

**Substance Abuse Treatment  
and Family Therapy  
(Revised)  
Part 2**

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# 4 Integrated Models for Treating Family Members

## In This Chapter...

Integrated Substance Abuse Treatment and Family Therapy

Integrated Models for Substance Abuse Treatment

Matching Therapeutic Techniques to Levels of Recovery

## Overview

In families in which one or more members has a substance abuse problem, substance abuse treatment and family therapy can be integrated to provide effective solutions to multiple problems. Counselors and therapists from the two disciplines seldom share similar professional training; consequently, the integrated treatment models described in this chapter can serve as a guide for conjoint treatment approaches.

The two disciplines can be integrated to a greater or lesser extent, ranging from simple staff awareness of the importance of the family to fully integrated treatment programs. This chapter discusses the advantages and limitations of integrated treatment models. The extent to which counselors are involved with families also can vary, and the extent of this involvement depends on several factors.

Care must be taken in the choice of an integrated therapeutic model. The theoretic basis of a number of models is given along with the techniques and strategies that are commonly used.

## Integrated Substance Abuse Treatment and Family Therapy

Most substance abuse treatment agencies serve a variety of clients—men and women, young and old, homeless and affluent individuals, from every racial and ethnic majority and minority group—with a wide range of substance abuse profiles. On any given day, a substance abuse treatment counselor may work with a 15-year-old girl caught with marijuana in her school locker, a 45-year-old woman whose drinking spiraled out of control after her husband's death, and a 35-year-old man faced with legal trouble stemming from his chronic use of crack cocaine. Some clients may be new immigrants with language and cultural barriers that affect treatment. Others with co-occurring medical or psychiatric disorders may require integrated treatment for the two problems. Some

clients may have decided to stop abusing substances, while others may wonder “what the big deal is about smoking a little dope.” When families are included in substance abuse treatment, the needs, problems, and motivations are exponentially increased.

The array of client needs, multiple family influences, and differences in counselors’ training and priorities, along with the difficult nature of most substance abuse problems, suggest that the family therapy and substance abuse treatment fields should work closely together. The resources and insights each discipline can bring

to treatment are the best arguments for integrating substance abuse treatment and family therapy. Integrated models of treatment would also avoid duplication of services, discourage an artificial split between therapy for family problems and substance abuse treatment, and effectively and efficiently provide services to clients and their families.

Combining substance abuse treatment and family therapy requires an integrated model. This term, for the purposes of this TIP, refers to a constellation of interventions that takes into account (1) each family member’s issues as

### **Figure 4-1** **Facets of Program Integration**

*Staff awareness and education.* Staff develops awareness of and participates in training designed to enhance their knowledge and conceptualization of the importance of the family as a strength and positive resource in substance abuse treatment. Staff generally understands that clients require support systems to maintain recovery and avoid relapse, but at this level, resources are almost completely informational in nature.

*Family education.* Educational opportunities, information, and informal referrals are presented to the general public and potential clients and families to learn about the role of families in the substance abuse treatment process. The substance abuse program generally lacks the financial and human resources to provide direct services to family members. Although some educational seminars may be offered, they are not mandatory for clients and families as part of a formal substance abuse treatment program. The focus is limited to providing information to a wider audience and a potential client pool about the role of the family in substance abuse treatment. Also, the agency offers high-quality referral lists to interested parties for follow-up.

*Family collaboration.* At this level, clients’ families are actively involved and understand their importance as a resource in the substance abuse treatment program. Substance abuse programs refer clients for family therapy services through coordinated substance abuse treatment efforts that maintain collaborative ties.

*Family therapy integration.* All components of the programs and policies related to full integration of family therapy into substance abuse treatment are in place. Systemwide, strengths-based, and family-friendly approaches are operational, culturally competent, and “one-stop assistance” for clients and families. A family culture pervades the organization at all levels and is supported by the appropriate infrastructure, specifically human and financial resources.

they relate to the substance abuse (perhaps a spouse who drinks excessively, a spouse who enables the drinking, and a child who acts out in reaction to the drinking), and (2) the effect of each member's issues on the family system. This TIP also assumes that while a substance abuse problem manifests itself in an individual (such as one person smoking crack cocaine), the solution will be found within the family system (for instance, new interactions that support not smoking crack cocaine).

Substance abuse counselors have developed specialized knowledge of addiction and recovery. They also may draw on personal recovery experiences. However, substance abuse counselors may not be familiar with the theories and techniques associated with family systems interventions. Though they generally are familiar with the influence a family exerts on one member's use of alcohol or illicit drugs, substance abuse counselors at times may see family issues as a threat to a client's recovery, particularly if the person abusing substances feels overwhelmed and unable to cope with the reactions of the family to treatment and the intense emotions evoked by treatment. The substance abuse counselor's goal is the client's recovery, and such issues as family pressures that threaten attainment of that goal should not be allowed to distract the client.

Family therapists, on the other hand, are well acquainted with the operation of family systems. However, they may not fully understand the needs and stresses of people with substance use disorders. Clients themselves may see the suggestion of family therapy as a return to repetitive intrafamily conflicts and emotional turmoil.

Family therapy or family-involved interventions and substance abuse treatment can be integrated to greater or lesser degrees along a continuum. Figure 4-1 presents four discrete facets of integration along this continuum. This model is not a prescriptive recipe for "how-to" integration, but a guide to strategies, descriptions, and activities involved in the different facets. Further discussion of these

facets is presented in chapter 6, Policy and Program Issues.

In the family collaboration level of program integration, substance abuse treatment clients are referred to various agencies for family therapy and other services. An alternative is the integration of a family-oriented case management approach, which uses referral to outside resources for family therapy as needed. Family-oriented case management can serve many of the purposes that family therapy does. For example, both work from the core premise that understanding any individual requires an appreciation of that person's entire ecological context.

Even when components of the treatment plan are mandated by other agencies, getting families' opinions on how to meet these requirements or preferences is imperative to keep their motivation to adhere to or follow through with the treatment plan. If the treatment plan is taken totally out of their hands, resistance naturally will become an issue. Wherever possible providers need to allow the family to make choices, even if it means providing only two alternatives to meet the requirements.

## Value of Integrated Models for Clients

Models of family therapy have been evolving over the past 60 years as counselors and researchers have worked to identify the determinants of substance use disorders, the factors that maintain these disorders, and the complex relationships between people with the disorders and their family members (McCrary and Epstein 1996). Paying attention to such issues has a number of advantages:

- *Treatment outcomes.* Family involvement in substance abuse treatment is positively associated with increased engagement rates for entry into treatment, decreased dropout rates during treatment, and better long-term

## ***Coordinating Services Among Multiple Agencies***

When families receive services from several providers, coordinating appointments, paperwork, and requirements in the family's primary language becomes a necessity. Indeed, coordination and service delivery are even more challenging and critical when families are refugees or immigrants who are unfamiliar with the language and culture. The following methods can be used to accomplish this coordination:

- Families involved with several agencies can become confused about who provides which services, or which deadlines are in effect. It is important for the larger system players to coordinate their efforts to help the family and clearly communicate the treatment plan to the family. Sometimes, a formal staff meeting attended by all service providers and the family can accomplish this function.
- Different agencies may recommend or require conflicting courses of action. For example, the social worker says go to school, the probation officer says get a job, and the children's school says be home when they are out of school. The counselor can resolve such conflicting demands by working with all service providers to develop a treatment plan that prioritizes tasks (for example, for an adolescent, attending school may be the first priority, followed by getting a job). At times, the therapist may need to act as an advocate for the family if other providers demand conflicting courses of action.
- Encourage the family to keep an up-to-date calendar, with appointments and requirements listed.
- If service providers leave an agency or new professionals are assigned to work with a family, the counselor should set up a meeting between the old and new providers and the family so that important information is made known to the new professional and the family has a chance to say goodbye to the departing practitioner.
- As a way to advocate for the client, monthly reports to all service providers can document treatment attendance, compliance with mandated activities, and progress toward goals. Monthly reports can also bring attention to parts of the treatment plan that are not working and need to be reformulated.
- Memos and reports can be used as interventions. For instance, sending a memo after a session reiterates what happened during the session, reinforces the positive, and can ask questions such as, "Did you realize such-and-such was happening?"
- Regularly scheduled meetings can help coordinate services for agencies that often work together, with paperwork documenting actions before and after these meetings.

outcomes (Edwards and Steinglass 1995; Stanton and Shadish 1997).

- *Client recovery.* When family members understand how they have participated in the client's substance abuse and are willing to actively support the client's recovery, the likelihood of successful, long-term recovery improves.
- *Family recovery.* When families are involved in treatment, the focus can be on the larger family issues, not just the substance abuse. Both the individual with the substance use disorder and the family members get the help they need to achieve and maintain abstinence (Collins 1990).
- *Intergenerational impact.* Integrated models can help reduce the impact and recurrence of substance use disorders in different generations.

## Value of Integrated Models for Treatment Professionals

In addition to the benefits for clients and their families, integrated models are advantageous to treatment providers. The practical advantages include

- *Reduced resistance.* In addition to the promise of better treatment outcomes, integrated models permit counselors to attend to the specific circumstances of each family in treatment. This focus accommodates the whole family and helps to diminish the family's resistance to treatment.
- *Flexibility in treatment planning.* Integrated models enable counselors to tailor treatment plans to reflect individual and family factors. For instance, each family member's stage of change can be taken into consideration (see chapter 3 for a description of the stages of change). Early in treatment, families may need education about substance abuse and its effects, while families in later stages of

## Benefits of an Integrated Substance Abuse and Family Therapy Program

The Family Intervention Program (FIP) is a good example of an integrated model for substance abuse treatment and family therapy. Jointly funded by New Jersey's Department of Human Services and Department of Health and Senior Services, FIP was designed to test the effectiveness of pairing a structural family therapist with a community resource specialist.

The program treated multiproblem families with adolescents (Fishman et al. 2001) whose presenting problems were substance abuse (by the adolescents or other family members), delinquency, and domestic violence. When compared to a family-therapy-only intervention, FIP was found to produce better results: Adolescents' substance abuse and delinquency declined, while academic performance and family relationships improved.

In one case, a 17-year-old client was suspended from school because of substance abuse. The community resource specialist was able to convince his school principal to lift the suspension provided the client continued to participate in the FIP program.

*Source:* Consensus Panel Member Fred Andes.

treatment may need help as they address such issues as trust, forgiveness, the acquisition of new leisure skills, changing roles, the reestablishment of boundaries within the family and at work, and changing the specific interaction patterns in the family that support substance abuse.

- *Flexibility in treatment approach.* Apart from the freedom to tailor treatment plans, integrated models enable counselors to adjust treatment approaches according to their own personal styles and strengths. For instance, counselors who enjoy working with adolescents and families can choose structural and strategic models that concentrate on family interactions, while those who prefer to capitalize on client competencies and strengths can choose solution-focused therapy. In this way, different treatment models can be used even within the same agency to meet both client and counselor needs.
- *Increased skill set.* Drawing from different traditional therapy models challenges counselors to be creative in their treatment approaches. With integrated models, for instance, substance abuse treatment counselors can work with a client's family members and see how each of their problems reverberates throughout the family system. Similarly, family therapists can experience working with people whose primary problems are substance use disorders.
- *Administration.* Integrated models enable administrators to get more for less. Despite

the obvious cost to cross-train family therapists and substance abuse counselors, the improved treatment outcomes more than offset the investment. New Jersey's Division of Addiction Training recently demonstrated this cost-to-benefit relationship (Fishman et al. 2001). In this process, integrated models accommodated the differences in theory, philosophy, and funding across multiple agencies. Further, models with proven efficacy could be duplicated across agencies, which added to the long-term cost-effectiveness.

## Limitations of Integrated Models

Despite their obvious value and demonstrated efficacy, integrated models for substance abuse treatment have some limitations:

- *Lack of structure.* If the various modalities in integrated models are not consistent and compatible, the combination can end up as little more than a series of disconnected interventions. Integrating interventions from different models to create a coherent and powerful treatment plan individually tailored to clients and their families requires knowledge of which therapies to use under particular circumstances and a sound protocol for therapy selection. Further, when high-risk threats such as suicide or family violence are present, more regimented protocols than usual may be needed to govern therapy selection.

## Collaborating To Treat American Indians

First Nations Community HealthSource, a nonprofit urban health clinic in Albuquerque, New Mexico, developed a co-therapist system that links family therapy and substance abuse treatment. A family therapist and a substance abuse counselor work with families together in an outpatient setting. The counselor teaming has helped decrease the number of treatment sessions needed to successfully treat substance abuse.

*Source:* Consensus Panel Member Greer McSpadden.

- *Additional training.* Integrated models require greater knowledge of more treatment modalities so additional training is necessary. Further, if substance abuse counselors and family therapists are to work together effectively, to some extent, they must learn each other's trade.
- *Mindset.* The major mindset shift necessary to using integrated models is between an individual model concentrating on pathology and a systemic (relational or behavioral) model focused on changing patterns of family interaction. Integrated models require both substance abuse counselors and family therapists to venture into new territory. Substance abuse counselors may be hesitant to engage the entire family either because they feel it is inappropriate or because they feel unprepared to manage sessions with an entire family. By the same token, family therapists' training runs counter to an emphasis on individuals within the family. Both substance abuse counselors and family therapists will need supervisory and administrative support to make necessary changes.
- *Administration.* Using several treatment models within an agency requires an agency-wide commitment to provide this variety of services. The use of multiple models within a single agency complicates scheduling for staff, clients, and families. Scheduling staff training for several models, as well as evaluating clients for the appropriateness of models available and the progress being made become more difficult. In addition, the collection and interpretation of treatment outcome data, including client outcomes, model efficacy, and cost-effectiveness, are more complex processes. However, these processes can be less complicated when the Patient Placement Criteria recommended by the American Society for Addiction Medicine are utilized by the agency to validate decision-making regarding the treatment of clients.
- *Reimbursement.* Third parties typically do not pay for family therapy interventions for substance abuse. Often, current funding pays either for mental health or substance abuse treatment. Without reimbursement for work

done with families, most such work will not be done, and potential substance abuse outcomes will not be realized. (This critical issue is discussed more fully in chapter 6.)

In sum, agencies and practitioners must balance the value of integrated treatment with its limitations. They must weigh flexibility and the potential for better treatment outcomes against the administrative challenge of additional training and its associated expenditures. In the end, agencies will need to decide what level of intervention they choose to bring to families in treatment and what integrated models they will use to do it.

## Levels of Involvement With Families

Substance abuse treatment professionals intervene with families at different levels during treatment (Conner et al. 1998; Levin 1998). The levels vary according to how individualized the interventions are to each family and the extent to which family therapy is integrated into the process of substance abuse treatment (see Figure 4-2, p. 80). At a low level of involvement, for example, a counselor might undertake an educational intervention, presenting general information about substance abuse that seems applicable to most families. With greater involvement with the family, a counselor might use a family therapy intervention that helps a family to define specific, collective changes it wants to make, which may or may not directly relate to substance abuse.

At each level, family intervention has a different function and requires its own set of competencies. In some cases, the family may be ready only for intermittent involvement with a counselor. In other cases, as the family reaches the goals set at one level of involvement, they may set further goals that require more intensive counselor involvement. The family's acceptance of problems and its readiness to change determine the appropriate level of counselor involvement with that family.

**Figure 4-2**

**Levels of Counselor Involvement With Families**

**Level 1—Counselor has little or no involvement with family**

At this level, the counselor contacts families for practical and legal reasons and provides no services to them. The counselor views the individual in treatment as the only client and may even feel that during treatment, the client must be protected from family contact. Interventions focus largely on the client's substance abuse and its effects on the individual. Funding and policies necessary for providing services to families are not in place, so the impact of substance abuse on the family is not a primary consideration. It is not uncommon for the family of a client to be regarded as a liability for the client.

**Level 2—Counselor provides psychoeducation and advice**

*Knowledge base*

The counselor's primary focus is on the client's substance abuse, but he or she is aware that it affects family relationships and that counseling will change family dynamics. For example, the family may increase its blaming of the person who is abusing drugs or alcohol, substance abuse problems among other family members may be exposed, and family secrets may be revealed.

*Relationship to family system*

The counselor is open to engaging clients and families in a collaborative way:

- Advising families about how to handle the rehabilitative needs of the client
- For large or demanding families, knowing how to channel communication through one or two key members
- Identifying gross family dysfunction that interferes with substance abuse treatment
- Referring the family for specialized family therapy treatment

**Level 3—Counselor addresses family members' feelings and provides support**

*Knowledge base*

The counselor understands normal family development and family reactions to stress.

*Relationship to family system*

The counselor is aware of personal feelings in relating to the client and family.

### *Skills*

- Asking questions that elicit family members' expressions of concern and feelings related to the client's condition and its effect on the family
- Empathically listening to family members' concerns and feelings and, where appropriate, normalizing them
- Forming a preliminary assessment of the family's level of functioning as it relates to the client's problem
- Encouraging family members in their efforts to cope with their situation as a family
- Tailoring substance abuse education to the unique needs, concerns, and feelings of the family
- Identifying family dysfunction and fitting referral recommendations to the unique situation of the family

## ***Level 4—Counselor provides systematic assessment and planned intervention***

### *Knowledge base*

The counselor understands the concept of family systems.

### *Relationship to family system*

The counselor is aware of his or her own participation in systems, including the therapeutic relationship, the treatment system, his or her own family system, and larger community systems.

### *Skills*

- Engaging family members, including reluctant ones, in a planned family conference or a series of conferences
- Structuring a conference with even a poorly communicating family in such a way that all members have a chance to express themselves
- Systematically assessing the family's level of functioning
- Supporting individual members while avoiding coalitions
- Reframing the family's definition of its problem in a way that makes problem-solving more achievable
- Helping family members view their difficulties as requiring new forms of collaborative efforts
- Helping family members generate alternative, mutually acceptable ways to cope with difficulties
- Helping the family balance its coping efforts by calibrating various roles so that members can support each other without sacrificing autonomy
- Identifying family dysfunction beyond the scope of primary care treatment; orchestrating a referral by informing the family and the specialist about what to expect from each other

## **Level 5—Family therapy**

### *Knowledge base*

The counselor has received training and supervision to move to this level of expertise. He understands family systems and patterns typical of dysfunctional families and interacts with professionals in other health care systems.

### *Relationship to family system*

The counselor can handle intense emotions in families and in him- or herself and maintain neutrality despite strong pressure from family members (or other professionals) to take sides.

### *Skills*

- Interviewing families or family members who are difficult to engage
- Efficiently generating and testing hypotheses about the family's difficulties and interaction patterns
- Escalating conflict in the family in order to break a family impasse
- Temporarily siding with one family member against another
- Constructively dealing with a family's strong resistance to change
- Negotiating collaborative relationships with professionals from other systems that are working with the family, even when these groups are at odds with one another

*Source:* Adapted from Doherty and Baird 1986. Used with permission.

Working with family physicians, Doherty and Baird (1986) established five levels of involvement with families for medical intervention. In Figure 4-2, the authors' work has been adapted to show levels of counselor involvement with the families of clients abusing substances.

Following are some specific examples for implementing the levels discussed in Figure 4-2:

- A Level 1 family intervention in substance abuse treatment may be conducted informally but is carefully thought out and planned to ensure clinical appropriateness. For example, rather than scheduling an appointment, the counselor could speak to a client's family members while they wait for the client attending a group.
- At Level 2, the counselor could provide education or advice to the family in the form of a short discussion of the stages of substance abuse and recovery.
- At Level 3, the counselor could educate the family on how substance abuse affects parenting, discussing how the mother and father could each improve their parenting skills and supporting them as they made changes.
- At Level 4, a counselor could intervene to define and change the interactional patterns and behavioral sequences around substance abuse or determine the exact behavioral sequence associated with drinking and establish ways to interrupt that sequence.
- At Level 5, the counselor might help the family define specific goals for change—goals that might or might not focus on substance abuse—and then help the family make those changes. The focus at Level 5 is broader than that at Level 4, and the counselor is apt to draw on wider skills and approaches to help the family meet its goals.

## **Determinants of the level of involvement**

To determine a counselor's level of involvement with a specific family, two factors must be considered:

*The counselor's level of experience and comfort.* Figure 4-2 can be used to determine the knowledge base and skills that a counselor needs to implement each of the five levels of family involvement.

*The family's needs and readiness to change.* Prochaska and colleagues' stages of change model (Prochaska et al. 1992; see chapter 3 for a description of the five stages) can be used to assess a family's readiness to change and suggests a level of counselor involvement appropriate for that change. A family in precontemplation, for instance, would do best with a lower level of intervention—Level 2 or 3—while a family in the maintenance phase might be ready for Level 5 family therapy—sorting out relationship issues that may not be directly related to substance abuse.

Both family and counselor factors must be considered when deciding a level of family involvement. Families should not be pushed rapidly toward change when they are not ready. If they are pushed too fast, their resistance increases, and they may leave treatment prematurely. Staff should not be placed unprepared in positions outside their level of development—even when no other staff is available. When therapists attempt to function in a level that is beyond their training, their interventions are typically ineffective, and they grow frustrated and demoralized. This is likely to affect the family negatively.

Figure 4-2 can be used to determine training needs to prepare counselors to intervene at different levels. Agencies can draw on the skills that substance abuse counselors and family therapists already have and develop the additional competencies listed. Credentialing bodies can also use systematic training to develop appropriate competencies in substance abuse and family therapy counselors.

## **Using the family to engage the client in treatment**

In some treatment models, such as the Johnson model and the Thomas and Yoshioka model, family members are used in a confrontive, unilateral intervention to engage the client in treatment. This can be a one-time intervention and has been shown to be successful (Johnson 1986; Thomas and Yoshioka 1989).

To engage the client in treatment, Kirby and colleagues (1999) recommend using the community reinforcement training intervention. This type of intervention has been shown to significantly improve the retention of family members in treatment and to induce people who use drugs to enter treatment. This behavioral intervention “provides motivational training” for family members (Kirby et al. 1999, p. 86) by showing them how to give positive rewards to the client for not using drugs and to ignore the client who uses drugs so that he or she experiences the negative consequences of use. When the client experiences particularly difficult times as a result of drug abuse, family members are encouraged to suggest counseling (Kirby et al. 1999).

## **Approaches to engagement**

A number of specific interventions have been developed to help clinicians use family members and other significant figures in a person's life to engage the person in substance abuse treatment. The following descriptions of interventions are adapted from a National Institute on Drug Abuse (NIDA) research monograph (Stanton 1997, pp. 161-168). Although only Unilateral Family Therapy relies on family therapy models, the Johnson Intervention and Community Reinforcement Training emerged from the substance abuse treatment field based on a range of background influences including pastoral and family counseling, community psychology, and behavioral reinforcement theories. Following are brief descriptions of each intervention:

- **Johnson Intervention.** Originally developed in the 1960s (Johnson 1973, 1986) at the Johnson Institute in Minneapolis, this intervention is a method for mobilizing, coaching, and rehearsing with family members, friends, and associates to help them confront someone they believe to have a substance use disorder. At that time, they voice their concerns, strongly urge entry into treatment, and explain the consequences in the event of refusal (which could include divorce or loss of a job). Interveners usually prepare in secret to use the element of surprise. Although the approach has mostly been applied with problem drinking, it has also been adapted for other types of substance abuse (Leipman et al. 1982).
- **Unilateral Family Therapy.** Developed by Thomas and colleagues (Thomas and Ager 1993; Thomas and Yoshioka 1989; Thomas et al. 1987), this approach has been applied with spouses (usually wives) of uncooperative family members who are abusing substances (typically alcohol). The therapist meets with the spouse over some months, with a focus on spousal coping, reducing the individual's substance use, and inducing the person with alcoholism to enter treatment. The method was influenced by the Johnson Intervention and the Community Reinforcement Approach (CRA), although the spouse usually carries this intervention out, which is called a "programmed confrontation."

By the fifth month, some open attempt (or a series of attempts) is made to get the person who is abusing alcohol into treatment. When other cases were added in which the potential clients had not entered treatment but had achieved and maintained clinically meaningful reductions in their drinking levels,<sup>1</sup> 37 percent of the people who abused alcohol and whose spouse was treated immediately had entered a program, compared with 11 percent for a

group for which treatment was delayed (Thomas et al. 1990).

- **Community Reinforcement Training (CRT).** This method was adapted from the original CRA to alcoholism treatment developed by Azrin and colleagues (Azrin 1976; Azrin et al. 1982; Hunt and Azrin 1973; Meyers and Smith 1995) and has been applied to cocaine dependence by Higgins and others (Higgins and Budney 1993; Higgins et al. 1993, 1994). CRT involves seeing a distressed family member (usually the spouse) the day that she telephones to get help for a family member with alcoholism. It also requires being available during nonworking hours in case the family member reaches a crisis point when the person who is abusing alcohol requests help. The approach attempts to take advantage of a moment when the person is motivated to get treatment by immediately calling a meeting at the clinic with the counselor, even in the middle of the night (Sisson and Azrin 1993).

This generally nonconfrontational program includes a number of sessions with the spouse in which checklists are completed and the spouse is taught how to implement a safety plan if the risk of physical abuse is high, encourage abstinence, encourage treatment seeking, and assist in treatment. Sisson and Azrin (1986) examined the effectiveness of this approach with 12 cases—seven in which a family member received CRT and five in which the person received traditional (e.g., Al-Anon) counseling. In six of the seven CRT cases, the individual who abused alcohol entered treatment, whereas none of the traditional cases entered treatment.

## **Selecting an integrated model for substance abuse treatment**

Care must be taken in the choice of an integrated therapeutic model. The model must accommodate the needs of the family, the style and preferences

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<sup>1</sup>Harm reduction concepts (e.g., reduced or decreased use as opposed to abstinence) discussed in this TIP are those of the authors and do not necessarily reflect policy or program directions of the Substance Abuse and Mental Health Services Administration or the Department of Health and Human Services.

of the therapist, and the realities of the treatment context (e.g., in a residential treatment setting one would not select an approach that demanded frequent contact with family members when clients come from a wide geographical area and family members would not be able to visit often).

The model also must be congruent with the culture of the people that it intends to serve. For example, some parents from Asian cultures may be perplexed by the assumption that children have a “voice” in the family (e.g., children who take on adult-like responsibilities by interpreting for parents, but do not hold adult-like responsibilities in the family). The model selected must accommodate differences in family structure, hierarchies, and beliefs about what is appropriate and expected behavior.

When choosing and applying a family systems model, certain basic questions must be considered:

- Does the model fit what is observed in the family? For instance, a general lack of predictable structure may call for structural family therapy, which would be inappropriate for a distant and conflicted couple who instead may need emotion-focused couples therapy. Further, does the model provide direction as to where to go with the family? Is the direction simple enough to address a chaotic family system, yet encompassing enough to address multiple presenting problems and family structures?
- Can the model be used when not all family members attend all sessions? Can it be used with only one family member, if only that one person is ready for treatment?
- Will the model work with the family of origin and address intergenerational issues, such as how the family got where it is, and how does that history influence the family now?
- Will the model help the counselor manage the amount of change in the family system? Will the counselor be able to manage the competing homeostatic and change needs of the family? If not, the result may be too much resistance

or too little change to satisfy the family.

- If the model uses a directive technique, will it increase the family’s resistance? Further, will that model’s directive nature fit the counselor’s style? Would the counselor, for example, be comfortable saying, “Say this to him now”? Or does the counselor need a model with a less directive style?
- How much time is required to implement the model? Is it applicable in the short term, such as 8 to 12 sessions? Do the model’s time requirements match the time available for therapeutic intervention?
- Is the model compatible with a particular family’s cultural characteristics? If the counselor were to use the model, would family members be inclined to view the counselor as a good match for their cultural practices and values? Some models suggest, directly or implicitly, that one and only one family organization or structure is healthy, and all others are inferior. Such views may be inappropriate for families whose cultural or ethnic belief system conflicts with a particular model’s assumptions and standards.

