5 Specific Populations

In This Chapter...

Overview

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

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

Introduction

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

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

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

Age

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

Children

Background issues

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

The use of inhalants is especially prevalent among children. The National Institute on Drug Abuse (NIDA)-funded 2001 Monitoring the Future survey found that more than 17 percent of eighth graders said they had abused inhalants at least once in their lives (Johnston et al. 2002). In a recent policy statement, the American Academy of Pediatrics (AAP) described inhalant abuse as "an under-recognized form of substance abuse with a significant morbidity and mortality" (AAP 1996, n.p.). For more information, see also TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (Center for Substance Abuse Treatment [CSAT] 1999*c*).

Application to family therapy

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

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

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

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

Adolescents

Background issues

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

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

Alcohol is the substance most often used and abused by adolescents, and its usage reflects troubling patterns (AAP 2001). In 2001, of people age 12 to 17, 10.7 percent reported binge alcohol use in the past month and 2.5 percent reported heavy alcohol use in the past month (binge drinking is defined as five or more drinks on the same occasion; heavy use is five or more drinks on the same occasion at least 5 days in the past month) (OAS 2003*a*).

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

Some specific risk factors for adolescent substance abuse include

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

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

Application to family therapy

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

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

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

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

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

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

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

Older Adults

Background issues

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

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

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

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

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

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

Application to family therapy

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

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

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

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

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

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

Other accommodations that are helpful for many older clients include

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

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

Women

Background Issues

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

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

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

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

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

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

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

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

Application to Family Therapy

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

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

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

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

Women who have lost custody of their children may need help to regain it once stable recovery has been achieved. In fact, working to get their children back may be a strong treatment motivator for women. Finally, childcare is one of the most important accommodations necessary for women in treatment. Children must be allowed to come to therapy sessions, or when such attendance is not appropriate, to be placed in suitable childcare.

Race and Ethnicity

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

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

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

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

African Americans

Background issues

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

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

Application to family therapy

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

Within-Group Diversity: Caribbean Black Populations

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

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

African-American families also are sensitive to a patronizing approach that Boyd-Franklin (1989) refers to as missionary racism. Therapists should be sensitive to the ways in which this message may be conveyed. Clinicians must be aware of any biases or attitudes regarding their African-American clients. To address this issue effectively, therapists may need assistance from supervisors or colleagues or training in cross-cultural situations (Wright 2001).

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

Santisteban et al. (1997) found that single-family therapy improved family relationships and reduced behavioral problems in African-American youngsters. African Americans also function very successfully in multiple family therapy. For many African-American Christians, the Bible is a longstanding source of truth and solace that helps them make sense of life (Reid 2000). Because of the church's centrality to their lives, a Bible-related recovery program has been found to be effective for African-American Christian families (Reid 2000).

African-American women

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

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

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

Parenting issues

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

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

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

Other factors

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

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

Hispanics/Latinos

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

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

Substance use in Hispanic/Latino communities

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

The role of acculturation in family functioning

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

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

Cultural characteristics that impact family therapy

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

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

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

Application to family therapy

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

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

Respeto and conflict

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

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

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

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

Communication styles

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

Falicov (1998) urges family therapists to adopt a tone of acceptance and eschew direct confrontation and demands for extensive disclosure throughout treatment. Therapists can ease the confrontational nature of therapy by employing humor, allusions, and diminutives. Disclosure is made easier when the family therapist takes a philosophical approach through storytelling, anecdotes, and metaphors. Other culturally harmonic tools include analogies, proverbs, popular songs, and unexpected statements that convey a sense of the absurdity of life (Falicov 1998). However, direct communication can and should be used when seeking informed consent or when an emergency situation exists.

> Perhaps the most widely acknowledged common thread among Hispanics/Latinos is the importance placed on family unity, the family's well-being, and the use of family as a support network.

