Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Brief Interventions and Brief Therapies for Substance Abuse

Treatment Improvement Protocol (TIP) Series

34

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8 Brief Family Therapy

Substance abuse disorders do not develop in isolation. For many individuals with substance abuse disorders, interactions with the family of origin, as well as the current family, set the patterns and dynamics for their problems with substances. Furthermore, family member interactions with the substance abuser can either perpetuate and aggravate the problem or substantially assist in resolving it. Family therapy is suggested when the client exhibits signs that substance abuse is strongly influenced by family members' behaviors or communications with them. Family therapy might be contraindicated if other family members are active substance abusers, violent, deny that the client's substance abuse is problematic, or remain excessively angry.

Family therapy is often used to examine factors that maintain a client's substance abuse behavior. To understand these factors, the therapist considers the family's various structural elements and how they contribute to the substance abuse. These elements might include the power hierarchy, roles, rules, alignments, and communication patterns within the family. Through family therapy, the clinician can help the family identify dysfunctional areas, adjust its hierarchy, change various roles that members play, change dysfunctional rules, alter dysfunctional alignments between family members, and replace dysfunctional communications with clear, direct, and effective communication.

Family involvement is often critical for success in treating many substance abuse disorders—most obviously in cases where elements of the family are inadvertently reinforcing or supporting the problem. In some cases, another family member has a different agenda from the rest of the family. For example, the husband of a recovering substance abuser may have taken on additional roles in the family as a result of the vacuum left when his wife was abusing substances. The husband may be unwilling to let her resume her place in the family or share control of the family budget, for example. Unless family therapy can shift his position, the client's recovery is likely to be impeded. When the whole family is involved in therapy, changes are faster and easier to maintain. In addition, the client gains a built-in support system.

Complex interactions between family dynamics and substance abuse have long been recognized (Lewis, 1937). Whalen suggested spousal psychopathology was a contributing factor in the onset and maintenance of substance abuse (Whalen, 1953). Jackson argued on the basis of interviews with members of Al-Anon that the depression, anxiety, and distress seen so often in family members of substance abusers stem from, rather than cause substance abuse disorders (Jackson, 1954).

Contrary to what had long been the popular opinion, most individuals with substance abuse disorders maintain close ties with their families.

Research has consistently shown that people with substance abuse disorders are in closer contact with their families of origin than the members of the general population of comparable age (Bekir et al., 1993; Douglas, 1987).

A number of reviews have found strong support for the use of family therapy methods for substance abuse treatment. Recent research even suggests that family and marital treatment produces better marital and drinking outcomes than nonfamily methods (Lowinson et al., 1997). At least one study that compared long-term and short-term family therapy (16 and 8 casework interventions over an 8- and a 4-month period, respectively) found that shorter services were often more beneficial (Garvin et al., 1976). However, comparable studies specifically on family therapy as applied to substance abuse disorders are lacking.

The Harvard Medical School Department of Psychiatry successfully used couples counseling in the context of treatment for alcohol-dependent clients. Studies of participants in the Harvard Counseling for Alcoholics' Marriages Project (Project CALM) showed that more than 50 percent of husbands with alcohol abuse disorders who participated remained alcohol free in the first year after treatment, compared with less than 30 percent of husbands treated in individual therapy. Participants in the program also had fewer marital separations. With the addition of a relapse prevention program, the results improved even further (Rotunda and O'Farrell, 1997).

Family therapy should be conducted by a clinician with a good understanding of family systems, dysfunctional family patterns, power struggles, and communication. Alcohol and drug counselors can learn to work with families, especially if they do not hold the family responsible for the substance abuse.

If possible, an appropriately trained family therapist should be available to conduct sessions involving a client's family.

Appropriateness of Brief Family Therapy

Long-term family therapy is not usually necessary within the context of treatment for substance abuse disorders. An exception is long-term residential treatment, during which the involvement of the client's family is highly recommended and often is an integral part of the therapeutic process. Making real progress with a family over a long period is challenging. Stumbling blocks, barriers, and pathology seem to emerge. Family members drop out and reenter the therapeutic process, and it becomes increasingly difficult for the therapist to avoid making decisions. The family may try to incorporate the therapist into the family system, routinely seeking direction in a crisis. Boundary and projection issues must be addressed. In short-term family therapy, the boundary between the therapist and the family is more clear. In general, it is easier to continue to help an individual work within the family system through subsequent individual therapy.