A model must accommodate the needs of the family, the style and preferences of the therapist, and the realities of the treatment context.

## Integrated Models for Substance Abuse Treatment

A great number of integrated treatment models have been discussed in the literature. Many are slight variations of others. Those discussed in this section are among the more frequently used integrated treatment models:

- Structural/strategic family therapy (Stanton 1981a; Stanton et al. 1982)
- Multidimensional family therapy (Liddle 1999; Liddle et al. 1992, 2001)
- Multiple family therapy (Kaufman and Kaufmann 1992)
- Multisystemic therapy (Henggeler et al. 1996)
- Behavioral and cognitive-behavioral family therapy (O'Farrell and Fals-Stewart 2000)
- Network therapy (Galanter 1993)
- Bowen family systems therapy (Bowen 1974)
- Solution-focused brief therapy (Berg and Miller 1992)

## **Structural/Strategic Family Therapy**

### ***Theoretical basis***

Structural/strategic family therapy assumes that (1) family structure—meaning repeated, predictable patterns of interaction—determines individual behavior to a great extent, and (2) the power of the system is greater than the ability of the individual to resist. The system can often override any family member's attempt at nonengagement (Stanton 1981a; Stanton et al. 1978).

## ***Integrated Structural/Strategic Family Therapy for Substance Abuse***

Therapy begins with an assessment of substance abuse, individual psychopathology, and family systems. If chemical dependence or serious substance abuse is discovered, therapy begins by working with the family to achieve abstinence. In the next phase, abstinence is consolidated by resolving dysfunctional rules, roles, and alliances. Then developmental issues and personal psychopathology are treated as part of the family contract. For example, an adolescent client's trouble accepting responsibility and a parent's depression can be part of what the family contracts to change. With that in place, a family plan for relapse prevention is incorporated. Finally, in the abstinence phase, intimacy deepens as families learn to appropriately express feelings, including hostility and mourning of losses.

Among the models in the above list, several have demonstrated effectiveness in treating substance use disorders: structural/strategic family therapy, multidimensional family therapy, multisystemic therapy, and behavioral and cognitive-behavioral family therapy. The others have not demonstrated research-based outcomes for substance abuse treatment at this point, but appear to have made inroads into the substance abuse treatment field.

Roles, boundaries, and power establish the order of a family and determine whether the family system works. For example, a child may assume a parental role because a parent is too impaired to fulfill that role. In this situation, the boundary that ought to exist between children and parents is violated. Structural/strategic family therapy would attempt to decrease the impaired parent's substance abuse and return that person to a parenting role.

Whenever family structure is improperly balanced with respect to hierarchy, power, boundaries, and family rules and roles,

structural/strategic family therapy can be used to realign the family's structural relationships. This type of treatment is often used to reduce or eliminate substance abuse problems. As McCrady and Epstein (1996) explain, the family systems model can be used to (1) identify the function that substance abuse serves in maintaining family stability and (2) guide appropriate changes in family structure.

### ***Techniques and strategies***

In this treatment model, the counselor uses structural/strategic family therapy to help families change behavior patterns that support substance abuse and other family problems. Because these patterns in dysfunctional families are typically rigid, the counselor must take a directive role and have family members develop, then practice, different patterns of interaction. Counselors using this treatment model require extensive training and supervision to direct families effectively.

One modification that flows from structural/strategic family therapy is strategic/structural systems engagement (SSSE). In SSSE, the family is helped to exchange one set of interactions that maintains drug use for another set of interactions that reduces it. In particular, SSSE targets the interactions linked to specific behaviors that, if changed, will no longer support the presenting problem behavior. Once the family, including the person with a substance use disorder, agrees to participate in therapy, the counselor can refocus the intervention on removing problem behaviors and substance abuse.

Another modification, brief strategic family therapy (BSFT), also flows from structural/strategic family therapy. In BSFT, structural family therapy "has evolved into a time-limited, family-based approach that combines both structural and strategic [problem-focused and pragmatic] interventions" (Robbins and Szapocznik 2000). BSFT is known to be effective among youth with behavioral problems and is commonly used for that purpose among

Hispanic families (Robbins and Szapocznik 2000).

BSFT is used to help counselors attract families that are difficult to engage in substance abuse treatment (Szapocznik and Williams 2000). In Hispanic families with adolescents using drugs, Szapocznik and colleagues reported that 93 percent of families were brought into treatment using standard BSFT, versus 42 percent in a control group. Treatment completion rates were higher among those receiving BSFT (Szapocznik et al. 1988). To achieve this improvement, BSFT was modified to a one-person family technique. The technique is based on the idea of complementarity (Minuchin and Fishman 1981), that is, when one family member changes, the rest of the family system will respond. Szapocznik and Williams (2000) used the one-person family technique with the first person in the family to request help. Once the whole family was engaged, they refocused attention on problem behavior and drug abuse.

One of the specific techniques used in structural/strategic family therapy is illustrated on p. 88.

While structural/strategic family therapy has been shown to be effective for substance abuse treatment, counselors must carefully consider using this approach with multiproblem families and families from particular cultures. Some points to consider are

- ***Culture.*** Counselors should become familiar with the roles, boundaries, and power of families from cultures different from their own. These will influence the techniques and strategies that will be most effective in therapy.
- ***Age and gender.*** Cultural attitudes toward younger people and women can affect how the counselor can best assume the directive role that structural/strategic family therapy requires.
- ***Hierarchies.*** Certain cultures are very attuned to relative positions in the family hierarchy. Sometimes, children may not ask questions of the parent. Other children will remove themselves from the situation until

## ***Structural/Strategic Family Therapy's Technique of Joining and Establishing Boundaries***

**Family:** The client is a 22-year-old Caucasian female who abuses prescribed medication and has problems with depression and a thought disorder. She is the younger of two children whose parents divorced when she was 3. She stayed with her mother, while her brother (age 7 at the time) went with their father. Both parents remarried within a few years. Initially, the families lived near each other, and both parents were actively involved with both children, despite ill feelings between the parents. When the client was 7, her stepfather was transferred to a location 4 hours away, and the client's interactions with her father and stepmother were curtailed. Animosity between the parents escalated. When the client was 8, she chose to live with her father, brother, and stepmother, and the mother agreed. The arrangement almost completely severed ties between the parents. At the time the client entered a psychiatric unit for detoxification, the parents had no communication at all. The initial family contact was with the father and stepmother. As the story unfolded, it became clear that the client had constructed different stories for the two family subsystems of parents. She had artfully played one against the other. This was possible because the birth parents did not communicate.

**Treatment:** The first task was to persuade the father to contact the mother and request that she attend a family meeting. He, along with the stepmother, agreed, though it took great courage to make the request because the father believed his daughter's negative stories about her relationship with the mother. In the next session, the older brother (the intermediary for the past 4 years) and his wife also attended. Because the relationship between the counselor and the paternal subsystem had already been established, it was critical to also join with the maternal subsystem before attempting any family system work. The counselor knew that nothing could be accomplished until the mother and stepfather felt an equal parental status in the group. This goal was reached, granting the mother free rein to tell the story as she saw it and express her beliefs about what was happening. A second task was to establish appropriate boundaries in the family system. Specifically, the counselor sought to join the separate parental subsystems into a single system of adult parents and to remove the client's brother and sister-in-law as a part of that subsystem. This exclusion was accomplished by leaving them and the client out of the first part of the meeting. This procedural action realigned the family boundaries, placing the client and her brother in a subsystem different from that of the parents. This activity proved to be positive and productive. By the end of the first hour of a 3-hour session, the parents were comparing information, routing incorrect assumptions about each other's beliefs and behaviors, and forming a healthy, reliable, and cooperative support system that would work for the good of their daughter. This outcome would have been impossible without taking the time to join with the mother and father in a way that allowed them to feel equal as parents. Removing the brother from the parental subsystem required the client to deal directly with the parents, who had committed themselves to communicating with each other and to speaking to their daughter in a single voice.

*Source:* Consensus Panel.

## ***Structural/Strategic Family Therapy in the Criminal Justice System***

Darius, a 21-year-old male from the San Juan pueblo in New Mexico, was referred to a clinic for court-mandated substance abuse counseling. He had just received his third violation for driving under the influence (DUI). Darius had been on probation since age 13 for various charges, including burglary and domestic violence, and he had a long history of alcohol and drug abuse. He had been on his own for 8 years and had no family involvement in his life. Darius had participated in several residential treatment programs, but he had been unable to maintain abstinence on his own.

When Darius entered outpatient treatment, he was extremely angry at “the system” and refused initially to cooperate with the therapist or his treatment plan. The therapist was pleasantly surprised that he did show up for his weekly sessions. The following interventions seemed to help Darius:

- The counselor suggested that one treatment goal might be for Darius to finally get off probation. At the time, he still had 18 months of probation remaining.
- The counselor helped Darius see the relationship of alcohol and drugs to his involvement with the criminal justice system.
- The counselor constructed a genogram depicting three generations of Darius’ family of origin. This portrayal illustrated a great deal of family disintegration linked to poverty, substance abuse, and his parents’ and grandparents’ boarding school experience.
- The counselor initiated couples therapy to help Darius stabilize a significant relationship.
- After conferring with the probation officer, the counselor decided that Darius would benefit from a 6-month trial of Antabuse treatment.
- The probation officer required that Darius find regular employment.

During the course of treatment, Darius was able to stop drinking and reevaluate his belief system against the backdrop of his family and the larger judicial system in which he had been so chronically involved. He came to be able to express anger more appropriately and to recognize and process his many losses from family dysfunction. Although many of his family members continued to abuse alcohol, Darius reconnected with an uncle who was in recovery and who had taken a strong interest in Darius’ future. Eventually, Darius formed a plan to complete his GED and to begin a course of study at the local community college. The counselor helped Darius to examine how the behaviors and responsibilities he took on in his family shaped his substance use.

*Source:* Consensus Panel.

The MDFT treatment format includes individual and family sessions, sessions with various family members, and extrafamilial sessions.

the parent notices they are not there. The professional needs to be attentive to who is who in the family. Who is revered? Who are friends? What is its history? Place of origin? All these are clues to understanding a family's hierarchy.

Counselors who use structural/strategic family therapy need to appreciate how a particular intervention might be experienced by family members.

If family members

experience the intervention as duplicitous, manipulative, or deceitful, the counselor may have broached a possible ethical line. As discussed in the section on informed consent in chapter 6, family therapists or substance abuse counselors might wish to explain in advance that such interventions could be part of the therapeutic process and obtain the client's informed consent for their possible inclusion. If clients have questions about the use of such interventions, they should be answered ahead of time and included as part of the informed consent.

For more detailed information about structural/strategic family therapy, refer to Charles Fishman's manual *Intensive Structural Therapy: Treating Families in Their Social Context* (1993) and Szapocznik and colleagues' *Brief Strategic Family Therapy* (in press).

The case study on p. 89 demonstrates how structural/strategic family therapy might work with a client from the criminal justice system.

## Multidimensional Family Therapy

### *Theoretical basis*

The multidimensional family therapy (MDFT) approach was developed as a stand alone, outpatient therapy to treat adolescent substance abuse and associated behavioral problems of clinically referred teenagers. MDFT has been applied in several geographically distinct settings with a range of populations, targeting ethnically diverse adolescents at risk for abuse and/or abusing substances and their families. The majority of families treated have been from disadvantaged inner-city communities. Adolescents in MDFT trials have ranged from high-risk early adolescents to multiproblem, juvenile justice-involved, dually diagnosed female and male adolescents with substance use problems.

As a developmentally and ecologically oriented treatment, MDFT takes into account the interlocking environmental and individual systems in which clinically referred teenagers reside (Liddle 1999). The clinical outcomes achieved in the four completed controlled trials include adolescent and family change in functional areas that have been found to be causative in creating dysfunction, including drug use, peer deviance factors, and externalizing and internalizing variables. The cost of this treatment relative to contemporary estimates of similar outpatient treatment favors MDFT. The clinical trials have not included any treatment as usual or weak control conditions. They have all tested MDFT against other manualized, commonly used interventions. The approach is manualized (Liddle 2002), training materials and adherence scales have been developed, and have demonstrated that the treatment can be taught to clinic therapists with a high degree of fidelity to the model (Hogue et al. 1998).

### *Research basis*

MDFT has been developed and refined over the past 17 years (Liddle and Hogue 2001). MDFT has been recognized as one of the most

promising interventions for adolescent drug abuse in a new generation of comprehensive, multicomponent, theoretically-derived and empirically-supported treatments (Center for Substance Abuse Treatment [CSAT] 1999c; NIDA 1999a; Waldron 1997). MDFT has demonstrated efficacy in four randomized clinical trials, including three treatment studies (one of which was a multisite trial) and one prevention study. Investigators have also conducted a series of treatment development and process studies illuminating core mechanisms of change.

### ***Techniques and strategies***

Targeted outcomes in MDFT include reducing the impact of negative factors as well as promoting protective processes in as many areas of the teen's life as possible. Some of these risk and protective factors include improved overall family functioning and a healthy interdependence among family members, as well as a reduction in substance abuse, drastically reduced delinquency and involvement with antisocial peers, and improved school performance. Objectives for the adolescent include transformation of a drug using lifestyle into a developmentally normative lifestyle and improved functioning in several developmental domains, including positive peer relations, healthy identity formation, bonding to school and other prosocial institutions, and autonomy within the parent-adolescent relationship. For the parent(s), objectives include increasing parental commitment and preventing parental abdication, improved relationship and communication between parent and adolescent, and increased knowledge about parenting practices (e.g., limit-setting, monitoring, appropriate autonomy granting).

### ***Core components***

MDFT is an outpatient family-based drug abuse treatment for teenagers who abuse substances (Liddle 2002). From the perspective of MDFT, adolescent drug use is understood in terms of a network of influences (i.e., individual, family, peer, community). This multidimensional

approach suggests that reductions in target symptoms and increases in prosocial target behaviors occur via multiple pathways, in differing contexts, and through different mechanisms. The therapeutic process is thought of as retracking the adolescent's development in the multiple ecologies of his or her life. The therapy is organized according to stage of treatment, and it relies on success in one phase of the therapy before moving on to the next. Knowledge of normal development and developmental psychopathology guides the overall therapeutic strategy and specific interventions.

The MDFT treatment format includes individual and family sessions, sessions with various family members, and extrafamilial sessions. Sessions are held in the clinic, in the home, or with family members at the court, school, or other relevant community locations. Change for the adolescents and parents is intrapersonal and interpersonal, with neither more important than the other. The therapist helps to organize treatment by introducing several generic themes. These are different for the parents (e.g., feeling abused and without ways to influence their child) and adolescents (e.g., feeling disconnected and angry with their parents). The therapist uses these themes of parent-child conflict as assessment tools and as a way to identify workable content in the sessions.

The format of MDFT has been modified to suit the clinical needs of different clinical populations. A full course of MDFT ranges between 16 and 25 sessions over 4 to 6 months, depending on the target population and individual needs of the adolescent and family. Sessions may occur multiple times during the week in a variety of contexts including in-home, in-clinic, or by phone. The MDFT approach is organized according to five assessment and intervention modules, and the content and foci of sessions vary by the stage of treatment.

## Multiple Family Therapy

### *Theoretical basis*

Multiple family therapy (MFT) is an eclectic variety of family therapy that is psychoeducational in nature, with roots in social network intervention, multiple impact therapy, and group meeting approaches. It is often used in residential settings and involves family members from groups of clients in treatment at the same time coming together (Kaufman and Kaufmann 1992b).

### *Techniques and strategies*

In general, families are personally invited to attend the MFT meeting and are oriented before the first session. Family members who are currently abusing drugs or alcohol are excluded. Families sit together in a circle, with several therapists interspersed among the group. The session starts with self-introductions. After the purpose of the meeting is described and the need for open communication is stressed, one family's situation is discussed for about an hour. Three or four families are the subject for each session, although all the families participate in the discussion (Kaufman and Kaufmann 1992).

In early treatment, families “support each other by expressing the pain they have experienced” (Kaufman and Kaufmann 1992, p. 76). Later, the ways the family has contributed to and enabled the client's substance abuse are identified. Homework is often assigned that gives family members new tasks, shifts their roles, and works to restructure the family. Techniques to improve communication that Kaufman finds useful are psychodrama, the “empty chair,” and family sculpture (Kaufman and Kaufmann 1992).

The MFT group can be used as a means to identify when a couple would benefit from couples therapy (Kaufmann and Kaufman 1992b). To make use of group interactions in this way and to ensure that the counselor feels comfortable in the role of coleading this type of large group, the counselor should receive adequate supervision.

## Multisystemic Family Therapy

### *Theoretical basis*

This model originated in the simple observation of high treatment dropout rates among adolescents in family therapy for their substance abuse. Programmatic features that seemed to lower dropout rates were identified and implemented to maximize accessibility of services and make treatment providers more accountable for outcomes (Henggeler et al. 1996).

### *Techniques and strategies*

Multisystemic therapy has proven useful as a method for increasing engagement in treatment in a study in which adolescents randomly assigned to this treatment were compared to a group receiving treatment as usual (Henggeler et al. 1996). Features of this therapy that are designed to make it successful include the following:

- Multisystemic therapy is provided in the home.
- Low caseloads allow counselors to be available on an as-needed basis around the clock.
- Family members are full collaborators with the therapist.
- It has a strengths-based orientation in which the family determines the treatment goals.
- It is responsive to a wide range of barriers to achieving treatment goals.
- Services are designed to meet individual needs of clients, with the flexibility to change as needs change.
- The counselor and other members of the treatment team assume responsibility for engaging the client and using creative approaches to achieve treatment goals (Henggeler et al. 1996).

Multisystemic therapy has influenced the development of other therapies, including functional family therapy, a brief prevention and treatment intervention used with delinquent youth and those with substance abuse problems (Sexton and Alexander 2000).

## ***Example of Behavioral and Cognitive–Behavioral Family Therapy***

**Family:** Peter, a 17-year-old white male, was referred for substance abuse treatment. He acknowledged that he drank and smoked marijuana, but minimized his substance use. Peter’s parents reported he had come home 1 week earlier with a strong smell of alcohol on his breath. The following morning, when the parents confronted Peter about drinking and drug use he denied using marijuana steadily, declaring, “It’s not a big deal. I just tried marijuana once.”

Despite Peter’s denial, his parents found three marijuana cigarettes in his bedroom. For at least a year, they had suspected Peter was abusing drugs. Their concern was based on Peter’s falling grades (from a B to a C student), his appearance (from meticulous grooming to poor hygiene), and unprecedented borrowing (he had borrowed a lot of money from relatives and friends, most of the time without repaying it).

For the first two family sessions, Peter, his older sister Nancy, 18, and their parents attended. During the sessions, Peter revealed that he resented his father’s overt favoritism toward Nancy, who was an honor student and popular athlete in her school, and the related conflict between the parents about the unequal treatment of Peter and Nancy. In fact, the father often was sarcastic and sometimes hostile toward Peter, disparaging his attitude and problems. Peter viewed himself as a failure and experienced depression, frustration, anger, and low self-esteem. Furthermore, Peter wanted to retaliate against his father by causing problems in the family. In this respect, Peter was succeeding. His substance abuse and falling grades had created a hostile environment at home.

**Treatment:** The counselor used cognitive–behavioral therapy to focus on Peter’s irrational thoughts (such as viewing himself as a total failure) and to teach Peter and other family members communication and problemsolving skills. The counselor also used behavioral family therapy to strengthen the marital relationship between Peter’s parents and to resolve conflicts between family members. Although the family terminated treatment prematurely after eight sessions, some positive treatment outcomes were realized. They included an improved relationship between Peter and his father, improved academic performance, and an apparent cessation of drug use (a belief based on negative urine test results).

*Source:* Consensus Panel.

## **Behavioral Family Therapy and Cognitive–Behavioral Family Therapy**

### ***Theoretical basis of behavioral family therapy***

Behavioral family therapy (BFT) combines individual interventions within a family problemsolving framework (Falloon 1991). BFT helps each family member set individual goals since the approach assumes that

- Families of people abusing substances may have problemsolving skill deficits.
- The reactions of other family members influence behavior.
- Distorted beliefs lead to dysfunctional and distorted behaviors (Walitzer 1999).
- Therapy helps family members develop behaviors that support nonusing and non-drinking. Over time, these new behaviors become more and more rewarding, leading to abstinence.

### ***Theoretical basis of cognitive–behavioral family therapy***

This approach integrates traditional family systems therapy with principles and techniques of BFT. The cognitive-behavioral combination views substance abuse as a conditioned behavioral response, one which family cues and contingencies reinforce (Azrin et al. 1994). The approach is also based on a conviction that distorted and dysfunctional beliefs about oneself or others can lead people to substance abuse and interfere with recovery. Cognitive–behavioral therapy is useful in treating adolescents for substance abuse (Azrin et al. 1994; Waldron et al. 2000).

### ***Techniques and strategies of behavioral family therapy***

To facilitate behavioral change within a family to support abstinence from substance use, the counselor can use the following techniques:

- *Contingency contracting.* These agreements stipulate what each member will do in exchange for rewarding behavior from other family members. For example, a teenager may agree to call home regularly while attending a concert in exchange for her parents' permission to attend it.
- *Skills training.* The counselor may start with general education about communication or conflict resolution skills, then move to skills practice during therapy, and end with the family's agreement to use the skills at home.
- *Cognitive restructuring.* The counselor helps family members voice unrealistic or self-limiting beliefs that contribute to substance abuse or other family problems. Family members are encouraged to see how such beliefs threaten ongoing recovery and family tranquility. Finally, the family is helped to replace these self-defeating beliefs with those that facilitate recovery and individual and family strengths.

### ***Techniques and strategies of cognitive-behavioral family therapy***

In addition to the behavioral techniques mentioned above, one effective cognitive technique is to find and correct the client's or the family's distorted thoughts or beliefs. Distorted personal beliefs may be an idea such as "In order to fit in (or to cope), I have to use drugs." Distorted messages from the family might be, "He uses drugs because he doesn't care about us," or, "He's irresponsible. He'll never change." Such messages can be exposed as incorrect and more accurate statements substituted.

An example of a technique used in behavioral family therapy to improve communication is presented on p. 95.

## ***Behavioral Family Therapy: Improving Communication***

**Family:** Delbert, a 49-year-old man with alcohol dependence, had stopped drinking during a 28-day inpatient treatment program, which he entered after a DUI arrest. He attended Alcoholics Anonymous (AA), worked every day, and saw his probation officer regularly. In many ways, Delbert was progressing well in his recovery. However, he and his wife, Renee, continued to have daily arguments that upset their children and left both Delbert and Renee thinking that divorce might be their only option. Delbert had even begun to wonder whether his efforts toward abstinence were worthwhile.

**Treatment:** Delbert and Renee finally sought help from the continuing care program at the substance abuse treatment facility where Delbert was a client. Their counselor, using a behavioral family therapy approach, met with them and began to assess their difficulty.

What became obvious was that their prerecovery communication style was still in place, despite the fact that Delbert was no longer drinking. Their communication style had developed over the many years of Delbert's drinking—and years of Renee's threatening and criticizing to get his attention. Whenever Renee tried to raise any concern of hers, Delbert reacted first by getting angry with her for "nagging all the time" and then by withdrawing. The counselor, realizing the couple lacked the skills to communicate differently, began to teach them new communication skills. Each partner learned to listen and summarize what their partner had said to make sure the point was understood prior to response.

To eliminate the overuse of blaming, the couple instead learned to report how their partner's actions affected them. For example, they learned to say, "I feel anxious when you don't come home on time," rather than to impugn their partner's character or motivation with invectives such as, "You are still as irresponsible as ever; that's why I can't trust you."

In addition, since both Delbert and Renee were focused on the negative aspects of their interactions, the therapist suggested they try a technique known as "Catch Your Partner Doing Something Nice." Each day, both Delbert and Renee were asked to notice one pleasing thing that their partner did. As they were able to do so, their views of each other slowly changed. After 15 sessions of marital therapy, their arguing had decreased, and both saw enough positive aspects of their relationship to merit trying to save it.

*Source:* Consensus Panel.

## ***La Bodega de la Familia, New York***

Family strengths and supports can be enhanced by resources in the criminal justice system. Strengthening families of offenders who use substances, and building partnerships among family, government, and community, form the methodology of La Bodega de la Familia, a community-based storefront program for offenders with substance use disorders on probation or parole and their families in New York City's Lower East Side. Research indicates that this program engages participants in treatment, decreases the use of incarceration because of relapse, and helps families use community resources to address issues such as substance abuse, domestic violence, mental illness, and HIV/AIDS.

La Bodega was created in 1996 as a demonstration project of the Vera Institute of Justice and recently incorporated as Family Justice, Inc., a national nonprofit organization. La Bodega's methodology tested the proposition that strengthening the families of those who abuse substances and who are under community-based criminal justice supervision can enhance treatment outcomes, reduce incarceration because of relapse, and lessen domestic abuse within families that often accompanies substance abuse. La Bodega has served more than 600 families, using Family Partnering Case Management (FPCM), an innovative technique that identifies and mobilizes a family's inherent strengths and resources as well as those of the community and government. La Bodega's storefront services also include counseling and relapse prevention training, walk-in assessment and referral for all neighborhood residents, and 24-hour crisis intervention in drug-related emergencies.

The participants define their "family," and are encouraged to use the broadest definition to capture the entire support network. Participants and their families help design and implement their service plans, increasing the likelihood of compliance with the plan and success in rehabilitation and reconnecting with their communities. La Bodega also serves a prevention function, exposing children, other family members, and neighbors to the ideas and skills needed to live without alcohol and illicit drugs.

La Bodega's staff is diverse in background, education, and experience. Most case managers hold advanced degrees and have special training in family work. A field manager focuses on creating and maintaining partnerships with probation, parole, housing police, service providers, and community-based organizations. The milieu is carefully managed and monitored to model the principles and behavior that families are encouraged to integrate into their daily lives. Constant training and supervision are provided to support the paradigm shift required to consider participants, their families, and government partners in a new light: as supports and resources. For example, when participants relapse or otherwise fail to comply with justice mandates, the justice and treatment systems usually narrow their focus. Using the principles and tools of FPCM, however, La Bodega widens the focus to consider the participant and the relapse in a broader context of family, neighborhood, and community.

*Source:* Sullivan et al. 2002.

## ***The Counselor as Advocate in the Network***

Debbie, a 24-year-old single mother of a 4-year-old, received general public assistance, which kept her involved with the child welfare system. It became apparent to the social worker at the child welfare agency that her financial and parenting difficulties were related to her alcohol dependence. After multiple failures in outpatient treatment, Debbie was faced with losing custody of her child. It was at this time that Debbie entered a 30-day inpatient program for women with substance use disorders.

After Debbie's successful completion of the inpatient program, she made the transition to a continuing care program. In this program, family therapy was initiated, with Debbie asking a female friend from a church she had been involved in to attend these sessions. The counselor initiated supervised visits between Debbie and her daughter, with the assistance of Debbie's friend. As Debbie made progress in substance abuse treatment, the frequency and length of the visits increased. After a year of sobriety, the counselor set the goal of reuniting the mother and child, with a court hearing scheduled for 3 weeks after the start of the pre-kindergarten program the child was enrolled in.

The substance abuse counselor took on the role of advocate to appeal the unfortunate timing of the hearing. The child's late entry into the class, she recognized, could create unnecessary adjustment problems for the child and result in school problems. The unnecessary stress could tax Debbie's new and tenuous parenting skills, which might lead to relapse. The counselor acted as an advocate for the client in a system that was not considering the full impact of its actions on a newly sober mother.

