Substance Abuse Treatment And Family Therapy

A Treatment Improvement Protocol

TIP 39

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Center for Substance Abuse Treatment
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2 Impact of Substance Abuse on Families

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Overview

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

Introduction

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

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

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

The effects of substance abuse frequently extend beyond the nuclear family. Extended family members may experience feelings of abandonment, anxiety, fear, anger, concern, embarrassment, or guilt; they may wish to ignore or cut ties with the person abusing substances. Some family members even may feel the need for legal protection from the person abusing substances. Moreover, the effects on families may continue for generations. Intergenerational effects of substance abuse can have a negative impact on role modeling, trust, and concepts of normative behavior, which can damage the relationships between generations. For example, a child with a parent who abuses substances may grow up to be an overprotective and controlling parent who does not allow his or her children sufficient autonomy.

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

People who abuse substances are likely to find themselves increasingly isolated from their families. Often they prefer associating with others who abuse substances or participate in some other form of antisocial activity. These associates support and reinforce each other's behavior.

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

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

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

deprived home and are afraid to express their outrage use drug abuse as one way to manage their repressed anger.

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

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

Families With a Member Who Abuses Substances

Client Lives Alone or With Partner

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

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

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

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

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

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

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

Client Lives With Spouse (or Partner) and Minor Children

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

Most available data on the enduring effects of parental substance abuse on children suggest that a parent's drinking problem often has a detrimental effect on children. These data show that a parent's alcohol problem can have cognitive, behavioral, psychosocial, and emotional consequences for children. Among the lifelong problems documented are impaired learning capacity; a propensity to develop a substance use disorder; adjustment problems, including increased rates of divorce, violence, and the need for control in relationships; and other mental disorders such as depression, anxiety, and low self-esteem (Giglio and Kaufman 1990; Johnson and Leff 1999; Sher 1997).

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

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

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

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

Client Is Part of a Blended Family

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

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

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

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

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

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

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

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

Older Client Has Grown Children

When an adult, age 65 or older, abuses a substance it is most likely to be alcohol and/or prescription medication. The 2002 National Household Survey on Drug Abuse found that 7.5 percent of older adults reported binge and 1.4 percent reported heavy drinking within the past month of the survey (Office of Applied Studies [OAS] 2003*a*). Veterans hospital data indicate that, in many cases, older adults may be receiving excessive amounts of one class of addictive tranquilizer (benzodiazepines), even though they should receive lower doses. Further, older adults take these drugs longer than other age groups (National Institute on Drug Abuse [NIDA] 2001). Older adults consume three times the number of prescription medicine as the general population, and this trend is expected to grow as children of the Baby Boom (born 1946–1958) become senior citizens (NIDA 2001).

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

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

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

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

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

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

Client Is an Adolescent and Lives With Family of Origin

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

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

- Violent behavior
- Delinquency
- Psychiatric disorders
- Risky sexual behavior, possibly leading to unwanted pregnancy or sexually transmitted diseases
- Impulsivity
- Neurological impairment
- Developmental impairment (Alexander and Gwyther 1995; CSAT 1999*e*)

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

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

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

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

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

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

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

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

Someone Not Identified as the Client Abuses Substances

Substance abuse may not be the presenting issue in a family. Initially, it may be hidden, only to become apparent during therapy. If any suspicion of substance abuse emerges, the counselor or therapist should evaluate the degree to which substance abuse has a bearing on other issues in the family and requires direct attention.

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

Other Treatment Issues

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

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

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

Some concurrent treatment may not involve the person with alcohol or illicit drug problems. Even if this person is not in treatment, family therapy with the partner and other family members can often begin, or family therapy can be an addition to substance abuse treatment. The detoxification period also presents valuable opportunities to involve family members in treatment. Family therapy may have more of an impact on family members than it does on the IP because it enhances all family members' ability to work through conflicts. It may establish healthy family conditions that support the IP moving into recovery later in his or her life, after the episode of treatment has ended. Sometimes the person who abuses substances will not allow contact with the family, which limits the possibilities of family therapy, but family involvement in substance abuse treatment can still remain a goal; this "resistance" can be restructured by allying with the person with the substance use disorder and stressing the importance of and need for family participation in treatment. Resiliency within the family system is a developing area of interest (for more information see, for example, www.WestEd.org).

Chapter 2 Summary Points From a Family Counselor Point of View

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