of family therapy, and explores this approach from a systems perspective. The chapter also presents the stages of change and levels of recovery from substance abuse. Effectiveness and cost benefits of family therapy are briefly discussed.

Introduction

The family has a central role to play in the treatment of any health problem, including substance abuse. Family work has become a strong and continuing theme of many treatment approaches (Kaufmann and Kaufman 1992*a*; McCrady and Epstein 1996), but family therapy is not used to its greatest capacity in substance abuse treatment. A primary challenge remains the broadening of the substance abuse treatment focus from the individual to the family.

The two disciplines, family therapy and substance abuse treatment, bring different perspectives to treatment implementation. In substance abuse treatment, for instance, the client is the identified patient (IP)—the person in the family with the presenting substance abuse problem. In family therapy, the goal of treatment is to meet the needs of all family members. Family therapy addresses the interdependent nature of family relationships and how these relationships serve the IP and other family members for good or ill. The focus of family therapy treatment is to intervene in these complex relational patterns and to alter them in ways that bring about productive change for the entire family. Family therapy rests on the systems perspective. As such, changes in one part of the system can and do produce changes in other parts of the system, and these changes can contribute to either problems or solutions.

It is important to understand the complex role that families can play in substance abuse treatment. They can be a source of help to the treatment process, but they also must manage the consequences of the IP's addictive behavior. Individual family members are concerned about the IP's substance abuse, but they also have their own goals and issues. Providing services to the whole family can improve treatment effectiveness.

Meeting the challenge of working together will call for mutual understanding, flexibility, and adjustments among the substance abuse treatment provider, family therapist, and family. This shift will require a stronger focus on the systemic interactions of families. Many divergent practices must be reconciled if family therapy is to be used in substance abuse treatment. For example, the substance abuse counselor typically facilitates treatment goals with the client; thus the goals are individualized, focused mainly on the client. This reduces the opportunity to include the family's perspective in goal setting, which could facilitate the healing process for the family as a whole.

Working out ways for the two disciplines to collaborate also will require a re-examination of assumptions common in the two fields. Substance abuse counselors often focus on the individual needs of people with substance use disorders, urging them to take care of themselves. This viewpoint neglects to highlight the impact these changes will have on other people in the family system. When the IP is urged to take care of himself, he often is not prepared for the reactions of other family members to the changes he experiences, and often is unprepared to cope with these reactions. On the other hand, many family therapists have hoped that bringing about positive changes in the family system concurrently might improve the substance use disorder. This view tends to minimize the persistent, sometimes overpowering process of addiction.

Both of these views are consistent with their respective fields, and each has explanatory power, but neither is complete. Addiction is a

major force in people with substance abuse problems. Yet, people with substance abuse problems also reside within a powerful context that includes the family system. Therefore, in an integrated substance abuse treatment model based on family therapy, both family functioning and individual functioning play important roles in the change process (Liddle and Hogue 2001).

What Is a Family?

There is no single, immutable definition of *family*. Different cultures and belief systems influence definitions, and because cultures and beliefs change over time, definitions of family by no means are static. While the definition of family may change according to different circumstances, several broad categories encompass most families:

- Traditional families, including heterosexual couples (two parents and minor children all living under the same roof), single parents, and families including blood relatives, adoptive families, foster relationships, grandparents raising grandchildren, and stepfamilies.
- Extended families, which include grandparents, uncles, aunts, cousins, and other relatives.
- Elected families, which are self-identified and are joined by choice and not by the usual ties of blood, marriage, and law. For many people, the elected family is more important than the biological family. Examples would include
 - Emancipated youth who choose to live among peers
 - Godparents and other non-biologically related people who have an emotional tie (i.e., fictive kin)
 - Gay and lesbian couples or groups (and minor children all living under the same roof)

The idea of family implies an enduring involvement on an emotional level. Family members may disperse around the world, but still be connected emotionally and able to contribute to the dynamics of family functioning. In family

therapy, geographically distant family members can play an important role in substance abuse treatment and need to be brought into the therapeutic process despite geographical distance.

Families must be distinguished from social support groups such as 12-Step programs—although for some clients these distinctions may be fuzzy. One distinction is the level of commitment that people have for each other and the duration of that commitment. Another distinction is the source of connection. Families are connected by alliance, but also by blood (usually) and powerful emotional ties (almost always). Support groups, by contrast, are held together by a common goal; for example, 12-Step programs are purpose-driven and context-dependent. The same is true of church communities, which may function in some ways like a family; but similar to self-help programs, churches have a specific purpose.

For practical purposes, family can be defined according to the individual's closest emotional connections. In family therapy, clients identify who they think should be included in therapy. The counselor or therapist cannot determine which individuals make up another person's family. When commencing therapy, the counselor or therapist needs to ask the client, "Who is important to you? What do you consider your family to be?" It is critical to identify people who are important in the person's life. Anyone who is instrumental in providing support, maintaining the household, providing financial resources, and with whom there is a strong and enduring emotional bond may be considered family for the purposes of therapy (see, for example, Pequegnat et al. 2001). No one should be automatically included or excluded.

In some situations, establishing an individual in treatment may require a metaphoric definition of family, such as the family of one's workplace. As treatment progresses, the idea of family sometimes may be reconfigured, and the notion may change again during continuing care. In other cases, clients will not allow contact with the family, may want the counselor or therapist to

see only particular family members, or may exclude some family members.

Brooks and Rice (1997, p. 57) adopt Sargent's (1983) definition of family as a "group of people with common ties of affection and responsibility who live in proximity to one another." They expand that definition, though, by pointing out four characteristics of families central to family therapy:

- Families possess *nonsummativity*, which means that the family as a whole is greater than—and different from—the sum of its individual members.
- The behavior of individual members is interrelated through the process of *circular causality*, which holds that if one family member changes his or her behavior, the others will also change as a consequence, which in turn causes subsequent changes in the member who changed initially. This also demonstrates that it is impossible to know what comes first: substance abuse or behaviors that are called "enabling."
- Each family has a pattern of *communication traits*, which can be verbal or nonverbal, overt or subtle means of expressing emotion, conflict, affection, etc.
- Families strive to achieve *homeostasis*, which portrays family systems as self-regulating with a primary need to maintain balance.

Anyone who is instrumental in providing support, maintaining the household, providing financial resources, and with whom there is a strong and enduring emotional bond may be considered family for the purposes of therapy.

The Concept of Family

In the United States the concept of family has changed during the past two generations. During the latter half of the 20th century in the United States, the proportion of married couples with children shrank—such families made up only 24 percent of all households in 2000 (Fields and Casper 2001). The idea of family has come to signify many familial arrangements, including blended families, divorced single mothers or fathers with children, never-married women with children, cohabiting heterosexual partners, and gay or lesbian families (Bianchi and Casper 2000).

Some analysts are concerned about indications of increasing stress on families, such as the increasing number of births to single mothers (from 26.6 percent in 1990 to 33 percent in 1999 [U.S. Census Bureau 2001c]). The increase in single-mother families, which typically have greater per-person expenses and less earning power, may help to explain why, in the general prosperity of the last half of the 20th century, the percentage of children living in the poorest families almost doubled, rising from 15 to 28 percent (Bianchi and Casper 2000).

Bengtson (2001) asserts that relationships involving three or more generations increasingly are becoming important to individuals and families, that these relationships increasingly are diverse in structure and functions, and that for many Americans, multigenerational bonds are important ties for well-being and support over the course of their lives.

The Family as an Ecosystem

Substance abuse impairs physical and mental health, and it strains and taxes the agencies that promote physical and mental health. In families with substance abuse, family members often are connected not just to each other but also to any of a number of government agencies, such as social services, criminal justice, or child protective services. The economic toll includes a huge drain on individuals' employability and other elements of productivity. The social and economic costs are felt in many workplaces and homes.

The ecological perspective on substance abuse views people as nested in various systems. Individuals are nested in families; families are nested in communities. Kaufman (1999) identifies members of the ecosystem of an individual with a substance abuse problem as family, peers (those in recovery as well as those still using), treatment providers, non-family support sources, the workplace, and the legal system.

The idea of an ecological framework within which substance abuse occurs is consistent with family therapy's focus on understanding human behavior in terms of other systems in a person's life. Family therapy approaches human behavior in terms of interactions within and among the subsets of a system. In this view, family members inevitably adapt to the behavior of the person with a substance use disorder. They develop patterns of accommodation and ways of coping with the substance use (e.g., keeping children extraordinarily quiet or not bringing friends home). Family members try to restore homeostasis and maintain family balance. This may be most apparent once abstinence is achieved. For example, when the person abusing substances becomes abstinent, someone else may develop complaints and/or "symptoms." (See box, p. 5, for an illustration.)

Family members may have a stronger desire to move toward overall improved functioning in the family system, thus compelling and even providing leverage for the IP to seek and/or remain in treatment through periods of ambivalence about achieving a sober lifestyle. Alternately, clarifying boundaries between dysfunctional family members—including encouraging IPs to detach from family members who are actively using—can alleviate stress on the IP and create emotional space to focus on the tasks of recovery.

What Is Family Therapy?

Family therapy is a collection of therapeutic approaches that share a belief in family-level assessment and intervention. A family is a system, and in any system each part is related to all other parts. Consequently, a change in

Homeostasis

A young couple married when they were both 20 years old. One spouse developed alcoholism during the first 5 years of the marriage. The couple's life increasingly became chaotic and painful for another 5 years, when finally, at age 30, the substance-abusing spouse entered treatment and, over the course of 18 months, attained a solid degree of sobriety. Suddenly, lack of communication and difficulties with intimacy came to the fore for the non-substance-abusing spouse, who now often feels sad and hopeless about the marital relationship. The non-substance-abusing spouse finds, after 18 months of the partner's sobriety, that the sober spouse is "no longer fun" or still does not want to make plans for another child.

Almost all young couples encounter communication and intimacy issues during the first decade of the relationship. In an alcoholic marriage or relationship, such issues are regularly pushed into the background as guilt, blame, and control issues are exacerbated by the nature of addictive disease and its effects on both the relationship and the family.

The possible complexities of the above situation illustrate both the relevance of family therapy to substance abuse treatment and why family therapy requires a complex, systems perspective. Many system-related answers are possible: Perhaps the non-substance-abusing spouse is feeling lonely, unimportant, or an outsider. With the focus of recovery on the addiction—and the IP's struggles in recovery—the spouse who previously might have been central to the other's drinking and/or maintaining abstinence, even considered the cause of the drinking, is now, 18 months later, tangential to what had been major, highly emotional upheavals and interactions. The now "outsider spouse" may not even be aware of feeling lonely and unimportant but instead "acts out" these feelings in terms of finding the now sober spouse "no fun." Alternatively, perhaps the now sober spouse is indeed no fun, and the problems lie in how hard it is for the sober spouse to relax or feel comfortable with sobriety—in which case the resolution might involve both partners learning to develop a new lifestyle that does not involve substance use.

The joint use of both recovery and family therapy techniques will improve marital communication and both partners' capacity for intimacy. These elements of personal growth are important to the development of serenity in recovery and stability in the relationship.

any part of the system will bring about changes in all other parts. Therapy based on this point of view uses the strengths of families to bring about change in a range of diverse problem areas, including substance abuse.

Family therapy in substance abuse treatment has two main purposes. First, it seeks to use the family's strengths and resources to help find or develop ways to live without substances of abuse. Second, it ameliorates the impact of

chemical dependency on both the IP and the family. Frequently, in the process, marshaling the family's strengths requires the provision of basic support for the family.

In family therapy, the unit of treatment is the family, and/or the individual within the context of the family system. The person abusing substances is regarded as a subsystem within the family unit—the person whose symptoms have severe repercussions throughout the family system. The familial relationships within this subsystem are the points of therapeutic interest and intervention. The therapist facilitates discussions and problemsolving sessions, often with the entire family group or subsets thereof, but sometimes with a single participant, who may or may not be the person with the substance use disorder.

A distinction should be made between family therapy and family-involved therapy. Family-involved therapy attempts to educate families about the relationship patterns that typically contribute to the formation and continuation of substance abuse. It differs from family therapy in that the family is not the primary therapeutic grouping, nor is there intervention in the system of family relationships. Most substance abuse treatment centers offer such a family educa-

tional approach. It typically is limited to psychoeducation to teach the family about substance abuse, related behaviors, and the behavioral, medical, and psychological consequences of use. Children also need age-appropriate psychoeducation programs prior to being grouped with other family members in either education or therapy. (For more information see chapter 6,

under “Family Education and Participation,” and see also *Children’s Program Kit: Supportive Education for Children of Addicted Parents* [Substance Abuse and Mental Health Services Administration (SAMHSA) 2003], developed by SAMHSA and the National Association for Children of Alcoholics.)

In addition, programmatic enhancements (such as classes that teach English as a second language) also are not family therapy. Although educational family activities can be therapeutic, they will not correct deeply ingrained, maladaptive relationships.

The following discussions present a brief overview of the evolution of family therapy models and the primary models of family therapy used today as the basis for treatment. Chapter 3 provides more detailed information about these models.

Historical Models of Family Therapy

Marriage and family therapy (MFT) had its origins in the 1950s, adding a systemic focus to previous understandings of the family. Systems theory recognizes that

- A whole system is more than the sum of its parts.
- Parts of a system are interconnected.
- Certain rules determine the functioning of a system.
- Systems are dynamic, carefully balancing continuity against change.
- Promoting or guarding against system entropy (i.e., disorder or chaos) is a powerful dynamic in the family system balancing change of the family roles and rules.

The *strategic school of family therapy* “introduced two of the most powerful insights in all of family therapy: that family members often perpetuate problems by their own actions; and that directives tailored to the needs of a particular family can sometimes

Family therapy is a collection of therapeutic approaches that share a belief in family-level assessment and intervention.

bring about sudden and decisive change” (Nichols and Schwartz 2001, p. 97).

Based on observations of the relationship between family structure and behavior, along with work with inner-city children and their families, Minuchin (1974) developed another approach, *structural family therapy*. Minuchin and Fishman (1981) believed that families use a limited repertoire of self-perpetuating relational patterns and that family members divide into subsystems with boundaries that regulate family communication and behavior. They sought to shift family boundaries so the boundary between parents and children was clearer. Intervention is aimed at having the parents work more cooperatively together and at reducing the extent to which children assume parental responsibilities within the family.

One major model that emerged during this developmental phase was *cognitive-behavioral family and couples therapy*. It grew out of the early work in behavioral marital therapy and parenting training, and incorporated concepts developed by Aaron Beck. Beck reasoned that people react according to the ways they think and feel, so changing maladaptive thoughts, attitudes, and beliefs would eliminate dysfunctional patterns and the triggers that set them in motion (Beck 1976). This union of cognitive and behavioral therapies in a family setting was new and useful. The therapist considers not only how people’s thoughts, feelings, and emotions influence their behavior, but also the impact they have on spouses and other family members. Cognitive-behavioral family therapy and behavioral couples therapy are two models that have strong empirical support.

Through the 1980s and 1990s, newer models of MFT were articulated. In response to the problem-focused strategic and structural family therapies, authors such as de Shazer, Berg, O’Hanlon, and Selkman promulgated *solution-focused family therapy* (e.g., Berg and Miller 1992; de Shazer 1988). They asserted that pinpointing the cause of poor functioning is

unnecessary and that therapy focused on solutions is sufficient to help families change.

Soon after the introduction of solution-focused therapy to the MFT landscape, White and Epston’s *Narrative Means to Therapeutic Ends* (1990) heralded the *narrative movement* in MFT. This family therapy development has focused on the way people construct meaning and how the construction of meaning affects psychological functioning.

In the early part of the 21st century, MFT seems poised to undergo another change, focused on empirically demonstrating the effectiveness of different approaches to therapy. The few models that have been tested empirically have shown promising results. For example, *functional family therapy*, *multisystemic therapy*, *multidimensional family therapy*, and *brief strategic family therapy* all have been shown to be highly effective in reducing acting-out behavior among adolescents and/or in reducing the risk for problem behavior among their younger siblings. Among the couples therapy models known to have reduced marital distress and psychological problems are *emotionally focused couples therapy*, *cognitive-behavioral couples therapy*, *behavioral couples therapy*, *integrative couples therapy*, and *systemic couples therapy*. (See chapter 3 for further information.)

Primary Family Therapy Models in Use Today

There are numerous variations on the family therapy theme. Some approaches to family therapy reach out to multiple generations or family groups. Some treat just one person, who may or may not be the IP. Usually, though, family therapy involves a therapist meeting with several family members. An expansive concept of family therapy also might spin off group programs that, for example, could treat the IP’s spouse, children in groups (children do best if they first participate in groups that

prepare them for family therapy), or members of a residential treatment setting.

Most family therapy meetings take place in clinics or private practice settings. Home-based therapy breaks from the traditional clinical setting, reasoning that joining the family where it lives can help overcome shame, stigma, and resistance. It is a return to the practices of social workers who, in the early 20th century, did their work in clients' homes (Beels 2002). Meeting the family where it lives also provides valuable information about how the family really functions.

Four predominant family therapy models are used as the bases for treatment and specific interventions for substance abuse:

1. The *family disease model* looks at substance abuse as a disease that affects the entire family. Family members of the people who abuse substances may develop codependence, which causes them to enable the IP's substance abuse. Limited controlled research evidence is available to support the disease model, but it nonetheless is influential in the treatment community as well as in the general public (McCrary and Epstein 1996).
2. The *family systems model* is based on the idea that families become organized by their interactions around substance abuse. In adapting to the substance abuse, it is possible for the family to maintain balance, or homeostasis. For example, a man with a substance use disorder may be antagonistic or unable to express feelings unless he is intoxicated. Using the systems approach, a therapist would look for and attempt to change the maladaptive patterns of communication or family role structures that require substance abuse for stability (Steinglass et al. 1987).
3. *Cognitive-behavioral approaches* are based on the idea that maladaptive behaviors, including substance use and abuse, are reinforced through family interactions. Behaviorally oriented treatment tries to change interactions and target behaviors that trigger substance abuse, to improve

communication and problemsolving, and to strengthen coping skills (O'Farrell and Fals-Stewart 1999).

4. Most recently, *multidimensional family therapy* (MDFT) has integrated several different techniques with emphasis on the relationships among cognition, affect (emotionality), behavior, and environmental input (Liddle et al. 1992). MDFT is not the only family therapy model to adopt such an approach. Functional family therapy (Alexander and Parsons 1982), multisystemic therapy (Henggeler et al. 1998), and brief strategic family therapy (Szapocznik et al. in press) all adopt similar multidimensional approaches.

Family Therapy in Substance Abuse Treatment

Goals of Family Therapy

The integration of family therapy in substance abuse treatment is still relatively rare. Family therapy in substance abuse treatment helps families become aware of their own needs and provides genuine, enduring healing for people. Family therapy works to shift power to the parental figures in a family and to improve communication. Other goals will vary according to which member of the family is abusing substances. Family therapy can answer questions such as

- Why should children or adolescents be involved in the treatment of a parent who abuses substances?
- What impact does a parent abusing substances have on his or her children?
- How does adolescent substance abuse impact adults?
- What is the impact of substance abuse on family members who do not abuse substances?

Whether a child or adult is the family member who uses substances, the entire family system

needs to change, not just the IP. Family therapy, therefore, helps the family make interpersonal, intrapersonal, and environmental changes affecting the person using alcohol or drugs. It helps the nonusing members to work together more effectively and to define personal goals for therapy beyond a vague notion of improved family functioning. As change takes place, family therapy helps all family members understand what is occurring. This out-in-the-open understanding removes any suspicion that the family is “ganging up” on the person abusing substances.

A major goal of family therapy in substance abuse treatment is prevention—especially keeping substance abuse from moving from one generation to another. Study after study shows that if one person in a family abuses alcohol or drugs, the remaining family members are at increased risk of developing substance abuse problems. The single most potent risk factor of future maladaptation, predisposition to substance use, and psychological difficulties is a parent’s substance-abusing behavior (Johnson and Leff 1999). A “healthy family structure can prevent adolescent substance abuse even in the face of heavy peer pressure to use and abuse drugs” (Kaufman 1990a, p. 51). Further, if the person abusing substances is an adolescent, successful treatment diminishes the likelihood that siblings will abuse substances or commit related offenses (Alexander et al. 2000). Treating adolescent drug abuse also can decrease the likelihood of harmful consequences in adulthood, such as chronic unemployment, continued drug abuse, and criminal behavior.

Therapeutic Factors

Because of the variety of family therapy models, the diverse schools of thought in the field, and the different degrees to which family therapy is implemented, multiple therapeutic factors probably account for the effectiveness of family therapy. Among them might be acceptance from the therapist; improved communication; organizing the family structure; determining accountability; and enhancing impetus for change, which increases the family’s motivation

to change its patterns of interaction and frees the family to make changes. Family therapy also views substance abuse in its context, not as an isolated problem, and shares some characteristics with 12-Step programs, which evoke solidarity, self-confession, support, self-esteem, awareness, and smooth re-entry into the community.

Still another reason that family therapy is effective in substance abuse treatment is that it provides a neutral forum in which family members meet to solve problems. Such a rational venue for expression and negotiation often is missing from the family lives of people with a substance problem. Though their lives are unpredictable and chaotic the substance abuse—the cause of the upheaval and a focal organizing element of family life—is not discussed. If the subject comes up, the tone of the exchange is likely to be accusatory and negative.

