Chapter 3 Approaches to Therapy

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

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

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

Differences in Theory and Practice

Theory

The fields of substance abuse treatment and family therapy share many common assumptions, approaches, and techniques, but differ in significant philosophical and practical ways that affect treatment approaches and goals for treatment. Further, within each discipline, theory and practice differ. Although of the two, substance abuse treatment is generally more uniform in its approach, in both cases certain generalizations apply to the practice of the majority of providers. Two concepts essential to both fields are denial and resistance presented by clients.

Denial and Resistance

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

In substance abuse treatment, the term *denial* is generally used to describe a common reaction of people with substance use disorders who, when confronted with the existence of those disorders, deny that they have a substance abuse problem. This is a complex reaction that is the product of psychological and physiological factors, especially those concerned with memory and the influence of euphoria produced by the substance of abuse. It is not a deliberate, willful act on the part of the person who is abusing substances but is rather a set of defenses and distortions in thinking caused by the use of substances. Family therapists' understanding of the term *denial* will vary more according to the particular therapist's theoretical orientation. For example, structural and strategic therapists might see denial as a *boundary issue* (referring to a barrier within the family structure of relationships), which may be necessary for maintaining an alliance or contributing to relationships that are too close or *enmeshed.* On the other hand, a solution-focused therapist might see denial as a strategy for maintaining stability and therefore not a "problem" at all, while a narrative therapist will simply see denial as another element in a person's story.

Resistance is, in contrast, a relatively straightforward negative response to someone expecting you to do something that you do not want to do. The clinician can minimize resistance by understanding the client's stage of change and being prepared to work with the client based on interventions geared to that stage. If clinicians treat individual clients (or their families) at their actual stage of readiness or level of motivation to change, they should encounter minimal client resistance. In other words, clinicians can only do so much when a client is not ready to change or try a new behavior. Still, counselors can help the client move slowly from one stage of change to another. If treatment is in sync with readiness for that treatment, resistance should not become a significant problem.[1]

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

There is a difference between the therapist saying (or believing) "You refuse to do _____" and saying/believing, "Let's explore what could be in the way of your doing _____." One way of dealing with client resistance is to offer the client some typical reasons for not complying: e.g., "Sometimes, when a client is unable to talk about his early childhood, it is because he is ashamed or embarrassed or afraid of crying or perhaps that I (the therapist) might think the information is bizarre. I wonder if this is something that is going on with you?" The same technique works with resistance to therapeutic suggestions for carrying out a plan constructed during a therapy session: "Sometimes, a client does not carry out the plan we've made because I was moving too fast or perhaps didn't know all of the dynamics that you find when you get home, or maybe because we didn't talk enough about the potential consequences for carrying out the action, for instance, maybe your child will run away or you need to try some other things first."

Source: Consensus Panel.

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

Many substance abuse treatment counselors base their understanding of a family's relation to substance abuse on a *disease model* of substance abuse. Within this model, practitioners have come to appreciate substance abuse as a "family disease"—that is, a disease that affects all members of a family as a result of the substance abuse of one or more members and that creates negative changes in their own moods, behaviors, relationships with the family, and sometimes even physical or emotional health. In other words, the individual member's substance abuse and the pain and confusion of the family relate to each other as cause and effect. Berenson and Schrier (1998) note that the disease model is pragmatic in orientation, having developed typically through practice and not having been drawn from theory or controlled experimentation. The disease model also views substance use disorders as having a genetic component and as being similar to recurrent medical diseases in that both are "chronic, progressive, relapsing, incurable, and potentially fatal" (Inaba et al. 1997, p. 66).

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

This theoretical perspective emphasizes reciprocal relationships. Substance abuse is believed to interact with dysfunctional family relationships, thereby maintaining both problems. Family therapists believe that interpersonal relationships need to be altered so that the family becomes an environment within which the person abusing substances can stop or decrease use and the needs of family members can be met. Family systems approaches have been developed out of a strong theoretical tradition, but do not have many empirical studies validating their effectiveness (Berenson and Schrier 1998). (See TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* [Center for Substance Abuse Treatment (CSAT) 1999*a*], for more information on the specific approaches to family therapy, all of which draw on a systems model.)