Counseling strategies

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

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

Hispanic/Latino family members will be much more forthcoming when the therapist solicits their feelings through subtle and indirect means.

instance, a discussion concerning how family members reconcile their culture of origin and American culture will reveal differing acculturation levels within the family. Therapists may also explore the issue through the simple exercise of having family members rate how close they feel to their culture of origin on a scale from 1 to 10. Naturally, in all cases, therapists must make arrangements so that language does not impede a family member's participation.

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

Other considerations include the following:

- A businesslike approach to treatment will not appeal to Hispanic/Latino families. A personable tack will yield much more effective results.
- Hispanic/Latino family members will be much more forthcoming when the therapist solicits their feelings through subtle and indirect means. Encouraging clients to speak forcefully and directly may have the unintended effect of inhibiting their participation (Paniagua 1998).
- The establishment of behavioral contracts may be an overly task-oriented approach for this population. Scheduling time ahead to resolve intimate issues may also not be acceptable to clients. Falicov (1998) recommends making homework assignments conditional because it is more collaborative, less presumptive, and more in keeping with a cultural affinity for spontaneity.
- Hernandez (2000) recommends that family therapists adopt a broader perspective than the disease model, to incorporate the impact of a toxic social environment and the effects of oppression as factors contributing to substance dependency. While still holding people with substance use disorders accountable for their actions, this approach helps to frame substance abuse as a communal problem and spur family members into learning more about the effects of oppression.
- Using fundamental spiritual precepts can inspire hope and patience. The endurance of suffering, the practice of forgiveness, and the importance of repentance may be fertile values to use in working with families with substance abuse. This strategy should only be used when it is in harmony with the spiritual views of the individual family or family member (Hernandez 2000).

Asian Americans

Background issues

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

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

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

Asian family structure

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

Rates of substance abuse in Asian communities

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

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

Application to family therapy

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

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

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

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

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

Opinions vary on whether family therapy is an appropriate vehicle with which to counsel Asian Americans with substance use disorders. Paniagua (1998) states that family therapy is effective because the family is more important than the individual in Asian families and the act of withholding information from family members is unfamiliar to many Asians. May Lai (2001) urges therapists to work with the client's family, but to use individual counseling rather than family therapy. Debates on the efficacy of involving Asian families in treating substance abuse often revolve around the presumed skill level of the therapist, not the fundamental importance of the client's relationship to his or her family. Clearly, counseling Asian-American families requires skill, delicacy, and knowledge of cultural factors.

Issues of acculturation

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

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

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

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

Communication styles

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

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

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

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

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

Engagement

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

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

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

Counseling Asian-American families requires skill, delicacy, and knowledge of cultural factors.

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

The second step in the engagement process is to acknowledge and strengthen the family's wishes to assist the family member in changing his or her behavior. Treatment planning for Asians with substance use disorders should consider the family's role as early as possible. Although involving the family adds complexity to the therapist's task, its integral importance cannot be overstated. It is critical to assess the individual's substance abuse in regard to the family's level of functioning (Chang 2000). Given cultural mandates to show deference to authority figures, Asian families may present as particularly compliant in treatment.

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

Other considerations in engaging Asian families are noted below:

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

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

American Indians

Background issues

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

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

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

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

- *Sharing*. Honor and respect are both gained by sharing and giving. When sufficient money is accumulated, some American Indians may stop working and spend time and energy in ceremonial activities. Refusing to share drinks or substances with a member of the same tribe may be considered an insult.
- *Cooperation*. Many American Indians value the tribe and family more than the individual. Instead of going to an appointment, some may instead assist a family member needing help. In a counseling setting, though they may agree with the counselor, they often will not follow through with the suggestions.
- *Noninterference*. Generally, American Indians do not like to interfere with others and prefer to observe rather than react impulsively. Rights of others are respected. They are often seen as permissive in child rearing.
- *Time orientation*. American Indians are often present-oriented. Punctuality or planning for the future may be de-emphasized. Tasks are completed according to a rational order and not according to deadlines.
- *Extended family orientation*. Interrelationships between relatives are important, and there is a strong respect for elders and their wisdom and knowledge.
- *Harmony with nature*. Rather than seeking to control the environment, many American Indians accept things as they are (Sue and Sue 1999).