In the supportive environment of family therapy, this uneasy silence can be broken in ways that feel emotionally safe. As the therapist brokers, mediates, and restructures conflicts among family members, emotionally charged topics are allowed to come into the open. The therapist helps ensure that every family member is accorded a voice. In the safe environment of therapy, pent-up feelings such as fear and concern can be expressed, identified, and validated. Often family members are surprised to learn that others share their feelings, and new lines of communication open up. Family members gain a broader and more accurate perspective of what they are experiencing, which can be

Family therapy in substance abuse treatment helps families become aware of their own needs and provides genuine, enduring healing for people.

empowering and may provide enough energy to create positive change. Each of these improvements in family life and coping skills is a highly desirable outcome, whether or not the IP's drug or alcohol problems are immediately resolved. It is clearly a step forward for the family of a person abusing substances to become a stable, functional environment within which abstinence can be sustained.

To achieve this goal, family therapy facilitates changes in maladaptive interactions within the family system. The therapist looks for unhealthy relational structures (such as parent-child role reversals) and faulty patterns of communication (such as a limited capacity for negotiation). In contrast to the peripheral role that families usually play in other therapeutic approaches, families are deeply involved in whatever changes are effected. In fact, the majority of changes will take place within the

family system, subsequently producing change in the individual abusing substances.

Family therapy is highly applicable across many cultures and religions, and is compatible with their bases of connection and identification, belonging and acceptance. Most cultures value families and view them as important. This preeminence suggests how important it is to include families in treatment. It should be acknowledged, however, that a culture's high regard for families does not always promote improved family functioning. In cultures that revere families, people may conceal substance abuse within the family because disclosure would lead to stigma and shame.

Additionally, the definition, or lack of definition, of the concept of "rehabilitation" varies greatly across cultural lines. Cultures differ in their views of what people need in order to heal. The identities of individuals who have the moral

Selected Research Outcomes of Family Approaches to Substance Abuse Treatment

- Bukstein (2000, p. 74) found that "family-focused interventions are empirically well-supported for youth with a conduct disorder or substance use disorder." He notes that 68 percent of adolescents with a substance use disorder also had a comorbid disruptive behavior disorder. Bukstein emphasizes that family therapy interventions can focus on the environmental factors that promote both disorders.
- Catalano et al. (1999) sought to determine whether family-focused interventions for parents on methadone would reduce their drug use and prevent children from starting to use drugs. After studying 144 methadone-treated parents with 78 children for a year, with 33 sessions of family training, the authors found significant improvements in parenting skills, less parental drug use, fewer deviant peers, and better family management.
- Cunningham and Henggeler's 1999 overview of multisystemic therapy, a family-based treatment model, found high rates of substance abuse treatment completion among youth with serious clinical problems.
- Diamond et al. (1996) reviewed advances in family-based treatment research. They cited a growing body of research indicating that family-based treatments are effective for a variety of child and adolescent disorders, including substance

abuse, schizophrenia, and conduct disorder. The studies all demonstrated the superiority of brief family treatment over individual and group treatments for reducing drug use.

- Friedman et al. (1995) conducted a study of 176 adolescent drug abuse clients and their mothers in six outpatient drug-free programs with family therapy sessions. The authors found that the more positively the client described the family's functioning and relationships at pretreatment, the more client improvement was reported by client or mother at follow-up. They concluded that the adolescents with better treatment outcomes began treatment with more positive perceptions of their families.
- In a review of controlled treatment outcome research, Liddle and Dakof (1995a) found that different types of family intervention can engage and retain people who use drugs and their families in treatment, significantly reduce drug use and other problem behaviors, and enhance social functioning. They also concluded that family therapy was more effective than therapy without families, but cautioned against overgeneralizing this finding because of methodological limitations and the relatively small number of studies.
- McCrady and Epstein (1996) noted that an extensive literature supports family-based models and the effectiveness of treatments based on the family disease, family systems, and behavioral family models. Research knowledge is limited, however, by a lack of attention to cultural, racial, sexual, and gender orientation issues among subjects; the lack of couples treatment research on people using drugs; and the lack of family treatment research on individuals with alcohol abuse disorders.
- O'Farrell and Fals-Stewart (2000) concluded that behavioral couples therapy led to more abstinence and better relationships, decreased the incidence of separation and divorce, reduced domestic violence, and had a favorable cost/benefit ratio compared to individual therapy.
- Shapiro (1999) describes La Bodega de la Familia, a family therapy approach used to reduce relapse, parole violations, and recidivism for individuals released from prison and jail. With intensive family-based therapies, the 18-month rearrest rate dropped from 50 to 35 percent.
- In a study using both family and non-family treatments for substance abuse, Stanton and Shadish (1997) concluded that (1) when family-couples therapy was part of the treatment, results were clearly superior to modalities that do not include families, and (2) family therapy promotes engagement and retention of clients.
- Walitzer (1999) analyzed two forms of family therapy (behavioral marital therapy and family systems therapy) for treating substance abuse, concluding that the model of choice depended on the problem at hand. If problems (such as poor communication) centered in the marriage, behavioral marital therapy was the better approach. If the problem involved a whole family organized around alcohol or illicit drugs, family systems therapy could be a superior strategy. In either case, her review "strongly indicates the critical role family functioning can have in both subtly maintaining an addiction and in creating an environment conducive to abstinence" (Walitzer 1999, p. 147).

authority to help (for example, an elder or a minister) can differ from culture to culture. Therapists need to engage aspects of the culture or religion that promote healing and to consider the role that drugs and alcohol play in the culture. (Issues of culture and ethnicity are discussed in detail in chapter 5.)

Effectiveness of Family Therapy

While there are limited studies of the effectiveness of family therapy in the treatment of substance abuse, important trends suggest that family therapy approaches should be considered more frequently in substance abuse treatment. Much of the federally funded research into

Family therapy is highly applicable across many cultures and religions, and is compatible with their bases of connection and identification, belonging and acceptance.

substance abuse treatment has focused on criminal justice issues, co-occurring disorders, and individual-specific treatments. One reason is that research with families is difficult and costly. Ambiguities in definitions of family and family therapy also have made research in these areas difficult. As a result, family therapy has not been the focus of much substance abuse research. However, evidence from the research that has been conducted, including that

described below, indicates that substance abuse treatment that includes family therapy works better than substance abuse treatments that do not (Stanton et al. 1982). It increases engagement and retention in treatment, reduces the IP's drug and alcohol use, improves both family and social functioning, and discourages relapse.

Although the effectiveness of family therapy is documented in a growing body of evidence, integrating family therapy into substance abuse treatment does pose some specific challenges:

- Family therapy is more complex than non-family approaches because more people are involved.
- Family therapy takes special training and skills beyond those typically required in many substance abuse treatment programs.
- Relatively little research-based information is available concerning effectiveness with subsets of the general population, such as women, minority groups, or people with serious psychiatric problems (O'Farrell and Fals-Stewart 1999).

The balance, however, certainly tips in favor of a family therapy in treating substance abuse. Based on effectiveness data and the consensus panel's collective experience, the consensus panel recommends that substance abuse treatment agencies and providers consider how they might incorporate family approaches, including age-appropriate educational support services for their clients' children, into their programs.

Cost Benefits

Only a few studies have assessed the cost benefits of family therapy or have compared the cost of family therapy to other approaches such as group therapy, individual therapy, or 12-Step programs. A small but growing body of data, however, has demonstrated the cost benefits of family therapy specifically for substance abuse problems. Family therapy also has appeared to be superior in situations that might in some key respect be similar to substance abuse contexts.

For example, Sexton and Alexander's work with functional family therapy (so called because it focuses its interventions on family relationships that influence and are influenced by, and thus are functions of, positive and negative behaviors) for youth offenders found that family therapy nearly halved the rate of re-offending—19.8 percent in the treatment

group compared to 36 percent in a control group (Sexton and Alexander 2002). The cost of the family therapy ranged from \$700 to \$1,000 per family for the 2-year study period. The average cost of detention for that period was at least \$6,000 per youth; the cost of a residential treatment program was at least \$13,500. In this instance, the cost benefits of family therapy were clear and compelling (Sexton and Alexander 2002).

Other studies look at the offset factor; that is, the relationship between family therapy and the use of medical care or social costs. Fals-Stewart et al. (1997) examined social costs incurred by clients (for example, the cost of substance abuse treatment or public assistance) and found that behavioral couples therapy was considerably more cost effective than individual therapy for substance abuse, with a reduction of costs of \$6,628 for clients in couples therapy, compared to a \$1,904 reduction for clients in individual therapy.

Similar results were noted in a study by the National Working Group on Family-Based Interventions in Chronic Disease, which found that 6 months after a family-focused intervention, reimbursement for health services was 50 percent less for the treatment group, compared to a control group. While this study looked at chronic diseases such as heart disease, cancer, Alzheimer's disease, and diabetes, substance abuse also is a chronic disease that is in many ways analogous to these physical conditions (Fisher and Weihs 2000). Both chronic diseases and substance abuse

- Are long-standing and progressive
- Often result from behavioral choices
- Are treatable, but not curable
- Have clients inclined to resist treatment
- Have high probability of relapse

Chronic diseases are costly and emotionally draining. Substance abuse is similar to a chronic disease, with potential for recovery; it even can lead to improvement in family functioning. Other cost benefits result from preventive aspects of treatment. While therapy usually

is not considered a primary prevention intervention, family-based treatment that is oriented toward addressing risk factors may have a significant preventive effect on other family members (Alexander et al. 2000). For example, it may help prevent substance abuse in other family members by correcting maladaptive family dynamics.

Other Considerations

Family therapy for substance abuse treatment demands the management of complicated treatment situations. Obviously, treating a family is more complex than treating an individual, especially when an unwilling IP has been mandated to treatment. Specialized strategies may be necessary to engage the IP into treatment. In addition, the substance abuse almost always is associated with other difficult life problems, which can include mental health issues, cognitive impairment, and socioeconomic constraints, such as lack of a job or home. It can be difficult, too, to work across diverse cultural contexts or discern individual family members' readiness for change and treatment needs.

These circumstances make meaningful family therapy for substance abuse problems a complex and challenging task for both family therapists and substance abuse treatment providers. Modifications in the treatment approach may be necessary, and the success of treatment will depend, to a large degree, on the creativity, judgment, and cooperation in and between programs in each field.

Complexity

Clinicians treating families have to weigh many variables and idiopathic situations. Few landmarks may be apparent along the way; for many families, the phases of family therapy are neither discrete nor well defined. This uncertain journey is made less predictable because multiple people are involved. For example, in an adolescent program, a child in treatment might have a parent with alcoholism. As the parent's substance abuse issues begin to surface, the child is withdrawn from treatment. This is why

children need to participate in a group of their own. In a family therapy program, the child's and the parent's substance abuse problems would be addressed concomitantly.

Another factor that can complicate any therapy process is external coercion, such as court-mandated treatment or mandates arising out of child protective services requirements. These situations can affect families in varied ways; treatment providers should approach mandated family therapy with heightened vigilance about the role of coercion in family process. Often in substance abuse treatment, a legal mandate or some other form of coercion makes therapy a requirement. The nature of mandated treatment is likely to have an effect on the dynamics of family therapy. It can place constraints on the therapist and raise distracting issues that have a negative effect on treatment, requiring more care, coordination of services, and case management. The legal and ethical thicket is dense in these circumstances. An exception is when the client is a minor, the courts can mandate treatment and family therapy. Practitioners should avail themselves of all relevant resources (e.g., professional associations, supervision, ethical guidelines, local and State legal and consumer organizations) before venturing to treat families under court order or similar situations. Therapists must form a working alliance with each family member and establish trust with the family so that sensitive information can be disclosed. This requires the therapist to demonstrate that she is on the family's side therapeutically, but she also needs to disclose to the family any other obligations she has as a result of her position. For example, by agreeing to treat the family under the particular circumstances at hand, the therapist might be obligated to make progress reports to probation or parole agencies.

Co-occurring problems

Even though an individual with a substance use disorder generally brings a family into treatment, it is possible that more than one person in the family has substance abuse problems, mental illness, problems with domestic

violence, or some other major difficulty. Substance abuse, in fact, may be a secondary reason for referral for therapy. Changing the family's maladaptive patterns of interaction may help to correct psychosocial problems among all family members. For more information about co-occurring mental and substance use disorders see the forthcoming TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT] in development k).

Biological aspects of addiction

Other important considerations involve the biological and physiological aspects of addiction and recovery. The recovery process varies according to the type of drug, the extent of drug use, and the extent of acute and chronic effects. Recovery also may depend, at least partly, on the extent to which the drugs are intertwined with antisocial behavior and co-occurring conditions. For the IP, post-acute withdrawal symptoms also will commonly present and interfere with family therapy for a significant period before gradually subsiding.

The biological aspects of addiction also may affect the type of therapy that can be effective. For example, family therapy may not be as effective for someone whose drug use has caused significant organic brain damage or for a person addicted to cocaine who has become extremely paranoid. Severe psychopathology, however, should not automatically exclude a client from family therapy. Even in these cases, with appropriate individual and psychopharmacological treatment, family therapy may be helpful (O'Farrell and Fals-Stewart 1999) since other members of the family might need and benefit from family therapy services.

Socioeconomic constraints

The socioeconomic status of a family in treatment can have far-reaching ramifications. During treatment, poverty has two immediate implications. First, therapy will need to address many survival issues—a therapist cannot explore

aspects of family systems or cognitive-behavioral traits if a family is being evicted, is not eating properly, is without financial resources and employment, or is experiencing some other threat to daily life. Second, the reimbursement systems that can be accessed probably will determine how long treatment will continue, irrespective of client needs. Therefore, family therapy treatments for substance abuse must be designed to be relatively brief and to target aspects of the family's environment that may be maintaining the drug abuse symptomatology (e.g., Robbins et al. in press). In addition, family members should be referred to Al-Anon, Alateen, and NAR-Anon to enhance their potential for long-term recovery.

Cultural competence

Cultural competence is an important feature in family therapy because therapists must work with the structures of families from many cultures. Knowledge of and sensitivity to cultures is involved in determining

- To what extent is the family's divergence from mainstream norms a function of pathology or a different cultural background?
- How is the family arranged—hierarchically? Democratically? Within this structure, what are the communication patterns?
- How well is this family functioning? That is, to what extent can the family meet its own goals without getting in its own way?
- What therapeutic goals are appropriate?
- What are the culture's prescribed roles for each family member?
- Who are the appropriately defined "power figures" in the family?

The need for cultural competence does not imply that a therapist must belong to the same cultural group as the client family. It is possible to develop cultural competence and work with groups other than one's own. A sensitive therapist pays attention, senses cultural nuances, and learns from clients. Even when the therapist is from the same culture as the family in treatment, trust cannot be assumed. It must be built. The expectations regarding the

therapist's role as an agent of change must be clearly discussed in relation to the developing trust with the family and individual members.

Issues related to cultural sensitivity and appropriateness are considered in greater detail in chapter 5 and in the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development *b*).

Stages of change and levels of recovery

The process of recovery is complex and multifaceted. One useful framework for understanding this process involves stages of change (Prochaska et al. 1992), which can be applied to an individual or to the whole family and used as a framework for treatment. The five stages of change are

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance

Individuals typically progress and regress in their movements through these stages (Prochaska et al. 1992). Although these stages can be applied to a whole family, not every family member necessarily will be at the same stage at the same time. The therapist needs to address where each family member is, for these factors play an important role in assessment and treatment matching decisions. For addi-

Substance abuse almost always is associated with other difficult life problems, which can include mental health issues, cognitive impairment, and socioeconomic constraints.

Treatment must be customized to the needs of each family and the person abusing substances.

tional information on the stages of change, refer to chapter 3 of this TIP and see also TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999b).

While Prochaska et al. (1992) conceptualized readiness for change, other researchers have modeled the stages of recovery after treatment has begun. One such model of the path through treat-

ment is Kaufman's (1990b) progressive levels of recovery:

- *Dry abstinence* is a time when clients must cope with problems revolving around the cessation of substance use (such as withdrawal, sudden realization of the actual damage intoxication has caused, and the shame that follows).
- *Sobriety, or early recovery*, concentrates on maintaining freedom from substances. Bit by bit, the client is helped to substitute health-sustaining behaviors for relationships and circumstances that precipitate substance use.
- *Advanced recovery* shifts from support to examination of underlying personal issues that predispose the client to substance use. Trust and intimacy are re-established, and the client moves through the termination of therapy.

This TIP approaches stages of change for families by combining Bepko and Krestan's stages of treatment for families (1985) and Heath and Stanton's stages of family therapy for substance abuse treatment (1998). Together, the phases of family change are

- *Attainment of sobriety*. The family system is unbalanced but healthy change is possible.
- *Adjustment to sobriety*. The family works on developing and stabilizing a new system.
- *Long-term maintenance of sobriety*. The family must rebalance and stabilize a new and healthier lifestyle.

Combining these two models provides a simple, straightforward categorization for a family's progress in recovery regarding attainment of, adjustment to, and long-term maintenance of sobriety. For additional information on these phases of family change, see chapter 4.

Unanswered research questions

At present, research cannot guide treatment providers about the best specific matches between family therapy and particular family systems or substances of abuse. Research to date suggests that certain family therapy approaches can be effective, but no one approach has been shown to be more effective than others. In addition, even though the right model is an important determinant of appropriate treatment, the exact types of family therapy models that work best with specific addictions have not been determined. However, a growing body of evidence over the past 25 years suggests that children benefit from participating in age-appropriate support groups. These can be offered by treatment programs, school-based student assistance programs, or faith-based communities.

Experience and sound judgment can distinguish many situations in which family therapy alone would or would not be a workable modality. Treatment must be customized to the needs of each family and the person abusing substances. An adolescent who is primarily smoking marijuana, for instance, is a good candidate for family systems work. On the other hand, if a youth is mixing cocaine, amphetamines, alcohol, and other drugs, the client is likely to need more extensive services—detoxification, residential treatment, or intensive outpatient

therapy—which can be used in addition to family therapy (Liddle and Hogue 2001).

Safety and Appropriateness of Family Therapy

Only in rare situations is family therapy inadvisable. Occasionally, it will be inappropriate or counterproductive because of reasons such as those as mentioned above. Sometimes, though, family therapy is ruled out due to safety issues or legal constraints. Family or couples therapy should not take place unless all participants have a voice and everyone can raise pertinent issues, even if a domineering family member does not want them discussed. Family therapy can be used when there is no evidence of serious domestic or intimate partner violence.

Engaging in family therapy without first assessing carefully for violence can lead not only to poor treatment, but also to a risk for increased abuse.

A systems approach presumes that all family members have roughly equal contributions to the process and have equity in terms of power and control. This belief is not substantiated in the research on family violence. Hence, family therapy only should be used when one family member is not being terrorized by another. Resistance from a domineering family member can be addressed and restructured by first allying with this family member and then gradually and gently questioning this person (and the whole family) about the appropriateness of the domineering behavior (Szapocznik et al. 1988). (See also appendix C, Guidelines for Assessing Violence.)

It is the treatment provider's responsibility to provide a safe, supportive environment for all participants in family therapy. Children benefit by attending support groups specifically for them; it is important to create a safe environment in which they can discuss family violence, abuse, and neglect. Usually, a way can be

found to include even the family member who has turned to violence as a way of dealing with problems. That person is a vital part of the family and will be pivotal in understanding the nature of the family violence. For example, Johnson (1995) distinguishes between common couple violence and patriarchal terrorism. The former is characterized by occasional violent outbursts by either spouse and is not likely to escalate. It is usually an intermittent response to conflict, and in therapy can be examined and channeled into more positive expression. Patriarchal terrorism, however, is systematic male violence with the goal of control. It may not be possible or advisable to include a chronically violent partner in the family therapy process.

Child abuse or neglect is another serious consideration. Children in violent homes have more physical, mental, and emotional health problems than do children in nonviolent homes. Children of people with alcohol abuse disorders suffer more injuries and poisonings than do children in the general population. Research has shown that when families exhibit both of these behaviors—substance abuse and child maltreatment—the problems must be treated simultaneously to ensure a child's safety. It should be noted that the withdrawal experienced by parents who cease using alcohol or drugs presents specific risks. The effects of withdrawal often cause a parent to experience intense emotions, which may increase the likelihood of child maltreatment. During this time, it is especially important that family support resources be made available to the family (Bavolek 1995), and that children know how to find safe adults to help. Any time a counselor suspects child abuse or neglect, laws require immediate reporting to local authorities. For further information, see TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000b).

Domestic violence is a serious issue among people with substance use disorders, and it must be factored into therapeutic considerations. If, for example, a restraining order prohibits spouses from seeing each other, the treatment provider must work within this limitation, using therapeutic configurations that make sure that a client who is abusive is not in a session with the person he or she has been barred from seeing. Often when there is concomitant family violence, the offender is mandated to complete a Batterer's Intervention Program before participating in any couple's work. At the same time, the victim/spouse is engaged in safety planning and sometimes treatment for his or her own issues.

Only the most extreme anger contraindicates family therapy. Kaufman and Pattison (1981) developed the concept of the need for a period of abstinence before sufficient trust can be built to counteract the anger. Including all family members in treatment and providing them a forum for releasing their anger may help to work toward that threshold. Redefining the problem as residing within the family as a whole can help transform the anger into motivation for change. In turn, this motivation can be used to restructure the family's interactions so that the substance abuse is no longer supported. The therapist's ability to reframe proposed obstructions by family members is often the key to creating a positive therapeutic direction.