### **Family/Larger System/Case Management Therapy**

#### ***Theoretical basis***

Family/larger system/case management therapy is for families who are or should be involved intensely with larger systems, which include the workplace, schools, health care, courts, foster care, child welfare, mental health, and religious organizations. The therapy also helps families interact with the larger systems in their lives.

For many families, dealing with larger systems is not a problem. Their dealings with the larger systems are routine and positive; when they have occasional difficulties they can navigate within larger systems. Other families, however, have recurrent problems and more frequent

dealings with larger systems. Often, interaction with large systems is intense and extensive throughout the family's life cycle, in many cases because of issues such as poverty, chronic illness, legal problems, and cultural and language barriers.

The goal of family/larger systems therapy is to empower the family in its dealings with larger systems. The empowerment begins when the counselor designates "the family as the major expert on the family" (Imber-Black 1991, p. 601). Imber-Black further suggests that counselors determine

- What larger systems affect the family?
- What agencies and agency subsystems regularly interact with family members?

- How is the family moved from one larger system to another?
- Is there a history of significant involvement with larger systems, and if so, regarding what issues? (Imber-Black 1991)

For example, families with substance abuse problems interact more regularly with the judicial system, because of arrests (e.g., for driving under the influence, loss of parental rights, and domestic violence). This connection can have an adverse effect on the family. It may limit finances, time together, and unity; stress family relationships; and result in loss of child custody. It can also complicate the therapeutic process, especially if the family is ordered to come to treatment. However, even though a family may resist and feel coerced, the judicial system can be the stimulus that gets the family treated and reconnected with social services. Family/larger system/case management therapy can be used effectively by probation and parole officers and by drug court officials. (See TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* [CSAT 1998a].)

### **Techniques and strategies**

In family/larger system/case management therapy the counselor assumes a role similar to that of a case manager. The counselor helps initiate contact with other systems, including agencies that can provide services to the client and his or her family members. The counselor can help the client navigate the maze of systems that he is involved with, including courts, law enforcement, social service agencies, and child welfare. To some extent, the counselor is a community liaison, who can provide information to clients about the resources in the community and advocate in the community for more funding and other support for substance abuse treatment.

## **Network Therapy**

### **Theoretical basis**

Network therapy harnesses the potential of therapeutic support from people outside of the immediate family, especially when conducting effective substance abuse interventions. By gathering those who genuinely care about the individual with a substance use disorder—especially friends and extended family members—the counselor helps encourage the individual who uses drugs to stop using and remain abstinent. Galanter (1993) also points to the importance of AA in network therapy.

Network therapy also attempts to connect people to the larger community. Network therapy is compatible with traditional healing practices, alternative medicine, AA attendance, and participation in community events such as pueblo feast days and arts and crafts fairs. Network therapy is especially useful for reconnecting urban American Indians with the larger community.

### **Techniques and strategies**

A counselor using network therapy is responsible for mobilizing the client's network. The counselor keeps people in the network informed and involved and encourages the client to accept help from the network and to accept the rewards that the network can offer.

## **Bowen Family Systems Therapy**

### **Theoretical basis**

Bowen family systems therapists believe that all family dysfunctions, including substance abuse, come from ineffective management of the anxiety in a family system. More specifically, substance abuse is viewed as one way for both individuals and the family as a group to manage anxiety. The person who abuses alcohol or drugs does so in part to reduce anxiety temporarily, and when the entire family can justifiably focus on the individual who uses drugs as the problem,

## ***Use of Bowen Family Systems Therapy With Immigrant Populations***

Although no demonstrated outcomes substantiate Bowenian therapy to address substance abuse, counselors have often used it to treat clients with substance use disorders who have immigrated to this country. It is believed that this therapeutic approach is a good match for such clients because it emphasizes the intergenerational transmission of anxiety and the effects of trauma that are passed down through generations.

The perspective that the “past is the present” provides a mechanism to understand the lowered self-esteem of a person who has lost everything of importance: language, homeland, culture, possessions, and often, a sense of cultural identity. For many the circumstances of migration are traumatic. Such losses are not only carried from the past, but continue to occur in the present as family members are subject to the indirect consequences of migration, such as unemployment or underemployment, marginal or overcrowded housing, untreated health problems, and poverty. In this situation, alcohol and drugs can provide an expedient way to blot out pain and hopelessness. Healing cannot begin until both the counselor and the client understand the significance of the loss of past cultural identification in light of a current substance use disorder.

it can deflect attention from other sources of anxiety.

A major source of anxiety can be a family’s reactivity, or the intensity with which the family reacts emotionally to relationship issues instead of carefully thinking them through. Ideally, family members are able to strike a balance between emotional reactivity and reason and are aware of which is which. This is called differentiation. Further, family members are autonomous, that is, neither fused with nor detached from others in the family.

Bowen family systems therapy is also based on the premise that a change on the part of just one family member will affect the family system. To reduce the family’s reactivity, for example, counselors coach the most motivated family members in ways to curb their reactivity and behave differently in their relationships. Such changes can decrease or even eliminate the problem that brought the family into treatment.

In Bowenian therapy, it is assumed that the past influences the present. In fact, it is still

“alive.” It is present in the form of emotional responses that can be passed down from one generation to another (Friedman 1991).

### ***Techniques and strategies***

The Bowenian approach to substance abuse often works through one person, and its scope is highly systemic. For instance, Bowen attempts to reduce anxiety throughout the family by encouraging people to become more differentiated, more autonomous, and less enmeshed in the family emotional system.

In Bowen’s view, specific and problematic anxiety and relationship patterns are handed down from generation to generation. Some intergenerational patterns that may require therapeutic focus are

- *Creating distance.* Alcohol and drugs are used to manage anxiety by creating distance in the family.
- *Triangulation.* An emotional pattern that can involve either three people or two people and an issue (such as the substance abuse). In the

latter situation, the substance is used to displace anxiety that exists between the two people.

- *Coping.* Substance abuse is used to mute emotional responses to family members and to create a false sense of family equilibrium.

## **Solution-Focused Brief Therapy**

### ***Theoretical basis***

Solution-focused brief therapy (SFBT) replaces the traditional expert-directed approach aimed at correcting pathology with a collaborative, solution-seeking relationship between the counselor and client. Rather than focusing on an extensive description of the problem, SFBT encourages client and therapist to focus instead on what life will be like when the problem is solved. The emphasis is on the development of a solution in the future, rather than on under-

standing the development of the problem in the past or its maintenance in the present.

Exceptions to the problem—that is, times when the problem does not happen and a piece of the future solution is present—are elicited and built on. This counters the client’s view that the problem is always present at the same intensity and helps build a sense of hope about the future.

Rooted in the strategic therapy model, de Shazer and Berg, along with colleagues at the Brief Family Therapy Center in Milwaukee, shifted solution-focused brief therapy away from its original focus, which was how problems are maintained (Watzlawick et al. 1974; Zeig 1985), to its current emphasis on how solutions develop (de Shazer 1988, 1991, 1997). SFBT has been increasingly used to treat substance use disorders since the publication of *Working with the Problem Drinker: A Solution-Focused Approach* (Berg and Miller

## ***Asking the Miracle Question***

If the answer to the miracle question (see p. 101) is “I don’t know,” as it often is, the client should be encouraged to take all the time needed before answering. The client can also be prompted, if necessary, with questions such as, “As you were lying in bed, what would you notice that would tell you a miracle had occurred? What would you notice during breakfast? What would you notice when you got to work?” Then the therapist should

- Expand on each change noticed. For example, the therapist might ask, “How would that make a difference in your life?” If the client answered that he would not wake up thinking about drinking, ask, “What would you think about? How would that make a difference?”
- Accept the client’s answer without narrowing it. Some clients say their miracle would be to win the lottery. The counselor should not narrow the response by saying, “Think of a different miracle.” Instead expand the response by asking questions such as, “What would be different in your life if you won the lottery?” “What would be different if you paid all your bills on time?”
- Make the vision interpersonal. Ask, “As your miracle starts to come true, what would other people notice about you?”
- Help the client see that elements of the miracle are already part of life. Even if those elements are small, ask, “How can you expand the influence of those small parts of the miracle?”

1992). Berg and Miller challenged the assumptions that problem drinkers want to keep drinking, are unaware of the damage drinking causes, and require an expert's help and information if they are to recover. Quite the contrary, SFBT counselors insist, people who abuse substances can direct their own treatment, provided they participate in the process of developing goals for therapy that have meaning for them and that they believe will make significant change in their lives.

SFBT is consistent with research that stresses the importance of collaborative, nonconfrontational therapeutic relationships in substance abuse treatment (Miller et al. 1993) and treatment matching as a means of increasing motivation for change (Prochaska et al. 1992). In fact, even substance abuse counselors who firmly believe in the disease model also accept and use SFBT as one component of substance abuse treatment (Osborn 1997). Further, McCollum and Trepper (2001) have put forth a system-based variation of the therapy specifically for use with families of people with substance use disorders.

As yet, however, little definitive research has confirmed the effectiveness of SFBT for substance abuse. Gingerich and Eisengart (2000) found and evaluated 15 studies on the outcome of SFBT in treating various problems. They concluded that "the 15 studies provide preliminary support for the efficacy of SFBT, but do not permit a definitive conclusion" (Gingerich and Eisengart 2000, p. 477), especially for substance abuse. Of the 15 studies, only two poorly controlled ones looked at the substance abuse population. One of them described a man with a 10-year drinking history. He achieved more days abstinent and more days at work per week during treatment as compared to before treatment (Polk 1996). The other study involved a therapist who used SFBT with 27 clients in treatment for substance use disorders. A larger percentage of the SFBT clients recovered (by study definitions) after two sessions and after seven sessions than did the comparison clients, but no details were

given about the severity of the cases or specific client outcomes (Lambert et al. 1998).

## ***Techniques and strategies***

In SFBT, the counselor helps the client develop a detailed, carefully articulated vision of what the world would be like if the presenting problem were solved. The counselor then helps the client take the necessary steps to realize that vision.

In addition, the counselor encourages clients to recall exceptions to problems, that is, times when the problem did not occur, and to examine and increase those exceptions. In this way, the client moves closer to the problem-free vision.

The techniques of solution-focused brief therapy are designed to be quite simple. They include the miracle question, exception questions, scaling questions, relational questions, and problem definition questions.

*The miracle question.* Perhaps the most representative of the SFBT techniques, the miracle question elicits clients' vision of life without the problems that brought them to therapy. The miracle question traditionally takes this form:

- I want to ask you a strange question. Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is that the problem that brought you here is solved. Because you are sleeping, however, you don't know that the miracle has happened. When you wake up tomorrow morning, what will be different that will tell you a miracle has happened, and the problem that brought you here has been solved? (De Jong and Berg 1997).

The miracle question serves several purposes. It helps the client imagine what life would be like if his problems were solved, gives hope of change, and previews the benefits of that change. Its most important feature, however, is its transfer of power to clients. It permits them to create their own vision of the change they want. It does not require them to accept a

## Case Study of Exceptions to Problem

**Family:** Darcy had been diagnosed with an alcohol use disorder. In family therapy, she and her husband Steve came to recognize a problem sequence known as a pursuer-distancer pattern. When Steve sensed Darcy distancing from him emotionally, he would begin to worry that she was in danger of going on another drinking binge. His response to this fear was to suggest that Darcy call her sponsor or go to extra AA meetings.

Steve's concern made Darcy feel her independence was threatened. She would get angry, refuse to take Steve's advice, and distance herself even more. Steve would then insist that she call her sponsor, and the tension between them would escalate into an argument. The quarrel often ended when Darcy stormed out of the house to spend the night with her sister, who was not a healthful influence. She would suggest a drink to calm Darcy's nerves—and then join her in a binge.

**Treatment:** After Darcy and Steve defined this sequence, the therapist helped them look for exceptions to it—times when the sequence started, but did not end in a binge. Both Darcy and Steve were able to identify a solution sequence. Darcy remembered a time when Steve was pestering her. Instead of going to her sister's house, she spent an hour online reading passages and trading messages and suggestions with the online recovery community. Then she called and had lunch with her sponsor before going to an AA meeting where her sponsor was the speaker that day. When she came home, she was able to reassure Steve that she was not tempted to drink at that point and suggested they go to a movie together. Steve recalled an occasion when he was getting anxious about Darcy, but instead of pestering Darcy, he mowed the lawn. The physical activity dissipated his anxiety, and he was then able to talk to Darcy calmly about his concerns without pressuring her to take any specific action. The therapist helped Darcy and Steve to build on these successful times, identifying ways to more positive sequences of behavior.

vision composed or suggested by an expert (Berg 1995).

*Exception questions.* Sometimes a continual problem is less severe or even absent. Hence, the substance abuse counselor might inquire, "Tell me about the times when you decided not to use, even though your cravings were strong." The answer will set the stage for examining how the client's own actions have helped lead to that different outcome.

*Scaling questions.* As a clear vision of change emerges, techniques begin to focus on helping the client make change happen. At this point, one especially useful technique is the scaling question. It might ask, On a scale of 1 to 10,

where 1 means one of your goals is met and 10 means all your goals are completely met, where would you rate yourself today? A good follow-up question is, What would it take for you to move from a 4 to a 5 on our 10-point scale? Such questions help clients gauge their own progress toward their goals and see change as a process rather than an event.

*Relational questions.* Helping clients set goals that take the views of important others into account can extend the benefits of change into the client's environment. A good relational question is, What will other people notice about you as you move closer and closer to your goal? For instance, an adolescent client might declare that he is completely confident

## **Figure 4-3**

### **Techniques To Help Families Attain Sobriety**

Techniques useful during the stage when the client and the family are preparing to make changes in their lives include the following:

#### **Multidimensional family therapy (Liddle 1999)**

- Motivate family to engage client in detoxification.
- Contract with the family for abstinence.
- Contract with the family regarding its own treatment.
- Define problems and contract with family members to curtail the problems.
- Employ Al-Anon, spousal support groups, and multifamily support groups.

#### **Behavioral family therapy (Kirby et al. 1999)**

- Conduct community reinforcement training interviews such as interviews with area clergy to help them develop ways to impact the community.

#### **Network and family/larger system (Galanter 1993; Imber-Black 1988)**

- Use the network (including courts, parole officers, employer, team staff, licensing boards, child protective services, social services, lawyers, schools, etc.) to motivate treatment.
- Interview the family in relation to the larger system.
- Interview the family and people in other larger systems that assist the family.
- Interview larger system representatives, such as school counselors, without the family present.

#### **Bowen family systems therapy (Bowen 1978)**

- Reduce levels of anxiety.
- Create a genogram showing multigenerational substance abuse; explore family disruption from system events, such as immigration or holocaust.
- Orient the nuclear family toward facts versus reactions by using factual questioning.
- Alter triangulation by coaching families to take different interactional positions.
- Ask individual family members more questions, so the whole family learns more about itself.

## **Figure 4-4**

### **Techniques To Help Families Adjust to Sobriety**

During the time that the client and the family are getting used to the changes in their lives, the following techniques are suggested by different models of family therapy:

#### **Structural/strategic systems (Stanton et al. 1982)**

- Restructure family roles (the main work of this model).
- Realign subsystem and generational boundaries.
- Reestablish boundaries between the family and the outside world.

#### **Multidimensional family therapy (Liddle 1999; Liddle et al. 1992)**

- Stabilize the family.
- Reorganize the family.
- Teach relapse prevention.
- Identify communication dysfunction.
- Teach communication and conflict resolution skills.
- Assess developmental stages of each person in the family.
- Consider family system interactions based on personality disorders, and consider whether to medicate for depression, anxiety, or posttraumatic stress disorder.
- Consider whether to address loss and mourning, along with sexual or physical abuse.

#### **Cognitive-behavioral family therapy (Azrin et al. 2001; Kirby et al. 1999; Waldron et al. 2000)**

- Conduct community reinforcement training interviews.
- Establish a problem definition.
- Employ structure and strategy.
- Use communication skills and negotiation skills training.
- Employ conflict resolution techniques.
- Use contingency contracting.

#### **Network interventions (Favazza and Thompson 1984; Galanter 1993)**

- Use AA, Al-Anon, Alateen, and Families Anonymous as part of the network.
- Delineate and redistribute tasks among all service providers working with the family.
- Use rituals when clients are receiving simultaneous and conflicting messages.

**Solution-focused family therapy** (Berg and Miller 1992; Berg and Reuss 1997; de Shazer 1988; McCollum and Trepper 2001)

- Employ the miracle question.
- Ask scaling and relational questions.
- Identify exceptions to problem behavior.
- Identify problem and solution sequences.

that he will not relapse. In reply, he might be asked, “Do you think your father is that confident?” Being urged to look at his situation from the perspective of the parent, who might only be somewhat confident that the client will not relapse, motivates the client to think about how he must behave to instill more confidence in this important other figure.

*Problem definition questions.* This technique, used with the families of people with substance use disorders, defines the steps that each person takes to produce an outcome that is not a problem (McCollum and Trepper 2001). The therapist helps the family define a problem it would like to solve, and then constructs the part each member plays in the sequence of behaviors leading up to that problem. Next, the therapist helps the family examine exceptions to the problem sequence and uses the exceptions to construct a solution sequence.

## Matching Therapeutic Techniques to Levels of Recovery

Both individuals and families go through a process of change during substance abuse treatment.

The consensus panel decided that one way of looking at levels of recovery for families is to combine 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 levels of family recovery 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.

Once change is in motion, the individual and family recovery processes generally parallel each other, although they may not be perfectly synchronized (Imber-Black 1990). For instance, family members may be aware of a drinking problem sooner than the person who is doing the drinking. When a person who drinks excessively comes to treatment, both the client and the family need education about alcohol abuse, and both need to think about seeking help to stop the drinking. Similarly, once the person who drinks decides to stop drinking and makes plans to do so, the family must learn to stop supporting the drinking. Familiar ways of interacting must change if the family is to maintain a healthy emotional balance and support abstinence. In short, as both the individual and the family change, both have to adjust to a change in lifestyle that supports sobriety or abstinence, the changes needed to maintain sobriety or abstinence, and a stable family system.

Different models of integrated treatment suggest different techniques that can be used at different levels of recovery. As the family addresses its challenges and the client addresses a substance use disorder, they will progress from attainment of sobriety to maintenance. The following summary figures, 4-3 (p. 103),

4-4 (p. 104), and 4-5, list techniques from a variety of treatment models that can be used with families at different levels of recovery in substance abuse treatment and family therapy.

Treatment goals for children in alcoholic families and adult children of people with substance use disorders include educating children about drinking; helping parents assume appropriate responsibility as parents; and examining the

role the adult played in his family of origin and how that role affects current relationships (Bepko and Krestan 1985). For more information, refer to TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000b), and the Adult Children of Alcoholics Web site, <http://www.adultchildren.org>.

### **Figure 4-5**

#### **Techniques To Help Families in Long-Term Maintenance**

The following techniques are suitable during the period when the gains made by the client and the family during treatment are being solidified and safeguards against relapse or returning to old habits are being implemented:

Family/larger system (Imber-Black 1988)

- Renegotiate relationships with larger systems. For instance, agree with Child Protective Services that once the family has completed treatment, the child(ren) can be returned to the home.

Network therapy (Galanter 1993)

- Employ Al-Anon, spousal support groups, and multifamily support groups.
- AA, Al-Anon, and Alateen are interventions long used to break the cycle of substance abuse and can complement other interventions.

## ***Chapter 4 Summary Points From a Family Counselor Point of View***

- For the successful integration of family-involved interventions or family therapy, treatment program design must be inclusive of the needs of all family members and the family as a whole. Adequate therapeutic time, trained clinicians, and an informed staff serve to increase effectiveness.
- Families can be used to foster client engagement and retention in treatment.
- In much the same way that group counseling helps clients by bringing together clients in different phases of the treatment process, multiple family therapy groups can help families see how progress is achieved by others and also serve as a reminder of what the early days of treatment were like.
- Integrating family techniques into substance abuse treatment is possible along a broad continuum from the utilization of specific techniques to the full-fledged adaptation of particular models.

# 5 Specific Populations

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Race and Ethnicity

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## Overview

Culturally competent practices and attitudes can be implemented at all levels of a treatment program to ensure appropriate treatment for families with substance abuse issues. The effectiveness of substance abuse treatment is undermined if treatment does not include community and cultural aspects—the broadest components of an ecological approach. Concerted efforts are instituted to identify and change preconceived notions or biases that people may have about other people’s cultural beliefs and customs.

This chapter provides information about several specific populations: children, adolescents, and older adults; women; cultural, racial, and ethnic groups; gays and lesbians; people with physical and cognitive disabilities; people in rural locations; and people with co-occurring substance use and mental disorders. In addition, information is provided regarding people who are HIV positive, people who are homeless, and veterans. Each section discusses relevant background issues and applications to family therapy.

## Introduction

This TIP uses the term *specific populations* to examine features of families based on specific, common groupings that influence the process of therapy. Whenever people are categorized or classified in this way, it is important to remember that individuals belong to multiple groups, possess multiple identities, and live their lives within multiple contexts. Different statuses may be more or less prominent at different times. The most important general guideline for the therapist is to be flexible and meet the family “where it is.”

It is vital that counselors be continuously aware of and sensitive to the differences between themselves and the members of the group they are counseling. Therapists bring their own cultural issues to therapy, and the therapist’s age, gender, ethnicity, and other characteristics may

figure in the therapeutic process in some way. Differences within the family also should be explored. Is the family a homogeneous group or one that represents several different backgrounds? What is the significance that family members assign to their own identities and to the identity of the therapist? These considerations and sensitivity to the specific cultural norms of the family in treatment must be respected from the start of therapy. If these factors are not apparent or explicit, the therapist should ask.

## Age

Age is an important factor in the therapeutic process. Substance use may have different causes and different profiles based on an individual's age and developmental stage. For example, a teenager may drink for different reasons than does a middle-aged father. The age of the person abusing substances is also likely to have different effects on the family. This TIP discusses three age groups: children, adolescents, and older adults.

## Children

### **Background issues**

While actual numbers of children who abuse substances are small compared to other age groups, children who use drugs are an underserved population—one as poorly identified as it is poorly understood. Nonetheless, substance abuse among children is of grave importance. Drug or alcohol use can have a severe effect on the developing brain and can set a potential pattern of lifelong behavior (Oxford et al. 2001).

The use of inhalants is especially prevalent among children. The National Institute on Drug Abuse (NIDA)-funded 2001 Monitoring the Future survey found that more than 17 percent of eighth graders said they had abused inhalants at least once in their lives (Johnston et al. 2002). In a recent policy statement, the American Academy of Pediatrics (AAP) described inhalant abuse as “an

under-recognized form of substance abuse with a significant morbidity and mortality” (AAP 1996, n.p.). For more information, see also TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (Center for Substance Abuse Treatment [CSAT] 1999c).

### **Application to family therapy**

When a child is abusing substances, single family therapy is probably the most useful approach. Regardless of the approach, the therapist will need to make accommodations and adjustments for children in therapy. For instance, children should not be left too long in the waiting room and should not be expected to sit still for an hour while adult conversation takes place around them.

Stith et al. (1996) interviewed 16 children between the ages of 5 and 13 who were involved in family therapy with their parents and siblings and found these children wanted to be involved in therapy, even when they weren't the identified patient (IP). They were aware that important things were happening in therapy and wanted to be part of them. They did, however, indicate that being part of family sessions often had been an unsatisfying experience dominated by adult conversation and time spent out of the session in the waiting room. The personal qualities of the therapist were important to the children. Finally, they said that if they were to be part of therapy, they needed to participate in ways that fit their styles of communication—activity and play.

Approaches to incorporate children in therapy via play—such as family puppet shows, family art projects, and board games with a therapeutic focus—can be modified to fit family therapy, and play therapy can be a valuable component of family sessions. The Association for Play Therapy defines play therapy as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (Bratton et al. n.d., p. 1).

Cooklin (2001) points out that play therapy does not mean playful interactions in therapy, but refers to more structured and often non-verbal processes such as the use of toys, games, puppets, models, or role playing. Its goal is to reduce the child's anxiety and to facilitate emotional processing. He also emphasizes, though, that when the client is a child, a level of playfulness is helpful in the therapist-client relationship.

## Adolescents

### **Background issues**

Youthful substance use is usually transitory, episodic, or experimental, but for some, it may be a serious, long-lasting indicator of other life problems (Furstenberg 2000). A growing body of research, primarily using animals, addresses the sensitivity of adolescents' brains to alcohol (see, e.g., Spear 2000). Substance use in the teen years is associated with disruptive behaviors such as conduct disorders, oppositional disorders, eating disorders, and attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD).

The United States has the highest rate of adolescent drug abuse of all industrialized nations (Liddle et al. 2001). The Overview of Findings From the 2002 National Survey on Drug Use and Health found that 17.6 percent of 12- to 17-year-olds reported drinking in the month preceding the survey, and 11.6 percent of 12- to 17-year-olds said they had used an illicit drug (Office of Applied Studies [OAS] 2003a). More than 65 percent of young people who were classified as heavy drinkers were also using illicit drugs (OAS 2002b).

Alcohol is the substance most often used and abused by adolescents, and its usage reflects troubling patterns (AAP 2001). In 2001, of people age 12 to 17, 10.7 percent reported binge alcohol use in the past month and 2.5 percent reported heavy alcohol use in the past month (binge drinking is defined as five or more drinks on the same occasion; heavy use is

five or more drinks on the same occasion at least 5 days in the past month) (OAS 2003a).

Substance use among adolescents is associated with poor school performance, problems with authority, and high-risk behaviors, including driving while intoxicated and unprotected sexual activity. Fifteen-year-olds who drink have been found to be seven times as likely to have sexual intercourse as their nondrinking contemporaries (AAP 2001). Sexually active teenagers who use alcohol or drugs are at greater risk of acquiring sexually transmitted diseases, including HIV/AIDS (AAP 2001).

Some specific risk factors for adolescent substance abuse include

- Antisocial behavior at a young age, especially aggression
- Poor self-esteem
- School failure
- ADD and AD/HD
- Learning disabilities
- Peers who use drugs
- Alienation from peers or family
- Depression and other mood disorders (e.g., bipolar disorder)
- Physical or sexual abuse (AAP 2001)

### **Application to family therapy**

A growing body of evidence supports family therapy's capacity to engage and retain clients in therapy and its efficacy in ameliorating adolescent drug use, as compared to other approaches (Liddle and Dakof 1995a). Specific family therapy approaches such as Brief Strategic Family Therapy (Szapocznik and

Age is an important factor in the therapeutic process. Substance use may have different causes and different profiles based on an individual's age and developmental stage.

Williams 2000) and Multidimensional Family Therapy (Liddle et al. 2001) have shown great promise in terms of usage reduction in adolescents and improvements in family functioning.

Part of the treatment process involves teaching adolescents to make choices and encouraging them to find alternatives to substance use. Parents can be instrumental in this process and the importance of modeling behavior should be emphasized. Siblings also should be drawn into therapy—sometimes the problems of an adolescent IP will overwhelm the needs of a quieter sibling. In general, family therapists can support families by providing opportunities for them to work on negotiation skills with their adolescent child. Therapists can teach parents techniques to decrease reactivity and ways to provide real and acceptable choices for their children. Children should be encouraged to handle developmentally appropriate tasks and to understand that outcomes are tied to behavior.

Moving therapy from the clinic to settings with which the adolescent is familiar and comfortable

can be a helpful strategy. Conducting sessions at an adolescent's home may promote a more open and sharing tone than sessions in a therapist's office. Scheduling of sessions must be sensitive not only to school obligations, but to extracurricular and social activities as well. Such flexibility is an important attribute for any therapist working with adolescents. When teens are not willing to engage in therapy/treatment, parents may be

encouraged to attend therapy to examine ways of working with their troubled teen.