Some traditional approaches encourage clients to work on themselves in isolation from others, but there are very few instances in which the opportunity to work with a client's family—for at least one or a few sessions—is not beneficial. Obviously, one such exception is when the client is unwilling to pursue this approach. Another instance best dealt with individually is when the client's situation involves issues of separation and individuation although conjoint family work often helps complete this process. Physical, emotional, or sexual abuse of the client by a family member may also rule out family therapy. Short-term

family therapy is an option that could be used in the following circumstances:

- When resolving a specific problem in the family and working toward a solution
- When the therapeutic goals do not require in-depth, multigenerational family history, but rather a focus on present interactions
- When the family as a whole can benefit from teaching and communication to better understand some aspect of the substance abuse disorder

Family therapy offers an opportunity to

- Focus on the expectation of change within the family (which may involve multiple adjustments)
- Test new patterns of behavior
- Teach how a family system works, and how the family supports symptoms and maintains needed roles
- Elicit the strengths of every family member
- Explore the meaning of substance abuse within the family

An obvious prerequisite for family therapy would seem to be the existence of a family. However, some therapists, including Haley, believe it is possible to "create" a family by drawing on the client's network of significant contacts. A more important question than whether the client is living with a family is, "Can the client's problem be seen as having a relational component (that is, involving two or more people)?" Rather than simply trying to identify existent family members, therapists can begin by conducting an assessment of the client's social network that would include significant others, friends, employers, and coworkers. These people are significant and helpful in the client's life and can be important elements of a client's recovery program.

The definition of "family" also varies in different cultures and situations. For example, for a substance abuser in a Native American group, the notion of family may extend to community members, including healers or others who can help promote or block change. Young children, although not the most powerful members of the family, often have helpful perceptions to contribute to the therapy process. In determining how and when to include children, it is important to consider their age and the nature of the subject matter the family will address. Parental sexual relations, obviously, should be discussed by the parents alone.

Family therapy approaches have been employed with a variety of specific substance-abusing subpopulations, including those who are dually diagnosed (Read et al., 1993; Reilly, 1991; Ryglewicz, 1991), Vietnam veterans with substance abuse disorders and posttraumatic stress disorder (Fahnestock, 1993; Moyer, 1988), older adults with substance abuse disorders (Amodeo, 1990; Crawley, 1993; Rathbone-McCuan and Hedlund, 1989), cocaine abusers (O'Malley and Kosten, 1988; Rice-Licare and Delaney-McLoughlin, 1990; Smokowski and Wodarski, 1996), HIV-positive clients with substance abuse disorders (Barth et al., 1993), and substance-abusing perpetrators of domestic violence (Flanzer, 1989; O'Sullivan, 1989).

Definitions of "Family"

The term "family therapy" evokes images of parents and children. However, as mentioned above, family therapy can involve a network beyond the immediate family, may involve only one family member in treatment or a few members of the family system, or may even include several families at once.

Network therapy views substance abuse disorders from a cognitive–behavioral perspective (Galanter, 1993; Galanter et al., 1997; Keller et al., 1997). In network therapy, significant nonfamily members, such as friends, extended family members, cousins, and grandparents, as well as family members, are

regarded as useful resources available to assist the client.

In contrast, some types of *family systems therapy* regard substance abuse as a symptom of an underlying pathology at work in the family. This approach seeks to restructure the family and the maladaptive behaviors which contribute to (or encourage) the client's substance abuse (Keller et al., 1997).

Conjoint couples therapy addresses couples issues within the family (Epstein and McCrady, 1998; Zweben et al., 1988). Typically, couples carry out assignments in dealing with key therapeutic themes, such as listing the factors that attracted each partner to the other, discussing how the relationship could regain that attraction, and looking at expectations of each partner, needs from the other partner, and resentments. Couples may need to explore their ideas about gender roles within the relationship, or they may have to explore their views on parenting, especially in regard to the disciplining of children. They may also be asked to share ways in which they communicate dissatisfaction or negative feelings about the ongoing substance abuse.