It is up to counselors and therapists to assess the potential for anger and violence and to construct therapy so it can be conducted without endangering any family members. Because of the life-and-death nature of this responsibility, the consensus panel includes guidelines for the screening and treatment of people caught up in the cycle of family violence. These recommendations, adapted from TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997b), are presented in appendix C. However, these guidelines are not a substitute for training; counselors and therapists should have training and supervision in handling family violence cases.

If, during the screening interview, it becomes clear that a batterer is endangering a client or a child, the treatment provider should respond to this situation before any other issue and, if necessary, suspend the rest of the screening interview until the safety of the client can be ensured. The provider should refer the client or child to a domestic violence program and possibly to a shelter and legal services, and should take necessary steps to ensure the safety of affected children. Any outcry of anticipated danger needs to be regarded with the utmost seriousness and immediate precautions taken.

Goals of This TIP

General Goals

Connections

The integration of family therapy into substance abuse treatment is an important development in the treatment of addictions. Historically, barriers have separated the fields, among them differences in credentialing, treatment models, and cost for higher-trained family therapists.

This TIP is intended to provide an opportunity for providers from both disciplines to learn from one another. It provides language that will help both fields talk about family therapy and addiction and facilitate a new and more collaborative way of thinking about substance abuse treatment.

In many States and jurisdictions, credentialing requirements are raising standards for substance abuse counselors and family therapists. These changes, which will require further education, provide opportunities for practitioners to expand their horizons as they upgrade their professional skills. This process can further cross-fertilize the fields by making the practitioners of both fields more familiar with each other's work.

Coverage for family therapy

The consensus panel hopes that substance abuse treatment and family therapy

practitioners will be able to use this TIP to help educate insurers and behavioral managed care organizations about the importance of covering family therapy services for clients with substance use disorders.

Goals for Specific Groups

Substance abuse treatment counselors

This TIP will help substance abuse treatment counselors

- Understand the impact of substance abuse on families taken as a whole
- Recognize that family members need treatment in the context of the family as a whole
- Appreciate the value of family therapy in treatment and integrate their interventions with the greater good of the family

Family therapists and other clinicians

This TIP will help family therapists become more aware of the presence and significance of chemical dependency and work with the substance abuse treatment community so family environments no longer contribute to or maintain substance abuse. It also is hoped that family therapists will come to appreciate models of substance abuse treatment and the context in which they are delivered.

Clinical supervisors

Clinical supervisors in substance abuse treatment programs and in family treatment programs can use this information to become aware of and knowledgeable about the potential connections between substance abuse treatment and family therapy. These supervisors will then be better equipped to incorporate appropriate family approaches into their programs and evaluate the performance of personnel and programs in both disciplines.

Treatment program administrators

Realizing how beneficial family therapy can be as an adjunct to or integrated part of substance abuse treatment, program administrators can use the TIP to train and motivate substance abuse treatment clinicians to include family members in treatment. Likewise, program administrators in family treatment programs can use the TIP to motivate and train family therapists to include the exploration of substance use disorders in family treatment.

Since it is difficult to find counselors who are expert in both fields, it is hoped that substance abuse treatment administrators will develop collaborative relationships with family therapy programs and manage necessary logistical issues. For example, finding adequate space is often an issue. Working hours, too, may have to be shifted, because staff will need to work some evenings to meet with family members.

Families

The consensus panel hopes that family therapists will begin to raise the issue of substance use as a critical issue that can negatively impact families and that substance abuse treatment counselors will use information in this TIP to inform families about what they can expect from treatment. The growing consumer health movement can be part of the education that emboldens families to ask for adequate treatment. The IP and family members should be encouraged to identify

- Why is treatment being pursued now?
- What are the costs and benefits of engaging in therapy now?
- How is “change” defined in the structure of “progress” in therapy?
- What are the key components of treatment for the family?

2 Impact of Substance Abuse on Families

In This Chapter...

Introduction

Families With a Member Who Abuses Substances

Other Treatment Issues

Overview

Family structures in America have become more complex—growing from the traditional nuclear family to single-parent families, stepfamilies, foster families, and multigenerational families. Therefore, when a family member abuses substances, the effect on the family may differ according to family structure. This chapter discusses treatment issues likely to arise in different family structures that include a person abusing substances. For example, the non–substance-abusing parent may act as a “superhero” or may become very bonded with the children and too focused on ensuring their comfort. Treatment issues such as the economic consequences of substance abuse will be examined as will distinct psychological consequences that spouses, parents, and children experience. This chapter concludes with a description of social issues that coexist with substance abuse in families and recommends ways to address these issues in therapy.

Introduction

A growing body of literature suggests that substance abuse has distinct effects on different family structures. For example, the parent of small children may attempt to compensate for deficiencies that his or her substance-abusing spouse has developed as a consequence of that substance abuse (Brown and Lewis 1999). Frequently, children may act as surrogate spouses for the parent who abuses substances. For example, children may develop elaborate systems of denial to protect themselves against the reality of the parent's addiction. Because that option does not exist in a single-parent household with a parent who abuses substances, children are likely to behave in a manner that is not age-appropriate to compensate for the parental deficiency (for more information, see *Substance Abuse Treatment: Addressing the Specific Needs of Women* [Center for Substance Abuse Treatment (CSAT) in development *e*] and TIP 32, *Treatment of Adolescents With Substance Use Disorders* [CSAT 1999*e*]). Alternately, the aging parents of adults with substance use disorders may maintain inappropriately dependent relationships with their grown

offspring, missing the necessary “launching phase” in their relationship, so vital to the maturational processes of all family members involved.

People who abuse substances are likely to find themselves increasingly isolated from their families.

The effects of substance abuse frequently extend beyond the nuclear family. Extended family members may experience feelings of abandonment, anxiety, fear, anger, concern, embarrassment, or guilt; they may wish to ignore or cut ties with the person abusing substances. Some family members even may feel the need for legal protection from the person abusing substances. Moreover, the effects

on families may continue for generations. Intergenerational effects of substance abuse can have a negative impact on role modeling, trust, and concepts of normative behavior, which can damage the relationships between generations. For example, a child with a parent who abuses substances may grow up to be an overprotective and controlling parent who does not allow his or her children sufficient autonomy.

Neighbors, friends, and coworkers also experience the effects of substance abuse because a person who abuses substances often is unreliable. Friends may be asked to help financially or in other ways. Coworkers may be forced to compensate for decreased productivity or carry a disproportionate share of the workload. As a consequence, they may resent the person abusing substances.

People who abuse substances are likely to find themselves increasingly isolated from their families. Often they prefer associating with others who abuse substances or participate in some

other form of antisocial activity. These associates support and reinforce each other’s behavior.

Different treatment issues emerge based on the age and role of the person who uses substances in the family and on whether small children or adolescents are present. In some cases, a family might present a healthy face to the community while substance abuse issues lie just below the surface.

Reilly (1992) describes several characteristic patterns of interaction, one or more of which are likely to be present in a family that includes parents or children abusing alcohol or illicit drugs:

1. *Negativism*. Any communication that occurs among family members is negative, taking the form of complaints, criticism, and other expressions of displeasure. The overall mood of the household is decidedly downbeat, and positive behavior is ignored. In such families, the only way to get attention or enliven the situation is to create a crisis. This negativity may serve to reinforce the substance abuse.
2. *Parental inconsistency*. Rule setting is erratic, enforcement is inconsistent, and family structure is inadequate. Children are confused because they cannot figure out the boundaries of right and wrong. As a result, they may behave badly in the hope of getting their parents to set clearly defined boundaries. Without known limits, children cannot predict parental responses and adjust their behavior accordingly. These inconsistencies tend to be present regardless of whether the person abusing substances is a parent or child and they create a sense of confusion—a key factor—in the children.
3. *Parental denial*. Despite obvious warning signs, the parental stance is: (1) “What drug/alcohol problem? We don’t see any drug problem!” or (2) after authorities intervene: “You are wrong! My child does not have a drug problem!”
4. *Miscarried expression of anger*. Children or parents who resent their emotionally deprived home and are afraid to express

their outrage use drug abuse as one way to manage their repressed anger.

5. *Self-medication.* Either a parent or child will use drugs or alcohol to cope with intolerable thoughts or feelings, such as severe anxiety or depression.
6. *Unrealistic parental expectations.* If parental expectations are unrealistic, children can excuse themselves from all future expectations by saying, in essence, “You can’t expect anything of me—I’m just a pothead/speed freak/junkie.” Alternatively, they may work obsessively to overachieve, all the while feeling that no matter what they do it is never good enough, or they may joke and clown to deflect the pain or may withdraw to side-step the pain. If expectations are too low, and children are told throughout youth that they will certainly fail, they tend to conform their behavior to their parents’ predictions, unless meaningful adults intervene with healthy, positive, and supportive messages.

In all of these cases, what is needed is a restructuring of the entire family system, including the relationship between the parents and the relationships between the parents and the children. The next section discusses treatment issues in different family structures that include a person who is abusing substances.

Families With a Member Who Abuses Substances

Client Lives Alone or With Partner

The consequences of an adult who abuses substances and lives alone or with a partner are likely to be economic and psychological. Money may be spent for drug use; the partner who is not using substances often assumes the provider role. Psychological consequences may include denial or protection of the person with the substance abuse problem, chronic anger,

stress, anxiety, hopelessness, inappropriate sexual behavior, neglected health, shame, stigma, and isolation.

In this situation, it is important to realize that both partners need help. The treatment for either partner will affect both, and substance abuse treatment programs should make both partners feel welcome. If a person has no immediate family, family therapy should not automatically be ruled out. Issues regarding a person’s lost family, estranged family, or family of origin may still be relevant in treatment. A single person who abuses substances may continue to have an impact on distant family members who may be willing to take part in family therapy. If family members come from a distance, intensive sessions (more than 2 hours) may be needed and helpful. What is important is not how many family members are present, but how they interact with each other.

In situations where one person is substance dependent and the other is not, questions of codependency arise. Codependency has become a popular topic in the substance abuse field. Separate 12-Step groups such as Al-Anon and Alateen, Co-Dependents Anonymous (CoDA), Adult Children of Alcoholics, Adult Children Anonymous, Families Anonymous, and Co-Anon have formed for family members (see appendix D for a listing of these and other resources).

CoDA describes codependency as being overly concerned with the problems of another to the detriment of attending to one’s own wants and needs (CoDA 1998). Codependent people are thought to have several patterns of behavior:

- They are controlling because they believe that others are incapable of taking care of themselves.
- They typically have low self-esteem and a tendency to deny their own feelings.
- They are excessively compliant, compromising their own values and integrity to avoid rejection or anger.

- They often react in an oversensitive manner, as they are often hypervigilant to disruption, troubles, or disappointments.
- They remain loyal to people who do nothing to deserve their loyalty (CoDA 1998).

Although the term “codependent” originally described spouses of those with alcohol abuse disorders, it has come to refer to any relative of a person with any type of behavior or psychological problem. The idea has been criticized for pathologizing caring functions, particularly those that have traditionally been part of a woman’s role, such as empathy and self-sacrifice. Despite the term’s common use, little scientific inquiry has focused on codependence. Systematic research is needed to establish the nature of codependency and why it might be important (Cermak 1991; Hurcom et al. 2000; Sher 1997). Nonetheless, specifically targeted behavior that somehow reinforces the current or past using behavior must be identified and be made part of the treatment planning process.

Client Lives With Spouse (or Partner) and Minor Children

Similar to maltreatment victims, who believe the abuse is their fault, children of those with alcohol abuse disorders feel guilty and responsible for the parent’s drinking problem. Children whose parents abuse illicit drugs live with the knowledge that their parents’ actions are illegal and that they may have been forced to engage in illegal activity on their parents’ behalf. Trust is a key child development issue and can be a constant struggle for those from family systems with a member who has a substance use disorder (Brooks and Rice 1997).

Most available data on the enduring effects of parental substance abuse on children suggest that a parent’s drinking problem often has a detrimental effect on children. These data show that a parent’s alcohol problem can have cognitive, behavioral, psychosocial, and emotional consequences for children. Among the lifelong problems documented are impaired learning

capacity; a propensity to develop a substance use disorder; adjustment problems, including increased rates of divorce, violence, and the need for control in relationships; and other mental disorders such as depression, anxiety, and low self-esteem (Giglio and Kaufman 1990; Johnson and Leff 1999; Sher 1997).

The children of women who abuse substances during pregnancy are at risk for the effects of fetal alcohol syndrome, low birth weight (associated with maternal addiction), and sexually transmitted diseases. (For information about the effects on children who are born addicted to substances, see TIP 5, *Improving Treatment for Drug-Exposed Infants* [CSAT 1993a].) Latency age children (age 5 to the onset of puberty) frequently have school-related problems, such as truancy. Older children may be forced prematurely to accept adult responsibilities, especially the care of younger siblings. In adolescence, drug experimentation may begin. Adult children of those with alcohol abuse disorders may exhibit problems such as unsatisfactory relationships, inability to manage finances, and an increased risk of substance use disorders.

Although, in general, children with parents who abuse substances are at increased risk for negative consequences, positive outcomes have also been described. Resiliency is one example of a positive outcome (Werner 1986). Some children seem better able to cope than others; the same is true of spouses (Hurcom et al. 2000). Because of their early exposure to the adversity of a family member who abuses substances, children develop tools to respond to extreme stress, disruption, and change, including mature judgment, capacity to tolerate ambiguity, autonomy, willingness to shoulder responsibility, and moral certitude (Wolin and Wolin 1993). Nonetheless, substance abuse can lead to inappropriate family subsystems and role taking. For instance, in a family in which a mother uses substances, a young daughter may be expected to take on the role of mother. When a child assumes adult roles and the adult abusing substances plays the role of a child, the boundaries essential to family functioning are

blurred. The developmentally inappropriate role taken on by the child robs her of a childhood, unless there is the intervention by healthy, supportive adults.

The spouse of a person abusing substances is likely to protect the children and assume parenting duties that are not fulfilled by the parent abusing substances. If both parents abuse alcohol or illicit drugs, the effect on children worsens. Extended family members may have to provide care as well as financial and psychological support. Grandparents frequently assume a primary caregiving role. Friends and neighbors may also be involved in caring for the young children. In cultures with a community approach to family care, neighbors may step in to provide whatever care is needed. Sometimes it is a neighbor who brings a child abuse or neglect situation to the attention of child welfare officials. Most of the time, however, these situations go unreported and neglected.

Client Is Part of a Blended Family

Anderson (1992) notes that many people who abuse substances belong to stepfamilies. Even under ordinary circumstances, stepfamilies present special challenges. Children often live in two households in which different boundaries and ambiguous roles can be confusing. Effective coparenting requires good communication and careful attention to possible areas of conflict, not only between biological parents, but also with their new partners. Popenoe (1995) believes that the difficulty of coordinating boundaries, roles, expectations, and the need for cooperation, places children raised in blended households at far greater risk of social, emotional, and behavioral problems. Children from stepfamilies may develop substance abuse problems to cope with their confusion about family rules and boundaries.

Substance abuse can intensify problems and become an impediment to a stepfamily's integration and stability. When substance abuse is part of the family, unique issues can arise. Such issues might include parental authority disputes, sexual or physical abuse, and

self-esteem problems for children.

Substance abuse by stepparents may further undermine their authority, lead to difficulty in forming bonds, and impair a family's ability to address problems and sensitive issues. If the noncustodial parent abuses drugs or alcohol, visitation may have to be supervised. (Even so, visitation is important. If contact stops, children often blame themselves or the drug problem for a parent's absence.)

If a child or adolescent abuses substances, any household can experience conflict and continual crisis. Hoffmann (1995) found that increased adolescent marijuana use occurs more frequently when an adolescent living with a divorced parent and stepparent becomes less attached to the family. With fewer ties to the family, the likelihood increases that the adolescent will form attachments to peers who abuse substances. Weaker ties to the family and stronger ones to peers using drugs increase the chances of the adolescent starting to use marijuana or increasing marijuana use.

Stepparents living in a household in which an adolescent abuses substances may feel they have gotten more than they bargained for and resent the time and attention the adolescent requires from the biological parent. Stepparents may demand that the adolescent leave the household and live with the other parent. In fact, a child who is acting out and abusing substances is not likely to be welcomed in either household (Anderson 1992).

Clinicians treating substance abuse should know that the family dynamics of blended families differ somewhat from those of nuclear families and require some additional

Data on the enduring effects of parental substance abuse on children suggest that a parent's drinking problem often has a detrimental effect on children.

considerations. Anderson (1992) identifies strategies for addressing substance abuse in a stepfamily:

- The use of a genogram, which graphically depicts significant people in the client's life, helps to establish relationships and pinpoint where substance abuse is and has been present (see chapter 3).
- Extensive historical work helps family members exchange memories that they have not previously shared.
- Education can provide a realistic expectation of what family life can be like.
- The development of correct and mutually acceptable language for referring to family relationships helps to strengthen family ties. The goal of family therapy is to restructure maladaptive family interactions that are associated with the substance abuse problem. To do this, the counselor first has to earn the family's trust, which means approaching family members on their own terms.

Older Client Has Grown Children

When an adult, age 65 or older, abuses a substance it is most likely to be alcohol and/or prescription medication. The 2002 National

Household Survey on Drug Abuse found that 7.5 percent of older adults reported binge and 1.4 percent reported heavy drinking within the past month of the survey (Office of Applied Studies [OAS] 2003a).

Veterans hospital data indicate that, in many cases, older adults may be receiving excessive amounts of one class of addictive tranquilizer (benzodi-

azepines), even though they should receive lower doses. Further, older adults take these drugs longer than other age groups (National Institute on Drug Abuse [NIDA] 2001). Older adults consume three times the number of prescription medicine as the general population, and this trend is expected to grow as children of the Baby Boom (born 1946–1958) become senior citizens (NIDA 2001).

As people retire, become less active, and develop health problems, they use (and sometimes misuse) an increasing number of prescription and over-the-counter drugs. Among older adults, the diagnosis of this (or any other) type of substance use disorder often is difficult because the symptoms of substance abuse can be similar to the symptoms of other medical and behavioral problems that are found in older adults, such as dementia, diabetes, and depression. In addition, many health care providers underestimate the extent of substance abuse problems among older adults, and, therefore, do not screen older adults for these problems.

Older adults often live with or are supported by their adult children because of financial necessity. An older adult with a substance abuse problem can affect everyone in the household. If the older adult's spouse is present, that person is likely to be an older adult as well and may be bewildered by new and upsetting behaviors. Therefore, a spouse may not be in a position to help combat the substance abuse problem. Additional family resources may need to be mobilized in the service of treating the older adult's substance use disorder. As with child abuse and neglect, elder maltreatment is a statutory requirement for reporting to local authorities.

Whether grown children and their parents live together or apart, the children must take on a parental, caretaking role. Adjustment to this role reversal can be stressful, painful, and embarrassing. In some cases, grown children may stop providing financial support because it is the only influence they have over the parent. Adult children often will say to "let them have their little pleasure." In other instances, chil-

Many health care providers underestimate the extent of substance abuse problems among older adults.

dren may cut ties with the parent because it is too painful to have to watch the parent's deterioration. Cutting ties only increases the parent's isolation and may worsen his predicament.

For a detailed discussion of substance problems in older adults, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997a) and TIP 26, *Substance Abuse Among Older Adults* (CSAT 1998d). See also chapter 5.

Client Is an Adolescent and Lives With Family of Origin

Substance use and abuse among adolescents continues to be a serious condition that impacts cognitive and affective growth, school and work relationships, and all family members. In the National Household Survey on Drug Abuse, of adolescents ages 12 to 17, 10.7 percent reported binge use of alcohol (five drinks on one occasion in the last month before the survey) and 2.5 percent reported heavy alcohol use (at least five binges in the previous month) (OAS 2003a). In addition, two trends described in TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999e), are increasing rates of substance use by youth and first onset of substance use at younger ages.

In a general population sample of 10- to 20-year-olds, roughly 12.4 percent (96 of 776) met criteria for a substance use disorder (Cohen et al. 1993). Alcohol and other psychoactive drugs play a prominent role in violent death for teenagers, including homicide, suicide, traffic accidents, and other injuries. Aside from death, drug use can lead to a range of possible detrimental consequences:

- Violent behavior
- Delinquency
- Psychiatric disorders
- Risky sexual behavior, possibly leading to unwanted pregnancy or sexually transmitted diseases
- Impulsivity
- Neurological impairment

- Developmental impairment (Alexander and Gwyther 1995; CSAT 1999e)

As youth abuse alcohol and illicit drugs, they may establish a continuing pattern of behavior that damages their legal record, educational options, psychological stability, and social development. Drug use (particularly inhalants and solvents) may lead to cognitive deficits and perhaps irreversible brain damage. Adolescents who use drugs are likely to interact primarily with peers who use drugs, so relationships with friends, including relationships with the opposite sex, may be unhealthy, and the adolescent may develop a limited repertoire of social skills.

When an adolescent uses alcohol or drugs, siblings in the family may find their needs and concerns ignored or minimized while their parents react to constant crises involving the adolescent who abuses drugs. The neglected siblings and peers may look after themselves in ways that are not age-appropriate, or they might behave as if the only way to get attention is to act out.