Gender also may have implications in family groupings for therapy sessions, particularly in families where abuse has occurred. There may be cases where father/son or mother/daughter sessions will be helpful.

For more information on substance abuse treatment with adolescents, see TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999c) and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999e).

## Older Adults

### **Background issues**

Although definitions of “older adults” vary, they typically refer to individuals age 60 and older. Up to 17 percent of older adults are estimated to have problems with alcohol or prescription drugs. Older men are much more likely than older women to abuse alcohol (Atkinson et al. 1990; Bucholz et al. 1995; Myers et al. 1984); women typically experience later onset of problem drinking than do men (Gomberg 1995; Hurt et al. 1988; Moos et al. 1991). For both men and women, substance abuse can lead to social isolation and loneliness, reduced self-esteem, family conflict, sensory losses, cognitive impairment, reduced coping skills, decreased economic status, and the necessity to move out of one's home and into a more supervised setting (CSAT 1998d).

There are two patterns of substance abuse among older adults. The first includes those for whom drug or alcohol abuse has been a chronic, lifelong pattern leading to significant impairment by the time they are older. The second includes older adults who have recently begun misusing alcohol or drugs in response to life transition issues, such as the death of a spouse. Through reduced tolerance and the decrease in the amount of body water (associated with aging) in which to dilute alcohol (Dufour and Fuller 1995; Kalant 1998), alcohol use

Up to 17 percent of older adults are estimated to have problems with alcohol or prescription drugs. Older men are much more likely than older women to abuse alcohol.

considered moderate and nonproblematic through a person's middle years can cause intoxication and dysfunction in an older person. In general, treatment is more effective and the prognosis more optimistic for people with later-onset substance disorders.

Diagnosis can be difficult in this age group (and misdiagnosis is more likely) because symptoms easily can be confused with age-related organic brain disorders or effects and interactions of prescribed medications. Depression or bone fractures from falls may be incorrectly attributed to the natural aging process. Family members may hide the older person's substance abuse. A retired person will not have problems at work related to substance abuse, and the behavior of those living alone often will go unobserved. Moreover, although older people often have many contacts with the health care system, they are not routinely screened for substance abuse (CSAT 1998d).

Ageism also contributes to the underdetection of substance abuse and mental disorders (e.g., depression) in older people. One study found that different expectations of younger and older people contributed to minimizing problems of older adults. Substance abuse and other problems were perceived as more significant when they were experienced by younger people (Ivey et al. 2000).

Prescription drug misuse and abuse are higher among older adults than any other age category. For some individuals, the misuse may be unintentional, because of confusion and the sheer amount of medicines they must manage. Some studies estimate that more than 80 percent of those over 65 take at least one prescription drug (Ray et al. 1993) and nearly one-third take eight or more prescription drugs daily (Sheahan et al. 1989). Older adults also take a disproportionately large amount of psychoactive mood-changing drugs (such as antidepressants, tranquilizers, and hypnotics). Moreover, they typically take these drugs longer than younger adults (Sheahan et al. 1995; Woods and Winger 1995). The cost of medication also is a factor related to compliance for older adults.

## **Application to family therapy**

While the efficacy of family therapy to treat older adults has not been extensively examined, some indications suggest it is an effective method to draw even the older person who lives alone back into a family context and reduce feelings of isolation. Although family ties can be beneficial at any stage of life, some older adults may regard involvement of their long-grown children in their lives as intrusive and threatening to their independence (Sluzki 2000). The therapist must respect the elder's autonomy and privacy, and obtain specific permission from the client to contact family members and communicate with them about substance abuse problems. The therapist also should be aware that adult children may have their own substance use problems and screen them carefully.

Alcohol use considered moderate and nonproblematic through a person's middle years can cause intoxication and dysfunction in an older person.

Therapists must be sensitive to the possibility of elder abuse, which is pervasive, though often overlooked. In some States, it is mandatory for all helping professionals to report elder abuse. Such reports of physical, psychological, financial, or emotional mistreatment or neglect have increased dramatically in the past 15 years, yet only a fraction of cases are ever reported. While a common perception is that elder abuse is a nursing home-related phenomenon, the fact is that perpetrators are most often the victims' family members (Brandl and Horan 2002).

Even when abuse is not a factor, older adults sometimes are infantilized and trivialized within the family. Likewise, family therapists must be cognizant of their own tendencies to infantilize

the elderly (Sluzki 2000). It is helpful to refrain from framing the substance abuse in pejorative terms, such as *heavy* and *problem drinking*. Instead, a less stigmatizing classification system may refer to a person as at-risk. Linking at-risk use to existing or potential medical conditions also places the problem in a medical framework and identifies it as a danger to health.

The family therapist working with older adults may also find it helpful to make extensive use of home visits. It is important to respect clients and their life experiences. Older people, especially those who feel isolated, may have a need to tell their stories (for example, growing up during the Great Depression), and the therapist needs to listen attentively. Telling stories is important and a developmentally appropriate behavior.

Other accommodations that are helpful for many older clients include

- Involving the older adult's physician and/or nursing staff.
- Recognizing and addressing barriers to treatment, such as ageism, lack of awareness, comorbidity of physical or mental disorders, transportation problems, client's time constraints, lack of staff expertise, and economic limitations.
- Addressing issues of loss, grief, death, and dying.
- Addressing concomitant substance use, including tobacco.
- Using supportive, nonconfrontational intervention approaches. Motivational interviewing is appropriate for some older adults.
- Acknowledging the cultural expectations regarding use to better understand the older client's perceptions of his or her own using.

For more information about substance abuse treatment and older adults, see TIP 26, *Substance Abuse Among Older Adults* (CSAT 1998d).

## Women

### Background Issues

According to data from the 2002 National Household Survey on Drug Abuse (OAS 2003a), 6.4 percent of American women reported using an illicit drug in the month preceding the survey, while 9.9 percent of women reported binge drinking in the same timeframe. In 2002, men continued to have higher rates of illicit drug use than women—10.3 percent of men compared to 6.4 percent of women (OAS 2003a).

Despite the significant number of women who abuse substances, the substance abuse treatment and research fields have been grounded historically in the needs and experiences of middle-aged, white males with alcoholism. Recent studies suggest that the causes, consequences, and costs of women's substance abuse are in many ways different from men's. For example, the onset of substance abuse among women is more likely to be tied to specific events, such as divorce or the death of a loved one. Women also tend to enter treatment at later stages than men, and women continue to encounter many gender-related barriers to treatment (Brady and Randall 1999; Chaney and White 1992). Moreover, in addition to the risks shared with men (i.e., hepatitis, HIV infection, malnutrition, unemployment, criminal acts, and arrests), women have been found to develop more severe alcohol-related medical problems while consuming smaller amounts of alcohol than men. Sexual, physical, or emotional abuse of women can increase their risk of substance abuse (Covington 2002).

In some respects, the psychological burden of women's substance abuse is likely to be greater than for men. One of the biggest psychosocial differentials between men and women who abuse substances is stigma. For a man, especially in certain cultures, drinking may be part of manhood. Women with substance use disorders often are referred to in derogatory and sexually charged terms. A mother with a substance abuse problem quickly is regarded as unfit and

may be confronted with losing her children. Although 9 out of 10 women stay with male partners who abuse substances, men are more likely to leave relationships with a woman who abuses substances (Hudak et al. 1999).

A recurring theme in the lives of women with substance use disorders is a lack of healthy relationships (Covington 2002). Brown et al. (1995) found that when women were drinking, they often lacked social support, particularly from their partners, and that their families often were opposed to their getting treatment. For more information, see the forthcoming TIP *Substance Abuse Treatment and Trauma* (CSAT in development i) and TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000b).

An important distinction in women's substance abuse has to do with their traditional roles as caretakers of children. Even before children are born, women who abuse illicit drugs and alcohol experience a variety of gynecological problems that can make birth control and pregnancy detection difficult, adding to the probability of infertility and problem pregnancies and births. Many studies of substance use and pregnancy have found poor pregnancy outcomes such as preterm delivery, fetal distress, and hemorrhage, whether the drug is alcohol, cocaine, opioids, marijuana, or nicotine (Brady and Randall 1999; Bry 1983).

A variety of other ills may influence the children of mothers who abuse substances, including increased risk for depression, anxiety, and conduct disorders (Brady and Randall 1999; Merikangas and Dierker 1998), higher rates of lifetime suicidal ideation (Pfeffer et al. 1998), and more frequent periods of living outside the nuclear family during childhood (Goldberg et al. 1996). Child abuse and neglect are also often associated with women's drug and alcohol abuse (Bijur et al. 1992; Casado-Flores et al. 1990; Famularo et al. 1986, 1992; Murphy et al. 1991).

Bays (1990) suggests a number of factors associated with drug abuse that put parents who abuse substances at greater risk of abusing

or neglecting their children. These include diverting family resources from meeting the needs of the children to supporting the substance abuse, criminal activity to support a substance use disorder, mental and physical illness, poor parenting skills, side effects of drugs, and family violence. In addition, the effects of prenatal drug exposure may produce characteristics in the children that interfere with attachment and put them at greater risk for abuse (Cook et al. 1990) and the development of substance abuse problems later in life (Merikangas and Dierker 1998; Muetzell 1995; Su et al. 1997). For further information about women's issues in substance abuse treatment, see the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development e).

## Application to Family Therapy

Family therapy for women with substance use disorders is appropriate except in cases in which there is ongoing partner abuse. Safety should always be the primary consideration. This could mean that the abusive partner progresses through treatment directed at impulse control or a batterers' program before any family or couples therapy is initiated to address the woman's substance abuse problem. This decision should be made after careful consultation with the professional staff overseeing the abusive partner's treatment. While the abusive partner's treatment is ongoing, it may be helpful for the client who has been victimized to participate in individual therapy or some type of group therapy focused on her experience with abuse.

A recurring theme in the lives of women with substance use disorders is a lack of healthy relationships.

Covington (2002) notes that substance abuse treatment is more effective for women when it addresses women's specific needs and understands their daily realities. Finkelstein (1994) likewise emphasizes the need for a holistic approach to achieve successful outcomes. Far-reaching changes, she points out, are needed in many areas of a woman's life, including employment, housing, health care, child care, children's services, family supports, legal rights, and division of labor within the family. To be responsive to a woman's needs, family therapy should address these broad areas. Amaro and Hardy-Fanta (1995), Covington (2002), and Finkelstein (1996), among other researchers and clinicians who work with female clients, also stress the importance of relationships in a woman's life and the need for a model to meet these needs. Family therapy, with its focus on the family unit and the relationships therein, can clearly help address these needs for women and help them improve their relationships.

Particular treatment issues relevant to women include shame, stigma, trauma, and control over her life. Women tend to hide their drinking and substance abuse because of the shame that is associated with it. It is important that women feel they are being treated with respect and dignity in treatment (Covington 2002; Hudak et al. 1999). Because of the high rates of victimization in women's lives, it is critical that the therapist addresses trauma in women's therapy in order for it to be successful. Substance abuse recovery and trauma recovery should occur together, and safety must be ensured in therapy (Covington 2002). Related is the issue of control in the woman's life in areas such as sex, money, food, and religion. Some control problems for women are internal and manifested in self-abusive behaviors, such as eating disorders or self-cutting.

Women who have lost custody of their children may need help to regain it once stable recovery has been achieved. In fact, working to get their children back may be a strong treatment motivator for women. Finally, childcare is one of the most important accommodations necessary

for women in treatment. Children must be allowed to come to therapy sessions, or when such attendance is not appropriate, to be placed in suitable childcare.

## Race and Ethnicity

Although a great deal of research exists on both family therapy and culture and ethnicity, little research has concentrated on how culture and ethnicity influence the core family and clinical processes (Santisteban et al. 2002). Rigorous investigations are needed to explore the dynamic interplay between "ethnicity, family functioning, and family intervention" (Santisteban et al. 2002, p. 331).

One important requirement is to move beyond ethnic labels and consider a host of factors—values, beliefs, and behaviors—that are associated with ethnic identity. Among major life experiences that must be factored into treating families touched by substance abuse is the complex challenge of determining how acculturation and ethnic identity influence the treatment process. Other influential elements include the effects of immigration on family life and the circumstances that motivated emigration (migration due to war or famine is a far more stressful process than voluntary migration to pursue upward mobility), and the sociopolitical status of the ethnically distinct family, in particular how the host culture judges people of the family's ethnicity (Santisteban et al. 2002).

Generalizations about barriers to treatment for racially and ethnically diverse men and women should be made with caution. Nevertheless, some barriers to treatment, particularly among African Americans and Hispanics/Latinos, have been investigated. They include problem recognition or perceptions of problem severity (for example, the belief that one's alcohol use is not a problem, or not a severe one, and that those affected can handle the problem on their own), costs associated with seeking treatment, as well as doubt about the efficacy of treatment (Kline 1996). Other barriers to treatment for these groups include inaccurate perceptions about the cost or availability of treatment

(especially for people who lack insurance), a cultural need to maintain dignity, negative beliefs about treatment (such as harsh rules in residential programs), and structural problems (such as too little treatment for people with no or inadequate insurance, inadequate detoxification facilities, and bureaucratic red tape) (Kline 1996). For more information about cultural competency, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development b).

## **African Americans**

### ***Background issues***

Many African Americans were able to overcome the destabilizing trauma of slavery by relying on the support of affectional ties, extended kinship ties, and multigenerational networks, among other strengths (Wilkinson 1993). Kinship bonds continue to provide support in coping with the difficulties of a discriminating society (Sue and Sue 1999). Paniagua (1998) states that family therapy is recommended with African-American families, and should specifically include emphasis on assigning tasks to be completed at home as well as role-playing scenarios to develop intrafamilial communication.

To work effectively with African-American families, family therapists must become familiar with the complex interactions, strengths, and

problems of extended families (Boyd-Franklin 1989). Many extended African-American families incorporate various related people into a network that provides emotional and economic support. Numerous adults and older children participate in raising younger children, often interchanging family functions and roles (Hines and Boyd-Franklin 1996). The practice of exchanging assistance, or reciprocity, is an essential part of extended family life. Such reciprocity may take the form of caring for another's child, knowing that the favor will be returned when necessary, or providing and receiving emotional support (Wright 2001). Many extended families also take in secondary members, such as cousins, siblings of the parents, elders of the parents, or grandchildren. In other cases, families take in children who are not biologically related. Approximately 1.4 percent of African-American children live in homes where they are unrelated to the head of the household (U.S. Census Bureau 2001b).

### ***Application to family therapy***

As with all individuals, African-American clients are sensitive to whether they are being treated with respect. Cultural information should be considered hypotheses rather than knowledge. Techniques shown to be effective with African Americans will be rendered ineffective if the therapist assumes an attitude that is alienating to clients.

## ***Within-Group Diversity: Caribbean Black Populations***

Interventions deemed appropriate and effective with African Americans born and raised in the United States may be inappropriate for other groups. For example, single-family therapy may not be effective with Caribbean Black populations. Because this culture values privacy so keenly, families may not discuss problems at all, even among themselves (Harris-Hastick 2001). In order to minimize the discomfort of West Indian clients, Harris-Hastick (2001) recommends offering an educational orientation about treatment, alcohol, and other drugs, scheduling individual sessions until clients can comfortably talk about themselves or be assigned to groups with other Caribbean members.

People of African ancestry are widely divergent. Therapies effective for African Americans may be inappropriate for immigrants from the Caribbean or Africa (see box, p. 117). The personal connection between family and therapist is the single most important element in working with African-American families. Without rapport, treatment techniques are worthless and the family will likely terminate therapy early (Wright 2001).

African-American families also are sensitive to a patronizing approach that Boyd-Franklin (1989) refers to as missionary racism. Therapists should be sensitive to the ways in which this message may be conveyed. Clinicians must be aware of any biases or attitudes

regarding their African-American clients. To address this issue effectively, therapists may need assistance from supervisors or colleagues or training in cross-cultural situations (Wright 2001).

Santisteban et al. (1997) found that single-family therapy improved family relationships and reduced behavioral problems in African-American youngsters. African Americans also function very successfully in multiple family therapy. For many African-American Christians, the Bible is a longstanding source of truth and

solace that helps them make sense of life (Reid 2000). Because of the church's centrality to their lives, a Bible-related recovery program has been found to be effective for African-American Christian families (Reid 2000).

To work effectively with African-American families, family therapists must become familiar with the complex interactions, strengths, and problems of extended families.

### *African-American women*

Mothers in African-American communities often are characterized in terms of their strength and devotion to family (Hines and Boyd-Franklin 1996). This role often proves stressful and destructive for African-American women with substance use disorders because they are committed to an exceptionally high level of responsibility. Perhaps as an additional result, they exhibit a high level of denial regarding their substance abuse.

Reid (2000) maintains that in African-American families where the mother has a substance use disorder, the family may react by persecuting her because of her failure to uphold the role as mother. Most often, however, the family will act to protect the mother's image, becoming her caretakers, keeping her substance abuse secret, and taking care of her children. This assistance may ultimately enable the mother's denial to become so strong that she considers treatment to be a violation of her self-respect and obligation to her family. In this scenario, a mother's loyalty to the family may eventually lead to a crisis, when the pressure of presenting a functional front becomes too great (Reid 2000).

Because the mythical role of the African-American superwoman prevents many mothers from seeking help, therapy must address these expectations. Addressing shame and guilt, and giving African-American women permission to acknowledge their personal needs, are essential points for recovery (Reid 2000).

### *Parenting issues*

Therapists often take exception to the strict parental discipline meted out in some African-American families. Sue and Sue (1999) warn against therapists' imposing their own beliefs and values on these parents; they say that "physical discipline should not be seen as necessarily indicative of a lack of parental warmth or negativity" (p. 241).

Many African-American families are headed by women. Functional single-parent African-American families are characterized by certainty

about who is in charge, precise understanding of roles and responsibilities, clear and flexible boundaries, children having access to the parent, children being cared for and having their needs met, and parents and children feeling free to seek and provide nurturance and communicate their needs. Some functional single-parent families have a parental child who helps the mother take care of other children, particularly while the mother is working. The existence of a parental child does not necessarily indicate dysfunction. These families may operate successfully as long as the child has access to activities with peers and the parent does not abandon responsibilities or inappropriately burden the child (Boyd-Franklin 1989).

### *Other factors*

Such factors as AIDS, violence, and disrupted families have had a profoundly negative effect on the African-American community. To counter this, effective substance abuse treatment should be life-affirming and emphasize an acquisition of power that moves the person with a substance use disorder, the family, and the community toward increased self-determination (Rowe and Grills 1993). Effective substance abuse treatment and recovery should “emphasize the positive potential of human behavior based on a value system and sense of order committed to the greater good of humankind” (Rowe and Grills 1993, pp. 26-27).

Counselors should also be aware of how racism impacts the family. Boyd-Franklin (1989) notes that even middle-class African Americans may experience diminished self-esteem and anxiety about maintaining their position. Some middle-class African-American families experience particularly intense pressure to maintain appearances (Boyd-Franklin 1989). These families often place a strong emphasis on respectability where causing shame for the family is considered to be particularly reprehensible and damaging.

## **Hispanics/Latinos**

Tremendous demographic and cultural heterogeneity exists within the Hispanic/Latino population. Indeed, even within a specific subgroup, there will be substantial variation based on regional, social, economic, and acculturation-related differences. “Most analyses have treated Hispanics as a single group, despite the fact that traditional alcohol use patterns vary among Hispanics with different countries of origin. In addition, studies among Hispanics typically have focused on male drinking patterns” (Caetano et al. 1998, p. 234).

An understanding of Hispanic/Latino subgroups must begin with knowledge of their families’ immigration history. Some people leave their home country voluntarily in order to pursue adventure or escape poverty. Refugees, on the other hand, may flee persecution, fear for their safety, and have much more pain and anger associated with their migration. Those who come from war-torn countries may show symptoms of posttraumatic stress disorder and other associated trauma.

### ***Substance use in Hispanic/Latino communities***

Substance use and abuse varies between Hispanic and Latino communities. Level of acculturation has a strong positive association with substance use. Specifically, more acculturated individuals report greater use of alcohol and other substances. Cuadrado and Lieberman (1998) assert that English-speaking Mexican Americans are eight times more likely to use marijuana than their Spanish-speaking peers, and among Puerto Ricans the same circumstances effect a fivefold increase.

### ***The role of acculturation in family functioning***

In attempting to navigate their new environment, many immigrants experience a loss in confidence, as well as shame, anger, and confusion. These emotional reactions generally result from

poverty, unemployment, social isolation, discrimination, lack of resources, sociopolitical marginality, and cultural shock (Hernandez and McGoldrick 1999). Any of these factors may contribute to substance abuse and impact family functioning.

### **Cultural characteristics that impact family therapy**

Perhaps the most widely acknowledged common thread among Hispanics/Latinos is the importance placed on family unity, the family's well-being, and the use of family as a support network. Familialism or familismo are terms that refer to a core construct among Hispanic and other ethnic-minority cultures. It has three components: (1) perceived obligations toward helping family members, (2) reliance on support from family members, and (3) the use of family members as behavioral and attitudinal referents (Marín and Marín 1991).

Generally, the typical nuclear family is embedded in an extended family with flexible and open boundaries. Hispanics/Latinos place a strong emphasis on extended family and clustering (Kaufman and Borders 1988), and there tend to be fluid boundaries between family members such as cousins, aunts, uncles, and grandparents. "The family is usually an extended system that encompasses not only those related by blood and marriage, but also *compadres* (godparents) and *hijos de crianza* (adopted children, whose adoption is not necessarily legal)" (Garcia-Preto 1996, p. 151).

Extended family members perform parental duties and functions, providing the children with the adult attention that is hard to come by in a large family (Falicov 1998). Relationships between siblings and cousins are strong and it is not uncommon to have few peer friendships outside the sibling subgroup. Godparents are practically an additional set of parents, acting as guardians or sponsors of the godchildren and maintaining a strong relationship with the natural parents (Falicov 1998).

### **Application to family therapy**

Despite substantial research documenting the underutilization of services by Hispanic/Latino families, single-family therapy can be used effectively with troubled Hispanic/Latino children and adolescents and their families. Santisteban et al. (1997) showed that family therapy could be effective in reducing behavior problems and improving family functioning in Hispanic/Latino children who were at high risk for drug abuse. Santisteban et al. (1996) and Szapocznik et al. (1988) demonstrated that single-family therapy using specialized engagement strategies could successfully engage reluctant families into treatment. Family therapy is consistent with the family orientation of Hispanics/Latinos, who welcome the involvement of all family members. Paniagua (1998) believes that family therapy "should be considered as the first therapeutic approach with all Hispanic clients" because it fits well with Hispanics' "view of familismo and extended family" (p. 51).

To the non-Hispanic family therapist, extended family relationships may at times appear enmeshed and over-involved. Therapists must understand the intensive emotional involvement among extended families (Guiao and Esparza 1997). Everyone who is relevant to the extended family network (i.e., whoever is central to the family's day-to-day functioning) should be involved within the family therapy session. Conducting multiple family therapy may meet with more success through focusing on the broader issues of strong relevance to Hispanic/Latino families that may be contributing to presenting problems. For example, these issues may include the powerful intrafamilial stresses due to acculturation and immigration (Santisteban et al. 2002). However, when bringing Hispanic families together, the family therapist must address confidentiality to enhance a sense of trust and privacy, particularly in small communities.

### **Respeto and conflict**

The respeto (respect) that Hispanic/Latino parents command from children has a different

internal meaning and set of expectations than the more egalitarian Anglo-American notion of “respect” (Falicov 1996). The extent to which parents prefer markedly hierarchical family relations has powerful implications for families and family therapy. When parents view good family functioning as consisting of marked levels of authority (nonegalitarian), they can perceive any type of open disagreements between parents and adolescents as disrespectful and unacceptable.

This view may clash with traditional Western models of family therapy in which full conflict emergence with resolution is valued, and in which both negative and positive emotions tend to be more easily expressed and tolerated. Hispanics/Latinos may perceive therapy interventions as incompetent or misguided if they openly encourage young people to speak their mind or tell parents what they really think. Care must be taken to ensure that children, who are generally encouraged to speak openly during sessions, do not violate the family’s disciplines and thereby prompt premature termination (Santisteban et al. 2002). The therapist should ask the family how it resolves conflict.

Although Hispanic/Latina women generally are accorded a great deal of respect, Hispanic society is more concerned with the needs of the social group as a whole than the needs of the individual. As a result, Hispanic/Latina women may be more strongly invested in others, as opposed to self-invested, a concept that grows out of the more individualistic goals of dominant-culture therapy (Trepper et al. 1997).

### *Communication styles*

Because open disagreement and demands for clarification are viewed as rude and insensitive, indirect communication is sometimes viewed as preferable. The use of impersonal third-person pronouns is one method of indirect communication. Sometimes Hispanic/Latino culture’s emphasis on smooth relationships may become excessive, leading to concealment and lies (Falicov 1998). Family therapists must gauge the extent to which communication patterns present such a hindrance.

Falicov (1998) urges family therapists to adopt a tone of acceptance and eschew direct confrontation and demands for extensive disclosure throughout treatment. Therapists can ease the confrontational nature of therapy by employing humor, allusions, and diminutives.

Disclosure is made easier when the family therapist takes a philosophical approach through storytelling, anecdotes, and metaphors. Other culturally harmonic tools include analogies, proverbs, popular songs, and unexpected statements that convey a sense of the absurdity of life (Falicov 1998). However, direct communication can and should be used when seeking informed consent or when an emergency situation exists.

### *Counseling strategies*

Family therapists should have a working knowledge of how substance abuse is defined in the families’ country of origin. Many countries of origin, such as Mexico, have a culture that is more permissive toward substance use. Immigration and acculturation into the U.S. may alter family members’ attitudes toward substance use. Any such changes must be addressed, given their immediate impact on family relations.

Clinicians should also explore family members’ experiences of migration, cultural transition, and ethnic-minority status. Holding an open discussion about these experiences allows therapists to analyze family stories and leads directly to issues affecting substance abuse. For

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instance, a discussion concerning how family members reconcile their culture of origin and American culture will reveal differing acculturation levels within the family. Therapists may also explore the issue through the simple exercise of having family members rate how close they feel to their culture of origin on a scale from 1 to 10. Naturally, in all cases, therapists must make arrangements so that

language does not impede a family member's participation.

Therapists who plan to work with Latino families who have migrated from Mexico should be familiar with spiritual healers, the *curandero* or *curandera* (i.e., folk healer). These healers can help resolve intrapsychic and interpersonal problems. Curanderismo, or the art of folk healing, is a particular treatment modality used primarily in Latino/Southwestern rural communities, although it is also prevalent in metropolitan areas with a large Latino population. Curanderos earn their trust from the community; the community validates their "practice." This modality contains a mix of psychological, spiritual, and personal belief factors. Since the curanderos are considered to be holy, they invoke God's and the Saints' blessings on people seeking their help.

Other considerations include the following:

- A businesslike approach to treatment will not appeal to Hispanic/Latino families. A personable tack will yield much more effective results.
- Hispanic/Latino family members will be much more forthcoming when the therapist solicits

their feelings through subtle and indirect means. Encouraging clients to speak forcefully and directly may have the unintended effect of inhibiting their participation (Paniagua 1998).

- The establishment of behavioral contracts may be an overly task-oriented approach for this population. Scheduling time ahead to resolve intimate issues may also not be acceptable to clients. Falicov (1998) recommends making homework assignments conditional because it is more collaborative, less presumptive, and more in keeping with a cultural affinity for spontaneity.
- Hernandez (2000) recommends that family therapists adopt a broader perspective than the disease model, to incorporate the impact of a toxic social environment and the effects of oppression as factors contributing to substance dependency. While still holding people with substance use disorders accountable for their actions, this approach helps to frame substance abuse as a communal problem and spur family members into learning more about the effects of oppression.
- Using fundamental spiritual precepts can inspire hope and patience. The endurance of suffering, the practice of forgiveness, and the importance of repentance may be fertile values to use in working with families with substance abuse. This strategy should only be used when it is in harmony with the spiritual views of the individual family or family member (Hernandez 2000).