Substance abuse patterns

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

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

Other relevant issues

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

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

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

Application to family therapy

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

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

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

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

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

Acculturation

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

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

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

Communication styles

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

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

Historically, the therapeutic relationship between American Indians and non-Indian therapists has been marked by racism (Sutton and Broken Nose 1996). Placed in this context, it is then clear that most American Indians will not discuss sensitive matters until trust has developed.

Culturally competent approaches

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

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

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

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

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

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

The more traditional an American Indian is, the more difficulty he or she will have with Alcoholics Anonymous (AA) concepts (Coyhis 2000). For many American Indians, the source of difficulty with AA is that the concepts derive from a European, Christian mindset (Duran and Duran 1995). White Bison is one example of an American-Indian alternative to the traditional AA approach that "integrates the medicine wheel with the twelve-step teachings of AA to adapt substance abuse recovery to Native American culture" (Krestan 2000, p. 36).

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

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

Sexual Orientation

Background Issues

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

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

Application to Family Therapy

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

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

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

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

Family therapists also must be careful not to overpathologize issues of boundaries and fusion. Many gay or lesbian couples appear to have more permeable boundaries than are commonly seen among heterosexual couples. For example, a lesbian may seek support from an ex-partner to help with difficulties with a current partner more often than would typically be seen in a heterosexual female. When violence between partners is a treatment issue, safety must be the therapist's main concern.

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

People With Physical or Cognitive Disabilities

Background Issues

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

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

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

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

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

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

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

Application to Family Therapy

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

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

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

Providers may be uncomfortable when first confronted with a person with a physical or cognitive disability. That unease can lead them to err in one of two directions: either enabling the person to use his disability to avoid treatment or refusing to recognize that a legitimate need for accommodation exists. Accommodation does not mean giving special preferences—it means reducing barriers to equal participation in the program. If a client believes that he or she needs an accommodation, the treatment provider will still need to determine if the request is legitimate or an attempt to manipulate the treatment program. However, a provider's vigilance in avoiding enabling may predispose him to reject legitimate requests for accommodation. If there is any doubt on the part of the provider regarding the legitimacy of the person's request, he or she should consult a disability expert in order to make this determination. Failure to make good faith efforts at accommodation could result in significant legal difficulties for programs or providers (for more information about the Americans With Disabilities Act see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* [CSAT 1998*e*]).

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

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

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

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

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

Most substance use disorder treatment professionals already have extensive knowledge of the complex ways in which psychological denial and substance abuse are intertwined, and they have developed methods of working with clients whose denial presents a significant obstacle to treatment. However, for people with disabilities, denial has additional dimensions. Some people with co-existing disabilities may experience two types of denial at once: denial of the substance use disorder and denial of the disability. The presence of a co-occurring disability can alter how a person manifests denial of his substance use disorder or can cause denial to be focused solely on the disability. For a person with a disability, substance use may also be a form of bargaining. He or she may think that substance use is something that is "allowed" in order to compensate for facing a disability. For clients, recognizing their substance abuse forces them to cope with all of the often painful emotions typically experienced by any person in recovery, in addition to those related to disability. For most people with severe disabilities, adjustment to this condition is considered a lifelong process (DeLoach and Greer 1981).

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

If the family therapist treating substance abuse is experiencing difficulty confronting the denial of the disability, he or she should consider a referral to a peer counselor at a Center for Independent Living (see appendix D), whose job is to help people with disabilities come to terms with the limitations of their disability. The two counselors can then work as a team.