Multifamily groups are often used in substance abuse treatment for educational purposes and as support groups. They can explore ways to attain strategic objectives relevant to each family, offer an opportunity for sharing knowledge, address boundary and communication issues, and expose participants to new ways of managing challenges. Participants realize they are not alone and are helped to maintain their substance-free lifestyle through learning new coping techniques and ways to stop enabling substance abuse. The therapist can apply the experiences of one family to help another. After one family describes a solution, the therapist may ask another, "Would that work in your family?" This approach can promote accountability for maintaining agreements with less stress than would occur in single-family therapy. Typically, four or five families participate, often achieving meaningful results rapidly (Kaufman and Kaufman, 1979).

This approach helps with boundary setting and reestablishment of the parent–child hierarchy. If a parent is the substance abuser, a family role reversal may have occurred in which the children have taken the parental role and become caretakers. In therapy and recovery, it is important that these boundaries be reclarified and that the correct parent–child hierarchy be reestablished. Not communicating is typical in families undergoing substance abuse treatment. One of the goals must be to reestablish lines of communication.

The disadvantage of this approach is that the families involved may not have much common experience; also, some families feel ashamed in this sort of encounter and are not willing to share their experiences. At times, this approach can lead client families simply to complain to one another, without being motivated to find new solutions. One of the responsibilities of the therapist leading the group is to guide the family in exploring alternatives and choosing among them.

Multiple family therapy offers an opportunity to deal with four concerns for families in which substance abuse has been a problem (Brill, 1981):

1. Inadequate internal family development
2. Family systems and role imbalance
3. Selected socialization variances within the family (i.e., differences in the desire and ability of family members to socialize)
4. Dysfunctional, ineffective family behaviors that maintain the problem

Some researchers believe that multiple family therapy is especially useful for families dealing with substance abuse disorders (Kaufman and Kaufman, 1979). In families where one or more members have a substance

abuse disorder, deterioration in the family system is usually seen. Multiple family therapy allows a quick assessment of the deterioration and stimulates a confrontation and strategy to reverse this process.

Furthermore, it is most useful in residential settings where the family is easily accessible, although it has also been successfully used in outpatient settings. Kaufman and Kaufman also found that it works best with highly motivated and involved clients and

> [R]educes the incidence of premature dropouts, acts as a preventive measure for other family members, builds a subculture that acts as an extended 'good family,' and creates and supports structural family changes that interdict the return of drug abuse (Kaufman and Kaufman, 1979, p. 84).

Theoretical Approaches

Many therapists are unfamiliar with effective ways to utilize supportive family members and significant others when treating substance abuse disorders (Bale, 1993; French, 1987; McCrady, 1991). This may stem in part from reliance on popular concepts drawn from the traditional "family disease" model, in which family members of the substance user are seen as suffering from the disease of "codependency" (Beattie, 1987; Coudert, 1972). Cermak even defines codependency using criteria similar to those used in the *Diagnostic and Statistical Manual for Mental Disorders,* 4th Edition [DSM-IV] (Cermak, 1986). According to Schutt,

> [T]he woman who lives with an alcoholic develops an enabling illness. She constantly stands between the alcoholic and his crises, thus enabling and condoning the further usage of the drug (Schutt, 1985, p. 5).

From this perspective, family members of the person with a substance abuse disorder "enable" the substance abuse to continue and so are thought to need help "detaching" or disengaging from their overresponsible involvement with the substance user (Al-Anon, 1979; Bepko, 1985). As a result, treatment often consists of a referral to Al-Anon and (less frequently) separate therapy groups for family members that exclude the substance user (Frankel, 1992; Friedman, 1990; McCrady, 1989; Regan et al., 1983).