## **Asian Americans**

### ***Background issues***

Asians are culturally diverse, with great variations of language, history, religion, and values. Caution should be used when addressing any of these groups as a whole.

Asians comprise more than 45 distinct subgroups (Barnes and Bennett 2002; Grieco 2001), speaking more than 60 languages (New York State Education Department 1997). The tremendous cultural differences between these groups make generalizations difficult. This complexity is increased by key variables such as reasons for migration, degree of acculturation, English-speaking capacity, family composition and intactness, education, and adherence to religious beliefs. Despite this diversity, Asian immigrants and refugees share many traits, including

- Deference to authority
- Emotional inhibition
- Adherence to specified roles
- Hierarchical families
- Gender-specific roles
- Extended family involvement (Sue and Sue 1999)

### ***Asian family structure***

Filial piety is highly valued in Asian cultures (Fang and Wark 1998; Herrick and Brown 1998). However, “filial piety can be a source of great anxiety when family obligations conflict with individual interests” (Fang and Wark 1998, p. 67). In Asian families, women tend to have fewer decisionmaking abilities than their Western counterparts. Families are patriarchal, with the eldest son having decisionmaking powers when parents reach old age. Elders are seen as wise, and as such are revered (Herrick and Brown 1998). However, the more acculturated an Asian-American family is, the more Western intrafamily relationships may become (Fang and Wark 1998).

## ***Rates of substance abuse in Asian communities***

Substance use within individual Asian communities has received scant attention with most studies placing Asians into a single ethnic category rather than as separate ethnic groups (Uehara et al. 1994) or categorizing Asians as “others.”

As seen with most immigrant communities, second- and third-generation Asian Americans, born in the United States, are at higher risk to begin using substances (Mercado 2000). As individuals become increasingly acculturated, their drinking patterns resemble those of European Americans. This acculturation may lead to intergenerational conflict, which in turn spurs the acculturated family member’s substance abuse in order to alleviate the conflict (Bhattacharya 1998; Makimoto 1998).

## ***Application to family therapy***

The contemporary image of Asian Americans is of a highly successful minority who experience little or no difficulty in American society. Mercado (2000) states that this “model-minority” myth, Asian Americans’ cultural values, and typical underutilization of mental health services have influenced substance abuse therapists into believing that Asian-American families are psychologically healthier and in less need than other ethnic groups. The model-minority myth also prevents Asian-American communities from receiving adequate financial commitment and increases Asian Americans’ alienation from other minority groups. Looking beyond this myth can help family therapists to better understand the Asian experience in America.

Asians may be hesitant to admit to having a substance use disorder, believing that to do so is an imposition and risks shaming the family. Family members are disinclined to confront people with substance use disorders preferring to minimize, deny, reject, or even ostracize the offending individual (Chang 2000). Inevitably, the result is a cycle of enabling that perpetuates the addictive process and leads to advanced

stages before coming to outside attention (Chang 2000). Unfortunately, for many Asian Americans with substance use disorders, this is the point at which treatment often commences. The opportunity for the IP to “save face” is a critical element in making therapy an acceptable part of healing.

Because Asian cultures are so intensively family-centered, the responsibility of maintaining filial obligations is perhaps the dominant concern in the life of most Asians (Herrick and Brown 1998). Given the central importance of family in Asian cultures, it is critical to assess the family’s part when treating Asian Americans with substance use disorders. The psychological influence of the family, particularly the older members, is considerable even when key members are missing as a result of loss, nonmigration, or emotional estrangement (Chang 2000). Family therapy with Asian Americans is least likely to include older generations. The primary reason for this absence, younger family members say, is that they hope to spare their elders any discomfort.

Working delicately and tactfully with elders is of foremost importance. When treating unresolved issues among older generations, therapists must demonstrate respect, reveal genuine empathy, and above all, avoid embarrassing older family members. Often family members, particularly the person with the substance use problem, will try to shield older family members from shame. Family therapists must be cognizant not to rush into exploration of sensitive areas. One method is to initially join with the family at a broad experiential level—sharing their salient traumatic incident—without prying for embarrassing or threatening details (Chang 2000).

Opinions vary on whether family therapy is an appropriate vehicle with which to counsel Asian Americans with substance use disorders. Paniagua (1998) states that family therapy is effective because the family is more important than the individual in Asian families and the act of withholding information from family members is unfamiliar to many Asians. May

Lai (2001) urges therapists to work with the client’s family, but to use individual counseling rather than family therapy. Debates on the efficacy of involving Asian families in treating substance abuse often revolve around the presumed skill level of the therapist, not the fundamental importance of the client’s relationship to his or her family. Clearly, counseling Asian-American families requires skill, delicacy, and knowledge of cultural factors.

### *Issues of acculturation*

As is common among immigrants, Asian-American families present widely varying levels of acculturation within the nuclear and extended family. The process of acculturation varies with each of the Asian groups, depending on their reasons for immigrating (e.g., for political or economic reasons) (Inouye 1999). Acculturation places traditional values and customs out of context (Chang 2000). It results in intensified isolation, removal of social supports, and a sense of alienation from the dominant culture. Asian immigrants may be psychologically maladjusted, despite the perception of their being part of a “model-minority” (May Lai 2001). The loss of family, and of the traditional conception of family, engenders a further loss of identity and place in the world.

The presence of the family will help the family therapist determine the individual’s and the family’s degree of adherence to traditional values and to assess the family conflicts that result from differential acculturation patterns between family members. Effective pretreatment assessment that includes key questions of acculturation must also include Asian Americans’ most significant psychological unit, the family (see for example Huff and Kline 1999).

Factors attributable to acculturation that cause conflict within Asian families are women receiving increased status, children no longer demonstrating the highest regard for their elders, and older family members losing their preeminence as the keepers of tradition. Additionally, Asian fathers’ traditional emotional distance from the family can become

a detriment in the United States, where family systems experience different demands.

### *Communication styles*

Western-style therapy often requires a frank and open discussion of feelings and problems to be effective. For Asians, directness risks confrontation and rudely ignores one's obligation to help maintain face. On the other hand, to be indirect enables one to convey meaning without challenging or insulting another. To underscore this point, Asian languages tend to be more metaphoric, while English words tend to have precise meanings (Chang 2000).

Furthermore, Asian culture places a high value on "saving face." A family striving to avoid the shame of a family member with a substance use disorder will likely perceive that member as a tremendous liability to the family's structure. Discussing such an issue in therapy with a nonfamily member (no matter how professional) can be interpreted as a sign of weakness for many Asian families (Lee 1996; Paniagua 1998).

For Asians, discussing one's inner feelings is often unfamiliar and culturally unacceptable. It is overly confrontational to seek open discussion of personal issues prior to establishing trust (Sue and Sue 1999). Intervention models that stress direct and explicit exchange between family members or client and therapist are likely to be either ineffective or harmful (Chang 2000). For example, traditional substance abuse therapy often teaches families to detriangulate by challenging one another directly (Mercado 2000). Asian Americans view such behavior, particularly across generations, as disrespectful.

Because traditional Asian families are grounded on a hierarchical structure, they negotiate differences through mediation. This hierarchy requires the counselor to function as a negotiator and follow the family structure when doing so (Sue and Sue 1999). The father, as head of the family, should be spoken to first in order to gather his insight into the family's problem.

It is important for therapists to focus most heavily on specifics when working with Asian families. Rather than discussing feelings, it is more effective to be problem focused and goal oriented (Paniagua 1998).

### *Engagement*

Attempts to underscore the influence of family dynamics as a key contributor to the family member's substance abuse may be received with disapproval and possible termination. Kim (1985) recommends an approach to pace the family's cultural expectations and limitations in relation to traditional Western psychotherapy, in an effort to continue engagement with the family.

The first step is to assert that the IP's *ailment* is indeed the problem—by implication not the client him- or herself. Complaining about physical ailments is an accepted means of communicating psychological stress. Rather than discussing anxiety and depression, Asians may complain about headaches, fatigue, restlessness, or disturbances in sleep and appetite (Sue 1997; Toarmino and Chun 1997). Taking the patient's blood pressure, ordering vitamins, or advising on minor physical ailments will increase the Asian patient's trust in the treatment facility (May Lai 2001). Sue and Sue (1999) also recommend acknowledging and treating physical problems before moving on to possible emotional factors. For example, focusing on the physical symptoms of the person with a substance use disorder (such as high liver enzyme) rather than substance abuse is

Given the central importance of family in Asian cultures, it is critical to assess the family's part when treating Asian Americans with substance use disorders.

## Counseling Asian-American families

requires skill, delicacy, and knowledge of cultural factors.

more culturally acceptable for Asian Americans. In addition, therapists should respect the client's need to use culturally relevant health care such as acupuncture and herbal medicines.

The second step in the engagement process is to acknowledge and strengthen the family's wishes to assist the family member in changing his or her behavior.

Treatment planning for Asians with substance use disorders should consider the family's role as early as possible. Although involving the family adds complexity to the therapist's task, its integral importance cannot be overstated. It is critical to assess the individual's substance abuse in regard to the family's level of functioning (Chang 2000). Given cultural mandates to show deference to authority figures, Asian families may present as particularly compliant in treatment.

The third step is for the therapist to stress that each family member's contribution is vital to helping the family member, and that without each family member's participation the problem will persist or worsen, further exacerbating the family's difficulties.

Other considerations in engaging Asian families are noted below:

- Family therapists should be careful that therapy does not breach proscribed gender roles or boundaries between generations. The first appointment should be made with the decisionmaker of the family, who will most likely be the father (Lee 1996).

- Asian clients respond best to credible experts who provide specific suggestions for alleviating distress (Lee 1996).
- Sensitivity to clients' privacy is just as important at a macro level. Because different Asian-American clients may live in the same tight-knit community, therapists should assure them of confidentiality and avoid sharing information regarding one client with another (May Lai 2001).
- Family therapists should not presume that therapy sessions will move forward on a regular basis. Counselors must choose between making the most of the first or initial sessions and scheduling ongoing regular sessions. Many Asians are unfamiliar with Western treatment models and will adopt a more infrequent, crisis-oriented approach to therapy (Lee 1996).
- Clients may feel slighted if the therapist spends limited time with the family without providing a thorough explanation of his or her plan for treatment.
- Lee (1996) recommends the therapist proceed on the assumption that the first session with the entire family will likely be the last, scheduling ample time beyond 1 hour to gather important family history and information.
- It may be effective to leverage the family's willingness and arrange a rapid follow-up (sooner than 1 week) to strengthen the budding therapeutic relationship.

In itself, successfully engaging the family of an Asian person with a substance use disorder goes a long way toward alleviating the IP's profound shame (Chang 2000). For the therapist, the challenge is successfully facilitating the engagement of family members while stretching them to improve their methods of interrelating.

## American Indians

### *Background issues*

There are 2.5 million American Indians living in the United States and an additional 1.6

million people who reported being American Indian and at least one other race (Ogunwole 2002). American Indians and Alaska Natives are an exceptionally heterogeneous group. The Federal government recognizes 562 distinct tribes in the United States (*Indian Entities Recognized* 2002), and each has its own culture.

For many American Indians, spirituality is a way of life rather than a part of life. American Indians differentiate between spirituality and religion. However, because Christian missionaries have been working in American-Indian communities for years, there is also a great deal of blended spiritual belief and modern religion (Coyhis 2000). Mixing spirituality and religion enables American Indians to pull from both sources for recovery (Coyhis 2000).

It is difficult to discuss specific values given the overwhelming diversity of American Indians. Sue and Sue (1999) offer a generalized description of American-Indian values:

- *Sharing.* Honor and respect are both gained by sharing and giving. When sufficient money is accumulated, some American Indians may stop working and spend time and energy in ceremonial activities. Refusing to share drinks or substances with a member of the same tribe may be considered an insult.
- *Cooperation.* Many American Indians value the tribe and family more than the individual. Instead of going to an appointment, some may instead assist a family member needing help. In a counseling setting, though they may agree with the counselor, they often will not follow through with the suggestions.
- *Noninterference.* Generally, American Indians do not like to interfere with others and prefer to observe rather than react impulsively. Rights of others are respected. They are often seen as permissive in child rearing.
- *Time orientation.* American Indians are often present-oriented. Punctuality or planning for the future may be de-emphasized. Tasks are completed according to a rational order and not according to deadlines.

- *Extended family orientation.*

Interrelationships between relatives are important, and there is a strong respect for elders and their wisdom and knowledge.

- *Harmony with nature.* Rather than seeking to control the environment, many American Indians accept things as they are (Sue and Sue 1999).

## **Substance abuse patterns**

American Indians and Alaska Natives report more illicit drug use and more binge and heavy alcohol use than any other ethnic group (OAS 2002*d*). During the period 1994-1999, 70 percent of American-Indian men and 59 percent of American-Indian women who entered treatment entered because of alcohol abuse. Marijuana was the illicit substance with the most admissions—13 percent of male admissions and 11 percent of female admissions (OAS 2001*b*). Peyote and other intoxicants traditionally used for American-Indian ceremonies continue to be used specifically for these sacred purposes (Weaver 2001).

American Indians are significantly more likely to die of alcohol-related causes than the general population (Penn et al. 1995). From 1994 to 1996, the alcoholism death rate of American Indians was 7 times the rate of all races in the United States (Indian Health Service 2002).

## **Other relevant issues**

American Indians have experienced 500 years of historical trauma including the purposeful disruption of the multigenerational family process and loss of land, language, culture, and identity (Duran and Duran 1995). When family therapists understand this historical oppression and validate in therapy the dysfunction that it has imposed on the multigenerational processes of American Indians, it may create an atmosphere of increased honesty and empower families to understand that some of their difficulties stem from external forces (Duran and Duran 1995).

Although many American Indians practice abstinence from alcohol and drugs, substance

abuse remains a tremendous problem with this population. Nearly one third of people of child-bearing age report heavy drinking, a major factor in the development of fetal alcohol syndrome (Sue and Sue 1999).

### ***Application to family therapy***

In general, the structure of the traditional American-Indian family focuses on all living generations and members of the extended family. Since children are highly valued in this ethnic group, the entire extended family ensures that they are provided guidance, discipline, and control (Attneave 1982). The primary tasks of the executive subsystem are shared responsibilities delegated among aunts, uncles, grandparents, and parents. The high level of involvement of the non-parent adults frees up the natural parents to have a more relaxed and spontaneous relationship with their children. Often, the emotional bond created between grandparents and grandchildren is a deep and long-lasting one (Attneave 1982).

There are numerous tribal differences among American-Indian families, with the phenomenon of the trigenerational extended family being the most fundamental and important constant. Families may be matriarchal or patriarchal in structure. No matter how this complex family organization varies, there is usually an older man or woman who holds a key administrative role (McGoldrick 1982). The usual family therapy intervention of separating the generations would not necessarily be the most appropriate intervention for this ethnic family group (McGoldrick 1982). It should be noted, too, that owing to the private nature of American-Indian families, multiple family involvement is likely not beneficial, and best confined to psychosocial education.

Many tribes do not make any distinction between the nuclear family and grandparents, uncles, aunts, and cousins (Brucker and Perry 1998; Napoliello and Sweet 1992). Many tribes characterize great uncles, great aunts, godparents, and biological grandparents as grandparents (Brucker and Perry 1998).

Sometimes the family includes medicine people and nonrelated people (Brucker and Perry 1998).

Within Indian culture, families work together to address problems. Family therapy's emphasis on systems and relationships is in particular cultural harmony with American Indians (Sutton and Broken Nose 1996). Sutton and Broken Nose (1996) emphasize the preferred use of culturally appropriate, nondirective approaches involving "storytelling, metaphor, and paradoxical interventions" (p. 33). Networking and ritual approaches are preferable to strategic or brief interventions (Sutton and Broken Nose 1996).

In certain cases a family member must go into inpatient treatment for substance abuse before family therapy can make any real impact. It is always possible, however, to continue to work with the family in preparation for the return of the family member to the home, with the goal of modifying family relations that may have contributed to the maintenance of the problem. The historical trauma experienced by American Indians combined with the usual considerations of codependency and enabling, for example, make family therapy for substance abuse treatment a challenging endeavor (Duran and Duran 1996).

### ***Acculturation***

Acculturation should be determined on an individual basis, as the problems, process, and goals for traditional and more acculturated American Indians may be quite different (Sue and Sue 1999). "More than 50 percent of American Indians and Alaska Natives reside in large metropolitan areas" (Hodge and Fredericks 1999, p. 279). There are urban Indians who may never have been to a reservation or do not know their tribal language. As a result, American Indians who are isolated from reservations or other areas of traditional living may experience a breakdown of social support systems (Hodge and Fredericks 1999).

Sue and Sue (1999) recommend that therapists delve into the ethnic differences between the

family and the therapist in an indirect manner. Therapists should also explore the family's value structure and examine any potential cultural or identity conflicts. Initial questions may ascertain whether the family lives on or near a reservation, and whether being connected to the tribe is of importance. Sue and Sue (1999) assert that mainstream therapies may well fit more acculturated Indian families. More traditional families, however, will first have to navigate trust issues.

### *Communication styles*

Gaining an individual's trust is essential. Many American Indians have experienced poor treatment, including racism, and will have a tendency to withdraw. Coyhis (2000) emphasizes that gaining an American Indian's trust involves aligning one's "spirit and intent" in such a manner that one's words and feelings are internally congruent or truthful (p. 86). Speaking with an American Indian as a human being, rather than as an "Indian," will help to build trust.

American Indians place greater emphasis on listening and observation than verbal exchange. Therapists should understand that clients "will communicate feelings and emotions through clues with their bodies, eyes, and tone of voice" (Paniagua 1998, p. 82). Direct eye contact can be a sign of disrespect for many American Indians (Paniagua 1998). Because of this communication style, it is important to be patient when working with American Indians. When a therapist asks an American Indian a question, she should wait for the answer before asking another question. American Indians listen carefully to the person to whom they are speaking, and sometimes enough time will pass after the therapist has asked a question that she may mistakenly believe the individual is nonresponsive. Paniagua (1998) suggests that therapists not take notes at the beginning of therapy as it can be taken as a sign that they are not listening.

Historically, the therapeutic relationship between American Indians and non-Indian therapists has been marked by racism (Sutton

and Broken Nose 1996). Placed in this context, it is then clear that most American Indians will not discuss sensitive matters until trust has developed.

### *Culturally competent approaches*

Therapists working with American-Indian families must be aware of how Western values conflict with traditional Indian culture. For example, while Western culture values an adolescent's steadily increasing independence from his or her parents, traditional Native culture does not. For traditional American Indians the goal for an adolescent may be precisely the opposite: increasing interdependence with the extended family (Sue and Sue 1999).

American Indians may require a greater degree of guidance than is usually provided in client-centered approaches (Sue and Sue 1999). Many American Indians arrive in treatment hoping for a culturally sensitive therapist who can offer practical and specific advice about their problems (Sutton and Broken Nose 1996).

While overly directive interventions may be seen as disrespectful and intrusive, therapists who combine family therapy with substance abuse treatment must be somewhat directive. Often, they are being forced to follow the mandates of the judicial system. So therapists must be very skillful, balancing cultural needs for an indirect approach with external needs demanding a more direct approach.

In general, the structure of the traditional American-Indian family focuses on all living generations and members of the extended family.

Therapists working with American-Indian families must be aware of how Western values conflict with traditional Indian culture.

Just as people in the dominant culture may seek the guidance of a counselor, American Indians will turn to an elder. It is also useful to find out whether the IP has an elder who will support him in the recovery process (Coyhis 2000).

The more traditional an American Indian is, the more difficulty he or she will have with Alcoholics Anonymous (AA) concepts (Coyhis 2000). For many

American Indians, the source of difficulty with AA is that the concepts derive from a European, Christian mindset (Duran and Duran 1995). White Bison is one example of an American-Indian alternative to the traditional AA approach that “integrates the medicine wheel with the twelve-step teachings of AA to adapt substance abuse recovery to Native American culture” (Krestan 2000, p. 36).

Paniagua (1998) suggests the following guidelines for therapists working with American-Indian clients:

- The therapist should involve all nuclear and extended family members, including tribal leaders and traditional healers.
- The therapist should present suggestions in a slow and calm manner, indicating attention to clients’ time-oriented approach.
- The therapist should determine whether all family members belong to the same tribe. Intertribal issues could be a source of conflict.
- The therapist should allow family members to be involved in directing the process of therapy.

## Sexual Orientation

### Background Issues

Sexual orientation refers to an individual’s identification as a heterosexual, lesbian, or gay person. Because of varying definitions and problems of identification, substance abuse in these populations has been difficult to quantify. Neither the National Household Survey on Drug Abuse (OAS 2003a) nor the Monitoring the Future survey (Johnston et al. 2002) has categories related to sexual orientation. Most of the work that has been done has looked at gay men and lesbian women.

Available data suggest that lesbian and gay sexual orientation increases a person’s risk for substance use and abuse. In a review of the literature, Hughes and Eliason (2002) report that gay and bisexual men use more inhalants and stimulant drugs than heterosexuals. They report that lesbian and bisexual women are more likely than heterosexual women to use marijuana and cocaine. The Gay and Lesbian Medical Association (GLMA) (2001) indicates that gay men and lesbians report alcohol problems nearly twice as often as heterosexuals, although drinking patterns do not seem to differ substantially because of a person’s sexual identity. Gay men and lesbians also are less likely to abstain from alcohol (GLMA 2001). For more information about working with the gay and lesbian population, see *A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT 2001).

### Application to Family Therapy

Research is insufficient to suggest the efficacy of any one type of family therapy over another for use with gay and lesbian people. Possibly more important than the school of therapy is the therapist’s knowledge, understanding, and acceptance of gay and lesbian people (Bepko and Johnson 2000). Treatment providers often are not trained in the specific needs of these populations, even though gay and lesbian individuals in treatment for substance abuse

often take part in family therapy (CSAT 2001). Lee (2000) suggests a dozen ways for therapists to create a nonthreatening environment for their clients. Tactics range from a sticker on the clinic door that states “This is a lesbian/gay safe place,” to explicit assurances of confidentiality, staff education about gay and lesbian issues and resources, and reassurances for gay and lesbian clients that they are not abnormal or deviant. Among Lee’s recommendations are, “Do not try to guess who is gay or lesbian” and “Do not try to persuade a client to choose a sexual orientation” (Lee 2000).

It is important for therapists to assess themselves for their own potential biases. To further bridge the gap when the sexual orientation of the therapist differs from that of clients, Bernstein (2000) suggests a cultural literacy model for heterosexual therapists working with gay and lesbian clients. When the therapist becomes familiar with the milieu of clients’ lives, the insight necessary for trusting therapeutic alliances may result. Most communities have some sort of visible gay organizations, and there are myriad Internet resources readily available.

Family can be a very sensitive issue for gay and lesbian clients. Therapists must be careful to use the client’s definition of family rather than rely on a heterosexual-based model. Likewise, the therapist should also accept whatever identification an individual chooses for him- or herself and be sensitive to the need to be inclusive and nonjudgmental in word choice. For example, gender-neutral words and phrases are preferred, such as partner rather than *husband* or *wife*. Such an approach will ensure a greater likelihood that people will continue with therapy.

Family therapists also must be careful not to overpathologize issues of boundaries and fusion. Many gay or lesbian couples appear to have more permeable boundaries than are commonly seen among heterosexual couples. For example, a lesbian may seek support from an ex-partner to help with difficulties with a current partner more often than would typically

be seen in a heterosexual female. When violence between partners is a treatment issue, safety must be the therapist’s main concern.

Many lesbian and gay clients may be reluctant to include other members of their families of origin in therapy because they fear rejection and further distancing. At a Minnesota treatment center for gay, lesbian, and bisexual people with substance use disorders, more than half were disinclined to involve their families because they feared rejection if their sexual orientation were revealed (Pinsof et al. 1996). In these cases, therapists can use one-person family therapy, which incorporates a family focus without treating the whole family of origin. It also should be stressed that gays and lesbians should not be encouraged to come out when they are not ready or when the family is not ready.

## People With Physical or Cognitive Disabilities

### Background Issues

There are four primary disability categories. Some conditions may be more difficult to categorize and some people may experience multiple conditions:

- *Physical* impairments are caused by congenital or acquired diseases and disorders or by injury or trauma. For example, spinal cord injury is a disorder that can cause paralysis. Physical disabilities include spina bifida, spinal cord injury, amputation, diabetes, chronic fatigue syndrome, carpal tunnel syndrome, and arthritis.
- *Sensory* impairments may be caused by congenital disorders, diseases such as encephalopathy or meningitis, or trauma to the sensory organs or brain. Sensory disabilities include blindness, deafness, and visual and hearing impairments.
- *Cognitive* impairments are disruptions of thinking skills, such as inattention, memory

problems, perceptual problems, disruptions in communication, spatial disorientation, problems with sequencing (the ability to follow a set of steps to accomplish a task), misperception of time, and perseveration (inappropriate repetitions). Cognitive disabilities include learning disability, traumatic brain injury, mental retardation, and AD/HD.

- *Affective* impairments are disruptions in the way emotions are processed and expressed. In this TIP, affective impairments are considered to include problems caused by both affective and mood disorders, such as major depression and mania. These impairments include the symptoms of mental disorders, such as disorganized speech and behavior, markedly depressed mood, and anhedonia (joylessness). Affective disabilities include depression, bipolar disorder, schizophrenia, anxiety, and posttraumatic stress disorder (PTSD) (CSAT 1998e, pp. 3-4).

People with disabilities are at much higher risk than the general population for substance abuse or substance dependence (Rehabilitation Research and Training Center on Drugs and Disability [RRTC] 1996). While 10 percent of the general population has a substance use disorder, studies consistently find that 20 percent of people qualifying for State vocational rehabilitation services meet diagnostic criteria for substance dependency (Moore and Li 1994; RRTC 1996; Robert Wood Johnson Foundation 1994; Schwab and DiNitto 1993). Other studies have found that the use of prescription medication in combination with alcohol and the use of other people's prescription medications are common for some people with physical disabilities (Moore and Polsgrove 1991). The routine of taking particular medications may itself provide feelings of control, stability, or safety. Additionally, some physicians prescribe medications in a palliative manner in an attempt to assist with disabilities they cannot cure, such as chronic pain or multiple sclerosis.

People with disabilities are more likely to use alcohol or drugs in part because they experience

unemployment, reduced recreational options, social isolation, homelessness, and abuse more frequently than the general population (DeLoach and Greer 1981; Marshak and Seligman 1993; Susser et al. 1991; Vash 1981). If these people also have substance use disorders, such problems are further exacerbated. People with disabilities are at risk for social isolation. They may be isolated because of their families' efforts to protect them, the physical difficulty of getting out to social settings, lack of opportunities to practice social skills, lack of physical stamina, trouble finding activities and negotiating transportation, poverty, and/or the discomfort people without disabilities experience when interacting with people with disabilities. An altered body image can make those with a recent disability onset (such as people using a wheelchair for the first time) reluctant to socialize.

In addition, physical limitations make some people fear violence or exploitation. People with disabilities are at greater risk of sexual abuse and domestic or other violence (Glover et al. 1995; Varley 1984). They are more likely to be victimized because they are perceived as unable to protect themselves. Depression and low self-esteem associated with their disabilities can also play a role in some people's victimization and substance use. Isolation and functional limitations leave many people with disabilities with few recreational options, yet they often have much unstructured time available. For example, people who have a visual impairment may face increased isolation, excess free time, and underemployment (Motet-Grigoras and Schuckit 1986; Nelipovich and Buss 1989). For more information, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998e).