Clinicians should not miss opportunities to include siblings, who are often as influential as parents, in the family therapy sessions treating substance abuse. Whether they are adults or children, siblings can be an invaluable resource. In addition, Brook and Brook (1992) note that sibling relationships characterized by mutual attachment, nurturance, and lack of conflict can protect adolescents against substance abuse.

Another concern often overlooked in the literature is the case of the substance-using adolescent whose parents are immigrants and cannot speak English. Immigrant parents often are perplexed by their child's behavior. Degrees of acculturation between family members create greater challenges for the family to address substance abuse issues and exacerbate intergenerational conflict.

In many families that include adolescents who abuse substances, at least one parent also abuses substances (Alexander and Gwyther 1995).

This unfortunate modeling can set in motion a dangerous combination of physical and emotional problems. If adolescent substance use is met with calm, consistent, rational, and firm responses from a responsible adult, the effect on adolescent learning is positive. If, however, the responses come from an impaired parent, the hypocrisy will be obvious to the adolescent, and the result is likely to be negative. In some instances, an impaired parent might form an alliance with an adolescent using substances to keep secrets from the parent who does not use substances. Even worse, sometimes in families with multigenerational patterns of substance abuse, an attitude among extended family members may be that the adolescent is just conforming to the family history.

Since the early 1980s, treating adolescents who abuse substances has proven to be effective. Nevertheless, most adolescents will deny that alcohol or illicit drug use is a problem and do not enter treatment unless parents, often with the help of school-based student assistant programs or the criminal justice system, require them to do so. Often, a youngster's substance abuse is hidden from members of the extended family. Adolescents who are completing treatment need to be prepared for going back to an actively addicted family system. Alateen, along with Alcoholics Anonymous, can be a part of adolescents' continuing care, and participating in a recovery support group at school (through student assistance) also will help to reinforce recovery.

For more information on substance use among adolescents, see chapter 5. See also TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999c), and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999e).

Someone Not Identified as the Client Abuses Substances

Substance abuse may not be the presenting issue in a family. Initially, it may be hidden, only to become apparent during therapy. If any

suspicion of substance abuse emerges, the counselor or therapist should evaluate the degree to which substance abuse has a bearing on other issues in the family and requires direct attention.

When someone in the family other than the person with presenting symptoms is involved with alcohol or illicit drugs, issues of blame, responsibility, and causation will arise. With the practitioner's help, the family needs to refrain from blaming, and reveal and repair family interactions that create the conditions for substance abuse to continue.

Other Treatment Issues

In any form of family therapy for substance abuse treatment, consideration should be given to the range of social problems connected to substance abuse. Problems such as criminal activity, joblessness, domestic violence, and child abuse or neglect may also be present in families experiencing substance abuse. To address these issues, treatment providers need to collaborate with professionals in other fields. This is also known as concurrent treatment.

Whenever family therapy and substance abuse treatment take place concurrently, communication between clinicians is vital. In addition to family therapy and substance abuse treatment, multifamily group therapy, individual therapy, and psychological consultation might be necessary. With these different approaches, coordination, communication, collaboration, and exchange of the necessary releases of confidential information are required.

With concurrent treatment, it is important that goal diffusion does not occur. Empowering the family is a benefit of family therapy that should not be sacrificed. If family therapy and substance abuse treatment approaches conflict, these issues should be addressed directly. Case conferencing often is an efficient way to deal constructively with multiple concerns and provides a forum to determine mutually agreeable priorities and treatment plan coordination.

Some concurrent treatment may not involve the person with alcohol or illicit drug problems. Even if this person is not in treatment, family therapy with the partner and other family members can often begin, or family therapy can be an addition to substance abuse treatment. The detoxification period also presents valuable opportunities to involve family members in treatment. Family therapy may have more of an impact on family members than it does on the IP because it enhances all family members' ability to work through conflicts. It may establish healthy family conditions that support the IP moving into recovery later in his or her life, after the episode of treatment has ended. Sometimes the person who abuses substances will not allow contact with the family, which limits the

possibilities of family therapy, but family involvement in substance abuse treatment can still remain a goal; this “resistance” can be restructured by allying with the person with the substance use disorder and stressing the importance of and need for family participation in treatment. Resiliency within the family system is a developing area of interest (for more information see, for example, <http://www.WestEd.org>).

Chapter 2 Summary Points From a Family Counselor Point of View

- Consider the “family” from the client’s point of view—that is, who would the client describe as a family member and who is a “significant other” for the client.
- Assess the “family”-members’ effectiveness of communications, supportiveness or negativity, parenting skills, conflict management, and understanding of addictive disease.
- Don’t give up, and try, try again—many families or family members at first reject any participation in the treatment process. But, after a period of separation from the client who is abusing substances, family members often become willing to at least attend an initial session with the counselor.

3 Approaches to Therapy

In This Chapter...

Differences in Theory and Practice

Family Therapy for Substance Abuse Counselors

Substance Abuse Treatment for Family Therapists

Overview

This chapter discusses the fields of substance abuse treatment and family therapy. The information presented will help readers from each field form a clearer idea of how the other operates. It also will present some of the basic theories, concepts, and techniques from each field so they can be applied in treatment regardless of the setting or theoretical orientation.

Substance abuse treatment and family therapy are distinct in their histories, professional organizations, preferred intervention techniques, and focuses of treatment. Training and licensing requirements are different, as are rules (both formal and informal) that govern conduct. The two fields have developed their own vocabularies. These differences have significant and lasting effects on how practitioners approach clients, define their problems, and undertake treatment.

Despite these variations, providers from both fields will continue to treat many of the same clients. It is useful, therefore, for clinicians in each field to understand the treatment that the other field provides and to draw on that knowledge to improve prospects for professional collaboration. The ultimate goal of increased understanding is the provision of substance abuse treatment that is fully integrated with professional family therapy.

Differences in Theory and Practice

Theory

The fields of substance abuse treatment and family therapy share many common assumptions, approaches, and techniques, but differ in significant philosophical and practical ways that affect treatment approaches and goals for treatment. Further, within each discipline, theory and practice differ. Although of the two, substance abuse treatment is

Denial and Resistance

The fields of substance abuse treatment and family therapy often use different terms and sometimes understand the same terms differently. For example, the term denial can have different meanings for a substance abuse counselor and a family therapist. Two family therapists with different theoretical orientations also may understand the meaning in different ways.

In substance abuse treatment, the term *denial* is generally used to describe a common reaction of people with substance use disorders who, when confronted with the existence of those disorders, deny that they have a substance abuse problem. This is a complex reaction that is the product of psychological and physiological factors, especially those concerned with memory and the influence of euphoria produced by the substance of abuse. It is not a deliberate, willful act on the part of the person who is abusing substances but is rather a set of defenses and distortions in thinking caused by the use of substances.

Family therapists' understanding of the term *denial* will vary more according to the particular therapist's theoretical orientation. For example, structural and strategic therapists might see denial as a *boundary issue* (referring to a barrier within the family structure of relationships), which may be necessary for maintaining an alliance or contributing to relationships that are too close or *enmeshed*. On the other hand, a solution-focused therapist might see denial as a strategy for maintaining stability and therefore not a "problem" at all, while a narrative therapist will simply see denial as another element in a person's story.

Resistance is, in contrast, a relatively straightforward negative response to someone expecting you to do something that you do not want to do. The clinician can minimize resistance by understanding the client's stage of change and being prepared to work with the client based on interventions geared to that stage. If clinicians treat individual clients (or their families) at their actual stage of readiness or level of motivation to change, they should encounter minimal client resistance. In other words, clinicians can only do so much when a client is not ready to change or try a new behavior. Still, counselors can help the client move slowly from one stage of change to another. If treatment is in sync with readiness for that treatment, resistance should not become a significant problem.

Resistance may be based on the client not yet being able to do something. When therapists can accept that clients are not always "resisting" because they don't want to do something, but perhaps because they are unable to do something, they are better able to enter the client's world to explore what is causing the resistance.

There is a difference between the therapist saying (or believing) "You refuse to do _____" and saying/believing, "Let's explore what could be in the way of your doing _____." One way of dealing with client resistance is to offer the client some typical reasons for not complying: e.g., "Sometimes, when a client is unable to talk about his early childhood, it is because he is ashamed or embar-

rassed or afraid of crying or perhaps that I (the therapist) might think the information is bizarre. I wonder if this is something that is going on with you?” The same technique works with resistance to therapeutic suggestions for carrying out a plan constructed during a therapy session: “Sometimes, a client does not carry out the plan we’ve made because I was moving too fast or perhaps didn’t know all of the dynamics that you find when you get home, or maybe because we didn’t talk enough about the potential consequences for carrying out the action, for instance, maybe your child will run away or you need to try some other things first.”

Source: Consensus Panel.

generally more uniform in its approach, in both cases certain generalizations apply to the practice of the majority of providers. Two concepts essential to both fields are denial and resistance presented by clients.

Clinical research (e.g., Szapocznik et al. 1988) has demonstrated that resistance (whether on the part of the person with a substance use disorder or on the part of another family member) to engaging family members into therapy accurately may reflect the family dynamics that help to maintain the substance abuse problem. Therefore, it may be important to work with the client and family to restructure this resistance in order to bring the family into treatment and correct the maladaptive interactional patterns that are related to the substance abuse problem.

Many substance abuse treatment counselors base their understanding of a family’s relation to substance abuse on a *disease model* of substance abuse. Within this model, practitioners have come to appreciate substance abuse as a “family disease”—that is, a disease that affects all members of a family as a result of the substance abuse of one or more members and that creates negative changes in their own moods, behaviors, relationships with the family, and sometimes even physical or emotional health. In other words, the individual member’s substance abuse and the pain and confusion of the family relate to each other as cause and effect. Berenson and Schrier (1998) note that the

disease model is pragmatic in orientation, having developed typically through practice and not having been drawn from theory or controlled experimentation. The disease model also views substance use disorders as having a genetic component and as being similar to recurrent medical diseases in that both are “chronic, progressive, relapsing, incurable, and potentially fatal” (Inaba et al. 1997, p. 66).

Family therapists, on the other hand, for the most part have adopted a *family systems model*. It conceptualizes substance abuse as a symptom of dysfunction in the family—a relatively stable symptom because in some way it serves a purpose in the family system. It is this focus on the family system, more than the inclusion of more people, that defines family therapy. The size of the family system can vary from two (in couples therapy) to an extended family, and may even involve multiple systems (for instance, schools and workplaces) that affect family members (Walsh 1997).

This theoretical perspective emphasizes reciprocal relationships. Substance abuse is believed to interact with dysfunctional family relationships, thereby maintaining both problems. Family therapists believe that interpersonal relationships need to be altered so that the family becomes an environment within which the person abusing substances can stop or decrease use and the needs of family members can be met. Family systems approaches have been developed out of a strong theoretical tradition,

but do not have many empirical studies validating their effectiveness (Berenson and Schrier 1998). (See TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* [Center for Substance Abuse Treatment (CSAT) 1999a], for more information on the specific approaches to family therapy, all of which draw on a systems model.)

The fields of family therapy and substance abuse treatment, despite their basic differences, are compatible. For example, family therapy may seem to have a monopoly on the systems approach, and substance abuse treatment may appear to focus solely on the individual, with less emphasis on the individual's relationship to any larger system. In fact, however, both family therapy and substance abuse treatment actually understand substance abuse in relation to systems. They simply focus treatment on different systems. Substance abuse treatment providers typically focus on a system consisting of a person with a substance use disorder and the nature of addiction. Family therapists see the system as a person in relation to the family. Clearly, the reaction of the family to the client, the reaction of the client to the family, and the nature of addiction can be mutually reinforcing dynamics.

Clinicians in both fields address client interactions with a system that involves something outside the self. It should be noted that neither substance abuse treatment nor family therapy routinely considers other, broader systems: culture and society. Multiple systems affect people with substance use disorders at different levels (individual, family, culture, and society), and truly comprehensive treatment would take all of them into consideration. Family and substance abuse treatment potentially undervalue the influence and power of gender and stereotypical roles imposed by the culture. Feminist and cultural family therapists caution that by ignoring the power differentials within and between cultures, therapists can potentially harm the client and family. For example, by not recognizing the differences in power between men and women, and advocating for parity and equality in a relationship, the

therapist might disrupt the power differential in a family and, if not addressed, cause more conflict and potential harm to the family.

The mental health field in general now recognizes addiction as an independent illness warranting specific treatment on an equal footing with mental health treatment (CSAT in development *k*). So, too, have the majority of family therapists (and group therapists—see CSAT in development *g*) recognized the importance of direct treatment attention for the addictive disorder in addition to family therapy interventions.

Practice

Following is a general overview of the differences that exist among many, but certainly not all, substance abuse and family therapy settings and practitioners.

Family interventions

Substance abuse treatment programs that involve the family of a person who is abusing substances generally use family interventions that differ from those used by family therapists. Psychoeducation and multifamily groups are more common in the substance abuse treatment field than in family therapy. Family interventions in substance abuse treatment typically refer to a confrontation that a group of family and friends have with a person abusing substances. Their goal is to convey the impact of the substance abuse and to urge entry into treatment. The treatment itself is likely to be shorter and more time-limited than that of a family therapist (although some types of family therapy, such as strategic family therapy, are brief).

The understanding of the relative importance of different issues in a client's recovery naturally influences the techniques and interventions used in substance abuse treatment and family therapy. Family therapists will focus more on intrafamily relationships while substance abuse treatment providers concentrate on helping clients achieve abstinence.

Spirituality

Spirituality is another practice that clinicians in the two fields approach differently. In part because of the role of spirituality in 12-Step groups, substance abuse treatment providers generally consider this emphasis more important than do family therapists. Family therapy developed from the mental health medical field, and as such the emphasis on the scientific underpinnings to medical practice reduced the role of spirituality, especially in theory and largely in clinical practice. The lack of emphasis on spiritual life in family therapy continues even though religious affiliation has been shown to negatively correlate with substance abuse (Miller et al. 2000; National Center on Addiction and Substance Abuse 2001; Pardini et al. 2000). Some family therapy is conducted within religious settings, often by licensed pastoral counselors. However, a standard concept of spirituality, whether religious in origin or otherwise, has not yet been clearly agreed on by clinicians of any discipline in the substance abuse treatment field.

Process and content

Family therapy generally attends more to the *process* of family interaction, while substance abuse treatment is usually more concerned with the planned *content* of each session. The family therapist is trained to observe the interactions of family members and employ treatment methods in response to those observations. Some family therapists may even see a client's substance abuse as a content issue (and therefore less significant than the family interactions).

For example, a wife might begin describing how upset and hopeless she felt when her husband had a slip, only to be interrupted by him in a subtly threatening tone and/or condescending manner. The family therapist might zero in on whether the husband regularly interrupts and aggressively changes the course of a conversation whenever his wife expresses emotions—in other words, is what just occurred an instance of a general pattern of interaction (process) between husband and wife? And, what is the

purpose/goal of the process—is it the husband's way of avoiding emotions or of avoiding his own disappointment about the slip and inability to have protected his wife from the consequence of illness? On the other hand, a substance abuse counselor might concentrate on the content of the issues raised by the interchange—that is, the counselor might point out to the husband that alcoholism is a family disease, that his slip does have serious consequences, and that his slip and his wife's initial upset and hopelessness are how the disease of alcoholism separates the person with the substance abuse disorder from what is held dear. The counselor might further focus on the content issues of handling slips, learning from them, and recognizing that they are sometimes part of a successful recovery.

A number of essential aspects of addictive disease form the general basis for substance abuse counseling. For addictions, certain themes are essential and are always explored—shame, denial, the “cunning, baffling, and powerful” nature of addiction (Alcoholics Anonymous [AA] 1976, pp. 58-59)—as well as the fact that recovery is a long-term proposition. These are all essential in part because most people with substance use disorders enter treatment with beliefs opposite to the facts. In contrast, these differences support the need for more cross-training between the two disciplines.

Focus

Even when treating the same clients with the same problems, clinicians in the fields of family therapy and substance abuse treatment typically

Both family therapy and substance abuse treatment understand substance abuse in relation to systems.

focus on different targets. For instance, if a man who has been abusing cocaine comes with his wife to a substance abuse treatment program, the counselor will identify the substance abuse as the presenting problem. Initially, at least, the substance abuse counselor will see the primary goal as arresting the client's substance use.

Research suggests that counselors and therapists need to balance their self-disclosure.

A family therapist, on the other hand, will see the family system—which could be just the couple—as an integral component of the substance abuse. The goals of the family therapist will usually be broader than the substance abuse counselor's, focusing on improving relational patterns throughout the family system. Because families change their patterns of interaction over the course

of recovery, they are believed to need continued assistance to avoid developing another dysfunctional pattern.

Identity of the client

Most often the substance abuse counselor regards the individual with the substance use disorder as the primary person requiring treatment. While practitioners from both fields would generally agree that a client with a substance use disorder needs to stop using substances, they may not agree on how that end can best be accomplished. A common assumption in substance abuse treatment is that the problems of other family members do not need to be resolved for the client to achieve and maintain abstinence. The substance abuse treatment provider may involve the family to some degree, but the focus remains on the

treatment needs of the person abusing substances. The family therapy community assumes that if long-term change is to occur, the entire family must be treated as a unit, so the family as a whole constitutes the client. Unfortunately, such integrated treatment is not always possible because of lack of funding.

Who is seen in treatment also varies by field. Even though many substance abuse treatment programs feature a component for family members, most counselors and programs will not involve a client's family in early treatment (an exception is the type of interventions that use family and friends to motivate a client to enter treatment). Most substance abuse treatment programs will work with the client's family once a client has achieved some level of abstinence. At the time the client enters treatment, however, substance abuse treatment providers often refer family members, including children, to a separate treatment program or to self-help groups such as Al-Anon, Nar-Anon, and Alateen (see appendix D). While educational support groups offer age-appropriate understanding about addiction as well as opportunities for participants to share their experiences and learn a variety of coping skills, few treatment programs provide such groups. School-age children can also be referred to student assistance programs at their schools.

In contrast, family therapists may not treat clients who are actively abusing substances, but may carry on therapy with other family members. Family therapists do not always meet with all members of the family but with several subgroups at different times, depending on the issues under discussion. For instance, children would likely not be present when parents are discussing marital conflict issues or struggling with the decision to separate or to stay together. However, when the issues under discussion include the behavior of the children, they would be expected to be present. However, children first need age-appropriate services so they can develop the necessary understanding about addiction, sort through their experiences and feelings, and become prepared to participate in family therapy.

Self-disclosure by the counselor

Training in the boundaries related to the therapist's or counselor's self-disclosure is an integral part of any treatment provider's education. Addiction counselors in recovery themselves are trained to recognize the importance of choosing to self-disclose their own addiction histories, and to use supervision appropriately to decide when and what to disclose. An often-used guide for self-disclosure is to consider the reason for revealing personal addiction history to the client, asking the question, "What is the purpose of the revelation? To assist the client in recovery or for my own personal needs?"

Many people who have been in recovery for some time and who have experience in self-help groups have become paraprofessional or professional treatment providers. Clients, it should be emphasized, must be credited and acknowledged for their ability to effect change in their own lives so that they might lay claim to their own change. It is common for substance abuse treatment counselors to disclose information about their own experiences with recovery. Clients in substance abuse treatment often have some previous contact with self-help groups, where people seek help from other recovering people. As a result, clients usually feel comfortable with the counselors' self-disclosure.

The practice of sharing personal history receives much less emphasis in family therapy, in part because of the influence of a psychoanalytic tradition in family therapy. For the family therapist, self-disclosure is not as integral a part of the therapeutic process. It is downplayed because it takes the focus of therapy off of the family. (More recent post-modern therapies such as narrative therapy and collaborative language systems emphasize the meaning of language and the subjectivity of truth. The therapist's talking about personal experiences to gain some shared truth with the client(s) is part of the process. "Truth" is co-created between therapist and client, so sharing is natural and represents what the client perceives and understands, and the therapist

attempts to open up different truths or stories that challenge the client's dominant story.)

Perhaps neither field has taken the best approach to therapist self-disclosure. Research suggests that counselors and therapists need to balance their self-disclosure. If the therapist never discloses anything, the result may be less self-disclosure by the client (Barrett and Berman 2001). Too much self-disclosure, on the other hand, might shut down conversation and decrease client self-disclosure. In addition, such information may be inappropriate for children who are present since they may not be able to process or comprehend the information, therefore adding to their confusion.

Regulations

Finally, different regulations also affect the substance abuse treatment and family therapy fields. This influence comes from both government agencies and third-party payors that affect confidentiality and training and licensing requirements. Federal regulations attempt to guarantee confidentiality for people who seek substance abuse assessment and treatment (42 U.S.C. §290dd-2 and 42 CFR Part 2). Treatment providers should be familiar with regulations in their State that may affect both confidentiality and training and licensing requirements. Confidentiality issues are complex; readers interested in additional information should see TAP 13, *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* (Lopez 1994), and TAP 18, *Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance* (CSAT 1996a).