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

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

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

Practice

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

Family interventions

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

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

Spirituality

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

Process and content

Family therapy generally attends more to the *process* of family interaction, while substance abuse treatment is usually more concerned with the planned *content* of each session. The family therapist is trained to observe the interactions of family members and employ treatment methods in

response to those observations. Some family therapists may even see a client's substance abuse as a content issue (and therefore less significant than the family interactions).

For example, a wife might begin describing how upset and hopeless she felt when her husband had a slip, only to be interrupted by him in a subtly threatening tone and/or condescending manner. The family therapist might zero in on whether the husband regularly interrupts and aggressively changes the course of a conversation whenever his wife expresses emotions—in other words, is what just occurred an instance of a general pattern of interaction (process) between husband and wife? And, what is the purpose/goal of the process—is it the husband's way of avoiding emotions or of avoiding his own disappointment about the slip and inability to have protected his wife from the consequence of illness? On the other hand, a substance abuse counselor might concentrate on the content of the issues raised by the interchange—that is, the counselor might point out to the husband that alcoholism is a family disease, that his slip does have serious consequences, and that his slip and his wife's initial upset and hopelessness are how the disease of alcoholism separates the person with the substance abuse disorder from what is held dear. The counselor might further focus on the content issues of handling slips, learning from them, and recognizing that they are sometimes part of a successful recovery.

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

Focus

Even when treating the same clients with the same problems, clinicians in the fields of family therapy and substance abuse treatment typically focus on different targets. For instance, if a man who has been abusing cocaine comes with his wife to a substance abuse treatment program, the counselor will identify the substance abuse as the presenting problem. Initially, at least, the substance abuse counselor will see the primary goal as arresting the client's substance use.

A family therapist, on the other hand, will see the family system—which could be just the couple—as an integral component of the substance abuse. The goals of the family therapist will usually be broader than the substance abuse counselor's, focusing on improving relational patterns throughout the family system. Because families change their patterns of interaction over the course of recovery, they are believed to need continued assistance to avoid developing another dysfunctional pattern.

Identity of the client

Most often the substance abuse counselor regards the individual with the substance use disorder as the primary person requiring treatment. While practitioners from both fields would generally agree that a client with a substance use disorder needs to stop using substances, they may not agree on how that end can best be accomplished. A common assumption in substance abuse treatment is that the problems of other family members do not need to be resolved for the client to achieve and maintain abstinence. The substance abuse treatment provider may involve the family to some degree, but the focus remains on the treatment needs of the person abusing substances. The family therapy community assumes that if long-term change is to occur, the entire family must be treated as a unit, so the family as a whole constitutes the client. Unfortunately, such integrated treatment is not always possible because of lack of funding.

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

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

Self-disclosure by the counselor

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

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

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

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

Regulations

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

Confidentiality issues for family therapists are less straightforward. For example, family therapists working with adolescents will have more trouble dealing with issues of client–therapist boundaries and confidentiality. Sometimes when treating adolescents who abuse substances, past or planned criminal behavior is evident. A strong interest in family therapy is restoring the authority of parents, yet State law might restrict the therapist's right to divulge information to parents unless the adolescent signs a properly worded release document. Laws differ from State to State, but they can be specific and strict about what therapists are required or permitted to do about reporting crime or sharing information with parents. For more information on this subject see TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999*e*).

Licensure and certification

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

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

NAADAC (The Association for Addiction Professionals, formerly the National Association of Alcohol and Drug Abuse Counselors) also provides certification in many States that also have IC&RC reciprocity. For substance abuse counselors at the most basic level, NAADAC demands less monitoring and fewer requirements than does IC&RC, though its higher-level credentials have many more requirements than those at the basic level.

NAADAC offers the only Master's level credential based on education and not experience. NAADAC's Web site is www.naadac.org. In addition, the Addiction Technology Transfer Centers, which are partially funded by CSAT, provide information at the Web site www.nattc.org with links to State, national, and international bodies that credential counselors. However, there is little training and few credentialing requirements for understanding the impact of addiction on children and effective ways to help them.

Assessment

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

Assessment in substance abuse treatment

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

Figure 3-1 Overview of Key Elements for Inclusion in Assessment

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

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

Skinner Trauma History

Since your 18th birthday, have you

- Had any fractures or dislocations to your bones or joints?
- Been injured in a road traffic accident?
- Injured your head?
- Been injured in an assault or fight (excluding injuries during sports)?
- Been injured after drinking? *Source:* Skinner et al. 1984.