## **Application to Family Therapy**

Frequently, people who do not have disabilities are uncertain how best to respond to those who do (Sue and Sue 1999).

Family therapists should take care to ensure that the language they use in describing physical and cognitive disabilities is sensitive and appropriate. As a general rule, one should always put people first, before their disabilities, referring to “people with disabilities” rather than “disabled people.” One should never refer to the disability in place of the person—not “the schizophrenic” but rather “a person with schizophrenia.” A person with a disability should not be called a “patient” or “case,” unless the context refers to a relationship with a doctor.

It is key that the therapist learns how well a person understands his or her disability. Some people will have a clear knowledge of the ways in which they are functionally limited, whereas others may deny having any limitations. Similarly, in the area of individual strengths, some people will have received extensive support from family, friends, and professional caregivers to pursue their interests and develop unique talents, but others may have been overly sheltered or may have experienced repeated failures. A treatment provider should confer with a disability expert on the delicate topic of how to discuss a client’s disability with him.

Providers may be uncomfortable when first confronted with a person with a physical or cognitive disability. That unease can lead them to err in one of two directions: either enabling the person to use his disability to avoid treatment or refusing to recognize that a legitimate need for accommodation exists. Accommodation does not mean giving special preferences—it means reducing barriers to equal participation in the program. If a client believes that he or she needs an accommodation, the treatment provider will still need to determine if the request is legitimate or an attempt to manipulate the treatment program. However, a provider’s vigilance in avoiding enabling may predispose him to reject legitimate requests for accommodation. If there is any doubt on the part of the provider regarding the legitimacy of the person’s request, he or she should consult a disability expert in order to make this determination. Failure to make good faith efforts at accommodation could result in significant legal

difficulties for programs or providers (for more information about the Americans With Disabilities Act see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* [CSAT 1998e]).

Appropriate approaches may depend on the type of disability. For example, multiple family therapy may help families to normalize and process the feelings of guilt and shame that stem from having a family member with a disability and a substance use disorder.

Perez and Pilsecker (1989) note the usefulness of integrating family therapy into an inpatient treatment program for people with substance use disorders and spinal cord injuries. Family therapy helped reduce client propensity to manage their injuries through substance abuse and reduced the likelihood of overdependency or overachievement (Perez and Pilsecker 1989).

For any number of reasons, whether it is to make life easier for themselves or to maintain the current patterns of a relationship, family members may contribute to the individual’s continued substance use. They may do so with the best of intentions. Family members may feel responsible for the individual’s condition (Sue and Sue 1999), or they may feel sorry for him and even encourage substance use as a way for him to feel better about himself (Schaschl and Straw 1989). The family and other caregivers may also be overprotective and undermine the potential for a greater degree of independence. In other instances, they may be weary from the strain of providing

Family therapists should take care to ensure that the language they use in describing physical and cognitive disabilities is sensitive and appropriate.

care and appear indifferent to the recovery process. For these reasons, family and caregivers should be included in family therapy, and their relationship patterns should be targets of treatment interventions.

Most substance use disorder treatment professionals already have extensive knowledge of the complex ways in which psychological denial and substance abuse are intertwined, and they have developed methods of working with clients whose denial presents a significant obstacle to treatment. However, for people with disabilities, denial has additional dimensions. Some people with co-existing disabilities may experience two types of denial at once: denial of the substance use disorder and denial of the disability. The presence of a co-occurring disability can alter how a person manifests denial of his substance use disorder or can cause denial to be focused solely on the disability. For a person with a disability, substance use may also be a form of bargaining. He or she may think that substance use is something that is “allowed” in order to

compensate for facing a disability. For clients, recognizing their substance abuse forces them to cope with all of the often painful emotions typically experienced by any person in recovery, in addition to those related to disability. For most people with severe disabilities, adjustment to this condition is considered a lifelong process (DeLoach and Greer 1981).

If the family therapist treating substance abuse is experiencing difficulty confronting the denial of the disability, he or she

should consider a referral to a peer counselor at a Center for Independent Living (see appendix D), whose job is to help people with disabilities come to terms with the limitations of their disability. The two counselors can then work as a team.

The host of life challenges facing family members with disabilities increases their risk of substance use disorder, makes treatment more complex, and heightens the possibility of relapse. If the family therapist’s agency does not provide services to assist clients in dealing with these challenges, coordination with an agency providing case management services for people with disabilities should be a priority. People with co-existing disabilities and substance use disorders may need assistance and individualized accommodations to

- Escape from abusive situations
- Learn to protect themselves from victimization
- Find volunteer work or other means of gaining a sense of productivity in lieu of paid employment (although paid employment is generally preferred)
- Develop prevocational skills such as basic grooming, dressing appropriately, using public transportation, and cooking
- Learn social skills missing because of substance use disorders and disability-related problems
- Learn to engage in healthy recreation
- Become educated about their legal rights to accessible environments and services as well as employment
- Obtain financial benefits to which they are entitled
- Build new peer networks

Because family members may feel responsible for the individual’s condition and present mostly with negativity, family therapists must address guilt and anger (Hulnick and Hulnick 1989). Hulnick and Hulnick (1989) suggest that family therapists assist both the family and the member with a disability to focus on the choices at their disposal. Such questions as “What are

A strengths-based approach to treatment is important for people with disabilities, because such clients may have been viewed in terms of what they cannot or should not attempt.

you doing that perpetuates the situation?” and “Are you aware of other choices that would have a different result?” can empower clients to understand that they retain the powerful option of making choices (Sue and Sue 1999, p. 325). Another effective strategy is reframing the disability through examination of the ways in which it may afford a learning or growth experience.

A strengths-based approach to treatment is especially important for people with disabilities, because such clients may have so frequently been viewed in terms of what they cannot or should not attempt that they may have learned to define themselves in terms of their limitations and inabilities. Well-intentioned family members and friends may encourage dependence and may even feel threatened when the member with a disability attempts to achieve a measure of independence.

However, people with disabilities must also understand their functional limitations, especially in relation to their risk for relapse. One of the overriding goals of treatment for people with disabilities is that they gain and maintain self-awareness about their functional limitations and capacities, as well as their substance use disorders. A better understanding of one’s unique learning needs is an important step toward abstinence. For example, some people with cognitive disabilities experience a great deal of difficulty learning from written material. This can be a particularly difficult limitation to acknowledge, especially in group settings or the workplace. The client who discovers that it is a sign of personal strength to make adjustments and seek accommodation for reading difficulties is not only more empowered to make important decisions relative to abstinence, but also understands the importance of, for example, expanding the repertoire of skills used to compensate for a low reading level.

Specific recommendations include the following:

- During the intake process, people with certain physical or cognitive disabilities may require a longer interview, and rest periods may need to be scheduled. Flexibility should

be built into interview scheduling. Counseling session times should also be flexible, so that sessions can be shortened, lengthened, or made more frequent, depending on the individual treatment plan.

- For people with cognitive impairments, it is important to remember to ask simple questions, repeat questions, and ask clients to repeat, in their own words, what has been said. Discussions should be kept concrete. People with mental retardation or traumatic brain injury may not understand abstract concepts. They should be asked to provide specific examples of a general principle.
- The use of verbal and nonverbal cues will help increase participation and learning for people with cognitive disabilities and make the group sessions run more smoothly for all. The counselor and the person with a disability can design the cues together but should keep them simple, such as touching the person’s arm and saying a code word (such as, “interrupting”).
- Clients with cognitive disabilities will often benefit from techniques such as expressive therapy or roleplaying. Assignments that require the use of alternative media in place of writing may work best with clients who have cognitive disabilities as well as those who are deaf. Clients who are blind will need assignments translated into their preferred method of communication (perhaps Braille or an audiotape). No matter what method is used, they will generally require more time to complete reading assignments.
- Regardless of the model of communication used by a person who is deaf or hard of hearing, the visual aspect of communication will be important. It is important to look directly at the person when communicating. This courtesy will allow a deaf person to try to read the lips of the counselor and to receive cues from facial expressions.
- Interpreters should usually be provided for people who are deaf or hard of hearing. The interpreter should be a neutral third party hired specifically to interpret for the counselor and the person who is deaf. A family member

or friend of the client should not be used as an interpreter. Only qualified interpreters should be used, as determined by either a chapter of the Registry of Interpreters for the Deaf or a State interpreter screening organization. If a person who is deaf is using an interpreter, group members will need to take turns during discussions. When addressing a person who is deaf, the counselor or group members should speak directly to the person as if the interpreter is not present.

- When working with an individual with a physical disability, table surfaces must be the correct height. In particular, wheelchairs should be able to fit beneath them. Counselors should try to place themselves so that they are no higher than the client. They should be aware of the pace of the interview, and attempt to gauge when clients are becoming fatigued. Counselors should periodically inquire how the client is doing and offer frequent breaks.
- People who use wheelchairs often come to regard the chair as an extension of themselves, and touching the chair may be offensive to them. Therapists should never take control of the wheelchair and push the person without permission.
- For people with cognitive disabilities, providers must systematically address what has been learned in the program and how it will be applicable in the next stage of treatment or aftercare. Some people are very context-bound in their learning, and providers cannot assume that the lessons learned in treatment will be applied in aftercare.
- If a person with a disability has limited transportation options, a therapist may arrange to conduct individual counseling by telephone, go to the person's house, or meet at a rehabilitation center or other alternative site. Going to the residence of an individual with a disability also provides valuable information about a client's lifestyle, interests, and immediate environmental challenges.
- Therapists should recommend literature to families that addresses enabling behavior in general and for people with disabilities in

particular. Disability resource agencies may be able to provide helpful literature. For a full discussion of these categories, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998e).

## People With Co-Occurring Substance Abuse and Mental Disorders

### Background Issues

Clients with substance use disorders often have a co-occurring mental disorder. Over the past 10 years, concern and attention to co-occurring conditions has increased sharply—focusing on the clinical and societal implications of treatment and understanding of people who have both a mental disorder and a substance use disorder. The importance of treatment for both disorders is now widely recognized. TIP 9, *Assessment and Treatment of Persons With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT 1994b) addressed “dual diagnosis” and a revision of that TIP is underway. (See the forthcoming TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT in development *k*]. The complexities and difficulties of diagnosis and treatment planning for people with co-occurring disorders are explored in detail in the revised TIP.)

Substance abuse treatment counselors and family therapists working with clients who have both a substance use disorder and a severe mental illness will want to be thoroughly familiar with the new advances related to co-occurring conditions, and the consensus panel recommends the new TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT in development *k*) as a good place to start. In addition, counselors and therapists working with anyone with co-occurring substance use and mental disorders will need to understand the complex

and varied ways the disorders interact within individuals and the necessary adaptations to treatment. The new TIP offers considerable background and detail on the main types of co-occurring conditions.

Prevalence data regarding co-occurring disorders are difficult to describe. The symptoms and behaviors associated with mental disorders are often caused by alcohol or drugs, or such drug or alcohol use exacerbates mental health symptoms. At least 30 percent of people with alcohol dependency meet criteria for an antisocial personality disorder (Schuckit 2000). In a review of studies related to co-occurring disorders, Sacks and colleagues found that in general, substance abuse treatment programs report that 50 to 75 percent of clients have a co-occurring disorder and mental health clinicians report 20 to 50 percent of clients with a co-occurring substance use disorder (Sacks et al. 1997).

Modern attention to treatment for people with co-occurring disorders emphasizes integrated treatment for both disorders by programs and staff knowledgeable and respective of each other's disciplines. When treatment for both conditions cannot be delivered by one treatment program, collaboration and consultations with other providers are considered essential (see the forthcoming TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT in development *k*] for more detailed information).

## Application to Family Therapy

The most appropriate approach to single family therapy for people with co-occurring disorders is an integrated approach that combines family interventions and substance abuse interventions (Sheils and Rolfe 2000). Psychoeducational family therapy that focuses on both psychosis and substance use is also helpful. Effective psychoeducation combines fundamental information, guidance and support, and allows for “low-key” engagement and continued assessment opportunities (Ryglewicz 1991). It is important to educate family members on the

ways that one disorder, if not properly monitored and treated, can set off the other.

In using an integrated family therapy model with co-occurring schizophrenia and substance use disorder, it is important to avoid strong confrontation and interventions that require high levels of insight, concentration, attention, and information processing. Multifamily groups may be well suited because of the benefit of family support, but may run into some trouble when symptoms of anxiety and paranoia are prominent. Sheils and Rolfe (2000) report that an integrated family therapy model for people with co-occurring schizophrenia and substance use disorder is currently being tested.

Treatment can be substantially supported and enhanced by direct involvement of the client's family. Family therapy is often necessary to address the feelings of guilt, sadness, and rage that may have accumulated among all family members. Family members should be encouraged to participate in Al-Anon and related self-help groups. When necessary, individual family members should be referred for treatment of specific problems.

For adolescents who have substance abuse problems with co-occurring disorders (primarily disruptive disorder and conduct disorder) family therapy is among the most well tested and efficacious interventions (Goyer et al. 1979; Szapocznik and Kurtines 1989; Waldron 1997). Liddle and Dakof (1995*b*) emphasize behavioral family techniques such as parent-management training and contingency

It is important to educate family members on the ways that one disorder, if not properly monitored and treated, can set off the other disorder.

contracting, and strategic-structural approaches including engagement strategies and restructuring family interaction for these adolescents. Behavioral, strategic, and structural techniques combine to form a functional family approach that targets the variety of problems markedly present in families of adolescents with co-occurring conduct disorder and substance use disorder (Alexander et al. 1990). Santisteban et al. (2003) have developed a family therapy model specifically designed for adolescents who meet criteria for both drug abuse and Borderline Personality Disorder (BPD). This model integrates concepts from Structural Family Therapy, Linehan's (1993) work with BPD adults, and substance abuse treatment.

An important feature of these treatment models contributing to their effectiveness is the blending of both mental health and substance abuse treatment models, with each applied at appropriate times and in appropriate situations according to the client's needs.

For example, in substance abuse treatment, clinical staff and fellow clients often aggressively confront clients who deny that they have a substance abuse problem or who minimize the severity of their problem. However, treatment of people with co-occurring disorders first

requires innovative approaches to engage them in treatment as a prerequisite to confrontation. The role of confrontation may need to be substantially modified, particularly in the treatment of disorganized clients or clients with psychosis who may tolerate confrontation only in later stages of treatment (when their symptoms are stable and they are engaged in the treatment process).

Traditionally, self-reliance is a strong value among rural citizens; receiving treatment can be perceived as an indication of weakness.

For clients who require medication, it is important to understand the use of medication from the client's perspective. Clients should be educated and thoroughly informed about the specific medication being prescribed, expected results, the medication's time course, possible side effects, and the possible results of combined medication and substance use. It is also critical to discuss with clients their understanding of the purpose for the medication, their beliefs about the meaning of medication, and their understanding of the meaning of adherence. Finally, it is important to ask clients what they expect from the medication and what they have been told about the medication. Whenever possible, family members and significant others should be educated regarding the medication.

## Rural Populations

### Background Issues

Rural America has experienced decimation of family farms and erosion of infrastructure (i.e., schools, mental health care). As a result, financial limitations may make it difficult to pay for treatment, for transportation to treatment sessions (particularly when long distances must be traveled to reach the nearest provider), or for necessary childcare during treatment. In addition, rural families are less likely to be covered by medical insurance (Rhoades and Chu 2000). Geographical isolation makes it difficult for families to build a consistent network of social support outside the family and to access available community resources.

The intimacy of the rural community affects both the confidentiality and the desirability of accessing mental-health services. The fact that people know the vast majority of members in a close-knit community creates additional stigma around addressing mental health or substance abuse issues. For instance, medical records may be reviewed by people who are friends or neighbors. In addition, therapy or counseling may be new to the rural area and not yet accepted as a normal process.

Because rural communities may have a tendency to tolerate more extreme forms of behavior, the impact of substance abuse on the user and his or her significant others may also be more extreme. Bagarozzi (1982) notes that rural people are often referred to treatment not because their behavior is considered deviant, but because it has exceeded acceptable community limits. For example, alcohol dependency itself may not be addressed as a problem until the individual who is abusing alcohol is arrested for criminal behavior or until he or she commits an extreme act of violence against a family member. Because rural communities may allow substance dependencies to worsen by keeping serious problems out of the reach of service providers and/or law enforcement, conditions often deteriorate until dramatic and tragic events cause the problem to surface. Public education may be useful if framed in a culturally acceptable manner.

Traditionally, self-reliance is a strong value among rural citizens. As a consequence, receiving treatment can be perceived as an indication of weakness (Bushy 1997). Tatum (1995) notes that along with self-reliance and pride, fatalism is a key Appalachian attitude that affects a therapist's ability to offer effective intervention and treatment strategies. Rural families also tend to be more doubtful about the effectiveness of mental health or substance abuse treatment services (Wagenfeld et al. 1994).

Rural women who are dependent on alcohol report a profound alienation that they describe as an "all-consuming" sense of the meaninglessness of their existence that involves intense feelings of despair and self-loathing (Boyd and Mackey 2000, p. 136). Many of these women grew up in family situations where alcoholism and abuse were prevalent. Forced at an early age to take on adult responsibilities that their dysfunctional parents could not maintain, these women report becoming intensely depressed, often leading lonely, joyless lives (Boyd and Mackey 2000).

## ***Patterns of substance abuse***

Substance abuse rates for rural populations generally equal or exceed those of urban populations (Kearns and Rosenthal 2001). Alcohol appears to be the most commonly abused substance among rural people, and alcohol-related problems such as arrests, hospitalization, and unintentional injuries are more common among rural populations (Kelleher et al. 1992).

Several studies have suggested that rural youth are more likely to have used drugs than their urban counterparts (National Center on Addiction and Substance Abuse [CASA] 2000; Edwards 1997; Stevens et al. 1995).

Although rural communities may have similar substance abuse rates, quite frequently the consequences are more pronounced and severe (CASA 2000). Because rural communities often combine reduced resources with low population density, they often have shortages of trained substance abuse professionals and great challenges providing accessible treatment programs. In 1993, 55 percent of U.S. counties were without a practicing psychologist, psychiatrist, or social worker, and all of these counties were rural (Pion et al. 1997).

## **Application to Family Therapy**

### ***Overcoming barriers to treatment***

There are a number of barriers encountered by substance abuse counselors and mental health practitioners when attempting to treat families in rural communities; however, counselors can work with families to overcome many of them (Bagarozzi 1982; Cutler and Madore 1980; Sayger and Heid 1990). For example, families that experience distress associated with a lack of financial resources may need help getting their basic needs met. Therapists can assist in finding resources for families through food banks, clothing banks, and health care resources.

The geographic dispersion of families in rural areas may require them to travel great distances in order to access treatment (Human and Wasem 1991). A family therapy provider has several options for addressing distance barriers (Bagarozzi 1982). The therapist may decide to contract with the family for a limited number of sessions and be very focused in the work. To address transportation barriers, the therapist may alternate sessions at the office with sessions at the client's home or choose a location in between (e.g., a local church or community center). It may be helpful to schedule extended sessions that allow bigger chunks of therapeutic work to occur every 2 or 3 weeks instead of weekly.

In-home family therapy may be of tremendous use in addressing problems of client isolation and inaccessibility to treatment. In addition, home-based services facilitate the initial step of accessing mental health services, a step that may be exceptionally difficult for rural clients due to fear of stigmatization or the rigorous work schedule associated with agriculture, mining, etc. Tatum (1995) asserts that taking programs to families, instead of expecting people to travel to an office, may go a long way toward overcoming reluctance to work with bureaucracy. Home visits may help therapists learn about clients within the context of their environment by witnessing their day-to-day reality. For example, a therapist may decide not to see a client because of body odor, but the issue takes on another dimension when the therapist understands that the client has no running water or electricity. Home visits may also help therapists and families to build increased rapport.

Tatum (1995) emphasizes that the key to successfully delivering therapeutic services in rural communities is gaining acceptance from the community and client population. Sometimes a therapist's lack of understanding of rural values and customs can create mistrust among residents and hinder effective treatment (Bushy 1997). For example, rural people may have a mistrust of outsiders and a fear of becoming involved in the "system" (Tatum

1995). Working to increase family and community involvement in the therapeutic process can help overcome obstacles such as the lack of social support and the stigma of receiving mental health services. It is essential for the therapist to identify all the important people in the family's life. This includes extended family and close friends who may become key players in the target family's change process. However, because of the intimacy of rural communities, therapists must balance the need to effect family change on a macro level with the equally important need of maintaining confidentiality.

### ***Use of self-help groups***

AA and similar self-help groups are frequently the only accessible resource available in rural communities. AA's family-like solidarity can instill hope and provide a valuable support system for people with substance abuse problems. For the family of the IP, 12-Step support groups include Al-Anon, Alateen, NarcAnon, Co-Dependents Anonymous, and Families Anonymous.

Family therapists can reframe AA in order to make its principles more in harmony with rural values. Tatum (1995) recommends the following:

- **Self-reliance**—this feature involves learning how to care for oneself.
- **Family system**—this element involves learning how one can create healthy families.
- **Working with faith-based (religious), community, and spiritual groups** is an opportunity to be mutually supportive and let others know about the importance of family therapy in substance abuse treatment. Though no precise definitions distinguish between the terms faith-based, spiritual, self-help, and community initiatives, conventional and practical distinctions do differentiate them. Faith-based programs have clear religious orientations. They may be community-oriented as well. Many churches, for example, coordinate substance abuse services in their communities, and their activities may involve people in the community and include spiritual and faith-based underpinnings as part of the

recovery approach. Because of the spiritual focus of 12-Step programs, they are sometimes confused with faith-based programs, but AA does not refer to or promote any religion or denomination. It only encourages connection with a higher power.

Every family therapist should be aware of the general distinctions among the groups and the sensitivities related to them. For example, people who belong to AA commonly dislike being characterized as religious or even as faith-based. The family therapist should be able to explain to a client that the various 12-Step programs are spiritual but not religious (and what the difference is). Therapists also need to know the specifics of their local groups that may well include understanding the availability of special AA groups, such as non-smoker meetings, young adult meetings, etc.

## Other Contextual Factors

### HIV Status

The Centers for Disease Control and Prevention (CDC) estimates that between 800,000 and 900,000 people in the United States are living with HIV infection, and about 625,000 are aware of their infection. As of June 2001, more than 457,000 people in this country had died of the disease (CDC 2002). The epidemic has had an impact far beyond mortality statistics, with far-reaching effects on systems as diverse as health care, food service, economics, and education.

HIV/AIDS has always been closely related to substance abuse, and the two have become increasingly intertwined. From July 2000 through June 2001, 25 percent of all reported AIDS cases were among people who also reported injection drug use (CDC 2002). The CDC also estimates that 25 percent of all new HIV infections were in people who reported injection drug use (CDC 2002). People who exchange sex for drugs represent another substantial at-risk group. The direct and indirect

role of substance abuse in the spread of AIDS was clearly established early in the American AIDS epidemic, and HIV/AIDS has changed the face of substance abuse treatment services.

In the 1980s the early reports about HIV/AIDS identified injection drug use (IDU) as a direct route of HIV infection. Cases directly attributed to IDU continued to rise through the 1990s. The number of estimated AIDS cases diagnosed annually declined substantially from 1996 through 1999, but the rate of decline slowed during 1999 and 2000. The leveling in overall AIDS incidence is occurring as the composition of the epidemic is changing. AIDS incidence declined in most populations but increases were observed in some groups, notably women and persons infected through heterosexual contact (CDC 2002). For further information, see TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000c).

Most likely, the IP in family therapy with HIV/AIDS will be an adult. Pediatric cases remain a small percentage of the total number. It is not uncommon, however, for an adult with AIDS to return to the parents' home for care, reverting to the offspring role. Children of these adults may need help as they anticipate the loss of their parent. HIV/AIDS has a profound effect on infected individuals. The severe medical effects are well documented. Psychological effects include adjustment disorders with anxiety and depression at the time of diagnosis, ongoing depression, grief and mourning, suicidal ideation and attempts, and cognitive and neurological impairment.

HIV/AIDS has always been closely related to substance abuse, and the two have become increasingly intertwined.

The therapist must be aware of the multiple family obligations and pressures for people with HIV and their family members.

The impact of infection and disease on family members is also wide and deep. Significant others will grapple with fear of infection and possibly reactions to having been exposed to HIV. Grief and mourning are also likely to be present, as are stress and loss similar to that experi-

enced with other chronic illnesses. Finally, there are the financial and emotional burdens that ongoing medical care of a person with HIV/AIDS places on a family.

### **Application to family therapy**

While integrated models are applicable, in addition the therapist must be aware of the multiple family obligations and pressures for people with HIV and their family members. Issues differ for different groups and individuals; for example, gay men, people who use drugs intravenously, and transfusion recipients. Stigma is almost always part of the picture, although it may vary according to the source of HIV infection; IDU is likely to be associated with the greatest amount of stigma.

An AIDS patient may return to his family system because his medical needs make it impossible for him to continue to live on his own. In many cases, the returning family member was at one time alienated from the family (e.g., because of sexual orientation or drug use). Reconciliation can be difficult, especially when complicated by medical crises. The family therapist needs to recognize this and consider when it is appropriate to involve family members in therapy.

A person with HIV/AIDS is likely to have complicated physical and medical needs. If necessary, the therapist should facilitate appropriate medical and pharmacological treatment. It is also important to determine if anyone else has been exposed to HIV by the client and if safe sex is being practiced. This inquiry can lead to difficult confidentiality issues. Specific regulations vary from State to State, and there may be gray areas between ethics and legality. While a therapist has some responsibility to the larger community, the primary obligation is to the client. To date, insufficient case law exists to say definitively that the Tarasoff ruling of the obligation to inform is directly applicable to behavior of people with HIV/AIDS. For further information, see the Legal Issues chapter of TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000c).

### **Homelessness**

In 1998, an estimated 38 percent of the Nation's homeless were families, with approximately 100,000 children sleeping each night in shelters, abandoned buildings, or on the street (Vanderbilt University Institute for Public Policy Studies 1999). Homelessness can take a variety of forms, from spending nights in shelters and days on the street, to setting up "housekeeping" in abandoned buildings, to moving around among friends, acquaintances, and relatives. Douyon et al. (1998) define homelessness as "the inability to secure regular housing when such housing is desired" (p. 210).

Studies have found that more than a million teenagers live in emergency shelters or on the streets on any given night. Many have families that would take them back, but some have been kicked out of their homes, and others are running from sexual or physical abuse or similarly intolerable circumstances. One study found that compared to adult counterparts, homeless teens were more likely to be female, and their behaviors were more likely to include sexual promiscuity, prostitution, unplanned pregnancy, and suicide attempts (Coco and Courtney 1998).

Most homeless people have a history of some sort of abuse. In a look at previously homeless people in shelter-based therapeutic communities, Jainchill et al. (2000) determined that 84 percent of women and 68 percent of men had either been physically or sexually abused. Their study found that homelessness was more likely to be episodic than constant in a person's life.

While it has long been presumed that the prevalence of substance use by homeless people is high, no definitive data are available on this subject. Some early studies have been called into question because they used lifetime rather than current measures of substance abuse. The National Coalition for the Homeless (NCH) concluded that "there is no generally accepted 'magic number' with respect to the prevalence of substance use disorders among homeless adults" (NCH 1999, n.p.). Some studies have found as many as two thirds of homeless people abuse alcohol, and half use illicit drugs. Surveys in shelters found 90 percent of residents with alcohol problems and more than 60 percent with illicit drug problems. Co-occurring psychiatric disorders are also common in homeless people, as are lack of education and job skills (Jainchill et al. 2000). (For more information on homelessness see the forthcoming TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT in development k].)