Confidentiality issues for family therapists are less straightforward. For example, family therapists working with adolescents will have more trouble dealing with issues of client-therapist boundaries and confidentiality. Sometimes when treating adolescents who abuse substances, past or planned criminal behavior is evident. A strong interest in family therapy is restoring the authority of parents, yet State law might restrict the therapist's right to divulge

information to parents unless the adolescent signs a properly worded release document. Laws differ from State to State, but they can be specific and strict about what therapists are required or permitted to do about reporting crime or sharing information with parents. For more information on this subject see TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999e).

Licensure and certification

Forty-two States require licenses for people practicing as family therapists (American Association for Marriage and Family Therapy [AAMFT] 2001). Although the specific educational requirements vary from State to State, most require at least a Master's degree for the person who intends to practice independently as a family therapist. Certain States, such as California, also require particular courses for licensure. Training in substance abuse treatment is generally not required, although the Commission on Accreditation for Marriage and Family Therapy Education of the AAMFT does suggest that family therapists receive some training in substance abuse counseling. (More information on the licensing and certification requirements of the various States is available online at <http://www.aamft.org/iMIS15/AAMFT/>—this Web site also features links to State agencies that oversee certification.)

The International Certification and Reciprocity Consortium (IC&RC) on Alcohol and Other Drug Abuse is the most far-reaching, providing credentials in prevention and/or counseling to counselors in 41 States, Puerto Rico, three branches of the military, 11 foreign countries, and the Indian Health Service. IC&RC has created standards for credentialing substance abuse counselors that require 270 hours of classroom education (on knowledge of substance abuse, counseling, and ethics, as well as assessment, treatment planning, clinical evaluation, and family services), 300 hours of onsite training, and 3 years of supervised work experience (IC&RC 2002).



NAADAC (The Association for Addiction Professionals, formerly the National Association of Alcohol and Drug Abuse Counselors) also provides certification in many States that also have IC&RC reciprocity. For substance abuse counselors at the most basic level, NAADAC demands less monitoring and fewer requirements than does IC&RC, though its higher-level credentials have many more requirements than those at the basic level. NAADAC offers the only Master's level credential based on education and not experience. NAADAC's Web site is <http://www.naadac.org>. In addition, the Addiction Technology Transfer Centers, which are partially funded by CSAT, provide information at the Web site <http://www.nattc.org> with links to State, national, and international bodies that credential counselors. However, there is little training and few credentialing requirements for understanding the impact of addiction on children and effective ways to help them.

Assessment

Specific procedures for assessing clients in substance abuse treatment and family therapy will vary from program to program and practitioner to practitioner. However, an overview of these activities is useful.

Assessment in substance abuse treatment

Assessments for substance abuse treatment programs focus on substance use and history. Figure 3-1 presents an overview of some of the key elements that are examined when assessing a client's substance abuse history—including important related concerns such as family relations, sexual history, and mental health.

Substance abuse counselors may not be familiar with ways family therapy can complement substance abuse treatment. Because of their focus on substances of abuse and the intrapsychic dynamics of the identified patient (IP), counselors simply may not think of referral for family therapy. Other counselors may view conflict in a family as a threat to abstinence and a reason

Figure 3-1

Overview of Key Elements for Inclusion in Assessment

Standard Medical History and Physical Exam, With Particular Attention to the Presence of Any of the Following

- Physical signs or complaints (e.g., nicotine stains, dilated or constricted pupils, needle track marks, unsteady gait, tattoos that designate gang affiliation, “nodding off”)
- Neurological signs or symptoms (e.g., blackouts or other periods of memory loss, insomnia or other sleep disturbances, tremors)
- Emotional or communicative difficulties (e.g., slurred, incoherent, or too rapid speech; agitation; difficulty following conversation or sticking to the point)

Skinner Trauma History

Since your 18th birthday, have you

- Had any fractures or dislocations to your bones or joints?
- Been injured in a road traffic accident?
- Injured your head?
- Been injured in an assault or fight (excluding injuries during sports)?
- Been injured after drinking?

Source: Skinner et al. 1984.

Alcohol and Drug Use History

- Use of alcohol and drugs (begin with legal drugs first)
- Mode of use with drugs (e.g., smoking, snorting, inhaling, chewing, injecting)
- Quantity used
- Frequency of use
- Pattern of use: date of last drink or drug used, duration of sobriety, longest abstinence from substance of choice (when did it end?)
- Alcohol/drug combinations used
- Legal complications or consequences of drug use (selling, trafficking)
- Craving (as manifested in dreams, thoughts, desires)

Family/Social History

- Marital/cohabiting status
- Legal status (minor, in custody, immigration status)
- Alcohol or drug use by parents, siblings, relatives, children, spouse/partner (probe for type of alcohol or drug use by family members since this is frequently an important problem indicator: “Would you say they had a drinking problem? Can you tell me something about it?”)
- Alienation from family
- Alcohol or drug use by friends
- Domestic violence history, child abuse, battering (many survivors and perpetrators of violence abuse drugs and alcohol)
- Other abuse history (physical, emotional, verbal, sexual)
- Educational level
- Occupation/work history (probe for sources of financial support that may be linked to addiction or drug-related activities such as participation in commercial sex industry)
- Interruptions in work or school history (ask for explanation)
- Arrest/citation history (e.g., DUI [driving under the influence], legal infractions, incarceration, probation)

Sexual History: Sample Questions and Considerations

- Sexual orientation/preference—“Are your sexual partners of the same sex? Opposite sex? Both?”
- Number of relationships—“How many sex partners have you had within the past 6 months? Year?”
- Types of sexual activity engaged in; problems with interest, performance, or satisfaction—“Do you have any problems feeling sexually excited? Achieving orgasm? Are you worried about your sexual functioning? Your ability to function as a spouse or partner? Do you think drugs or alcohol are affecting your sex life?” (A variety of drugs may be used or abused in efforts to improve sexual performance and increase sexual satisfaction; likewise, prescription and illicit drug use and alcohol use can diminish libido, sexual performance, and achievement of orgasm.)
- Whether the patient practices safe sex (research indicates that substance abuse is linked with unsafe sexual practices and exposure to HIV).
- Women’s reproductive health history/pregnancy outcomes (in addition to obtaining information, this item offers an opportunity to provide some counseling about the effects of alcohol and drugs on fetal and maternal health).

Mental Health History: Sample Questions and Considerations

- **Mood disorders**—“Have you ever felt depressed or anxious or suffered from panic attacks? How long did these feelings last? Does anyone else in your family experience similar problems?” (If yes, do they receive medication for it?)
- **Other mental disorders**—“Have you ever been treated by a psychiatrist, psychologist, or other mental health professional? Has anyone in your family been treated? Can you tell me what they were treated for? Were they given medication?”
- **Self-destructive or suicidal thoughts or actions**—“Have you ever thought about committing suicide?” (If yes: “Have you ever made an attempt to kill yourself? Have you been thinking about suicide recently? Do you have a plan?” [If yes, “What means would you use?"]) Depending on the patient’s response and the clinician’s judgment, a mental health assessment tool such as the Beck Depression Inventory or the Beck Hopelessness Scale may be used to obtain additional information, or the clinician may opt to implement his own predefined procedures for addressing potentially serious mental health issues.)

Source: CSAT 1997a.

to keep that family out of the treatment process. For safety reasons, the seriousness of conflict should be assessed, and the client will need some time to adjust and build rapport with the counselor before being introduced to family therapy.

Eventually, almost all clients with substance use disorders can benefit from some form of family therapy, because the educational sessions for families that are commonly used in substance abuse treatment settings are not always sufficient to bring about necessary, lasting systemic changes in the client’s family relationships. A number of factors will influence a decision about the types and relative intensity of treatment the client should receive. The client’s level of recovery may have the greatest effect on her ability to participate both in substance abuse treatment and family therapy, as well as the usefulness of that therapy for all members of the family. (See chapter 4 for a discussion of the levels of recovery.)

While family therapy in addition to substance abuse treatment is highly desirable, managed care guidelines and government regulations are certain to affect referrals. The decisions of

payors will consequently be a major determinant of the services a program offers and the services a client is willing to seek. If funding agencies do not support family therapy, the counselor may decide to work on family dynamics only through the single symptomatic individual. There is a great need for the training of substance abuse counselors to do family therapy as well. This can be done if the counselor is trained to do family treatment with a single individual. Additionally, family therapists need better preparation in graduate school plus supervised work in order to work effectively in the field of substance treatment specifically. (See chapter 4 for a discussion of integrated treatment.) These are vital first steps toward integrating the two approaches. An integrated approach might well have an important effect on funding policies, allowing more individuals to receive substance abuse treatment integrated with family therapy.

Family therapists and screening, assessment, and referral for substance abuse

Family therapy assessments focus on family dynamics and client strengths. The primary assessment task is the observation of family interactions, which can reveal patterns such as triangulation (which is a means of evading confrontation between two people by bringing a third person into the issue) along with the family system's strengths and dysfunction. The sources of dysfunction cannot be determined simply by asking individual family members to identify problems within the family. The family therapist needs to observe family interactions to determine alliances, conflicts, interpersonal boundaries, communication and meaning, and other relational patterns. Therapists with different theoretical orientations give different degrees of attention to particular aspects of family interaction. Methods for evaluating these interactions also vary with the therapist's theoretical orientation.

In addition to an assessment of dysfunction and strengths, family therapists should be trained and experienced in screening for substance abuse and be familiar with the role that substance abuse plays in family dynamics. Although most family therapists screen for mental or physical illness and physical, sexual, or emotional abuse, issues of substance abuse might not be discovered because the therapist is not familiar with questions to ask or cues provided by clients. Some family therapists

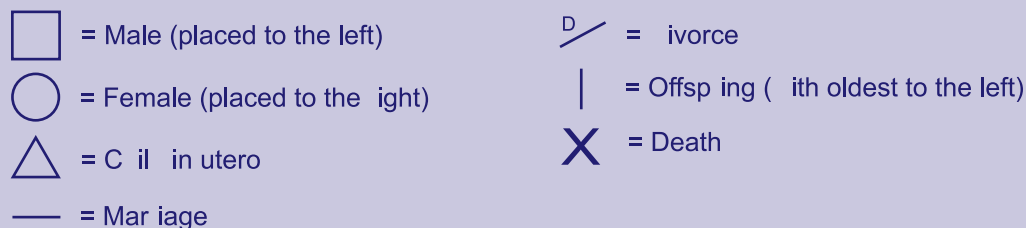
may extend the evaluation to how multiple systems (family of origin, family of choice, schools, workplaces) affect the client family at hand.

Genograms

One technique used by family therapists to help them understand family relations is the genogram—a pictorial chart of the people involved in a three generational relationship system, marking marriages, divorces, births, geographical location, deaths, and illness (McGoldrick and Gerson 1985). This is typically explained to the client during an initial session and developed as sessions progress, is used for discussion points, and is especially helpful when client and therapist reach a point of being “stuck” in the therapeutic process. Genograms can be used to help identify root causes of behaviors, loyalties, and issues of shame within a family. Working on a genogram can create bonding and increased trust between the therapist and client (see Figure 3-2).

The genogram has become a basic tool in many family therapy approaches. Significant physical, social, and psychological dysfunction may be added to it. Though the preparation of a genogram is not standardized, most of them begin with the legal and biological relationships of family members. They may also note family members' significant events (such as births, deaths, and illnesses), attributes (religious affiliation, for instance), and the character of relationships (such as alliances and conflicts). Different genogram styles search out different information and use different symbols to depict

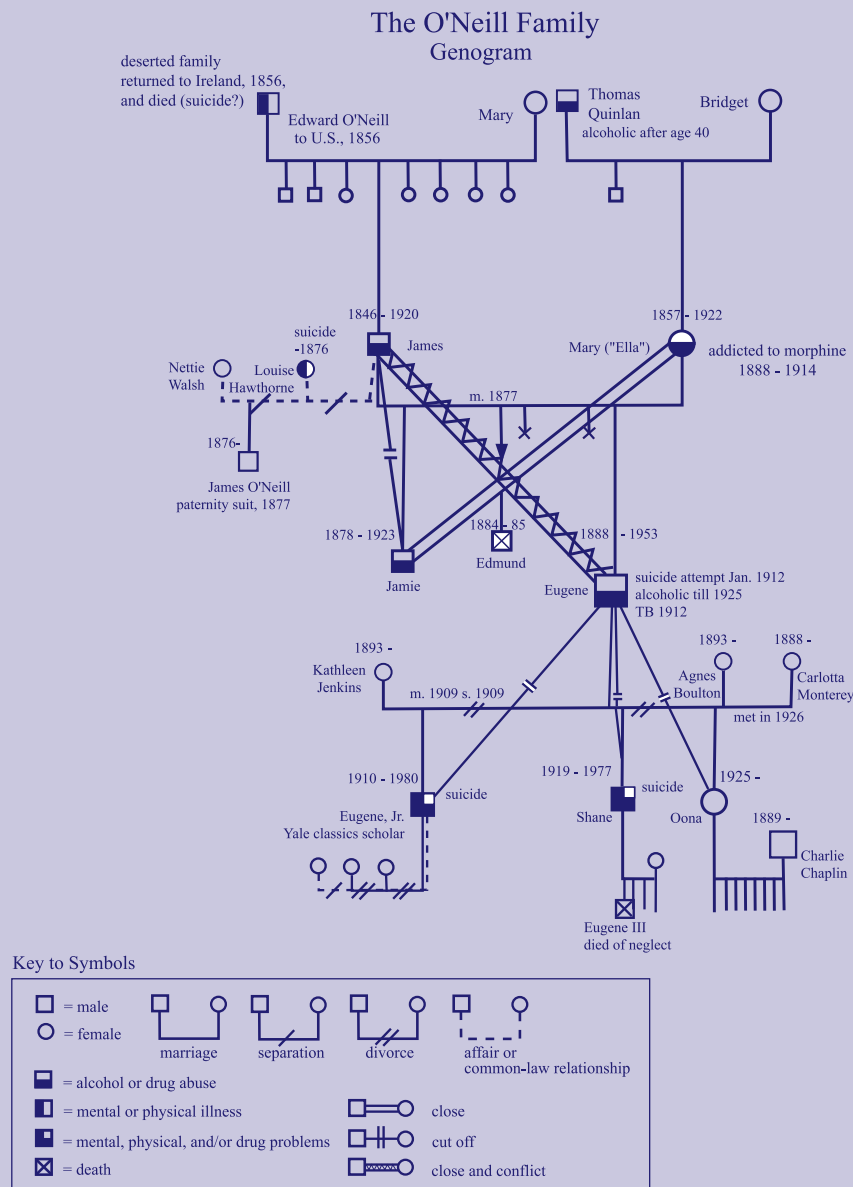
Figure 3-2
Basic Symbols Used in a Genogram



relationships. In addition, a genogram can show “key facts about individuals and the relationships of family members. For example, in the most sophisticated genogram one can note the highest school grade completed, a serious childhood illness, or an overly close or distant relationship. The facts symbolized on the genogram offer clues to the family’s secrets and

mythology since families tend to obscure what is painful or embarrassing in their history” (McGoldrick 1995, p. 36). A *family map* is a variation of the genogram that arranges family members in relation to a specific problem (such as substance abuse).

Figure 3-3
Eugene O’Neill Genogram



Source: Reprinted with permission from McGoldrick 1995.

Family therapists should be prepared to integrate ongoing family therapy with treatment for substance abuse.

Genograms enable clinicians to ascertain the complicated relationships, problems, and attitudes of multigenerational families. Genograms can also be used to help family members see themselves and their relationships in a new way (McGoldrick and Gerson 1985). The genogram can be a useful tool for substance abuse treatment counselors who want to understand how family relationships affect

clients and their substance abuse. Figure 3-2 (p. 42) shows the basic symbols used to construct a genogram.

The genogram reproduced in Figure 3-3 (p. 43) depicts five generations in Eugene O'Neill's family. The family history shows a pattern of substance abuse and suicide. O'Neill described his own family, in slightly fictionalized terms, in *Long Day's Journey Into Night*, in which readers can see how the dysfunctional pattern of fusion resulted in a family with a "desperate need to distort reality to reassure themselves of their closeness [yet the distortion was] the very thing that prevent[ed] their connection" (McGoldrick 1995, p. 107).

Rarely will an IP and/or family enter treatment with the detailed knowledge of their family over generations as revealed in the above diagram of Eugene O'Neill's family. At the first interview an attempt is made to fill in as much genogram information as possible about the extended family, particularly the family of origin and if present, the family of procreation. Family members are given assignments to interview other family members to fill in the gaps, often an insightful experience as more and more of

the family's history is uncovered and understood.

Screening and assessment issues

When a family therapist refers a client to specialized treatment for a substance use disorder, the client need not be excluded from participation in family therapy. Family therapists instead should be prepared to integrate ongoing family therapy with treatment for substance abuse. When first meeting a family that includes someone who is abusing substances, family therapists can take specific steps to evaluate the situation and prepare the family for involvement in substance abuse treatment. O'Farrell and Fals-Stewart (1999) suggest holding an interview before beginning therapy during which the family therapist can determine whether a family member who is abusing substances is in treatment or what his stage of readiness for treatment is. (TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999b], has information and instruments for assessing a client's readiness to change substance abuse behavior, and for information on screening for substance abuse, see chapter 2 of TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* [CSAT 1997a].)

Next, the therapist should determine whether an immediate intervention is needed or whether the family can return for a more thorough assessment later. In the former instance, the therapist should refer the individual to a detoxification program or other appropriate treatment. In the latter instance, the therapist should tell the family what will be involved in a more extensive assessment, which will take place at the first therapy session. The therapist also should assess the appropriateness of including any children in the process and when would be the most effective time to include them.

All family therapists should be able to perform a basic screening for substance abuse. In a survey of its membership, the AAMFT found that the great majority (84 percent) reported screen-

ing someone for abuse within the previous year (Northey 2002). An overwhelming majority (91 percent) had referred a client to a substance abuse treatment provider, though few of the therapists routinely diagnosed or treated substance abuse (Northey 2002). As part of their professional preparation, AAMFT-certified family therapists are trained to use the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revised (DSM-IV-TR) (APA 2000), which presents standard definitions of substance use disorders. Some simple screening instruments for substance use disorders can be found in TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT 1994f), and TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997a). More specific information on screening instruments for use with adolescents can be found in TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999c).

Constraints and Barriers to Family Therapy and Substance Abuse Treatment

Family therapists and substance abuse counselors should respond knowledgeably to a variety of barriers that block the engagement and treatment of clients. While the specific barriers the provider will encounter will vary for clients in different treatment settings, basic issues arise in both substance abuse treatment and family therapy. Issues of family motivation/influence, balance of hierarchical power, and general willingness for the family and its members to change are essential topics to review for appropriate interventions.

Contextual factors that affect motivation and resistance

The differential influence of power

The approaches used by the substance abuse treatment and family therapy fields to motivate clients typically have been different. Traditional substance abuse treatment models often have adopted the 12-Step practice that requires people in recovery to accept their powerlessness over the substance formerly abused—after all, despite repeated efforts to control the substance, it regularly has defeated the person using it and disrupted the user's life and family. Realizing powerlessness over the substance and the damage it causes provides motivation to break free of it. Within the 12-Step tradition, a person is empowered by the program and by “surrendering.” Though somewhat paradoxical, the addicted person regains empowerment by giving up the struggle with something he cannot control (the outcome following the use of drugs) for something over which he does have control (the ability to work his program of recovery and do those tasks that strengthen and foster ongoing recovery). Confusion over the use of the 60-year-old term “powerlessness“ within 12-Step programs has often led people erroneously to feel that 12-Step programs were antithetical to empowerment points of view.

Family therapy has a tradition of empowerment. Family therapy grew from a perceived need to bring to the therapy session respect and attention to each individual's needs, interests, expressions, and worth. Family therapists have historically accomplished this by making a special effort to “bring out” those members who might remain in the background, such as adolescents and children.

Of course, it is not desirable to cast a person abusing substances as a totally powerless entity. Many clients who abuse substances already may feel economically or socially powerless, and some others may belong to a culture that does not emphasize individual control over destiny. For these clients, especially, it is

important to stress that recovery is within their power to accomplish and that it is something that they can choose to accomplish (Krestan 2000).

No simple rule governs the existence and use of hierarchical power relations in therapeutic settings, but clinicians need to be aware that power relationships exist. Therapists always have more power in therapeutic interactions than clients do. This reality has no easy solution. While client autonomy is a primary value in all clinical work, at times therapists must act from a position of overt power to prevent violence or suicide, or to protect an abused child. Clinicians need to be aware that such power differences exist and use these differences in such a way as to establish trust and promote client self-determination and autonomy as much as possible. Clients need to be able to trust clinicians—which involves according them power—but clients also need to believe in their personal capacity to change and to learn to manage their own lives effectively. It is especially important that the client come to feel that she has the power to successfully handle treatment and recovery program activities.

Stages of change

Families with substance abuse problems constitute a vulnerable population with many complicating psychosocial issues. For example, job-related or legal troubles might result in someone being sent for treatment who has never considered the need for or possibility of treatment. In the ideal situation, the family voluntarily seeks help; most frequently, when a family member requests substance abuse help for another member there is great variation in client motivations for substance abuse treatment. Substance abuse treatment can be initiated by the person with a substance use disorder, a family member, or even through mandated treatment by an employer or the legal system.