Alcohol and Drug Use History

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

Family/Social History

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

Sexual History: Sample Questions and Considerations

- Sexual orientation/preference—"Are your sexual partners of the same sex? Opposite sex? Both?"
- Number of relationships—"How many sex partners have you had within the past 6 months? Year?"
- Types of sexual activity engaged in; problems with interest, performance, or satisfaction—"Do you have any problems feeling sexually excited? Achieving orgasm? Are you worried about your sexual functioning? Your ability to function as a spouse or partner? Do you think drugs or alcohol are affecting your sex life?" (A variety of drugs may be used or abused in efforts to improve sexual performance and increase sexual satisfaction; likewise, prescription and illicit drug use and alcohol use can diminish libido, sexual performance, and achievement of orgasm.)
- Whether the patient practices safe sex (research indicates that substance abuse is linked with unsafe sexual practices and exposure to HIV).

- Women's reproductive health history/pregnancy outcomes (in addition to obtaining information, this item offers an opportunity to provide some counseling about the effects of alcohol and drugs on fetal and maternal health).

Mental Health History: Sample Questions and Considerations

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

Source: CSAT 1997*a*.

Substance abuse counselors may not be familiar with ways family therapy can complement substance abuse treatment. Because of their focus on substances of abuse and the intrapsychic dynamics of the identified patient (IP), counselors simply may not think of referral for family therapy. Other counselors may view conflict in a family as a threat to abstinence and a reason to keep that family out of the treatment process. For safety reasons, the seriousness of conflict should be assessed, and the client will need some time to adjust and build rapport with the counselor before being introduced to family therapy.

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

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

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

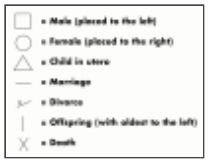
Family therapy assessments focus on family dynamics and client strengths. The primary assessment task is the observation of family interactions, which can reveal patterns such as triangulation (which is a means of evading confrontation between two people by bringing a third person into the issue) along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

In addition to an assessment of dysfunction and strengths, family therapists should be trained and experienced in screening for substance abuse and be familiar with the role that substance abuse plays in family dynamics. Although most family therapists screen for mental or physical illness and physical, sexual, or emotional abuse, issues of substance abuse might not be discovered because the therapist is not familiar with questions to ask or cues provided by clients. Some family therapists may extend the evaluation to how multiple systems (family of origin, family of choice, schools, workplaces) affect the client family at hand.

Genograms

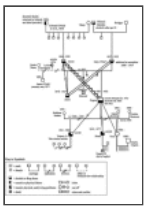
One technique used by family therapists to help them understand family relations is the genogram—a pictorial chart of the people involved in a three generational relationship system, marking marriages, divorces, births, geographical location, deaths, and illness (McGoldrick and Gerson 1985). This

is typically explained to the client during an initial session and developed as sessions progress, is used for discussion points, and is especially helpful when client and therapist reach a point of being "stuck" in the therapeutic process. Genograms can be used to help identify root causes of behaviors, loyalties, and issues of shame within a family. Working on a genogram can create bonding and increased trust between the therapist and client (seeFigure 3-2).



Figure

Basic Symbols Used in a Genogram. The genogram reproduced in Figure 3-3 depicts five generations in Eugene O'Neill's family. The family history shows a pattern of substance abuse and suicide. O'Neill described his own family, (more...)



Figure

Eugene O'Niell Genogram. *Source:* Reprinted with permission from McGoldrick 1995. Rarely will an IP and/or family enter treatment with the detailed knowledge of their family over generations as revealed in the above diagram of Eugene O'Neill's (more...)

The genogram has become a basic tool in many family therapy approaches. Significant physical, social, and psychological dysfunction may be added to it. Though the preparation of a genogram is not standardized, most of them begin with the legal and biological relationships of family members. They may also note family members' significant events (such as births, deaths, and illnesses), attributes (religious affiliation, for instance), and the character of relationships (such as alliances and conflicts). Different genogram styles search out different information and use different symbols to depict relationships. In addition, a genogram can show "key facts about individuals and the relationships of family members. For example, in the most sophisticated genogram one can note the highest school grade completed, a serious childhood illness, or an overly close or distant relationship. The facts symbolized on the genogram offer clues to the family's secrets and mythology since families tend to obscure what is painful or embarrassing in their history" (McGoldrick 1995, p. 36). A *family map* is a variation of the genogram that arranges family members in relation to a specific problem (such as substance abuse).