Family systems models, on the other hand, instead of focusing on individual personality disorders, generally regard substance abuse and dependence as symptoms of dysfunctional interpersonal dynamics within the family (Bowen, 1974; Gorad et al., 1971). From this perspective, the substance abuse meets a need on some level for the family as a whole and inadvertently reinforces the substance abuse (Davis et al., 1974; Stanton, 1977). Chafetz and colleagues, for example, cite a family who laughed and joked together while the father was intoxicated during an experimental session in contrast to the same family's rather flat affect during a session when the father was sober (Chafetz et al., 1974). The father's alcohol abuse was seen as having become necessary for this family to express their positive emotions. Based on similar anecdotal evidence, many family treatment approaches have evolved that seek to identify the specific role or family-level "adaptive function" served by substance abuse, with the goal of bolstering interpersonal functioning in this area in order to reduce these secondary gains from substance abuse for the individual and the family (Bepko, 1985; Stanton and Todd, 1982; Steinglass et al., 1977). Several family treatment models are described below.

Strategic family therapy (Haley, 1976) and the related Milan school of family therapy (Selvini-Palazzoli et al., 1978) target the positive interpersonal aspects of substance abuse specifically, acknowledging directly its benefits to the family (e.g., "With your husband unemployed as a result of his drinking, he can be home when the children get out of school"), as well as the negative consequences the family

might face if the substance abuse were to end (Fisch et al., 1982; Haley, 1987). Together with such paradoxical interventions as suggesting the family may not yet be ready to change, these interventions often provoke "spontaneous" growth on the part of the family (Weeks and L'Abate, 1979; Winn, 1995). See Chapter 5 in this TIP for more information on strategic and interactional therapies, which often involve the family directly.

Structural family therapy looks beyond the specific family dynamics around substance abuse disorders to more general imbalances in family relationships that might maintain substance abuse, such as extreme disengagements and inappropriate coalitions between family members, especially across generational lines (Minuchin, 1974). Salvadore Minuchin has had an enormous impact on both the theory and practice of structural family therapy, although many of his concepts have been modified as they have been incorporated into the spectrum of modalities. Minuchin stressed the importance of the hierarchy of power within the family and identifying dysfunctional uses of power (e.g., "scapegoating"). It is important to understand both healthy and dysfunctional roles within the family: alignments, collusions, and communication patterns. These key points are routinely explored in family therapy, although many therapists would not feel comfortable "imposing" their own model of health on a family—an issue that did not trouble Minuchin.

Structural therapists explore current family organization, especially hierarchy and intimacy, while encouraging the family to loosen rules and expectations that might be locking the substance abuser into a dysfunctional role (Minuchin and Fishman, 1981; Stanton, 1977). In one of the earliest applications of family therapy for substance abuse disorders, Stanton and Todd worked successfully with families of young male heroin addicts to reestablish parental authority and define clearer intergenerational boundaries, especially between these men and their mothers (Stanton and Todd, 1982).

Bowenian family therapy (Bowen, 1978) also focuses on family-of-origin emotional attachment patterns and unresolved separation issues to make sense of substance abuse disorders. Instead of working through the parental generation, however, adults and adolescents are helped to differentiate and define themselves as individuals by acknowledging and curtailing their residual emotional entanglements. As a result, substance abuse is no longer needed as a way to deny their family-of-origin attachments (Bowen, 1974).

Contextual family therapy (Boszormenyi-Nagy and Spark, 1973) is another transgenerational family model that has been applied in work with families affected by substance abuse (Flores-Ortiz and Bernal, 1989). This approach emphasizes ethical legacies and unconscious loyalties passed along from one generation to the next. For example, the adolescent substance abuser loyally provides her parents the opportunity to vent unresolved anger left from their own upbringing. Treatment helps clarify the ways these unconscious "ledgers" are passed down from generation to generation, and parents are encouraged to deal with their childhood issues directly instead of acting them out through their own children.

Other family therapy models deemphasize the systemic "function" of the substance abuse or family pathology and concentrate instead on utilizing family strengths and enlisting family members as agents of change to motivate the substance user and provide support for ongoing recovery (Liddle et al., 1992; Meyers et al., 1998; Noel and McCrady, 1993; Sisson and Azrin, 1993). This is particularly the case with multiple family therapy models and family psychoeducational groups (Kaufman and Kaufman, 1979; Kymissis et al., 1995; O'Farrell et al, 1985). Frankel described conducting separate

groups for parents and adolescents (Frankel, 1992). Szapocznik and colleagues also extended the family group model to prevention with families of adolescents at high risk of developing a substance abuse disorder (Szapocznik et al., 1989).