The stages of change model has been helpful for understanding how to enhance clients' motivation. During the recovery process, indi-

viduals typically progress and regress in their movement through the stages. Stages of change have been described in several ways, but one especially helpful concept (Prochaska et al. 1992) divides the process of changing into five stages:

- ***Precontemplation.*** At this stage, the person abusing substances is not even thinking about changing drug or alcohol use, although others may recognize it as a problem. The person abusing substances is unlikely to appear for treatment without coercion. If the person is referred, active resistance to change is probable. Otherwise, a person at this stage might benefit from non-threatening information to raise awareness of a possible problem and possibilities for change. While families in this stage may think, "This has to stop!" they frequently resort to often-used defenses such as protecting, hiding, and excusing the IP. When the IP is in the precontemplation stage, the therapist works to establish rapport and offer support for any positive change.
- ***Contemplation.*** A person in this stage is ambivalent and undecided, vacillating over whether she really has a problem or needs to change. A desire to change exists simultaneously with resistance to change. A person may seek professional advice to get an objective assessment. Motivational strategies are useful at this stage, but aggressive or premature confrontation may provoke strong resistance and defensive behaviors. Many contemplators have indefinite plans to take action in the next 6 months or so. In this stage, families waver between "She can't help it" and "She won't do anything." The level of tension and threat rises. The role of the therapist is to encourage ambivalence. Helping the IP to see both the pros and cons of substance use and change helps her to move toward a decision. Client education is an effective tool for creating ambivalence.
- ***Preparation.*** In this stage, a person moves to the specific steps to be taken to solve the problem. The person abusing substances has increasing confidence in the decision to

change and is ready to take the first steps on the road to the next stage, action. Most people in this stage are planning to take action within the next month and are making final adjustments before they begin to change their behavior. One or more family members in this stage begin to look for a solution. They may seek guidance and treatment options. Here, the therapist's role is to encourage the person to work toward his goal. The goal may be as simple as creating a written record of every drink during the time between sessions.

- **Action.** Specific actions are initiated to bring about change. Action may include overt modification of behavior and surroundings. This stage is the busiest, and it requires the greatest commitment of time and energy. Commitment to change is still unstable, so support and encouragement remain important in preventing dropout and regression in readiness to change. At this point the forces for change in a family reach critical proportions. Ultimatums and professional interventions are often necessary. The role of the therapist is to encourage the person and continue providing client education to reinforce the decision to stop substance abuse.
- **Maintenance.** Day-to-day maintenance sustains the changes prior actions have accomplished, and steps are taken to prevent relapse. This stage requires a set of skills different from those that were needed to initiate change. Alternative coping and problemsolving strategies must be learned. Problem behaviors need to be replaced with new, healthy behaviors. Emotional triggers of relapse have to be identified and planned for. Gains have been consolidated, but this stage is by no means static or invulnerable. It lasts as briefly as 6 months or as long as a lifetime. In maintenance the family adjusts to life without the involvement of substances (Prochaska et al. 1992). During this stage it is important to maintain contact with the family to review changes and potential obstacles to change. Reminding family members that it is a strength, not a weakness, to use support to maintain changes can help them relate to what should be the therapist's enthusiasm for

recovery of not only the IP, but for the entire family. The therapist's goal is relapse prevention; to teach the IP and family about relapse, how to prepare for difficult times and places, and to never give up.

During recovery from substance abuse, relapse and regression to an earlier stage of recovery are common and expected—though not inevitable

(Prochaska et al.

1992). When setbacks

occur, it is important for the person in recovery to avoid getting stuck, discouraged, or demoralized. Clients can learn from the experience of relapse and then commit to a new cycle of action. Treatment should provide comprehensive, multidimensional assessment to explore all reasons for relapse.

Termination (entered from the maintenance stage) is the exit—the final goal for all who seek freedom from dependence on substances. The individual (or family) exits the cycle of change, and the danger of relapse becomes less acute. In the substance abuse field, some dispute the idea that drug or alcohol problems can be terminated and prefer to think of this stage as remission achieved through maintenance strategies.

Confrontation

Generally, substance abuse treatment has relied on confrontation more than family therapy has. For a long time, within the substance abuse treatment community it was believed that confronting clients and breaking through their defenses was necessary to overcoming denial. Some preliminary research has suggested that a confrontational approach is

During the recovery process, individuals typically progress and regress in their movement through the stages of change.

sometimes the least effective method for getting certain clients to change substance abuse behavior (Miller et al. 1998). Treatment of substance abuse has shifted away from confrontational approaches and moved toward more empathic approaches, such as those favored in family therapy. Still, family therapists should be aware of how confrontation has been used and is still used in some substance abuse treatment programs.

Motivation levels

Motivating a person or a family to enter and remain in treatment is a complex task, made all the more complicated by the fact that the IP and the family may have different levels of motivation (as may different members of the family). Many factors related to a client's family, such as maintaining custody of children or preserving a marriage, can be used to motivate clients. All the same, group and family loyalty will affect people differently. These loyalties

may motivate some to enter treatment, but the same loyalties can deter others. To some extent, realizing one's powerlessness over the substance and the damage it causes provides motivation to break free of it, although it might be noted that simple awareness may not be enough alone to provide sufficient motivation.

Clinicians in both substance abuse treatment and family therapy also need to

consider the motivation level of the family of a person abusing substances. The fact that a person with a substance use disorder is motivated to seek treatment is not evidence that the person's family is equally motivated. The family members may have been discouraged by

treatment in the past, and they may no longer believe or hope that any treatment will enable their family member to stop abusing substances. They may also conclude that the treatment system did not respond to their needs.

On the other hand, some or all of the family members might also gain some benefit from the family's continued dysfunction, so they may deny that the whole family needs treatment and urge clinicians to focus only on the problems of the person who abuses substances. It may even be harder to motivate family members than it is to prompt the person with the substance use disorder.

Family members may also fear treatment because there are specific issues in the family (such as sexual abuse or illegal activity) that they do not wish to reveal or change. In such cases, the therapist must be clear with family members about his ethical obligations to reveal information if certain topics are raised. For example, the law and ethics require therapists to report child abuse. Moreover, the therapist must not push family members to talk about difficult issues before they are ready to do so.

A family's resistance to treatment might stem from the treatment system's replication of problems it has encountered at other levels of society. Large agencies and systems may seem untrustworthy and threatening. A family may fear that the system will disrupt it, leading to such consequences as losing custody of a child. Mandated treatment and treatment providers who work in conjunction with the criminal justice system may add a layer to a family's sense of injustice.

Principles of motivational interviewing, which can be used with both the person abusing substance and the family system, are discussed in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999b, p. 40).

Psychoeducational groups are also useful for helping family members understand what to expect from treatment. Participation in psychoeducational groups often helps to

Motivating a person or a family to enter and remain in treatment is a complex task.

motivate them to become more involved in treatment (Wermuth and Scheidt 1986) by making them aware of the dynamics of substance abuse and the role the family can play in recovery. Multifamily groups help families see that they can benefit from treatment as others have (even if the family member who uses substances does not maintain abstinence) (Conner et al. 1998; Kaufmann and Kaufman 1992b). These two frequently used interventions are particularly useful for involving a family early in treatment and motivating it to continue treatment.

Cultural barriers to treatment

Cultural background can affect attitudes concerning such factors as proper family behavior, family hierarchy, acceptable levels of substance use, and methods of dealing with shame and guilt. Forcing families or individuals to comply with the customs of the dominant culture can create mistrust and reduce the effectiveness of therapy. A knowledgeable treatment provider, however, can work within a culture's customs and beliefs to improve treatment rather than provoke resistance to treatment.

To develop effective treatment strategies for diverse populations, the treatment provider must understand the role of culture and cultural backgrounds, recognize the cultural backgrounds of clients, and know enough about their culture to understand its effect on key treatment issues. This sensitivity is important at every stage of the treatment process, and the clinician's knowledge must continually improve in work with people of different ethnicities, sexual orientations, functional limitations, socioeconomic status, and cultural backgrounds (all of which are considered cultural differences for the purposes of this TIP). (Chapter 5 of this TIP and the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* [CSAT in development b] will provide more information on working with people

from various cultures and providing culturally competent treatment.)

Integrating Substance Abuse Treatment and Family Therapy

The integration of substance abuse treatment and family therapy may be accomplished at several levels (see chapter 4 for a full discussion of integrated models of treatment). Agencies may opt for full integration that would offer both family therapy and substance abuse treatment in the same location with the same or different sets of staff members. As an alternative, agencies might create a partial integration by setting up a system of referral for services. Regardless of the form integration takes, clinicians working in either field need to be aware of the practices and ideas of the other field. There should be mutual respect and a willingness to communicate between practitioners. They should know when to make a referral and when to seek further consultation with a practitioner from the other field. Clinicians in each field need to tailor their approaches to be optimally effective for clients who have received or are receiving treatment from a practitioner in the other field.

Family Therapy for Substance Abuse Counselors

Substance abuse counselors should not practice family therapy unless they have proper training and licensing, but they should be informed about family therapy to discuss it with their clients and know when a referral is indicated. Substance abuse counselors can also benefit from incorporating family therapy ideas and techniques into their work with individual clients, groups of clients, and family groups. In order to promote integrated treatment, training in family therapy techniques and concepts

Substance abuse counselors can also benefit from incorporating family therapy ideas and techniques into their work.

should be provided to substance abuse counselors.

This section builds on content presented in chapter 1 that explained the potential role of family therapy in substance abuse treatment programs. This section presents the basic principles of family therapy models and suggested ways to apply these principles in one's practice. Chapter 4 discusses the specific integrated family

therapy models developed for treating clients with substance use disorders.

Traditional Models of Family Therapy

The family therapy field is diverse, but certain models have been more influential than others, and models that share certain characteristics can be grouped together. Family therapy theories can be roughly divided into two major groups. One includes those that focus primarily on problemsolving, where therapy is generally brief, more concerned with the present situation, and more pragmatic. The second major group includes those that are oriented toward intergenerational, dynamic issues; these are longer-term, more exploratory, and concerned with family growth over time. Within these larger divisions, other categories can be developed based on the assumptions each model makes about the source of family problems, the specific goals of therapy, and the interventions used to induce change.

In recent years, calls for the use of evidence-based treatment models have increased. It may be necessary to use evidence-based approaches, especially for adolescents, to get managed care organizations to pay for services. A declaration that a provider is using an evidence-based model, however, may become complicated because the majority of family therapists are eclectic in their use of techniques, and few adhere strictly and exclusively to one approach. Furthermore, evidenced-based approaches may not be appropriate for all cultures or adaptable to practice in all settings. It is important that the research-to-practice issues should be addressed and that research, conducted under conditions that may be artificial to the practice of therapy, be carefully critiqued. The *Journal of Marital and Family Therapy* devoted a full issue (Vol. 28, No. 1, January 2002) to a discussion of "best practice" models and the challenges of developing research based in practice.

Family Therapy Approaches Sometimes Used in Substance Abuse Treatment

Several family therapy models are presented below.¹ These have been adapted for working with clients with substance use disorders. None was specifically developed, however, for this integration. A number of self-help programs or programs that address issues related to having a family member who has a substance use disorder, such as Adult Children of Alcoholics programs or Al-Anon, are also available (see also appendix D).

Behavioral contracting

Theorist: Steinglass. See Steinglass et al. 1987.

View of substance abuse

- Substance abuse stresses the whole family system.

¹The theories presented in this section are those of the authors and do not necessarily reflect the positions, views, and opinions of the CSAT, the Substance Abuse and Mental Health Services Administration (SAMHSA), or the Department of Health and Human Services (HHS).

- Substance abuse is the “central organizing principle” for a “substance-abusing” family (as distinguished from a family with a member who has a substance use disorder, but in which substance use is not yet woven into the family system).
- Families with members who abuse substances are a highly heterogeneous group.

Goals of therapy

- Identify and address the family’s problems (including substance abuse by one or more family members) as family problems.
- Develop a substance-free environment.
- Help families cope with the emotional distress (the “emotional desert”) that the removal of substance abuse can cause.

Strategies and techniques

- Develop a written contract to ensure a drug-free environment.
- Use enactments and rehearsals to enlighten the family system about triggers of substance use, to anticipate problems, and avoid them.
- Use family restabilization or reorganization to change functioning and organization.

Bepko and Krestan’s theory

Theorists: Bepko and Krestan. See Bepko and Krestan 1985.

View of substance abuse

- Focus is on the person who abuses substances and the substance of abuse as a system (while also looking at intrapersonal, interpersonal, and gender systems).

Goals of therapy

- Help everyone in the family achieve appropriate responsibility for self and decrease inappropriate responsibility for others.
- Three phases of treatment, each with a separate set of goals:

- **Presobriety:** Unbalance the system that was balanced around substance abuse in order to promote sobriety.
 - **Early Sobriety:** Balance the system around a self-help group; maintain people in a corrective context (a zone of right relationship, avoiding overinflated pride and abject self-loathing) with a recognition that no one stays there all the time.
 - **Maintenance:** Rebalance the system in a deep way by going back and working on developmental tasks that were previously missed.
- Clarify adaptive consequences of substance abuse.

Strategies and techniques

(1) Presobriety

- Interrupting and blocking emotional and functional over-responsibility using the pride-system of the spouse and the individual with a substance use disorder.
- Referring to self-help group.

(2) Early sobriety

- Same-sex group therapy with a specific model.
- Reparative and restorative work with children (in order to have children express feelings in a safe environment).

(3) Maintenance

- Anger management; dealing with toxic issues such as sexual abuse.
- Looking at gender stereotypes with respect to sex, power, anger, and control.

Behavioral marital therapy

Theorists: McCrady and Epstein. See Epstein and McCrady 2002.

View of substance abuse

- Developed to treat alcohol problems in a couples counseling framework.

- Uses a social-learning framework to conceptualize drinking (or other substance use) problems and family functioning.
- Examines current factors maintaining substance use, rather than historical factors.
- Cognitions and affective states mediate the relationship between external antecedents and substance use, and expectancies about the reinforcing value of substances play an important role in determining subsequent substance use.
- Substance abuse is maintained by physiological, psychological, and interpersonal consequences.
- Substance use is part of a continuum that ranges from abstinence to nonproblem use to different types of problem use. From this perspective, problems may be exhibited in a variety of forms, some of which are consistent with a formal diagnosis, and some of which are milder or more intermittent. This perspective differs significantly from the psychiatric diagnostic approach of the DSM-IV-TR (APA 2000) in that it does not assume that certain symptoms cluster, nor that an underlying syndrome or disease state is present (although it does not exclude that possibility, either).

Goals of therapy

- Abstinence is the preferred goal for treatment.
- Other goals include
 - Developing coping skills for both partners to address substance abuse.
 - Developing positive reinforcers for abstinence or changed use.²
 - Enhancing the functioning of the relationship.
 - Developing general coping skills.
 - Developing effective communication and problemsolving skills.
 - Developing relapse prevention skills.
- Other couple-specific goals may also be identified.

Strategies and techniques

- Intervene at multiple levels, with
 - The individual who is abusing substances
 - The spouse
 - The relationship as a unit
 - The family
 - Other social systems
- Begin with a detailed assessment to determine the primary factors contributing to the maintenance of the substance use, the skills and deficits of the individual and the couple, and the sources of motivation to change.
- Help the client assess individual psychological problems associated with use, potential and actual reinforcers for continued use and for decreased use² or abstinence, negative consequences of use and abstinence, and beliefs and expectations about substance use and its consequences.
- Teach individual coping skills (e.g., self-management planning, stimulus control, substance refusal, and self-monitoring of use and impulses to use).
- Teach behavioral and cognitive coping skills individually tailored to the types of situations that are the most common antecedents to use.
- Provide clients with a model for conceptualizing substance abuse and how it can be changed.
- Teach spouses a variety of coping skills based on an individualized assessment of behaviors that may either cue or maintain substance use (for instance, learning new ways to discuss use and learning new responses to partner's use).
- Use substance-related topics (such as how to manage a situation where substances are being used or what to tell family and friends about the treatment) to teach problemsolving and communication skills.
- Help clients identify interpersonal situations and people associated with substance use,

²Harm reduction concepts (e.g., reduced or decreased use as opposed to abstinence) discussed in this TIP are those of the authors and do not reflect SAMHSA/HHS policy or program directions.

and situations and people supportive of abstinence or decreased use.³

Brief strategic family therapy

Theorists: Szapocznik and Kurtines. See Santisteban et al. 1996; Szapocznik et al. 2003; Szapocznik and Williams 2000.

Kurtines, Santisteban, Szapocznik, and Williams have researched family therapy for adolescents and their families with specific focus on the family environment. They feel their manualized approach has a strong evidence base for use with such families; however, they do not suggest the use of the approach with adults with addictions, as there have been no efforts to study the approach with adult clients.

View of substance abuse

- Adolescents' lack of success dealing with developmental challenges leads them to substance abuse.
- Rigid family structures can increase substance abuse (as parents need to be able to renegotiate as the adolescent grows).
- Intrafamily and acculturation conflict impact relationships negatively and increase substance abuse.

Goals of therapy

- Change parenting practices (such as leadership, behavior control, nurturance, and guidance).
- Improve the quality of relationship and bonding between parents and the adolescent(s).
- Improve conflict resolution skills.

Strategies and techniques

- Do preliminary phone work to determine who will be resistant to treatment and engagement.
- Identify the normal processes of acculturation and then help families learn to transcend these differences.
- Block or reframe negativity and promote supportive interactions.
- Modify program based on data and research.

- Provide culturally competent treatment.
- Actively work on engaging family.
- Intervene in the family system through the parents rather than directly intervening (and therefore put traditional hierarchies back into place).

Multidimensional family therapy (MDFT)

Theorist: Liddle. See Liddle 1999; Liddle and Hogue 2001.

View of substance abuse

- Developed to treat adolescent drug problems and related behavioral problems such as conduct disorder from a multiple systems perspective.
- Adolescent substance abuse is a multidetermined and multidimensional disorder.
- Uses an integrative developmental, environmental, and contextual framework to conceptualize the beginning, progression, and cessation of drug use and abuse.
- Uses knowledge about risk and protective factors to arrive at a case conceptualization that includes and integrates individual, familial, and environmental factors.
- Both normative (failure to meet developmental challenges and transitions) and nonnormative (abuse, trauma, mental health, and substance abuse in the family) crises are instrumental in starting and maintaining adolescent drug problems.

The family therapy field is diverse, but certain models have been more influential than others.

³Harm reduction concepts (e.g., reduced or decreased use as opposed to abstinence) discussed in this TIP are those of the authors and do not reflect SAMHSA/HHS policy.

Goals of therapy

- To facilitate a process of adaptation to the youth's and family's developmental challenges since drug use and other problem behavior will desist when sufficient adaptive developmentally appropriate functioning is restored or created.
- To enhance and bolster the psychosocial functioning of the youth and family in their key developmental domains.
- To improve adolescent functioning in several realms, including individual developmental adaptation, coping skills relative to drug and problemsolving situations, peer relations, and family relationships.
- To improve parents' functioning in several realms including their own personal functioning (e.g., substance abuse or mental health issues) and functioning in their parental role (e.g., parenting practices).
- To improve family functioning as evidenced by changes in day-to-day family environment and family transactional patterns.
- To improve adolescent and parent functioning in the extrafamilial domain, including more adaptive and positive transactions with key systems such as school and juvenile justice.

Strategies and techniques

- The overall therapeutic strategy calls for multilevel, multidomain, multicomponent interventions.
- Treatment is flexible; MDFT is a therapy system rather than a one-size-fits-all model. As such, therapy length, number, and frequency of the sessions is determined by the treatment setting, provider, and family.
- Treatment format includes individual and family sessions, and sessions with various and extra familial sessions.
- Treatment begins with an indepth, multisystems assessment that uses a developmental/ecological and risk and protective factor framework to establish an MDFT case conceptualization.
- The case conceptualization individualizes the treatment system and pinpoints areas of

strength and deficit in the multiple and interlocking realms of a teen's psychosocial ecologies.

Multifamily groups

Theorist: Kaufman. See Kaufman and Kaufmann 1992.

View of substance abuse

- Traditional medical model and disease concept.

Goals of therapy

- Work to achieve abstinence for family member(s) with substance use disorders.
- Consolidate abstinence by focusing on resolving dysfunctional rules, roles, and alliances.
- After sobriety is achieved, deepen intimacy through appropriate expression of suppressed feelings (such as mourning of losses or hostility).
- Maintain a sober family core that acts as a central homeostatic organizer for the client who abuses substances, especially during times of stress.

Strategies and techniques

- Therapy begins with an assessment of substance abuse, individual psychopathology, and family systems.
- Address developmental issues and individual Axis I and II disorders, and include these issues as part of a family contract.
- Prepare a family relapse prevention plan.
- Make use of 12-Step and other self-help modalities.

Multisystemic therapy

Theorist: Henggeler. See Cunningham and Henggeler 1999; Henggeler et al. 1998.

View of substance abuse

- Understand fit between substance abuse and the broader systemic context:
 - Understand specific problems in a real-world context.

- Serious clinical problems, such as substance abuse, are multi-determined and influenced by variables from multiple systems.

Goals of therapy

- The initial goal is to engage family members and, if necessary, to identify barriers to engagement and develop strategies for overcoming those barriers.
- Examine the strengths and needs of each system and their relationship to the identified problem.
- Address risk and protective factors as they impact the family from a range of sources.
- Family members and caregivers have a major role in defining treatment goals.

