# 4 Integrated Models for Treating Family Members

## In This Chapter...



## Overview

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

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

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

## Integrated Substance Abuse Treatment and Family Therapy

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

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

The array of client needs, multiple family influences, and differences in counselors' training and priorities, along with the difficult nature of most substance abuse problems, suggest that the family therapy and substance abuse treatment fields should work closely together. The resources and insights each discipline can bring to treatment are the best arguments for integrating substance abuse treatment and family therapy. Integrated models of treatment would also avoid duplication of services, discourage an artificial split between therapy for family problems and substance abuse treatment, and effectively and efficiently provide services to clients and their families.

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

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

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

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

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

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

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

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

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

Family therapy or family-involved interventions and substance abuse treatment can be integrated to greater or lesser degrees along a continuum. Figure 4-1 presents four discrete facets of integration along this continuum. This model is not a prescriptive recipe for "how-to" integration, but a guide to strategies, descriptions, and activities involved in the different facets. Further discussion of these facets is presented in chapter 6, Policy and Program Issues.

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

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

## Value of Integrated Models for Clients

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

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

## Coordinating Services Among Multiple Agencies

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

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

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

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

## Value of Integrated Models for Treatment Professionals

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

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

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

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

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

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

*Source:* Consensus Panel Member Fred Andes.

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

- *Flexibility in treatment approach.* Apart from the freedom to tailor treatment plans, integrated models enable counselors to adjust treatment approaches according to their own personal styles and strengths. For instance, counselors who enjoy working with adolescents and families can choose structural and strategic models that concentrate on family interactions, while those who prefer to capitalize on client competencies and strengths can choose solution-focused therapy. In this way, different treatment models can be used even within the same agency to meet both client and counselor needs.
- *Increased skill set.* Drawing from different traditional therapy models challenges counselors to be creative in their treatment approaches. With integrated models, for instance, substance abuse treatment counselors can work with a client's family members and see how each of their problems reverberates throughout the family system. Similarly, family therapists can experience working with people whose primary problems are substance use disorders.
- *Administration.* Integrated models enable administrators to get more for less. Despite the obvious cost to cross-train family therapists and substance abuse counselors, the improved treatment outcomes more than offset the investment. New Jersey's Division of Addiction Training recently demonstrated this cost-to-benefit relationship (Fishman et al. 2001). In this process, integrated models accommodated the differences in theory, philosophy, and funding across multiple agencies. Further, models with proven efficacy could be duplicated across agencies, which added to the long-term cost-effectiveness.

## Limitations of Integrated Models

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

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

## *Collaborating To Treat American Indians*

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

*Source:* Consensus Panel Member Greer McSpadden.

- *Additional training*. Integrated models require greater knowledge of more treatment modalities so additional training is necessary. Further, if substance abuse counselors and family therapists are to work together effectively, to some extent, they must learn each other's trade.
- *Mindset*. The major mindset shift necessary to using integrated models is between an individual model concentrating on pathology and a systemic (relational or behavioral) model focused on changing patterns of family interaction. Integrated models require both substance abuse counselors and family therapists to venture into new territory. Substance abuse counselors may be hesitant to engage the entire family either because they feel it is inappropriate or because they feel unprepared to manage sessions with an entire family. By the same token, family therapists' training runs counter to an emphasis on individuals within the family. Both substance abuse counselors and family therapists will need supervisory and administrative support to make necessary changes.
- *Administration*. Using several treatment models within an agency requires an agency-wide commitment to provide this variety of services. The use of multiple models within a single agency complicates scheduling for staff, clients, and families. Scheduling staff training for several models, as well as evaluating clients for the appropriateness of models available and the progress being made become more difficult. In addition, the collection and interpretation of treatment outcome data, including client outcomes, model efficacy, and cost-effectiveness, are more complex processes. However, these processes can be less complicated when the Patient Placement Criteria recommended by the American Society for Addiction Medicine are utilized by the agency to validate decision-making regarding the treatment of clients.
- *Reimbursement*. Third parties typically do not pay for family therapy interventions for substance abuse. Often, current funding pays either for mental health or substance abuse treatment. Without reimbursement for work done with families, most such work will not be done, and potential substance abuse outcomes will not be realized. (This critical issue is discussed more fully in chapter 6.)