### ***Application to family therapy***

The homeless are people with multiple and complex needs. First consideration must be given to their basic human concerns, such as health, shelter, and safety. Many homeless women and children have fled situations of domestic violence. Social service and health needs are best addressed by networking with the range of agencies that provide services to meet their needs. Connecting clients with funding agencies will also address concerns of paying for treatment.

A therapist must address homelessness early on to find the homeless family a place to live and

help apply for services for which it is eligible. Following these initial steps, therapists can then assess substance abuse and the particular factors that have led to the homelessness. Homelessness does not have a single cause. The counselor should look for strengths by using such tools as perseverance, creativity, and humor.

Many homeless people do not have a family group to bring into therapy, even by the most inclusive interpretations of *family*. It may be impossible to reconnect families of origin with some clients who have been cut off due to substance abuse, mental illness, and related problems. Still, family dynamics remain integral to the functioning of even the most isolated individuals, and one-person family therapy may be an effective approach in substance abuse treatment if family members are not reachable or amenable to being in treatment. It might seem at first glance that a family genogram would yield little useful information, but constructing one can be helpful and it may allow for surprising insights. It should look at not only an individual's family of origin, but also the family of choice, if such a structure exists.

It is important for the therapist to consider how reality is defined. For example, a homeless person may talk of how she was thrown out by her family, while her family speaks of her leaving voluntarily. The therapist needs to help sort through these alternate realities, although absolute truth may be elusive. Even what seems an obvious fact (e.g., a person's life would be better if he stopped abusing substances) may be hard for an individual to recognize and accept.

### **Veterans**

The statistics relating to veterans and substance abuse do little more than provide snapshots that hint at the extent of the problem and the efforts being made to treat it. For example, in fiscal year 2000, the Department of Veterans Affairs (VA), which provides health services for the Nation's veterans, counted 366,429 clients diagnosed with a substance use disorder. In

2000, more than 55,000 veterans were admitted to publicly funded substance abuse treatment facilities (OAS 2003b). According to the VA studies, 76 percent of homeless veterans have experienced alcohol, drug, or mental disorders in the past month and 93 percent at some time in their life. Most homeless veterans (98 percent) are male (National Coalition for Homeless Veterans 2002).

In 2000, alcohol was the primary substance of abuse (68 percent). Cocaine was the next most commonly reported substance used (15 percent), followed by heroin/opioids (8 percent) (OAS 2003b).

PTSD results from experiencing or witnessing traumatic life-threatening events such as combat, terrorist acts, natural disasters, or personal violence and is characterized by a set of cognitive-behavioral symptoms (i.e., hypervigilance, emotional avoidance and numbing, and intrusive memories). Researchers have recognized the high risk for PTSD among veteran populations since studies of Vietnam War veterans began to emerge. Studies comparing Vietnam veterans to World War II and Korean War veterans found that Vietnam veterans were more likely to experience distress related to loss of friends and memories of brutality, while the older veterans' symptoms were more often related to physical injuries or capture (Johnston 2000).

PTSD is associated with an increased rate of substance abuse. One study found that 34.5 percent of men and 26.9 percent of women with a lifetime history of PTSD reported drug or alcohol abuse or dependence at some point in their lives. This rate compares to substance abuse incidence of 15.1 percent and 7.6 percent in men and women, respectively, who did not have PTSD. Stress of any sort is a potent trigger for substance abuse and relapse, not only because of the psychological effects of stress, but because it is now understood to initiate a biological process, thereby increasing certain brain chemicals (NIDA 2002). Veterans who experienced domestic violence as children and then the trauma of war have a double burden to bear.

## **Application to family therapy**

Little specific family therapy research about veteran populations exists. The most common path to substance abuse treatment for veterans is the criminal justice system (including driving while intoxicated referrals), especially for veterans under the age of 25 (OAS 2001b). A technique that might be helpful in tracking and changing family behavior is family behavior loop mapping. Liepman et al. (1989) describe this tool as a method of diagramming the repetitive behavior cycles specific to wet and dry phases in substance abuse affected families.

The therapist can help the veteran locate services, including benefits to which they are entitled. Therapists need to know where local veteran centers are. If treatment is difficult to access, it may be hard to get families involved.

A psychological issue that many veterans must address is survivor guilt—having lived while their comrades perished. The issue of abandoned children may also be difficult for veterans. A number of veterans fathered children while in the service. For example, American military men in Vietnam fathered many offspring. These lost families often need to be addressed in family therapy. Therapy sessions with veterans can become graphic and horrifying. The therapist must be able to work with high levels of intensity.

Veterans' wives, particularly, may need support, and support groups can be helpful. Children may face a number of issues related to a parent's veteran status. Therapists have observed, for example, that as the children of Vietnam veterans approach the age their fathers were when they went to Vietnam (usually late teens), the fathers begin pressuring them to learn to be tough.

## ***Chapter 5 Summary Points From a Family Counselor Point of View***

- Children and adolescents can represent a number of challenging concerns and might require referral, especially for concerns about inhalant abuse or abuse and neglect.
- Older adults may require referral to distinguish organic mental disorders that are substance-related from other organic brain disorders.
- The complex roles and demands that can be placed on women within some families requires special attention, including enhanced assessment processes and possible ancillary services.
- Diversity, disability, and co-occurring disorders often require administrative, clinical, and supervisory sensitivity.

# 6 Policy and Program Issues

## In This Chapter...

Primary Policy Concerns

Program Planning Models

Other Program Considerations

Directions for Future Research

## Overview

This chapter provides information about the importance of improving services to families and discusses some policy implications for effectively joining family therapy and substance abuse treatment. Of special importance in this effort is the inclusion of key stakeholders in the substance abuse treatment and family therapy fields, among them the Federal government, insurance companies, frontline and executive staff members from both disciplines, researchers, consumers, and others who make decisions about service delivery.

This chapter also presents program planning models developed by the consensus panel that provide a framework for the broad inclusion of family therapy into substance abuse treatment. These models cover (1) the issues surrounding staff education about families and family therapy, (2) family education about the roles of families in treatment and recovery from substance abuse, (3) how substance abuse treatment providers can collaborate with family therapists, and (4) methods for integrating family therapy activities into substance abuse treatment programs.

Considerations for substance abuse treatment program administrators, such as guidelines for implementation, ethical and legal issues, and evaluating outcomes are addressed for each of the four program planning models. The chapter also discusses the counseling adaptations and training and supervision issues that arise for substance abuse counselors and other staff when programs promote attention to family issues and family therapy techniques.

## Primary Policy Concerns

Though many substance abuse counselors and family therapists have learned to incorporate aspects of each system's approaches, to be instructive this TIP finds it necessary to proceed as if "family therapy" and "substance abuse treatment" have heretofore existed in isolation from each other and as if each were reducible to a specific limited set of

techniques, approaches, attitudes, and points of view. The reader should keep in mind that it is an overly simplified presentation that follows and that the overlap among practitioners and the fields is probably much greater than the artificial separation employed as a vehicle for the presentation of primary policy concerns. With this caveat in mind, the merging of family therapy techniques with substance abuse treatment warrants consideration of three primary policy questions:

- When is family therapy appropriate?
- What are the funding and reimbursement options for family modalities?
- What role does the criminal justice system play in mandating substance abuse treatment with a family focus?

## Challenges to Merging Family Therapy and Substance Abuse Treatment

There is considerable evidence to support treatment that taps the power of the family and the community but, at the same time, weaving a different modality with its own distinct values into a treatment program can be a challenge. This may explain in part why many substance abuse treatment programs have been slow to integrate the strengths-based approach essential to effective work with families.

One major impediment to merging the two disciplines effectively is identifying the underlying values of each and then determining whether alternatives would work better. The different values associated with previous forms of substance abuse treatment and family therapy have important implications for combining the two in the future. These implications will affect the entire organizational spectrum. Though the incorporation of family therapy into substance abuse treatment presents an opportunity to improve the status quo, it also challenges these two divergent modalities to recognize, delineate, and possibly reconcile their differing outlooks. At a basic level, for example, agencies can develop common action plans founded on

evidence-based research and goals to ensure more success for the client. Such plans could be developed according to the four-tier model described in chapter 4, which guides the development of different levels of family involvement.

Another major policy implication, as noted by O'Farrell and Fals-Stewart (1999), is that family therapy requires special training and skills that are not common among staff in many substance abuse treatment programs. A substance abuse treatment program committed to family therapy will need to consider the costs associated with providing extensive training to line and supervisory staff to ensure that everyone understands, supports, and reinforces the family therapist's work.

For a traditional family therapy approach to be successful, it is necessary to consider how everyone who works in and with a program treats clients and their families. The entire substance abuse treatment program must be examined to verify that the ideas espoused in family therapy are fully integrated into all aspects of the program, including forms, policies, procedures, and mission statement. Further, in providing some level of family involvement or therapy within substance abuse treatment, other problems may need to be resolved, such as

- Substance abuse counselors and family therapists sometimes have different goals.
- Research to support the integration of classic family therapy into substance abuse treatment is not definitive, although recent research studies have shown support for certain types of family-based treatments with certain types of client/family groups.
- Conflicting interests and standards regarding confidentiality must be reconciled.

Given the complexity of incorporating full-scale family therapy consistently in substance abuse treatment and the finite resources with which many substance abuse treatment programs are working, family involvement may be a more attractive alternative. Family involvement and

family therapy are two points on a continuum rather than completely distinct.

## What Are the Funding and Reimbursement Options for Family Modalities?

The documented cost savings and public health benefits associated with family therapy support the idea of reimbursement (O'Farrell et al. 1996a, b). However, like the substance abuse treatment system, the American health care insurance system focuses care on the individual. Little, if any, reimbursement is available for the treatment of family members, even less so if "family" is broadly defined to include a client's nonfamilial support network. For example, under Medicare, family therapy is a covered expense, when done by a licensed and certified Medicare mental health provider, but the system does not certify and therefore does not reimburse family therapists. With Medicaid, administered by States, reimbursement policies vary. Also, the Elementary and Secondary Education Act does not recognize family therapists as qualified mental health or substance abuse services providers.

If a family wants services, and the client is unwilling to participate, the family should not be excluded. Ideally, family members should be able to receive appropriate services, if requested. What must be changed so that families can receive those benefits? Who would fund a more inclusive process? The known and interactive barriers—reimbursement and attitudes—must be resolved in order to include families more fully in the treatment process. Regardless of the context in which family therapy is delivered, if the operational policy of States or insurance companies is not to reimburse, then policy discussions need to develop processes to remove that barrier. Recent evidence of the effectiveness of family involvement, as well as clinical and research evidence that supports family therapy for substance abuse treatment (Liddle et al. 2001; Stanton and Shadish 1997), may eventually move funders to alter payment systems so that families can be included.

## What Role Does the Criminal Justice System Play in Mandating Substance Abuse Treatment With a Family Focus?

The criminal justice system is a major source of referrals to substance abuse treatment, especially among people with low incomes. Such legally coerced referrals come with powerful leverage that strongly affects the treatment process. Providers should be prepared to address several issues: If a treatment program requires family member participation and the client refuses to involve them, or the treatment episode is not successful, what are the consequences to both client and family? What happens if a family-focused approach is in place and the family does not show up? Do you punish the client? If such questions are not anticipated and answered adequately, the result may be harm to, rather than assistance for, the client and/or the family.

There is considerable evidence to support treatment that taps the power of the family and the community.

## Program Planning Models

Including family therapy issues in substance abuse treatment settings at any level of intensity requires a systematic and continuous effort. The four program planning models presented in this section—staff education, family

The goal for educating staff about family therapy and family issues is to increase staff awareness of the role of family involvement in substance abuse, dependence, treatment, recovery, and relapse.

education and participation, provider collaboration, and family integration—were developed by the consensus panel and provide a framework for program administrators and staff/counselors. The framework identifies key issues: guidelines for implementation, ethical and legal issues, outcomes evaluation, counseling adaptations, and training and supervision. Some programs may be limited to educating staff about family therapy and how family issues relate to substance abuse, treatment, and recovery.

Many programs already involve families in the treatment process in some way, and those programs might wish both to promote ongoing staff education about family therapies and to increase or improve the ways in which families participate in the substance abuse treatment program and continuing care. A program might decide to create or expand its collaborations with family therapy providers and other social service agencies. Although integrating family therapy into substance abuse treatment might require a significant investment of time and resources, the consensus panel hopes that treatment programs can use the integration models suggested to facilitate such changes.

## Staff Education

The goal for educating staff about family therapy and family issues is to increase staff (and therefore client) awareness of the role of family

involvement in substance abuse, dependence, treatment, recovery, and relapse. Increasing staff's knowledge of the family as a unit and the influence of the ecological setting within which the substance abuse occurs should be one outcome of the staff education activities. Support for becoming knowledgeable about family therapy issues, as well as for program changes designed to integrate or enhance the delivery of such services to clients and their families, begins with the chief administrative and clinical staff. These staff members need to demonstrate their value of such knowledge and activities and that they are willing to commit the necessary resources in an ongoing fashion.

## ***Issues for substance abuse treatment program administrators***

Program administrators must assess the amount of effort and support required to develop staff education activities related to family issues. When the agency does not have in-house resources, it might be best to seek input from the entire staff about any staff knowledge of resources in the community and/or specific providers worth considering for participation in the educational activities. To be sure, program administrators will need to gauge the compatibility of outside presenters' views of addiction against the substance abuse treatment program's viewpoints and materials. Although viewpoints regarding substance abuse and its treatment need not be identical for all family therapy presenters, the program administrator might wish to give advanced thought to how to address issues that could arise over conflicting views. Administrators need to be aware of the costs that are involved; sometimes the resources are not readily available and can be costly, especially in areas where access to care is restricted.

In some locations there might be numerous inexpensive or even free educational activities that relate to family issues and family therapy—from local college courses to evening presentations given by various community

organizations. In other locations it may be much more difficult and expensive to access direct presentations, and program administrators may seek resources through e-learning possibilities. Of course, this TIP itself and other State and Federal resources, such as one of the regional Addiction Technology Transfer Centers (<http://www.nattc.org>), which receive funding from the Center for Substance Abuse Treatment (CSAT), are good places to start.

Though it is unlikely that there will be any legal or ethical issues associated with providing education on family issues to substance abuse counselors or staff, it is certainly the best practice in terms of credentialing to check with licensing or certification agencies. This will ensure that any professional invited into one's agency is in good standing and has the background and training that are represented in the person's resume. As far as outcome evaluation, many presenters have their own "pre- and post-" questionnaires to demonstrate that participants have acquired certain information from the presentation. Certain accrediting organizations require such program evaluation components in order for a presentation to be eligible for consideration as continuing education credits. Of equal, if not greater, importance would be formal or informal mechanisms for obtaining participants' own assessments of the educational activities.

And finally, some time and attention will need to be devoted to help staff digest the family therapy education they receive, especially in terms of their comfort level about what the training implies as far as their counseling or treatment. Along these same lines, staff might have concerns about the amount of training and supervision necessary to employ any or all of the techniques described or suggested. Again, resources to meet these concerns might be available in-house, in the community, or through distance learning possibilities. Designing a set of educational and training activities so that these activities can help staff satisfy their various education requirements and compensation for any extra time devoted to such endeavors are important ways to support

staff interest and appreciation of family therapy educational training. The provision of opportunities for ongoing supervision could be a powerful way to communicate a program's commitment to families and the family's role in treatment and recovery and to show support of staff in becoming familiar with new techniques and approaches.

### ***Issues for staff and trainers***

Treatment center staff—from substance abuse counselors to supervisors, nurses, and physicians—are likely to have varied backgrounds in terms of familiarity with family issues and/or family therapy. Therefore, educational activities will need to be appropriate for the participants. Many substance abuse treatment counselors will be familiar with the "family disease model" of substance abuse. Such familiarity is likely to range from being familiar with certain terminology to using the family disease model in individual and group substance abuse treatment, including family involvement. Some counselors or staff will be trained and thoroughly familiar with one or more family therapy treatment systems.

In addition to being sensitive to staff's level of familiarity with the material, trainers must also understand and be sensitive to staff culture. Ways of adapting material for staff to understand and development of new strategies of teaching are the responsibilities of the trainer. Staff may not have the basic knowledge to adapt the new material and might need assistance in understanding how the information is meaningful and applicable to their populations and cultures.

### **Family Education and Participation**

Many substance abuse treatment facilities offer "family counseling" as part of the therapies employed by the treatment program (Office of Applied Studies 2002a). However, the nature of such family counseling can vary widely from one facility or treatment provider to another. The consensus panel recognizes that some

treatment programs may have no or limited family involvement and other programs may vary in the extent of family participation. The consensus panel's focus is on family education and involvement that is informed by the full range of family therapy information and the possibilities presented throughout the TIP. Consequently, family education and participation stresses the importance of the family in substance abuse treatment and calls for changes in the intake assessment process, education of the family, counselor training and caseloads, confidentiality issues, and special followup and outcome measures.

Assessment is one of the most important components of any substance abuse treatment program. When focused on families, an assessment instrument generates data that can help the substance abuse professional identify resources in the family that may promote treatment success. Collecting data about the client's family serves several purposes:

- It yields a more thorough, and perhaps more accurate, family history.
- It presents an opportunity to confirm and clarify information on the client.
- It can provide insight into the context where substance abuse most often occurs and where it may have started or accelerated.
- It sets the tone for a continuing focus on the family.
- It identifies family resources to help plan long-term care.
- It documents specific information that can determine treatment goals.

The importance of enhancing family involvement can be emphasized by staff. The following types of questions encourage further discussion about family dynamics and involvement, emphasizing a strengths-based model. However, staff should be careful about asking for details in a way that may be experienced by the client as an interrogation:

- Who can support you in treatment?
- Do you know someone who is abstinent who can support you?

- Who in the past has been the most helpful to you?
- Tell me about a safe place where you can live.
- Who is taking care of your children while you are in treatment?
- Does anyone in your family use substances?
- Is anyone in your family recovering from substance abuse?
- Have your family members noticed a decline in your substance use?
- How would your family react to your recovery from substance abuse?
- What does your family think about you being here? Did you tell them? Why or why not?
- Is substance use an important part of your family life?
- Who in your family has jobs? Goes to school?
- Who is the last person in your family who saw you cry?
- Where did you eat dinner last Sunday?

Education of the family proceeds along a continuum that includes strategies such as providing Internet access, informal referral and educational opportunities, and printed materials such as pamphlets, videotapes, and reference books. Some tools can help families understand their importance in substance abuse treatment. Modified genograms, for example, help families understand substance abuse from the focus on its history to the larger context of clients' lives (see chapter 3 for more information on genograms). Another example is psychoeducational groups, which can focus on families' strengths and help family members change common behavior patterns that may contribute to conflicts. A family therapy directed strengths-based perspective may help families learn skills to solve conflicts and identify common feelings or thoughts related to substance abuse and families. Psychoeducation can be conducted in groups with several families in a single session, making the approach highly cost-effective. From a clinical perspective, psychoeducational groups may increase a family's sense of support and reduce stigma within and between families.

Family involvement in treatment can also be construed as a continuum based on the level of background and training required for staff to implement family activities into treatment. From the perspective of the treatment process, the introduction of family activities requires accommodation from traditional program activities and orientation. Minimal family activities, such as the construction of a genogram, require limited counselor training and virtually no changes in any other substance abuse program aspects. Family therapy techniques that require a detailed examination of community influences and contingencies for rewarding recovery activities might require significant staff training, significant shifts in program scheduling, and shifts in the relationships among program staff and community resources.

### ***Issues for substance abuse treatment program administrators***

#### ***Counselor training and caseloads***

If counselors improve their skills and are able to do more complex clinical work with families, such expansion of their roles as counselors will place added burdens on them. Working with families will increase the amount of clinical time for each client so overall adjustments in a counselor's caseload might be necessary, especially when one considers that work with families can at times bring with it a heavy emotional burden. Staff burnout prevention needs to be considered, and difficulties with the stressors associated with additional training, information, and so on need to be monitored.

#### ***Confidentiality***

Informed consent and confidentiality issues will require careful consideration by program administrators. Ideally, clients in substance abuse treatment will sign informed consent forms, acknowledging their understanding of the potential risks and benefits of family program activities, and family members (including children, when appropriate) will also sign such forms. Informed consent forms can describe in

detail, for example, the program or staff responsibilities regarding the reporting of information that is required by law (such as elder abuse, child abuse or neglect, infectious disease, or duty to warn—depending on the particular laws of the State or locale and Federal laws). Additionally, separate confidentiality warnings might be included in the informed consent form so that clients and their families realize and agree that the loss of confidentiality resulting from families meeting in groups is understood and agreed to by all.

In regard to confidentiality, there must be strict adherence to all confidentiality laws, including the specific requirements for any and all releases of information.

Substance abuse treatment centers bear a responsibility for ensuring that treatment providers or outside presenters understand the strict requirements of confidentiality imposed by direct Federal laws, State law, and professional ethics within

the substance abuse field. For example, if these issues are not clarified, family members may regard sign-up sheets as violating their confidentiality. If family members sign a log sequentially, the program will illegally disclose to client B that client A is in treatment. These issues become especially complicated when a client identifies as “family” people who are neither related by blood nor by law and wishes to include friends or coworkers.

Education of the family proceeds along a continuum that includes strategies such as providing Internet access, informal referral and educational opportunities, and printed materials.

## Outcomes

Evaluating the outcome benefits and drawbacks of family education activities and new ways of incorporating family techniques into the treatment process can be qualitative or quantitative, simple or complex. Simple questionnaires and feedback sessions are what many program administrators want to consider; some administrators might want to pursue more intensive analyses that employ focus groups and performance measurement techniques that are developed by outside experts. Such performance measurements might include a change in the percentage of clients who agree to have their families participate in treatment, an increase in the number of contacts counselors have with family members, monitoring the number of requests for the program's free materials related to families and treatment, and a host of other possibilities.

## Issues for staff and trainers

Training and supervision issues are similar to those that arise from staff education, but such concerns can reach a higher level of intensity. Being educated about family issues and family therapy might imply certain changes or expectations for counselor behaviors, whereas the

inclusion of family education and family involvement in the treatment process brings the responsibilities and expectations for the counselors to a much higher level. Counselors and staff will be expected to know more, explain nuances to family members, and incorporate any new family program activities into their general style and treatment approach. For this level of family

participation, substance abuse counselors will require significant training and supervision. The professional associations of staff members may offer guidance in terms of suggested or required background or training to meet acceptable standards; and, of course, organizations that traditionally include family therapy modalities usually have standard curricula and training requirements that they promote.

## Provider Collaboration

Collaboration goes beyond referral; it indicates that the substance abuse treatment program and the family social service agency have established an ongoing relationship so that the treatment that takes place at one provider agency is communicated to and influences the course of treatment or services at the other. Such provider collaborations will ensure high-quality referrals, effective outreach, and meaningful partnerships with community resources. Such relationships should encourage family participation in both substance abuse and family-oriented services. Of course, determining what a family needs is a decision to be made in the family and not by the substance abuse treatment provider. From this perspective, the provider encourages empowerment within families to determine their own direction.

Given the complexities of informed consent and confidentiality that arise from adding family education to a program's offerings, developing collaborative relationships with family therapy and related agencies is no easy task. Staff members will be called on to be knowledgeable about family-involved treatment models and services and be familiar with community resources. Matching the resources of various providers with a family's needs and providing the family with information about the pros and cons of various alternatives will require a strong community perspective and resource commitment on the part of the substance abuse treatment agency.

Provider collaborations will ensure high-quality referrals, effective outreach, and meaningful partnerships with community resources.

## ***Issues for substance abuse treatment program administrators***

Resources need to be provided to monitor and ensure that high-quality referrals, outreach, and partnership components are in place within the agency and community. Examples of such resources include

- Family education sessions where families can learn more about substance abuse and family involvement.
- A comprehensive referral system that can facilitate the participation of families and clients in treatment-based, family therapeutic activities.
- Expanded informed consent, which will often be necessary.
- Client and family education about both the benefits and challenges of using any particular provider or service, and clients should understand the relationships among service systems. In addition, program administrators may need to develop “disclaimers” for clients so they understand that a substance abuse treatment agency cannot be responsible for the actions of another agency’s staff or policies.

For many provider collaboration arrangements a memorandum of understanding (MOU) can be developed to help clarify and guide the interrelationships. Coordinated efforts include active involvement of substance abuse staff in the therapeutic process and continuous contact with the family therapist at the external agency. Detailed understanding of each other’s processes and protocols, as well as detailed MOUs, can avoid redundancies and improve quality—for example, if each program screens for mental health issues, coordinating the screening processes will avoid duplication and unnecessary confusion on the part of clients, especially if the different screening approaches were to yield different results. Another example is how the MOU establishes separate responsibilities for on-call service provision and responses to crises.

To ensure adequate communication flow to meet the challenges of coordinating provider activities, program administrators face allocating personnel resources for a variety of tasks, from documentation and information coordination to joint public speaking and presentations. Someone could be designated as the provider collaboration coordinator—perhaps as part of quality assurance duties or a position that implements, monitors, evaluates, supervises, updates, and educates staff about the relationships with other providers. Staff could be assigned duties related to cross-training efforts and participate in each other’s boards, committees, or multiagency efforts.

Program administrators would also have to consider other costs and the taxing of resources by the responsibilities of collaborating with other providers. Confidentiality and informed consent will be repetitive issues, whether it is how to manage group forms of treatment in the other agency or how to address the Health Insurance Portability and Accountability Act (HIPAA) requirements (for more information on HIPAA see the following Web site: <http://www.hhs.gov/ocr/hipaa>). Additional considerations might include policies for non-clients on the treatment premises, space considerations, security, insurance issues to be sure that one’s liability protection remains secure, as well as reimbursement issues.

Evaluation and outcome measurement remain challenges for administrators; yet, provider collaboration might offer opportunities to use instruments developed by other providers, gain feedback from other professionals, and offer clients a chance to express themselves to a neutral party by having one agency survey clients about the client’s views of the other agencies. Supervisors from each agency are likely to be interested in the views of each other’s personnel. The following evaluative questions can be asked in any outcome scenario that involves referring families to other agencies:

- What family members are actually going to the other agency to which they were referred?

- What does the family like about going to the other agency?
- What aspects of treatment from the other agency are helpful?
- What does the other agency provide that this agency also provides?

### ***Issues for staff and trainers***

Staff in both agencies can expand their knowledge about substance abuse education and family resources in the community. Staff members should be informed about family-involved treatment models and provide information using collateral resources to build trust with family members. Supervisors are likely to be called on to help staff accommodate the changes and new information generated by collaboration with other providers.

Staff should learn to avoid “splitting”—that is, where a client regards one provider as “good” and the other as “bad,” with the implicit attempt to get the “good” provider to agree that the other provider is incompetent, ineffective, or corrupt. Sometimes a variant of triangulation, splitting regularly results in the client becoming upset or attempting to use the “split” to avoid responsibility or consequences for behavior. In any case, staff profit from being as well informed as possible about the details of the programs and resources of collaborative providers, especially in terms of cultural competency issues. For example, it can be important to know the extent to which a collaborating provider can provide accommodations for people with disabilities, from accessible bathrooms to assistive technologies.

### ***Recommendations for collaboration***

#### ***Cross-training***

Generally speaking, there is a shortage of (1) well-trained substance abuse treatment professionals, (2) well-trained substance abuse treatment professionals knowledgeable about family issues, and (3) well-trained family therapists who are proficient in traditional substance abuse treatment techniques. The integration of

family therapy into substance abuse treatment programs will have to address these shortages, a goal that could be accomplished—at least in part—through cross-training. Cross-training needs to be addressed in the educational system as well. Requiring a variety of core class work would enable both substance abuse counselors and family therapists to be better equipped to address both substance abuse and mental health issues.