Strategies and techniques

- Interventions are designed to promote responsible behavior.
- Interventions are present-focused and action-oriented, targeting specific and well defined problems.
- Provide developmentally appropriate interventions.
- Daily or weekly effort by family members is required.
- Place responsibility on therapist for overcoming barriers.

Network therapy

Theorist: Galanter. See Galanter 1993.

View of substance abuse

- Traditional medical model and disease concept.

Goals of therapy

- Balance the family system in terms of gender, age, relationship, and so on.
- Family and significant others work to help the individual who abuses substances maintain his abstinence and a stable support system that promotes his recovery.
- Focus is on the individual's efforts to maintain abstinence.

Strategies and techniques

- Create secure, stable, substance-free residence.
- Avoid people, places, and things that promote substance use. Encourage self-help group attendance.
- Establish a healthy support system.
- Avoid areas of conflict and negative exchanges.
- Family and significant others work as a team and are coached to help the person abusing substances to achieve and maintain abstinence.

Solution-focused therapy

Theorists: Berg, Miller, and de Shazer. See Berg and Miller 1992; Berg and Reuss 1997; de Shazer 1988.

View of substance abuse

- Emphasis is placed on the solutions that are available to the family, not on how the problem developed or what function it might serve.

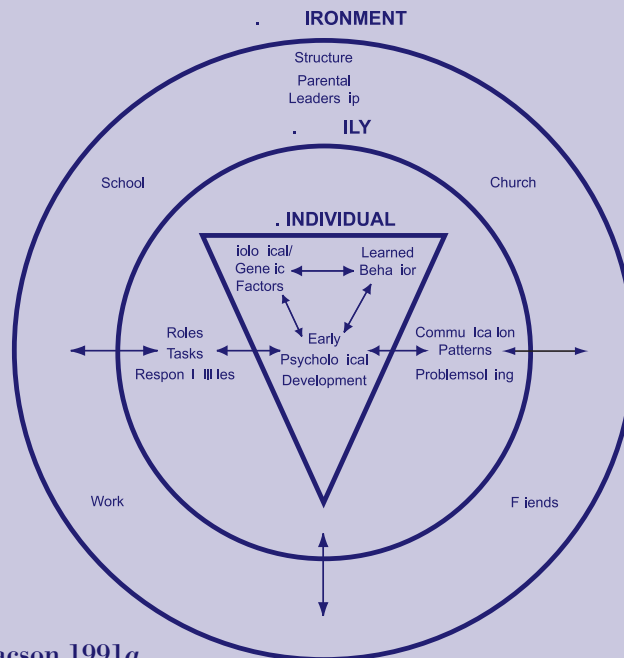
Goals of therapy

- A therapeutic relationship needs to be built on trust and respect.
- Help client to realize that she can maintain sobriety and has done so on occasions in the past.
- Goals of therapy are defined by the client.
- Focus on exceptions (such as times when substance abuse does not occur).
- Focus on problems that can be solved and on finding unique solutions to those problems that can enhance optimism.
- The focus is on solution, not problems. Focus on solutions by asking the IP how she will

Few family therapists adhere strictly and exclusively to one approach.

Figure 3-4

Individual, Family, and Environmental Systems



Source: Adapted from Isaacson 1991a.

know the problem is improved. What will she be doing? How will she be feeling?

Strategies and techniques

- Use solution-focused techniques to help the family system realize its ability to help the member abusing substances to maintain abstinence.
- Make rapid transitions to identifying and developing solutions intrinsic to the family.

Stanton’s therapeutic techniques

Theorist: Stanton. See Stanton et al. 1982.

View of substance abuse

- Substance abuse is part of a cyclical process that takes place between connected people who form an intimate, interdependent, and interpersonal system.
- Substance use often begins in adolescence as an attempt at individuation.

- Within the family there is a “complex homeostatic system” of feedback that serves to maintain stability and in the process maintains substance abuse behavior.

Goals of therapy

- Specific goals are negotiated with the family at the beginning of treatment.
- There are, though, three primary stated goals:
 - The IP should be substance free.
 - The IP should be either gainfully employed or involved in some sort of school or training program.
 - The IP should establish a stable and autonomous living situation.

Strategies and techniques

- Emphasize present situation.
- Alter repetitive behavioral sequences.
- Emphasize process over content.

- Therapist joins with family but takes active role in directing therapy.
- Therapist assigns behavioral tasks.
- Therapist may attempt to “unbalance” the system in order to prompt change.

Wegscheider-Cruse’s theory

Theorist: Wegscheider-Cruse. See Wegscheider 1981.

View of substance abuse

- Substance abuse is a progressive family disease affecting every member and every facet of life.
- In the substance-abusing family system, the members, in the interests of their own survival, assume behavioral patterns that maintain a balance. When one member becomes dependent on a substance, it affects the others, causing psychological and/or biological symptoms. As the member who abuses substances progressively experiences a sense of worthlessness, so do all other family members.
- There are six basic roles family members assume:
 - Substance abuser
 - Enabler
 - Hero
 - Scapegoat

- Lost child
- Mascot

Goals of therapy

- Make the family system more open, flexible, and whole—as the family system begins to change, other problems will subside as well.

Strategies and techniques

- Educate every family member about the disease.
- Break through the family’s denial.
- Confront any crisis.
- Treat the immediate problems of substance abuse.
- Offer concrete recommendations for help, including self-help group attendance.

Family Therapy Concepts That Substance Abuse Counselors Can Use

The field of family therapy has developed a number of theoretical concepts that can help substance abuse treatment providers better understand clients’ relationships with their families. In addition, a number of therapeutic practices can assist in the treatment of substance use disorders in the context of family systems. This section provides information about some of these concepts and practices. For more

Family Therapy With an Individual Client

Szapocznik and colleagues studied a one-person family approach for treating adolescents who abused substances (Szapocznik et al. 1983, 1986). They compared one-person family therapy with a family group; in both treatments therapists used structural and strategic therapy techniques. (There was, however, no nontherapy control group, nor was there a control that used a different therapeutic approach.) After a 6-month follow-up that included 61 percent of original participants, adolescent clients in both groups were found to have decreased their substance use, and the families improved their ability to function. The authors note, however, that one-person family therapy was most effective when carried out by an experienced therapist proficient in strategic family therapy (Robbins and Szapocznik 2000).

The field of family therapy has developed a number of theoretical concepts that can help substance abuse treatment providers better understand clients' relationships with their families.

information, refer to citations in the previous section. In addition, Nichols and Schwartz's *The Essentials of Family Therapy* (2001) provides an overview of the background, theory, and practices of family therapy. Also, see appendix D, which lists further sources of information.

There are a number of theoretical approaches to family therapy, but most of them share many concepts and assumptions. Perhaps foremost among these is the

acceptance of the principles of systems theory that views the client as a system of parts embedded within multiple systems—a community, a culture, a nation. (See Figure 3-4, p. 57, for a graphic depiction of the relationship of these multiple systems.) The family system has unique properties that make it an ideal site for assessment and intervention to correct a range of problems, including substance abuse.

Elements of the family as a system

Complementarity. Complementarity refers to an interactional pattern in which members of an intimate relationship establish roles and take on behavioral patterns that fulfill the unconscious needs and demands of the other. An implication when treating substance abuse is that the results of one family member's recovery need to be explored in relation to the rest of the family's behavior.

Boundaries. Structural and strategic models of family therapy stress the importance of paying attention to boundaries within the family system,

which delineate one family member from another; generational boundaries within families; or boundaries between the family and other systems, and regulate the flow of information in the family and between systems outside the family. Ideally, boundaries should be clear, flexible, and permeable, allowing movement and communication (Brooks and Rice 1997). However, dysfunctional patterns can arise in boundaries ranging from extremes of enmeshment (smotheringly close) to disengagement (unreachably aloof). When boundaries are too strong, family members can become disengaged and the family will lack the cohesion needed to hold itself together. When boundaries are too weak, family members can become psychologically and emotionally enmeshed and lose their ability to act as individuals. Appropriate boundaries vary from culture to culture, and the clinician needs to consider whether a pattern of disengagement or enmeshment is a function of culture or pathology.

Subsystems. Within a family system, subsystems are separated by clearly defined boundaries that fulfill particular functions. These subsystems have their own roles and rules within the family system. For example, in a healthy family, a parental subsystem (which can be made up of one or more individual members) maintains a degree of privacy, assumes responsibility for providing for the family, and has power to make decisions for the family (Richardson 1991). These subsystem rules and expectations can have a strong impact on client behavior and can be used to motivate or influence a client in a positive direction.

Enduring family ties. Another important principle of family therapy is that families are connected through more than physical proximity and daily interactions. Strong emotional ties connect family members, even when they are separated. Counselors need to address issues, such as family loyalty, that continue to shape behavior even if clients have detached in other ways from their families of origin. With regard to treatment, it is possible to involve a client in a form of family therapy even if family members are not physically present (see below), and

the focus of the therapy is on the family system and not the individual client.

Change and balance. Family rules and scripts are not unchangeable, but families exhibit different degrees of adaptability when faced with the need to change patterns of behavior. A tendency in all families, though, is homeostasis—a state of equilibrium that balances strong, competing forces in families as they tend to resist change so as to maintain the family's balance—that must be overcome if change is to occur. In order to function well, families need to be able to preserve order and stability without becoming too rigid to adapt. Flexibility therefore is an important quality for a high-functioning family, although too much flexibility can lead to a chaotic family environment (Walsh 1997).

Capacity for change

Families that have members who abuse substances are more likely to show a lack of flexibility, rather than an excess. In a family organized around substance abuse, the tendency toward homeostasis means that other family members, in a misguided attempt to prevent disruption in the family, may enable continued abuse and keep the person using substances from attaining abstinence. Families that are adjusted to substance use—called an alcoholic family by Steinglass and colleagues (1987)—have found ways to accommodate a person's substance abuse and perhaps gain something from the abuse. Steinglass and colleagues (1987) found that alcoholic families generally have limited ideas of acceptable behavior and are particularly wary of change. In many cases, the presence of alcohol (or other substances of abuse) is necessary for family members to express emotion, communicate with one another, have a short-term resolution of conflicts, or express intimacy. It is important to note that the client maintains a consistent “set point” for a level of success in his role within the family.

Adjusting to abstinence

Mostly because of policy and funding, family interventions in substance abuse treatment often target a client's family for a limited period of time. Family therapists, however, can present a good case for long-term family therapy. In a systems model, a problem such as substance abuse can have both beneficial and harmful effects, and a family will adapt its behavior to the substance abuse. In addition to explaining the phenomenon of enabling, this model also explains why the family of a client who has a substance use disorder can be expected to act differently (and not always positively) when the individual with a substance use disorder enters recovery. A family may react negatively to an individual member's cessation of substance use (e.g., children may behave more aggressively or lie and steal to restabilize the family dynamics), or there may be a period of relative harmony that is disrupted when other problems that have been suppressed begin to surface. For example, family members may express resentment and anger more directly to the recovering person. If these other problems are not dealt with, the family's reactions may trigger relapse. Family therapy techniques can resolve problems formerly masked by substance abuse to ensure that the family helps, rather than hinders, a client's long-term abstinence (Kaufman 1999).

Triangles

Murray Bowen developed the concept of *triangulation*, which occurs when two family members dealing with a problem come to a place where they need to discuss a sensitive issue. Instead of facing the issue, they divert their energy to a third member who acts as a go-between, scapegoat, object of concern, or ally. By involving this other person, they reduce their emotional tension, but prevent their conflict from being resolved and miss opportunities to increase the intimacy in their relationship (Nichols and Schwartz 2001). In families organized around substance abuse, a common pattern is for one parent to be closely allied with a child while the other parent remains distant. In such a triangle, one person, often the child, will actively abuse

BMT Exercises To Increase Commitment and Goodwill

Catch Your Partner Doing Something Nice: Clients are initially asked to notice and record at least one act each day that shows love or caring from their partners. After the next session, clients are instructed to notice and then tell their partner what they have observed. Each client is then asked to pick a favorite caring behavior from the list and act it out in a role-playing exercise. The therapist gives positive feedback and constructive suggestions based on the role-playing exercise. The person acting out the activity can repeat it, incorporating the therapist's suggestions. This exercise is designed to improve spouses' care-taking and communication skills as well as build appreciation for one another (O'Farrell 1993).

Caring Days: Each partner is told to select 1 day of the week when he or she will shower the other with acts of kindness and caring. At the next session, the other partner is asked to guess which day was selected. This exercise helps partners notice and understand what each does for the other, while increasing positive actions within the relationship.

Shared Rewarding Activities: Conflict or dysfunction resulting from substance abuse can lead to a significant decline in the amount of time couples spend together in recreational activities. To change this pattern, this exercise first requires couples to list activities they enjoy doing with their partner (either with or without children, inside or outside the home).

At their next session the couple shares their lists, and the therapist points out areas of agreement on both lists. Cotherapists then role-play how they would go about agreeing on and planning a shared activity. The therapist models ways to present activities in a positive manner, plan for potential problems, and learn to agree on activities. Couples subsequently plan and carry out a mutually enjoyable activity (Noel and McCrady 1993).

Source: Adapted from Walitzer 1999.

substances (Brooks and Rice 1997). Triangulation is especially common in families that have low levels of differentiation (that is, high levels of enmeshment), but it does occur to some extent in all families (Brooks and Rice 1997; Nichols and Schwartz 2001).

The third party in a triangle need not be a family member. As Nichols and Schwartz note, "Whenever two people are struggling with conflict they can't resolve, there is an automatic tendency to draw in a third party" (2001, p. 21). Counselors should be aware of the possi-

bility of becoming involved in a triangle with clients by competing with the client's family over the client. This process is especially common in programs that treat only the client without involving the family. Triangulation involving the counselor leaves a client feeling torn between the family and the treatment program, and for this reason, the client often terminates treatment (Stanton 1997). A substance of abuse can also be considered an entity with which the client triangulates to avoid deeper levels of intimacy.

Family Therapy Techniques That Substance Abuse Counselors Can Use

Family therapists have developed a range of techniques that can be useful to substance abuse treatment providers working with individual clients and families. The techniques listed are drawn from the range of family therapy approaches described earlier. The consensus panel selected the techniques on the basis of their usefulness and ease of use in substance abuse treatment settings, and not because they are from a particular theoretical model. This list of techniques should not be considered comprehensive.

Some family therapy techniques are similar to those already used in substance abuse treatment, but they are directed toward a different group of clients. For example, behavioral family therapy uses behavioral contracting, positive reinforcement, and skill building, all of which would be familiar to practitioners who use behavioral and cognitive-behavioral approaches with individual clients. The major difference is that behavioral family therapy focuses on how the family influences one member's substance abuse behaviors and how the family can be taught to respond differently.

Behavioral techniques

Behavioral Marital Therapy (BMT) is a behavioral family approach for the treatment of substance use disorders. BMT attempts to increase commitment and positive feelings within a marriage and improve communication and conflict resolution skills (Walitzer 1999). This is important because marital relationships where one partner abuses substances are typically marked by conflict and dissatisfaction. Improvements in the quality of marital interactions can increase motivation to seek treatment and decrease the likelihood of marital dissolution after abstinence is achieved. In situations where one or both partners are unable to participate sincerely because they are too angry or where there is violence, these techniques may not be suitable. Specific techniques include

exercises designed to increase a couple's positive feelings toward one another (see below), improve communication skills by teaching reflective listening techniques (described in more detail in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999b]), and teach negotiation skills (Noel and McCrady 1993; O'Farrell 1993). BMT and related approaches have been shown to improve both a client's participation in substance abuse treatment and treatment outcomes (Steinglass 1999), as well as improving relations between partners (Jacobson et al. 1984).

Structural techniques

In structural family therapy, family problems are viewed as the result of an imbalanced or malfunctioning hierarchical relationship with indistinct or enmeshed, too rigid, or flexible interpersonal boundaries. The complexities of these approaches defy any brief, simple review. Though it well oversimplifies the complexities, one could say that the primary goal is to strengthen or rearrange the structural foundation so the family can function smoothly (Walsh 1997). After an assessment stage, the therapist generally begins by preparing, with the family, a written contract that clearly describes the goals of treatment and explains the steps necessary to reach them. This contract increases the likelihood that the family will return after the first session because they have a clear idea of how they will resolve their problems (Kaufman 1999).

The structural family therapist generally tries to be warm and empathic while at the same time remaining firm and objective (Huycke 2000) in therapeutic relationships with clients. The therapist motivates clients to change through a process of *joining* with the family. During this process, the therapist

- Identifies and adjusts to the family's way of relating to each other, which will make resistance less likely.
- Conveys understanding and acceptance to each person in the family so that everyone

will trust the therapist enough to take his or her advice.

- Shows respect to each person by virtue of their family role, which could mean, for example, asking parents first for their views on the problem at hand.
- Listens as each person expresses feelings, because most people in therapy think that no one understands or cares how they feel.
- Makes a special effort to form linkages with family members who are angry, powerful, or doubtful about therapy so that they are engaged (Nichols and Schwartz 2001).

According to Minuchin and Fishman (1981) joining is “more an attitude than a technique” (p. 31), and Kaufmann and Kaufman (1992a) indicate that the process is very deliberate at first, becoming more natural as therapy progresses. While joining typically confirms the family’s positive traits and supports the family so that members have the confidence and strength to change, it can also mean challenging the family to provide an impetus to change.

One of the basic techniques of structural family therapy is to mark boundaries so that each member of the family can be responsible for him- or herself while respecting the individuality of others. One of the ways to make respectful individuation possible is to make the family aware when a family member

- Speaks about, rather than to, another person who is present
- Speaks for others, instead of letting them speak for themselves
- Sends nonverbal cues to influence or stop another person from speaking

When appropriate, the therapist will take action necessary to stop behaviors that contribute to enmeshment in the family.

The therapist needs to observe the family closely by tracking family interactions or by having the family enact a dysfunctional behavior pattern within the therapy session. The therapist then acts accordingly either to restructure boundaries that are too rigid or strengthen

boundaries that have become enmeshed or fused. For example, in families where substance abuse is present, one parent often becomes over-involved with a child. In such cases, the therapist needs to strengthen boundaries that support the parents as a unit (or subsystem) capable of maintaining a hierarchical relation with their children and able to resist interference from older generations of the family or people outside the family (Kaufman 1999).

Structural therapists motivate and teach a family new ways of behaving using structuralization. Using this process, the therapist sets an example for how family members should behave toward one another. After observing a problem behavior, such as the family’s ignoring one family member’s thoughts and needs, the therapist acts in a contrary way (paying special attention to what the usually ignored person thinks, feels, or desires). By setting an example in this manner, the therapist provides a model for how the family can behave and applies gentle pressure on family members to change their behavior.

Other important techniques for restructuring family relations include system recomposition, structural modification, and system focusing (Aponte and Van Dusen 1981). System recomposition helps family members build new systems (perhaps outside the family) or remove themselves from existing systems (which can imply physical separation or changing existing patterns of interaction and communication).

Structural modification is the process of constructing or reorganizing patterns of interaction (for instance, by shifting triangles to develop better functioning alliances). System focusing, also called reframing or relabeling, is the process of presenting another perspective on an apparent problem so that it appears solvable or as having positive effects for those who look at it as a problem. Relabeling can help family members see their own complicity in one member’s relapse by showing them what they might lose if the recovery were to succeed. For example, the therapist might show children that they gain greater freedom if their parents abuse substances. Relabeling also makes new

Adjunctive Pharmacotherapy for Substance Use Disorders

A variety of pharmacological interventions have been developed to aid in the treatment of substance use disorders, and many more are in development. The information provided here is merely an introduction to this topic. Further, the information is subject to change as new medications are approved by the Food and Drug Administration.

Medications are available that can help:

- Discourage continued substance use. These include disulfiram (Antabuse) for alcohol use and naltrexone (Revia) for alcohol and opioid abuse.
- Suppress withdrawal symptoms. These include benzodiazepines for alcohol withdrawal and methadone maintenance for opioid addiction.
- Block or alleviate cravings or euphoric effects. These include methadone, levo-alpha-acetyl-methadol (LAAM), and buprenorphine for opioids, and naltrexone for alcohol and opioids.
- Replace an illicit substance with one that can be administered legally. These include methadone and other forms of opioid replacement therapy.
- Treat co-occurring psychiatric disorders.

Medications should be used in conjunction with other therapeutic interventions (CSAT 1998c). Research findings indicate that the use of medication in substance abuse treatment is much more effective when combined with psychosocial interventions (McLellan et al. 1993).

Appendix A of TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997a), details specific pharmacological interventions for substance abuse treatment. TIP 28, *Naltrexone and Alcoholism Treatment* (CSAT 1998c), is also a reference on this topic. See also the forthcoming TIP *Medication-Assisted Treatment for Opioid Addiction* (CSAT in development d).

options for solving problems more apparent and can act to provoke family members to change their behavior. Overall, structural intervention techniques may be difficult to use without some further training. However, they can be employed easily in assessment to understand the ways by which the organization of the family may be structured to support the substance use.

Strategic techniques

Strategic family therapy shares many techniques and concepts with structural family therapy, which are often used together. For example, reframing or relabeling is a process common to both approaches. The structural therapist seeks to alter the basic structure of family relations working on the theory that this will improve the presenting problem. The strategic therapist, however, focuses on solving one specific problem that the family has identified and is concerned only with basic family interactions

and behavior that perpetuate the presenting problem. To the strategic therapist, interactions are not the result of underlying structural problems (Walsh 1997).