Genograms enable clinicians to ascertain the complicated relationships, problems, and attitudes of multigenerational families. Genograms can also be used to help family members see themselves and their relationships in a new way (McGoldrick and Gerson 1985). The genogram can be a useful tool for substance abuse treatment counselors who want to understand how family relationships affect clients and their substance abuse. Figure 3-2 shows the basic symbols used to construct a genogram.

Screening and assessment issues

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

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

All family therapists should be able to perform a basic screening for substance abuse. In a survey of its membership, the AAMFT found that the great majority (84 percent) reported screening someone for abuse within the previous year (Northey 2002). An overwhelming majority (91 percent) had referred a client to a substance abuse treatment provider, though few of the therapists routinely diagnosed or treated substance abuse (Northey 2002). As part of their professional preparation, AAMFT-certified family therapists are trained to use the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revised (DSM-IV-TR) (APA 2000), which presents standard definitions of

substance use disorders. Some simple screening instruments for substance use disorders can be found in TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT 1994*f*), and TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997*a*). More specific information on screening instruments for use with adolescents can be found in TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*c*).

Constraints and Barriers to Family Therapy and Substance Abuse Treatment

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

Contextual factors that affect motivation and resistance

The differential influence of power

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

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

Of course, it is not desirable to cast a person abusing substances as a totally powerless entity. Many clients who abuse substances already may feel economically or socially powerless, and some others may belong to a culture that does not emphasize individual control over destiny. For these clients, especially, it is important to stress that recovery is within their power to accomplish and that it is something that they can choose to accomplish (Krestan 2000).

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

Stages of change

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

The stages of change model has been helpful for understanding how to enhance clients' motivation. During the recovery process, individuals typically progress and regress in their movement through the stages. Stages of change have been described in several ways, but one especially helpful concept (Prochaska et al. 1992) divides the process of changing into five stages:

- *Precontemplation*. At this stage, the person abusing substances is not even thinking about changing drug or alcohol use, although others may recognize it as a problem. The person abusing substances is unlikely to appear for treatment without coercion. If the person is referred, active resistance to change is probable. Otherwise, a person at this stage might benefit from non-threatening information to raise awareness of a

possible problem and possibilities for change. While families in this stage may think, "This has to stop!" they frequently resort to often-used defenses such as protecting, hiding, and excusing the IP. When the IP is in the precontemplation stage, the therapist works to establish rapport and offer support for any positive change.

- *Contemplation*. A person in this stage is ambivalent and undecided, vacillating over whether she really has a problem or needs to change. A desire to change exists simultaneously with resistance to change. A person may seek professional advice to get an objective assessment. Motivational strategies are useful at this stage, but aggressive or premature confrontation may provoke strong resistance and defensive behaviors. Many contemplators have indefinite plans to take action in the next 6 months or so. In this stage, families waver between "She can't help it" and "She won't do anything." The level of tension and threat rises. The role of the therapist is to encourage ambivalence. Helping the IP to see both the pros and cons of substance use and change helps her to move toward a decision. Client education is an effective tool for creating ambivalence.
- *Preparation*. In this stage, a person moves to the specific steps to be taken to solve the problem. The person abusing substances has increasing confidence in the decision to change and is ready to take the first steps on the road to the next stage, action. Most people in this stage are planning to take action within the next month and are making final adjustments before they begin to change their behavior. One or more family members in this stage begin to look for a solution. They may seek guidance and treatment options. Here, the therapist's role is to encourage the person to work toward his goal. The goal may be as simple as creating a written record of every drink during the time between sessions.
- *Action*. Specific actions are initiated to bring about change. Action may include overt modification of behavior and surroundings. This stage is the busiest, and it requires the greatest commitment of time and energy. Commitment to change is still unstable, so support and encouragement remain important in preventing dropout and regression in readiness to change. At this point the forces for change in a family reach critical proportions. Ultimatums and professional interventions are often necessary. The role of the therapist is to encourage the person and continue providing client education to reinforce the decision to stop substance abuse.
- *Maintenance*. Day-to-day maintenance sustains the changes prior actions have accomplished, and steps are taken to prevent relapse. This stage requires a set of skills different from those that were needed to initiate change. Alternative coping and problemsolving strategies must be learned. Problem behaviors need to be replaced with new, healthy behaviors. Emotional triggers of relapse have to be identified and planned for. Gains have been consolidated, but this stage is by no means static or invulnerable. It lasts as briefly as 6 months or as long as a lifetime. In maintenance the family adjusts to life without the involvement of substances (Prochaska et al. 1992). During this stage it is important to maintain contact with the family to review changes and potential obstacles to change. Reminding family members that it is a strength, not a weakness, to use support to maintain changes can help them relate to what should be the therapist's enthusiasm for recovery of not only the IP, but for the entire family. The therapist's goal is relapse prevention; to teach the IP and family about relapse, how to prepare for difficult times and places, and to never give up.