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

## Levels of Involvement With Families

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

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

## Figure 4-2
## Levels of Counselor Involvement With Families

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

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

### Level 2—Counselor provides psychoeducation and advice

#### *Knowledge base*

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

#### *Relationship to family system*

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

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

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

#### *Knowledge base*

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

#### *Relationship to family system*

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

### *Skills*

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

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

### *Knowledge base*

The counselor understands the concept of family systems.

### *Relationship to family system*

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

### *Skills*

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

### *Level 5—Family therapy*

#### *Knowledge base*

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

#### *Relationship to family system*

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

#### *Skills*

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

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

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

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

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

## Determinants of the level of involvement

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

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

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

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

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

## Using the family to engage the client in treatment

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

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

## Approaches to engagement

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

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

By the fifth month, some open attempt (or a series of attempts) is made to get the person who is abusing alcohol into treatment. When other cases were added in which the potential clients had not entered treatment but had achieved and maintained clinically meaningful reductions in their drinking levels,[1] 37 percent of the people who abused alcohol and whose spouse was treated immediately had entered a program, compared with 11 percent for a group for which treatment was delayed (Thomas et al. 1990).

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

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

## Selecting an integrated model for substance abuse treatment

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

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

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

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

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

- Does the model fit what is observed in the family? For instance, a general lack of predictable structure may call for structural family therapy, which would be inappropriate for a distant and conflicted couple who instead may need emotion-focused couples therapy. Further, does the model provide direction as to where to go with the family? Is the direction simple enough to address a chaotic family system, yet encompassing enough to address multiple presenting problems and family structures?
- Can the model be used when not all family members attend all sessions? Can it be used with only one family member, if only that one person is ready for treatment?
- Will the model work with the family of origin and address intergenerational issues, such as how the family got where it is, and how does that history influence the family now?
- Will the model help the counselor manage the amount of change in the family system? Will the counselor be able to manage the competing homeostatic and change needs of the family? If not, the result may be too much resistance or too little change to satisfy the family.
- If the model uses a directive technique, will it increase the family's resistance? Further, will that model's directive nature fit the counselor's style? Would the counselor, for example, be comfortable saying, "Say this to him now"? Or does the counselor need a model with a less directive style?
- How much time is required to implement the model? Is it applicable in the short term, such as 8 to 12 sessions? Do the model's time requirements match the time available for therapeutic intervention?
- Is the model compatible with a particular family's cultural characteristics? If the counselor were to use the model, would family members be inclined to view the counselor as a good match for their cultural practices and values? Some models suggest, directly or implicitly, that one and only one family organization or structure is healthy, and all others are inferior. Such views may be inappropriate for families whose cultural or ethnic belief system conflicts with a particular model's assumptions and standards.

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

## Integrated Models for Substance Abuse Treatment

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

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

## Structural/Strategic Family Therapy

### *Theoretical basis*

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

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

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

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

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

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

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

## Techniques and strategies

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

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

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

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

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

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

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

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

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

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

*Source:* Consensus Panel.

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

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

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

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

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

*Source:* Consensus Panel.

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

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

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

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

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

## Multidimensional Family Therapy

### *Theoretical basis*

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

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

### *Research basis*

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

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

## Techniques and strategies

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

## Core components

MDFT is an outpatient family-based drug abuse treatment for teenagers who abuse substances (Liddle 2002). From the perspective of MDFT, adolescent drug use is understood in terms of a network of influences (i.e., individual, family, peer, community). This multidimensional approach suggests that reductions in target symptoms and increases in prosocial target behaviors occur via multiple pathways, in differing contexts, and through different mechanisms. The therapeutic process is thought of as retracking the adolescent's development in the multiple ecologies of his or her life. The therapy is organized according to stage of treatment, and it relies on success in one phase of the therapy before moving on to the next. Knowledge of normal development and developmental psychopathology guides the overall therapeutic strategy and specific interventions.

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

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

## Multiple Family Therapy

### *Theoretical basis*

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

### *Techniques and strategies*

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

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

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

## Multisystemic Family Therapy

### *Theoretical basis*

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

### *Techniques and strategies*

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

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

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

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

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

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

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

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

*Source:* Consensus Panel.

## Behavioral Family Therapy and Cognitive–Behavioral Family Therapy

### *Theoretical basis of behavioral family therapy*

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

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

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

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

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

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

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

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

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

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

## *Behavioral Family Therapy: Improving Communication*

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

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

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

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

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

*Source:* Consensus Panel.

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

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

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

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

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

*Source:* Sullivan et al. 2002.