Different approaches fit into the strategic approach. All of them have in common relabeling/reframing and a focus on sequence of interactions. They differ in the scope (length) of the interaction they observe; however they all look for the sequence of interaction and then develop a directive to modify the sequence.

Directives are part of strategic therapy's emphasis on change taking place outside of therapy sessions. Indirect techniques are specific types of directives that may seem unrelated or contradictory to the task at hand but that actually help the family move toward its goal. Reframing is an indirect technique.

Solution-focused techniques

Solution-focused approaches to family therapy build on many of the ideas and techniques used in strategic therapy (Berg and Miller 1992; Berg and Reuss 1997; de Shazer 1988). This approach is less concerned with the origins of problems and more oriented toward future changes in family interactions. The solution-focused therapist fosters confidence and optimism, so solution-focused approaches do not focus on problems and deficiencies, but rather on solutions and clients' competencies. A variety of solution-focused therapies have been developed specifically for the treatment of substance abuse. Because of its narrow focus on the presenting problem, solution-focused family therapy works well with many existing substance abuse treatment approaches.

Although solution-focused therapy appears to be somewhat at odds with traditional substance abuse treatment approaches, Osborn (1997) found that many alcoholism counselors endorse the fundamental assumptions and approach of solution-focused therapy. Even if one does not completely adopt the solution-focused therapy approach, some of this model's techniques can be used with a variety of other approaches, including a focus on the past. One such tech-

nique is to ask the client to remember a time when problem behaviors were not present and then to examine what behaviors occurred during these times. "Can you think of a time when the problem was not happening or happening less? What was happening? What were things like at that point? How can that behavior be repeated now?" The focus on past exceptions, whether deliberate (cases where the clients controlled the problem) or random (cases where the problem disappeared temporarily because of factors beyond the client's control), helps clients to see that change is possible and that at times, the apparent problems abated.

Another technique is to use the "miracle question," which is, "If a miracle occurred, and the presenting problem disappeared, how would you know that the problem had disappeared?" The miracle question is useful because it helps clients see how their lives can be different. This technique is described in greater detail in chapter 4.

Additional information on strategic and solution-focused approaches to the treatment of substance use disorders can be found in TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999a).

Substance Abuse Treatment for Family Therapists

The causes of substance abuse are multidetermined, with biological, psychological, social, and spiritual components. Within the substance abuse treatment field, a variety of different approaches are used. Two of the most common are described in this section.

Traditional Theoretical Understandings of Substance Abuse

Two models have contributed to our contemporary understanding of substance abuse and

dependence: the medical (or disease) model and the sociocultural model.

Medical model

The medical model of addiction emphasizes the biological, genetic, or physiological causes of substance abuse and dependence. A body of biological research suggesting a genetic component to substance abuse supports this theory (Cloninger 1999), particularly in the case of alcoholism, since it is the type of substance abuse that has been most thoroughly researched (Li 2000) and it is the type involved in the vast majority of substance use disorders. The model is also supported by research that demonstrates how various substances of abuse can cause long-term changes in brain chemistry (Blum et al. 2000; London et al. 1999). From a medical perspective, treatment involves medical care and can include the use of pharmacotherapy to help manage withdrawal and assist in behavior change. (See below for more information on pharmacological treatments for substance use disorders.)

The ideas of the medical model can be incorporated into family therapy. For example, the model is based in part on a belief in a genetic predisposition to substance abuse, which can just as easily be understood as one element in family therapists' idea of the transgenerational transmission of problems. In family therapy, the recognition is growing, too, that the field needs to develop a better understanding of pharmacological treatments for disorders that affect family dynamics. For this reason, family therapists need some knowledge of the medical issues related to substance abuse and need to know when to refer clients for an assessment of a potential substance use disorder.

Sociocultural theories

Sociocultural approaches to substance abuse focus on how stressors in the social and cultural environment influence substance use and abuse. Theorists from this school propose that environmental influences such as socioeconomic

status, employment, level of acculturation, legal penalties, family norms, and peer expectations can have a significant influence on a person's substance use and abuse. Treating substance abuse, according to these theories, requires changing a person's physical and social environment. Particular interventions include economic empowerment, job training, social skills training, and other activities that can improve a client's

socioeconomic environment. Other interventions may involve community- and faith-based activities or participation in self-help groups, all of which can help the client regain hope and connect with other people. Sociocultural interventions often stress the strengths of clients and families.

Holistic approach

Each of the two models presented above—medical and sociocultural—has some validity and research to support its credibility. Most treatment providers, however, do not believe that any one of these approaches adequately describes the causes or suggests a single preferred treatment for substance use disorders. The holistic model, a biopsychosocial model, has been presented as a way to understand the multifaceted problem of substance abuse (Wallace 1989).

Many providers also add a spiritual component to the biopsychosocial approach, making it a biopsychosocial-spiritual approach. This is a fourth model for understanding substance abuse, one that regards recovery from substance

The causes of substance abuse are multidetermined, with biological, psychological, social, and spiritual components.

Family therapists should be familiar with at least the most common substance abuse treatment modalities.

abuse as, at least in part, a spiritual journey. This fourth model is heavily influenced by the 12-Step approach to recovery. The consensus panel believes that effective treatment will integrate these models according to the treatment setting, but will always take into account all of the factors that contribute to substance use disorders.

Nonetheless, the consensus panel believes that family therapy (as distinguished from family education programs or visiting programs) has a place in all treatment modalities. The panel has highlighted ways to use family interventions in most of the treatment settings described here.

Detoxification services

People who have a substance use disorder will likely require a period of detoxification before they can begin intensive treatment. Detoxification is not substance abuse treatment, but for many clients it is an essential precursor to treatment. Without subsequent treatment, detoxification is unlikely to have any lasting effect (Gerstein 1999). Not all clients with substance use disorders require the same intensity of detoxification services. Detoxification services range from medically managed inpatient services to services that can take place in outpatient or even social service settings.

The most intensive detoxification service is a medically managed inpatient program set in a facility with medical resources. Medically managed programs can treat a wide range of medical complications that can arise in people detoxifying from dependence on substances of abuse. Inpatient programs have the advantage of allowing clinicians to limit clients' access to substances of abuse and to observe them around the clock if necessary. Clients who require this level of care include those who have had severe overdoses, have acute or chronic medical or psychiatric conditions, are pregnant, or have developed considerable physical dependence (CSAT in development *a*; Inaba et al. 1997). Providers should also be aware that most insurers do not cover this level of service unless the client meets certain clearly defined medical criteria.

Medically managed outpatient programs can provide medication and a range of medical services, but patients are free to leave the premises and are not as closely monitored as are those in inpatient programs. This option is useful for clients who have conditions that require medication and treatment, but not

Common Treatment Modalities

A variety of treatment modalities are widely used in substance abuse treatment. Family therapists should be familiar with at least the most common substance abuse treatment modalities in order to be able to make effective referrals and understand other components of clients' treatment regimens. When referring a client to a particular substance abuse treatment program, however, a number of factors must be considered in addition to the necessary intensity of treatment and the specific services available. Some main considerations are

- The client's expressed needs and desires
- A recommendation from a substance abuse treatment professional (if there is any doubt about the treatment modality to which the client should be referred)
- The client's insurance or other available funding sources and the types of treatment they cover
- The client's work setting and family arrangements, especially whether they allow the client to leave for an extended period of time

24-hour observation. Compared to inpatient services, outpatient detoxification is much less expensive and causes less disruption in the client's life.

Many clients do not require medically managed services, and for them, social detoxification programs (either residential or outpatient) may be the best option. Social detoxification programs provide counseling and other forms of nonpharmacological assistance for managing withdrawal, but generally do not have any onsite medical services. Furthermore, most social detoxification is carried out without the use of medications. Staff members do, however, observe a client closely (especially in residential settings) and can contact a physician or nurse if necessary. It is rare, however, to find any of these modalities in their pure form; most are a blend of methods and modalities.

Detoxification programs typically involve families by providing psychoeducational family groups or similar short-term activities, but they lack the time and resources for more extensive family treatment.

For more information on detoxification procedures in both community and hospital settings, see the forthcoming TIP *Detoxification and Substance Abuse Treatment* (CSAT in development a), a revision of TIP 19 (CSAT 1995d).

Short-term residential

Short-term residential programs provide intensive treatment to clients who live onsite for a relatively short period (usually 3 to 6 weeks). The majority of these programs provide multiple treatment interventions, including group and individual counseling, assessments, the development of a strong connection with self-help groups and instruction in its principles, psychoeducational groups, and pharmacological interventions to reduce craving and discourage use.

Short-Term Inpatient Treatment (SIT) is the therapeutic approach predominantly used in programs oriented toward insured populations (Gerstein 1999). SIT is a highly structured 3- to

6-week inpatient program. Patients receive psychiatric and psychological evaluations, assist in developing a recovery plan based on the tenets of AA, attend educational lectures and groups, meet individually with counselors and other professionals, and participate in family or codependent therapy. Patients also receive intensive follow-up care lasting from 3 months to 2 years, with less intensive follow-up after that.

Many short-term residential programs feature some sort of treatment intervention for clients' family members. The Hazelden Family Center, for example, is a 5- to 7-day residential family program that explores relationship issues common among families with a member who abuses substances. A majority of the family programs used in short-term residential treatment involve psychoeducational family groups. Most such programs do not provide traditional family therapy, even if they offer some other form of family-oriented treatment.

There is no reason family therapy cannot be integrated into short-term residential programs, though the short duration of therapy may require more intensive and longer (than 1 hour) sessions because work with a family will often end when the client with the substance use disorder leaves treatment. Unfortunately, clients may have to become engaged in an entirely different system for their continuing care, as funding for services may not carry over. Further, family therapy would need to be highly structured (as other activities in these programs are) and the therapist would need to work around a schedule of other activities in the treatment program. If family therapy is being added to an inpatient residential program, it should not take the place of family visiting hours. Clients also need recreational time with their families.

Some short-term residential programs may intentionally refrain from including family therapy because providers believe that clients in early recovery are unable to manage painful issues that often arise in family therapy. That may be true in some cases, but even if a client

is unable to deal simultaneously with the cessation of substance use and family issues, the family of the client can still benefit from family therapy.

Long-term residential treatment (or therapeutic community)

A long-term residential (LTR) program will provide round-the-clock care (in a nonhospital setting), along with intensive substance abuse treatment for an extended period (ranging from months to 2 years). Most LTR programs consider themselves a form of therapeutic community (TC), but LTRs can make use of additional treatment models and approaches, such as cognitive-behavioral therapy, 12-Step work, or relapse prevention (Gerstein 1999).

The traditional TC program provides residential care for 15 to 24 months in a highly structured environment for groups ranging from 30 to several hundred clients. According to the TC model, substance abuse is a form of deviant behavior, so the TC works to change the client's entire way of life. In addition to helping clients abstain from substance abuse, TCs work on eliminating antisocial behavior, developing employment skills, and instilling positive social attitudes and values (De Leon 1999).

TC treatment is not limited to specific interventions, but involves the entire community of staff and clients in all daily activities, including group therapy sessions, meetings, recreation, and work, which may involve vocational training and other support services. Daily activities are highly structured, and all participants in the TC are expected to adhere to strict behavioral rules. Group sessions may sometimes be quite confrontational. A TC ordinarily also features clearly defined rewards and punishments, a specific hierarchy of responsibilities and privileges, and the promise of mobility through the client hierarchy and to staff positions. The TC has become a treatment option for incarcerated populations (see the forthcoming TIP *Substance Abuse Treatment for Adults in the Criminal Justice System* [CSAT in development

j]) and a modified version of the TC has been demonstrated to be effective with clients with co-occurring substance use and other mental disorders (for more information on the modified TC, see the forthcoming TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT in development k], a revision of TIP 9 [CSAT 1994b]).

Clients in TCs often lack basic social skills, come from broken homes and deprived environments, have participated in criminal activity, have poor employment histories, and abuse multiple substances. For these reasons, the TC process is more a matter of providing habilitation than rehabilitation (De Leon 1999). As Gerstein notes, the TC environment in many ways “simulates and enforces a model family environment that the patient lacked during developmentally critical preadolescent and adolescent years” (1999, p. 139).

Family therapy is not generally an intervention provided in TCs (at least not in the United States), but TC programs can use family therapy to assist clients, especially when preparing them to return to their homes and communities.

Outpatient treatment

Outpatient treatment is the most common modality of substance abuse treatment. It is also the most diverse, and the type of treatment provided, as well as its frequency and intensity, can vary greatly from program to program. Some, such as those that offer walk-in services, may offer only psychoeducation, while intensive day treatment can rival residential programs in range of services, assessment of client needs, and effectiveness (National Institute on Drug Abuse 1999a).

The most common variety of outpatient program is one that provides some kind of counseling or therapy once or twice a week for 3 to 6 months (Gerstein 1999). Many of these programs rely primarily on group counseling, but others offer a range of individual counseling and therapy options, and some do offer family therapy. Some outpatient programs offer case management and referrals to needed services such as

vocational training and housing assistance, but rarely provide such services onsite, not because they do not see the need, but because funding is unavailable. The services are often offered in specialized programs for clients with co-occurring substance use and other mental disorders.

Outpatient treatment has distinct advantages. Compared to inpatient treatment, it is less costly and allows more flexibility for clients who are employed or have family obligations that do not allow them to leave for an extended period of time. Research has demonstrated, as with many other modalities, that the longer a client is in outpatient treatment the better are his chances for maintaining abstinence for an extended period of time. Studies of outpatient treatment have documented high drop-out rates in this modality, so many clients do not remain in treatment long enough to receive the optimal benefit (Gerstein 1999). For this reason, exit planning, resource information, and community engagement should start in the beginning of treatment.

Because of the great diversity in services offered by outpatient treatment programs it is difficult to generalize about the use of family therapy. Certainly, however, family therapy can be implemented in this setting, and a number of outpatient treatment programs offer various levels of family intervention for their clients. (For more information see the forthcoming TIP *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* [CSAT in development c].)

Opioid addiction outpatient treatment

A specific type of outpatient treatment known as opioid addiction treatment or methadone maintenance involves the administration of opioid substitutes, such as methadone and LAAM, to clients who are opioid-dependent. (Methadone requires a daily dosage, but LAAM only needs to be administered every 2 or 3 days.) This pharmaceutical substitute acts to prevent withdrawal symptoms, reduce drug craving, eliminate euphoric effects, and stabilize mood and mental states. The side effects of

these prescribed medications are minimal, and they are administered orally, thereby eliminating many of the hazards associated with injection drug use. Methadone maintenance programs require daily attendance for new clients, but many programs allow clients to take doses home if they have complied with treatment requirements for a period of time (for example, if urine tests are negative for illicit drugs and clients have attended counseling sessions regularly).

In October 2002, the Food and Drug Administration (FDA) approved the use of buprenorphine for opioid dependence. Physicians may dispense it or prescribe it to clients in their offices if they (1) obtain a waiver exempting them from Federal requirements regarding prescribing controlled substances and (2) obtain subspecialty board certification or training in treatment and management of patients with opioid dependence. Information and training are available at SAMHSA's Web site (<http://www.buprenorphine.samhsa.gov>). A physician locator at this Web site can help clients find qualified physicians in their area (Clay 2003).

SAMHSA's CSAT is engaged with treatment experts, State and other Federal officials, and patient representatives to develop guidelines and other educational materials on the use of medications such as methadone and LAAM and alternative therapies in the treatment of addictions. CSAT's Division of Pharmacologic Therapies manages the day-to-day regulatory oversight activities necessary to implement new SAMHSA regulations (42 C.F.R. Part 8) on the use of opioid agonist medications (methadone

A number of outpatient treatment programs offer various levels of family intervention for their clients.

and LAAM) approved by the FDA for addiction treatment. These activities include supporting the certification and accreditation of more than 1,000 opioid treatment programs that collectively treat more than 200,000 patients annually (more information can be found at <http://www.dpt.samhsa.gov>).

Opioid addiction treatment has been shown to be an effective way to mitigate the harmful consequences of substance abuse, reduce criminal activity, slow the spread of AIDS in the treated population, reduce the client death rate, and curb illicit substance use (Effective Medical Treatment of Opiate Addiction 1997; Gerstein 1999). Despite these findings, approximately 1 in 4 individuals do not respond well to this treatment for a variety of reasons that are not apparent in clients prior to treatment (Gerstein 1999). Retention rates and outcomes are improved, however, if methadone maintenance programs offer more frequent counseling and provide higher doses (an average of 60 to 120 milligrams per day) of methadone (Gerstein 1999). (For more information see the forthcoming *TIP Medication-Assisted Treatment for Opioid Addiction* [CSAT in development d]).

Understanding 12-Step Self-Help Programs

Family therapists would benefit from attendance at 12-Step programs to understand the concepts and to see in action the principles that might be helpful to their clients. Anyone can attend an open 12-Step meeting (see a local telephone directory or AA's Web site at <http://www.aa.org>, and click on "contact local AA"), and therapists who attend meetings and process the information with knowledgeable supervisors or colleagues are able to converse with clients about meeting attendance, problems, benefits, and methods of utilizing 12-Step meetings in conjunction with the therapeutic process. Experience with attendance at 12-Step meetings helps therapists to address issues of resistance when clients say that the meetings are not appropriate for them (e.g., "everyone is different from me," or "they make me tell

things I don't want to talk about.") Another benefit of therapists' attendance at meetings is the ability to prepare a client for attendance. The therapist can give an overview of what to expect; for example, it is not necessary to put a donation in the basket as it is passed; it is okay to say "pass" if people are taking turns talking by going around the room, seat-by-seat; how people use sponsors, and so on.

Considering how common substance abuse is in our society, all family therapists need to understand the philosophy behind the disease concept of substance abuse; the concepts of 12-Step programs (such as powerlessness and surrender); the signs, symptoms, and stages of substance abuse; and the specific issues, problems, and needs of children. Some evidence suggests that these ties are already strong. For example, Northey (2002) found in a recent survey that 89 percent of family therapists do refer clients to self-help groups. Family therapists also need to understand the language and terminology of the substance abuse treatment field and DSM-IV-TR's definitions of substance use disorders.

It is important that therapists realize that family therapy organized around substance abuse will not be effective unless the substance abuse is dealt with directly. Therapy should also address the substance abuse problem first if other changes are to take place successfully (O'Farrell and Fals-Stewart 1999). Therapists should also understand that substance use disorders are typically chronic, progressive, relapsing conditions. Relapse should be viewed as part of the recovery process and not as a cause for automatic termination of treatment. Family therapists must be apprised of community services for people with substance use disorders and be able to refer clients to them.

Substance abuse treatment providers recognize the importance that spirituality (regardless of the particular faith or spiritual path chosen) can have in recovery. The use of spirituality and self-help principles may seem foreign to some family therapists' conception of treat-

ment, but these ideas are widely used and accepted within the substance abuse treatment community. Family therapists can use spirituality by recommending that families connect (or reconnect) with their spiritual traditions or discuss spiritual beliefs.

Some self-help ideas, such as sponsorship (a mentoring component for clients), can also be applied within a family therapy setting. Connecting a family who is new to treatment with another more experienced family in treatment can help both, encouraging the new family to see the possible gains and helping the more experienced family reaffirm its commitment to treatment and the difference it has made.

12-Step groups are the mutual self-help modality most commonly used, but there are other self-help groups that go beyond the substance abuse

field. In fact, some of these groups are called mutual aid groups because they go beyond the traditional AA self-help 12-Step programs. Examples include Deaf and Hard of Hearing 12-Step Recovery Resources (http://www.michdhh.org/health_care/recovery_community.html), Depression and BiPolar Support Alliance (<http://www.dbsalliance.org>), and the National Alliance for the Mentally Ill (<http://www.nami.org>). The Internet can serve as a good point for finding out local information about these kinds of groups. A listing of various mutual aid resources by the Behavioral Health Recovery Management project can be found at <http://www.bhrm.org>. See also the National Mental Health Consumer's Self-Help Clearinghouse at <http://www.mhselfhelp.org>.

Chapter 3 Summary Points From a Family Counselor Point of View

- If background and training are largely within the family therapy tradition, develop an ever-deepening understanding of the subtleties and pervasiveness of denial.
- If background and training are largely within the substance abuse treatment field, develop an ever-deepening understanding of the subtleties and impact of family membership and family dynamics on the client and the members of the client's family.
- When the going gets tough, get help. Both substance abuse counselors and family therapists are likely to need help from each other with different situations. Consultations and collaboration are key elements in ensuring clients' progress.
- Develop thorough and effective assessment processes.
- Consider specialized training on one or more specific family therapy techniques or approaches.
- Match techniques to stage of change and phase of treatment.



Center for Substance Abuse Treatment.
Substance Abuse Treatment and Family Therapy.
Treatment Improvement Protocol (TIP) Series, No. 39.
HHS Publication No. (SMA) 15-4219.
Rockville, MD: Substance Abuse and Mental Health Services Administration,
2015.

As part of its coursework, Quantum Units Education uses the above-referenced article published by the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA). HHS and SAMHSA have no affiliation with Quantum Units Education and have not endorsed Quantum Units Education's course or business in any way.

Quantum Units Education

Affordable. Dependable. Accredited.

www.quantumunitsed.com