During recovery from substance abuse, relapse and regression to an earlier stage of recovery are common and expected—though not inevitable (Prochaska et al. 1992). When setbacks occur, it is important for the person in recovery to avoid getting stuck, discouraged, or demoralized. Clients can learn from the experience of relapse and then commit to a new cycle of action. Treatment should provide comprehensive, multidimensional assessment to explore all reasons for relapse.

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

Confrontation

Generally, substance abuse treatment has relied on confrontation more than family therapy has. For a long time, within the substance abuse treatment community it was believed that confronting clients and breaking through their defenses was necessary to overcoming denial. Some preliminary research has suggested that a confrontational approach is sometimes the least effective method for getting certain clients to change substance abuse behavior (Miller et al. 1998). Treatment of substance abuse has shifted away from confrontational approaches and moved toward more empathic approaches, such as those favored in family therapy. Still, family therapists should be aware of how confrontation has been used and is still used in some substance abuse treatment programs.

Motivation levels

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

substance and the damage it causes provides motivation to break free of it, although it might be noted that simple awareness may not be enough alone to provide sufficient motivation.

Clinicians in both substance abuse treatment and family therapy also need to consider the motivation level of the family of a person abusing substances. The fact that a person with a substance use disorder is motivated to seek treatment is not evidence that the person's family is equally motivated. The family members may have been discouraged by treatment in the past, and they may no longer believe or hope that any treatment will enable their family member to stop abusing substances. They may also conclude that the treatment system did not respond to their needs.

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

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

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

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

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

Cultural barriers to treatment

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

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

Integrating Substance Abuse Treatment and Family Therapy

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

Family Therapy for Substance Abuse Counselors

Substance abuse counselors should not practice family therapy unless they have proper training and licensing, but they should be informed about family therapy to discuss it with their clients and know when a referral is indicated. Substance abuse counselors can also benefit from incorporating

family therapy ideas and techniques into their work with individual clients, groups of clients, and family groups. In order to promote integrated treatment, training in family therapy techniques and concepts should be provided to substance abuse counselors.

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

Traditional Models of Family Therapy

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

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

Family Therapy Approaches Sometimes Used in Substance Abuse Treatment

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

Behavioral contracting

Theorist: Steinglass. See Steinglass et al. 1987.

View of substance abuse

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

Goals of therapy

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

Strategies and techniques

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

Bepko and Krestan's theory

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

View of substance abuse

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

Goals of therapy

- Help everyone in the family achieve appropriate responsibility for self and decrease inappropriate responsibility for others.
- Three phases of treatment, each with a separate set of goals:
- Presobriety: Unbalance the system that was balanced around substance abuse in order to promote sobriety.
- Early Sobriety: Balance the system around a self-help group; maintain people in a corrective context (a zone of right relationship, avoiding overinflated pride and abject self-loathing) with a recognition that no one stays there all the time.
- Maintenance: Rebalance the system in a deep way by going back and working on developmental tasks that were previously missed.
- Clarify adaptive consequences of substance abuse.

Strategies and techniques

(1) Presobriety

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

(2) Early sobriety

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

(3) Maintenance

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

Behavioral marital therapy

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

View of substance abuse

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

Goals of therapy

- Abstinence is the preferred goal for treatment.
- Other goals include
    - Developing coping skills for both partners to address substance abuse.
    - Developing positive reinforcers for abstinence or changed use. [2]
    - Enhancing the functioning of the relationship.
    - Developing general coping skills.
    - Developing effective communication and problemsolving skills.

Footnotes

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

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 reflect SAMHSA/DHHS policy or program directions.

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