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

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

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

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

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

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

Specific recommendations include the following:

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

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

- When working with an individual with a physical disability, table surfaces must be the correct height. In particular, wheelchairs should be able to fit beneath them. Counselors should try to place themselves so that they are no higher than the client. They should be aware of the pace of the interview, and attempt to gauge when clients are becoming fatigued. Counselors should periodically inquire how the client is doing and offer frequent breaks.
- People who use wheelchairs often come to regard the chair as an extension of themselves, and touching the chair may be offensive to them. Therapists should never take control of the wheelchair and push the person without permission.
- For people with cognitive disabilities, providers must systematically address what has been learned in the program and how it will be applicable in the next stage of treatment or aftercare. Some people are very context-bound in their learning, and providers cannot assume that the lessons learned in treatment will be applied in aftercare.
- If a person with a disability has limited transportation options, a therapist may arrange to conduct individual counseling by telephone, go to the person's house, or meet at a rehabilitation center or other alternative site. Going to the residence of an individual with a disability also provides valuable information about a client's lifestyle, interests, and immediate environmental challenges.
- Therapists should recommend literature to families that addresses enabling behavior in general and for people with disabilities in particular. Disability resource agencies may be able to provide helpful literature. For a full discussion of these categories, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*).

People With Co-Occurring Substance Abuse and Mental Disorders

Background Issues

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

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

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

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

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

Application to Family Therapy

The most appropriate approach to single family therapy for people with co-occurring disorders is an integrated approach that combines family interventions and substance abuse interventions (Sheils and Rolfe 2000). Psychoeducational family therapy that focuses on both psychosis and substance use is also helpful. Effective psychoeducation combines fundamental information, guidance and support, and allows for "low-key" engagement and continued assessment opportunities (Ryglewicz 1991). It is important to educate family members on the ways that one disorder, if not properly monitored and treated, can set off the other.

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

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

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

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

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

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

For example, in substance abuse treatment, clinical staff and fellow clients often aggressively confront clients who deny that they have a substance abuse problem or who minimize the severity of their problem. However, treatment of people with co-occurring disorders first requires innovative approaches to engage them in treatment as a prerequisite to confrontation. The role of confrontation may need to be substantially modified, particularly in the treatment of disorganized clients or clients with psychosis who may tolerate confrontation only in later stages of treatment (when their symptoms are stable and they are engaged in the treatment process).

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

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

Rural Populations

Background Issues

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

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

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

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

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

Patterns of substance abuse

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

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

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

Application to Family Therapy

Overcoming barriers to treatment

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

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

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

Tatum (1995) emphasizes that the key to successfully delivering therapeutic services in rural communities is gaining acceptance from the community and client population. Sometimes a therapist's lack of understanding of rural values and customs can create mistrust among residents and hinder effective treatment (Bushy 1997). For example, rural people may have a mistrust of outsiders and a fear of becoming involved in the "system" (Tatum 1995). Working to increase family and community involvement in the therapeutic process can help overcome obstacles such as the lack of social support and the stigma of receiving mental health services. It is essential for the therapist to identify all the important people in the family's life. This includes extended family and close friends who may become key players in the target family's change process. However, because of the intimacy of rural communities, therapists must balance the need to effect family change on a macro level with the equally important need of maintaining confidentiality.

Use of self-help groups

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

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

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

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

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

Other Contextual Factors

HIV Status

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

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

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

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

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

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

The impact of infection and disease on family members is also wide and deep. Significant others will grapple with fear of infection and possibly reactions to having been exposed to HIV. Grief and mourning are also likely to be present, as are stress and loss similar to that experienced with other chronic illnesses. Finally, there are the financial and emotional burdens that ongoing medical care of a person with HIV/AIDS places on a family.

Application to family therapy

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

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

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

Homelessness

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

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

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

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

Application to family therapy

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

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

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

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

Veterans

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

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

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

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

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

Application to family therapy

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

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

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

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

Chapter 5 Summary Points From a Family Counselor Point of View

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