## *The Counselor as Advocate in the Network*

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

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

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

## Family/Larger System/Case Management Therapy

### *Theoretical basis*

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

For many families, dealing with larger systems is not a problem. Their dealings with the larger systems are routine and positive; when they have occasional difficulties they can navigate within larger systems. Other families, however, have recurrent problems and more frequent dealings with larger systems. Often, interaction with large systems is intense and extensive throughout the family's life cycle, in many cases because of issues such as poverty, chronic illness, legal problems, and cultural and language barriers.

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

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

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

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

### *Techniques and strategies*

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

## Network Therapy

### *Theoretical basis*

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

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

### *Techniques and strategies*

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

## Bowen Family Systems Therapy

### *Theoretical basis*

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

## Use of Bowen Family Systems Therapy With Immigrant Populations

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

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

it can deflect attention from other sources of anxiety.

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

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

In Bowenian therapy, it is assumed that the past influences the present. In fact, it is still "alive." It is present in the form of emotional responses that can be passed down from one generation to another (Friedman 1991).

### Techniques and strategies

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

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

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

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

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

## Solution-Focused Brief Therapy

### *Theoretical basis*

Solution-focused brief therapy (SFBT) replaces the traditional expert-directed approach aimed at correcting pathology with a collaborative, solution-seeking relationship between the counselor and client. Rather than focusing on an extensive description of the problem, SFBT encourages client and therapist to focus instead on what life will be like when the problem is solved. The emphasis is on the development of a solution in the future, rather than on understanding the development of the problem in the past or its maintenance in the present. Exceptions to the problem—that is, times when the problem does not happen and a piece of the future solution is present—are elicited and built on. This counters the client's view that the problem is always present at the same intensity and helps build a sense of hope about the future.

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

### *Asking the Miracle Question*

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

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

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

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

As yet, however, little definitive research has confirmed the effectiveness of SFBT for substance abuse. Gingerich and Eisengart (2000) found and evaluated 15 studies on the outcome of SFBT in treating various problems. They concluded that "the 15 studies provide preliminary support for the efficacy of SFBT, but do not permit a definitive conclusion" (Gingerich and Eisengart 2000, p. 477), especially for substance abuse. Of the 15 studies, only two poorly controlled ones looked at the substance abuse population. One of them described a man with a 10-year drinking history. He achieved more days abstinent and more days at work per week during treatment as compared to before treatment (Polk 1996). The other study involved a therapist who used SFBT with 27 clients in treatment for substance use disorders. A larger percentage of the SFBT clients recovered (by study definitions) after two sessions and after seven sessions than did the comparison clients, but no details were given about the severity of the cases or specific client outcomes (Lambert et al. 1998).

## Techniques and strategies

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

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

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

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

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

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

## Case Study of Exceptions to Problem

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

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

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

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

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

*Scaling questions*. As a clear vision of change emerges, techniques begin to focus on helping the client make change happen. At this point, one especially useful technique is the scaling question. It might ask, On a scale of 1 to 10, where 1 means one of your goals is met and 10 means all your goals are completely met, where would you rate yourself today? A good follow-up question is, What would it take for you to move from a 4 to a 5 on our 10-point scale? Such questions help clients gauge their own progress toward their goals and see change as a process rather than an event.

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

## *Figure 4-3*
## *Techniques To Help Families Attain Sobriety*

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

**Multidimensional family therapy** (Liddle 1999)

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

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

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

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

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

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

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

## *Figure 4-4*
## *Techniques To Help Families Adjust to Sobriety*

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

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

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

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

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

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

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

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

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

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

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

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

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

## Matching Therapeutic Techniques to Levels of Recovery

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

The consensus panel decided that one way of looking at levels of recovery for families is to combine Bepko and Krestan's stages of treatment for families (1985), and Heath and Stanton's stages of family therapy for substance abuse treatment (1998). Together, the levels of family recovery are

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

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

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

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

Treatment goals for children in alcoholic families and adult children of people with substance use disorders include educating children about drinking; helping parents assume appropriate responsibility as parents; and examining the role the adult played in his family of origin and how that role affects current relationships (Bepko and Krestan 1985). For more information, refer to TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*), and the Adult Children of Alcoholics Web site, http://www.adultchildren.org.

### *Figure 4-5*

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

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

Family/larger system (Imber-Black 1988)

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

**Network therapy** (Galanter 1993)

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

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

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