Though ideally counselors would be adequately trained in both family therapy and substance abuse treatment, that ideal is likely to remain the exception rather than the rule. Family therapists can certainly obtain some training in substance abuse treatment, especially in the areas of screening, assessment, motivational enhancement, and relapse prevention, as well as in specific approaches such as cognitive-behavioral therapy or 12-Step programs. Perhaps the first four levels of involvement with families suggested in chapter 4 could accommodate a training approach for family-oriented substance abuse counselors with various levels of training. Additionally, many family therapy techniques—such as telling family stories—can be of great importance in the process of substance abuse treatment engagement.

#### ***Partnerships***

A shift from the individual to the family in substance abuse treatment models would necessitate collaboration, partnership, and joint funding at all levels. One such example was announced in July 2002, involving the Department of Housing and Urban Development (HUD), the Department of Health and Human Services, and the Department of Veterans Affairs, who have joined together to end chronic homelessness within 10 years (U.S. HUD 2002). Collaborations such as this one highlight how the Federal government has begun to recognize and address the fragmentation, duplication, and isolation that exist within and among agencies, a model that could be transposed to the family therapy/substance abuse treatment arena.

*In the community.* One empowering partnership model is a consumer-based collaboration that incorporates community perspectives in the development of substance abuse treatment programs. Inclusion of community members' perspectives can heighten their commitment as key stakeholders, involve them in their own care, and reduce the levels of opposition to substance abuse treatment. It inherently validates the listening process of communities and develops trust. La Bodega de la Familia (see chapter 4 for a more complete description) was the first treatment center accepted unanimously by the community board on the Lower East Side of New York. More than 200 meetings were conducted with community members and police, probation, city council, and community providers, the results of which were used to start the program. This process allowed for the possibility of creating an innovative system of intervention that people want and will use, and does not impose a middle-class family therapy model or a "one-size-fits-all" approach on the community it serves.

It remains to be seen whether a model that shifts the power to the consumer provides reliable outcome or impact data, but it does allow communities to tailor interventions with positive impact. Focus groups and other methods are used to engage communities and learn about how people do or do not use services. A major precaution is that often in an open forum, participants may say what they want, but then do not use the service. It falls on the lead agency to validate the consumer and to operate from the perspective that this is a community-led movement, not a professionally led one. Including consumer voices grounds the validity of the program and shifts the traditional paradigm, while also heeding the voices of substance abuse providers, therapists, and other key stakeholders. An additional benefit is that a consumer-led movement is a strategy that can engage legislators and lay the groundwork for policy shifts related to community-based substance abuse treatment and family involvement.

*In the workplace.* The workplace is another potential partnership area for family therapy and substance abuse treatment. Many Employee Assistance Programs (EAPs) know and make referrals to family therapists who are also knowledgeable about substance abuse. Ongoing research by EAPs on the effectiveness of such referrals and treatment episodes could stimulate others to be more inclusive of familial involvement in substance abuse treatment.

An ancillary issue to this kind of partnership is the potential need for large numbers of people trained in family-involved or family therapy systems work. For example, if the number of families who are served at Level 4 of the model discussed in chapter 4 increases, there may not be enough well-trained clinicians to provide those services. Also, competencies should be designated to guide training on family issues, general family therapy, and family therapy to treat substance abuse.

## **Family Integration**

Programs at the ideal level are fully functional and culturally competent in their operations, policies, procedures, and philosophical approaches as they relate to the integration of family therapy into substance abuse treatment. At this level, adequate infrastructure, financing, and human resources are available to implement and sustain the integrative project. Program activities are based on the strengths of families and an enhanced view of the family as a positive influence and resource. Social,

Staff profit from being as well informed as possible about the details of the programs and resources of collaborative providers.

individual, and family supports are in place to improve family dynamics and prevent relapse.

At this level, a “family culture” is promoted with certain principles about families and substance abuse treatment present throughout the organization and client interactions. Fully integrated programs have multiple staffing patterns with clinical personnel who are educated, comfortable, and competent in substance abuse treatment and family therapy. These programs also have nonclinical staff educated on the importance of family involvement in substance abuse treatment. All clinical staff are cross-trained in family work, substance abuse, and family case management, as well as knowledgeable about social services and other available resources in the community.

### ***Issues for substance abuse treatment program administrators***

The total integration of substance abuse treatment and family-based approaches throughout the organization, its policies, and program practices is a challenge at all levels. Ideally, best practice is formed from

evidence-based, family-supported therapeutic modalities that have been replicated across a variety of populations, have been evaluated rigorously, and are monitored for adherence.

Culturally competent practices are present throughout the organization, its policies, practices, and procedures at this level. In the course of substance abuse treatment and family therapy, close attention is paid to

racial and ethnic influences, class, gender, and spiritual values.

Agency administrators prioritize the integration of families into substance abuse treatment and identify model(s) and therapeutic interventions that best address community needs.

Throughout the agency, the staff has a thorough understanding of how family will be engaged in the substance abuse treatment and family therapy processes, and implementation of treatment is well coordinated.

A comprehensive range of program activities are available, including

- Screening and assessment for substance abuse and family issues
- Substance abuse treatment
- Family therapy or family-involved interventions
- Information and outreach, using multimedia approaches such as the Internet and videos
- Community partnerships
- Education and psychoeducation
- Therapeutic home-based interventions and family case management services
- Individual and family counseling and parent education
- Process and outcome evaluation

Linkages are established with social services agencies, or those that interact with child welfare agencies, to provide assistance with transportation, housing, health care, food, and childcare. Infrastructural concerns are also addressed, such as the availability and use of physical space; the use of multimedia, including the Internet and videos; and the availability of bilingual informational materials.

With full integration, the notion and practice of informed consent are rigorously implemented and enforced. Fundamentally, this requirement means each family member receives clear, accurate information about what will happen when, or if, they engage in substance abuse treatment and family therapy. Informed consent protects clients before, during, and

Programs at the ideal level are fully functional and culturally competent in their operations, policies, procedures, and philosophical approaches.

after treatment. Clients should grant informed consent only when an agreement about treatment objectives has been reached; treatment and available services have been explained; and benefits, risks, possible side effects, and complications are discussed thoroughly (Barker 1998). Clients are also informed of the potential risks of forgoing services, possible alternatives to proposed treatment, and information that links evidence-based support with various services (Marsh 2001). In family therapy, each competent participant gives informed consent for therapy to proceed (Barker 1998).

Confidentiality extends to all individuals in treatment. Exceptions include the need to reveal information to protect clients from harm (such as suicide, homicide, and physical and sexual abuse). Every agency is required to have a formal confidentiality policy to avoid violations of laws, statutes, and accreditation requirements. Policies are also subject to outside mandates. Those agencies that receive Federal funding must comply with Federal regulations, or 42 C.F.R., Part 2, which guarantees strict confidentiality of information about people who have been in treatment for substance abuse. Participant-identifying information must not be disclosed either to other participants (including family members) or to other service providers without a specific release form that complies with the regulations. Program staff may disclose confidential information to other staff members in the same program if it is necessary for the provision of treatment. The regulations stipulate exceptions to the prohibition on disclosure, including medical emergencies, mandated reports of child abuse or neglect, and, in States that mandate it, elder abuse and neglect. The balance between individual needs and those of family members can often turn individual family members against each other during conflict. If staff members are required to divulge such information, all family members should be informed of agency policy and practices.

## ***Issues for staff and trainers***

At this level, all staff—from the receptionist to the executive director—are trained about the important role of the family as a positive influence in the substance abuse treatment process. They have varying degrees of familiarity with the models described in chapter 4. Clinical staff are trained more thoroughly in the tools and techniques of traditional family therapy and multisystemic approaches, public speaking and presentation skills, the relationship between substance abuse and families and partners, and relating with the surrounding ecosystem.

Staff understand the cultural, social, political, and economic forces that affect the various racial and ethnic groups (CSAT 1999b). A culturally competent model of substance abuse treatment and family therapy addresses the sociocultural factors affecting substance abuse patterns among members of various racial and ethnic groups as a crucial prerequisite in providing adequate treatment (CSAT 1999b). From this perspective, adequate treatment is characterized by

- Staff knowledge of the native language of the client, whenever possible
- Staff sensitivity to the cultures of the client populations
- Staff backgrounds representative of those of the client population

Staff are trained in culturally competent strategies that promote respect and dignity for clients and encourage them to discuss issues without inhibition or fear of termination.

At this level, all substance abuse counselors are certified and clinicians are licensed family therapists or licensed professionals with advanced training in family therapy. Continuing education about various approaches to family work and substance abuse treatment is necessary and supported. Ongoing training in other topics such as domestic violence, child abuse and neglect, elder abuse and neglect, posttraumatic stress disorder, and cardiopulmonary resuscitation is also recommended. All staff members are

cross-trained in family-based approaches and substance abuse treatment.

Clinical supervisors are licensed family therapists or have completed advanced specialized training and coordinate the work in substance abuse treatment and family therapy.

Supervisors should have specific experience in family-based modalities and family therapy. Supervisors also need to be informed about a range of auxiliary topics, including childcare, liability concerns related to children, provision of space, and documentation.

## Other Program Considerations

### Cultural Competence

An organizational culture that is infused with the values of cultural competence and diversity on every level will highlight and implement such values concretely in staffing patterns, language, and cultural issues related to families and substance abuse. Concerted efforts should be made to hire staff and build an organizational culture that reflects the diversity of the client populations served. Program assessments are achieved by exploring institutional assumptions regarding services for specific racial and ethnic communities. This information is used to reduce bias resulting from institutional misperceptions and cultural ignorance or inexperience. For more information about cultural competence, including organizational cultural competence, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development b).

### Outcome Evaluation Procedures and Reports

Some outcome evaluation procedures include the development of standard measures to determine the treatment program's efficacy; data collection and database development, which generally require more intensive procedures; and the examination of the

relationship between utilization and outcome for every family member treated.

To determine the substance abuse treatment program's efficacy, tracking procedures can be used to record the number of clients returning to the workforce, those involved with medical service providers, and whether treatment correlates with a reduction in the number of client arrests.

Outcomes for family members are examined by the relationship between utilization and outcome, the number of times the client and family members were seen, and the relationship to outcomes. Because the treatment program is in-house, utilization rates can be monitored closely.

Culturally competent evaluation plays a significant role in facilitating outcome evaluation. To be effective, culturally competent evaluation relies heavily on an in-depth understanding of the role that culture plays in substance abuse (Cervantes and Pena 1998). Evaluators should incorporate cultural factors such as acculturation, language, family values, and community attitudes into evaluation design (Cervantes and Pena 1998). Additionally, culturally relevant instruments are critical to the overall evaluation effort. Knowledge of the sociocultural, demographic, and psychological factors specific to the cultural group is necessary. If the evaluation design does not include cultural differences, incorrect conclusions may be drawn about program effectiveness (Cervantes and Pena 1998). An understanding of risk and protective factors as they relate to culture is important in evaluation efforts as well as understanding resiliency factors in a culture.

### Long-Term Followup

Monitoring rearrests, recidivism, and readmission to substance abuse treatment programs can serve as measures of long-term functioning. Collection of long-term followup data is difficult and rare in healthcare treatment research in general, and especially in the substance abuse field. Vaillant (1995) provides

family related outcome measures such as marital happiness. Though Hser et al. (2001) present significant long-term research outcomes in narcotics treatment, the consensus panel knows of no such long-term followup with a focus on family.

## Directions for Future Research

Since its advent in the 1950s, family therapy has been characterized as having theoretical roots that are anecdotal, intuitive, and empirical, rather than scientific (Barker 1998). That opinion may stem mainly from (1) the separation between researcher and therapist, which exists in all mental health disciplines, and (2) the development of family therapy as an outgrowth of studies conducted on family research into schizophrenia, the mostly unscientific results of which were then extrapolated to a wider range of family problems (Barker 1998). In the absence of a well-articulated conceptual framework, it is impossible to draw definitive conclusions about the efficacy of family therapy (Collins 1990). Research in several areas could serve to address this issue.

### New Treatment and Therapy Models

Many advances are being made in the field of family-based treatment for adolescent drug abuse that can serve as pilot models for adult treatment. One valuable insight has been the general shift from focusing exclusively on individual or family variables to change or improve treatment outcomes for adolescents and adults to more complex, multicomponent interventions that incorporate more dimensions and domains in and outside the family (Liddle and Dakof 1995a). This movement has culminated in the perspective that multicomponent, comprehensive, community-based, multisystemic approaches must be supported to reap the best outcomes. Ideally, such comprehensive coordinated efforts can be meshed with other related ones—domestic violence, for example—

to develop a coordinated community response to a variety of issues that can fit well with multisystemic responses to substance abuse and family involvement. Unfortunately, within the family therapy and family-focused intervention domains, the need for more comprehensive strategies is often outweighed by the complexity of making them viable and implementing them within communities. Cultural and linguistic barriers and a lack of trained bilingual and bicultural staff make this task even more challenging.

Another possible research area relates to the critical need to describe, measure, and report on the process of therapy itself. Investigators would have to make sure that the therapy methods chosen are actually being implemented, making it possible to determine outcomes and identify reliable, therapeutic methods that can help families make desirable changes. As newer forms of family therapy emerge, it is unknown whether radically new approaches to research will be required.

### Assessment and Classification

A second area for future research is in the assessment and classification process used to determine the type, duration, and intensity of family therapy. Currently, no valid, reliable, acceptable way to categorize families by the way they interact has emerged (Barker 1998). Developing one has been difficult primarily because the diversity of families defies easy categorization. Blended families, gay and lesbian families, adoptive families, as well as

An organizational culture that is infused with the values of cultural competence and diversity on every level will highlight and implement such values concretely.

Another possible research area relates to the critical need to describe, measure, and report on the process of therapy itself.

those with divergent religious beliefs and cultural norms and values, are just a few variations (Barker 1998). Despite attempts at categorization, classifications have relied typically on uncritical understandings of developmental models that purport to designate the particular stage families *should have* reached, based on the ages of children and the stage the family *has* reached

(Barker 1998).

Classical definitions notwithstanding, what researchers and therapists need to classify and assess are *relationships* and the measurement of change in relationships in valid, reliable ways. Should success be measured in terms of the presenting problem of the client or in terms of the change in the family system? Specifying the goals and interventions used would permit clearer comparisons of the two approaches (Collins 1990). Further, how do culturally competent understanding and values regarding the role of families figure into traditional models of family development? The need for more explicit categorizations and assessment methods must be addressed.

## Outcome Measurement

A third research area concerns the need for outcome research. Many researchers have proposed guidelines for the design of family therapy research, including the need for studies to have clinical relevance, standardized treatment manuals, and resolve the debate between the reliability of comparative studies and “within-model comparisons” (Barker 1998). Collins (1990) recommends consideration of objective outcomes (not just self-reported

information) and the measurement of a wide range of outcomes, such as the ability to hold a job, manage finances, or stay married.

## Prevention

Prevention strategy is another area that holds promise for future research. A small but growing number of programs are testing whether family-based interventions can serve as prevention or early intervention strategies (particularly with problem drinking). Family therapy researchers could benefit from more clearly defining what a healthy family is as much as what a dysfunctional family is. All these efforts are important in exploring whether preventive strategies can improve family functioning and prevent family pathology. Prevention opportunities exist in schools (truancy, deviant behaviors, expulsion), in the workplace (poor attendance, identified mental health and substance abuse problems), and in churches (families might ask for help around a specific family problem from a pastor, priest, or other spiritual leader).

## Technology

A fifth research area relates to technological advances that have the potential to benefit substance abuse treatment efforts, namely the Internet and e-mail. King and colleagues (1998) explored the use of the Internet as a tool to assist family therapy, especially where family members are geographically separated. The researchers also studied the potential value and use of e-mail and writing to facilitate family therapy.

The advantages of e-mail communication in family therapy include allowing family members to contribute whenever their schedules permit, delay responses until they have been fully thought out, and create a permanent record, which reduces the risk of misunderstanding. One drawback for e-mail communication is possible misinterpretation due to lack of tonal cues. Other uses of writing in family therapy include personal narrative, programmed writing, and letter writing, all of which can be

communicated via e-mail. The use of e-mail may make family therapy possible at times when it would otherwise not be feasible.

Another key element that is being used is remote telemedicine. This use of cameras and monitors has been an excellent way to overcome some of the barriers in rural areas where both coverage and transportation have in the past prevented consistent involvement in treatment.

## **Additional Possibilities**

Clear information is also needed in the following areas:

- How effective are various approaches to family therapy in substance abuse treatment?
  - How should family therapy be tailored to be appropriate with specific populations?
  - How do agencies increase the rate of engagement of families? What role does cultural competence play in the engagement and retention of clients?
  - Does the classic family therapy model fit across ethnic groups? If not, what are more feasible options?
- How can competence with families be developed?
  - How can the resources of families and communities be identified and mobilized?
  - What family differences are important in the treatment of youth, adults, and specifically children?
  - What kinds of research and models can increase our understanding of the family role in relapse?
  - How will these efforts be funded?
  - What changes need to take place for both private and public payment of these services?

The oversimplification of the above might lead some readers to feel as if there is a wide gap between family therapy and substance abuse treatment and that it is a giant leap to move from doing one to doing the other. However, this is not the case. Many people have amended and augmented their customary way of doing their job with input from the other field, and it is certainly not the intent of this TIP to leave the reader with the idea that drawing from the other field requires great change or effort. Rather, the exact opposite is the goal.

# Appendix B:

## Glossary

### **Affect**

Feeling or emotion, especially as manifested by facial expression or body language.

### **Affective/spiritual acculturation**

A family's sense of connectedness to its ethnic traditions.

### **BCT**

Behavioral couples therapy.

### **Behavioral acculturation**

The degree to which a family participates in traditional or dominant-culture activities as opposed to other culture-specific activities.

### **BMT**

Behavioral marital therapy.

### **Boundary**

An invisible though often effective barrier within a relationship that governs the level of contact. Boundaries can appropriately shape and regulate relationships. Two dysfunctional types of boundaries are those that are (1) so rigid, inhibiting meaningful interaction so that the people in the relationship are said to be “disengaged” from each other, or (2) so loose that individuals lose a sense of independence so that the “enmeshed” relationship stifles individuality and initiative.

### **CBT**

Cognitive-behavioral therapy.

### **Codependence**

A state of being overly concerned with the problems of another, to the detriment of one's own wants and needs.

### **Cognitive acculturation**

A client's grasp of and the extent of his involvement in the customs, beliefs, values, and language of a given culture.

**Complementarity**

A pattern of human interactions in which partners in an intimate relationship establish roles and take on behavioral patterns that fulfill the unconscious needs and demands of the other.

**Disengagement**

The state of being unreachably aloof or distant from others.

**Ecological view of substance abuse**

A conception of substance abuse that is analogous to that of an ecological system in nature. Substance abuse occurs within a complex of systems, including families, communities, and societies. It may be assumed that all of the elements of this “ecological” system will have some influence on all the other elements.

**Enmeshment**

The state of being in which two people are so close emotionally that one perceives the other as “smothering” him or her with affection, concern, attention, etc. Enmeshment also can occur without a conscious sense of it.

**Family structure**

Repeated, predictable patterns of interaction between family members that influence individual behavior to a considerable extent.

**Family therapy**

An approach to therapy based on the idea that a family is—and behaves as—a system. Interventions are based on the presumption that when one part of the system changes, other parts will change in response. Family therapists therefore look for unhealthy structures and faulty patterns of communication.

**Family-involved therapy**

The programmatic involvement of family members in the substance abuse treatment program to correct family relationships that provoke or support continued substance abuse. Family-involved therapy is distinct from family therapy in that it may not view the entire family as the object of therapeutic interest and may not always intervene in the family’s relational system.

**Genogram**

A pictorial chart of the people involved in a three-generational relationship system, marking marriages, divorces, births, geographical location, deaths, and illness. Significant physical, social, and psychological dysfunction may be added. A genogram assists the therapist in understanding the family and is used to examine a family’s relationships.

**Homeostasis**

A natural process in which multigenerational competing forces seek to maintain a state of equilibrium (i.e., balance).

**Idiopathic**

Of, relating to, or designating a disease having no known cause.

**Integrated models**

A constellation of interventions that takes into account (1) each family member’s issues as they relate to the substance abuse and (2) the effect of each member’s issues on the family system.

**IP**

Identified patient.

**MFT**

Marriage and family therapy.

**One-person family therapy**

Therapy incorporating a family focus without treating the whole family.

**Phases of family change**

A model of family change that includes three elements occurring in a series: attainment of sobriety, adjustment to sobriety, and long-term maintenance of sobriety.

**Psychoeducation**

A combination of information about substance abuse and recovery, group support, and examination of interactions that result in conflict. Facilitators collaborate with the family to change these provocative interactions, reduce household stress, and create an atmosphere conducive to recovery.

**Social/environmental acculturation**

A family's patterns of socialization or acquisition of familiarity with its social and environmental elements.

**Somatic**

Of, relating to, or affecting the body.

**Stages of change**

One model of the phases of substance abuse recovery: precontemplation, contemplation, preparation, action, and maintenance.

**Traditional family**

The nuclear family (two parents and minor children all living under the same roof), single parent, and families including blood relatives, foster relationships, grandparents raising grandchildren, and stepfamilies.

**Triangulation**

This 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.

# Appendix C: Guidelines for Assessing Violence

It is up to therapists to assess the potential for anger and violence and 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 included recommended guidelines for the screening and treatment of people caught up in the cycle of domestic violence. These recommendations are adapted from TIP 25, *Substance Abuse Treatment and Domestic Violence* (Center for Substance Abuse Treatment 1997b).

If during the screening interview, it becomes clear that a batterer is endangering a client, 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 to a domestic violence program and possibly to a shelter and legal services.

## ***Screening guidelines for domestic violence and other abusive behavior***

1. To determine if someone has endured domestic violence, look for physical injuries, especially patterns of untreated injuries to the face, neck, throat, and breasts. Other indicators may include
  - Inconsistent explanations for injuries and evasive answers when questioned about them
  - Complications in pregnancy, including miscarriage, premature birth, and infant illness or birth defects
  - Stress-related illnesses and conditions such as headache, backache, chronic pain, gastrointestinal distress, sleep disorders, eating disorders, and fatigue
  - Anxiety-related conditions, such as heart palpitations, hyperventilation, and panic attacks

- A sad, flat affect or talk of suicide
  - History of relapse or noncompliance with substance abuse treatment plans
2. Always interview clients about domestic violence in private. Ask about violence using concrete examples and hypothetical situations rather than vague, conceptual questions. Screening questions should convey to survivors that no battering is justified and that substance abuse is not an acceptable excuse for violent behavior.
  3. As soon as it is clear that a client has been or is being battered, domestic violence experts should be contacted.
  4. The provider should contact a forensics expert to document the physical evidence of battering.
  5. Referrals should be made whenever appropriate for psychotherapy and specialized counseling. Staff training in domestic violence is important so that substance abuse treatment counselors can respond effectively to a domestic violence crisis.
  6. A survivor of domestic violence who relocates to another community should be referred to the appropriate shelter programs within that community.
  7. Because batterers in treatment frequently harass their partners (threatening them by phone, mail, and messages sent through approved visitors), telephone and visitation privileges of batterers and survivors in residential substance abuse treatment programs should be carefully monitored.
  8. The discussion of family relationships, which is an element of all substance abuse screening interviews, can be used to identify domestic violence and gauge its severity.
  9. A good initial question to investigate the possibility that a client is abusing family members is, “Do you think violence against a partner is justified in some situations?” A third-person example may be used, followed by specific, concrete questions that define the extent of the violence:
    - What happens when you lose your temper?
    - When you hit (person), was it a slap or a punch?
    - Do you take car keys away? Damage property? Threaten to injure or kill (person)?
  10. Once it has been confirmed that a client has been abusive—whether physically, sexually, or psychologically—the provider should contact a domestic violence expert, either for referral or consultation. Treatment providers should ensure that the danger the batterer poses is carefully assessed.
  11. The provider should be direct and candid, avoiding vague or euphemistic language, such as, “Is your relationship with your partner troubled?” Instead, ask about “violence,” and keep the focus on behavior.
  12. Become familiar with batterers’ rationalization and excuses for their behavior:
    - *Minimizing*: “I only pushed her.” “She bruises easily.” “She exaggerates.”
    - *Claiming good intentions*: “When she gets hysterical, I have to slap her to calm her down.”
    - *Blaming intoxication*: “I was drunk.” “I’m not myself when I drink.”
    - *Pleading loss of control*: “Something snapped.” “I can only take so much.” “I was so angry, I didn’t know what I was doing.”
    - *Faulting the partner*: “She drove me to it.” “She really knows how to get to me.”
    - *Shifting blame* to someone or something else: “I was raised that way.” “My probation officer is putting a lot of pressure on me.” “I’ve been out of work.” Substance abuse treatment providers should frame screening questions so that they do not allow a batterer to blame the person battered or a drug.

13. When treating a client who batters, providers should try to ensure the safety of those who have been or may be battered (partners and children, usually) during any crisis that precedes or occurs during the course of his treatment.
14. Treatment providers should mandate that batterers sign a “no-violence contract” stating that the client will refrain from using violence in- and outside the program.
15. Treatment providers should determine the relationship between the substance abuse and the violent behavior:
  - When you take/drink (substance), exactly when does the violence occur?
  - How much of your violent behavior occurs while you are drinking or on other drugs?
  - What substances lead to violence?
  - What feelings do you have before and during the use of alcohol or other drugs?
  - Do you use substances to get over the violent incident?
16. After identifying the chain of events that precedes or triggers violent episodes, the provider and client should formulate strategies for modifying those behaviors and recognizing emotions that contribute to violent behavior.
17. Providers of services to clients who batter should watch for signs that the clients are misinterpreting the 12-Step philosophy to excuse continued violence. For example, the first step is admitting powerlessness over alcohol. Thus the client may be one short rationalization away from excusing a violent act while intoxicated, which is later justified because the substance “made me do it.” Another danger is that batterers will call their partners “codependent” to shift blame for battering to the person harmed.
18. Referrals to self-help aftercare groups such as Batterers Anonymous should be made

only after the client has completed a batterers’ intervention program and has remained nonviolent for a specified period of time.

## **Screening for child abuse**

19. Inquiries into possible child abuse should not occur until the limits of confidentiality, as defined in Title 42, Part II, of the Code of Federal Regulations (or 42 C.F.R. II) have been explained and the client has acknowledged receipt of this information in writing. Clients also must be informed that mandated reporters (such as substance abuse treatment providers) are required to notify a child protective services agency if they suspect child abuse or neglect.
20. During initial screening, the interviewer should attempt to determine whether a client’s children have been physically or emotionally harmed and whether their behavior has changed. Have they become mute? Do they scream, cry, or act out?
21. The substance abuse treatment provider should not assess children for abuse or incest. Only personnel with special expertise should perform this delicate function. The treatment provider should, however, note any indications of child abuse occurring in a client’s household and pass these suspicions on to the appropriate agency.
22. Indications of child abuse that can crop up in a client interview include:
  - Has a protective services agency been involved with anyone who lives in the home?
  - Do the children’s behaviors, such as bedwetting or sexual acting out, indicate abuse?
  - Is extraordinary closeness noted between a child and another adult in the household?
  - Does the client report blackouts? (Batterers often claim to black out during a violent episode.)

23. If a treatment provider suspects that a client's child has been violently abused, the provider must immediately refer the child to a health care provider. If the parent will not take the child to a doctor (who is required by law to report suspected abuse), the provider must contact home health services or child protective services.
24. If the treatment provider reports suspected or definite child abuse or neglect, the provider must assess the impact on any client also being battered and develop a safety plan if one is deemed necessary.
25. Providers should be aware that if a child has been or is being abused by the mother's partner, it is likely that the mother is also being abused.

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