Behavioral marital therapy (BMT) models concentrate on teaching and practicing guidelines for clear communication and conflict resolution, marital enhancement, and substance abuse-specific coping skills such as ways to handle relapse productively. The BMT component was developed as part of the Program for Alcoholic Couples Treatment, a research study that received good empirical support after controlled trials (McCrady, 1989). Forty-five people with alcohol abuse disorders and their spouses were randomly assigned to one of three types of spouse involvement during outpatient treatment (approximately 15 sessions) and then followed over a 2-year period.

The first type of treatment was Minimal Spouse Involvement (MSI), where the spouse attended all sessions but only as an observer. Client and clinician worked together to prepare an inventory of the substance abuser's incentives to change and a functional analysis of the substance abuse behavior utilizing the Time-Line Follow-Back Interview (Sobell et al., 1980) and a Drinking Patterns Questionnaire (Zitter and McCrady, 1993). Drinking-specific interventions geared to the client were then taught, including alcohol refusal skills, learning to self-monitor drinking urges and consumption rates on a daily basis, rearranging contingencies to support abstinence, restructuring irrational cognitions, plus developing alternative relaxation and assertiveness skills (McCrady et al., 1986).

The second of the three treatment types, Alcohol-Focused Spouse Involvement (AFSI), included the same drinking-specific assessments and interventions but also assessed the couple using a modified version (Noel and McCrady, 1993) of the Spouse Behavior Questionnaire (Orford et al., 1975). Spouses were trained using role-playing and rehearsals to reinforce abstinence and decrease any of their behaviors that could trigger renewed alcohol consumption. Spouses were also instructed to let the drinker experience negative consequences from drinking and to be more assertive regarding the impact of the alcohol use.

The third type of treatment included all of the training above, plus a BMT component (McCrady et al., 1986). Each couple's interactional behaviors were initially assessed using the Locke-Wallace Marital Adjustment Test (Locke and Wallace, 1959) and Areas of Change Questionnaire (Birchler and Webb, 1977). Couples in the BMT group were taught ways to enrich their relationship by planning and carrying out shared fun activities, designating special "love days" to demonstrate their affection, and practicing good communications skills with planned family discussions, as well as techniques for problemsolving and negotiation. Finally, to offset the *abstinence violation effect* (a description of which is in Chapter 4) (Marlatt, 1978), couples were coached to regard any relapse that might occur as an opportunity to sharpen their efforts rather than give up. Booster sessions were sometimes scheduled up to 6 months posttreatment (Noel and McCrady, 1993).

Based on followup assessments at 6 months, couples in the BMT group reported better marital satisfaction and relapsed more slowly after treatment than the other two groups. Clients with partners in the BMT group were also more likely than those with "Minimal Spouse Involvement" to complete treatment (McCrady et al., 1986). Eighteen months after treatment, couples who had received BMT reported enjoying greater relationship satisfaction with fewer marital separations.

In addition, the rate of abstinence among the BMT couples had gradually continued to improve after treatment ended rather than dropping off, as occurred with the other two groups in this study and most other substance abuse treatment programs (McCrady et al., 1991). In support of this particular finding, Stout and colleagues reported the same pattern of improvement 2 years after a similar BMT trial with a different sample of 229 clients with alcohol use disorders (O'Farrell and Cowles, 1989).

According to Noel and McCrady, this long-term effectiveness suggests that marital therapy may prevent relapse during early recovery by stabilizing the substance user's interpersonal context (Noel and McCrady, 1993). Similar BMT approaches have recently been successfully employed with male substance abusers and their partners (Fals-Stewart et al., 1996) and applied in relapse prevention (McCrady, 1993) with booster sessions spread out over the following year (O'Farrell et al., 1993). A BMT approach specifically for female substance abusers is also being studied (Wetchler et al., 1993).

Network therapy approaches (Favazza and Thompson, 1984; Galanter, 1993) recognize the potential support from those outside the immediate family, especially in terms of conducting effective substance abuse interventions. Gathering together those who genuinely care about the welfare of the substance abuser, especially friends and extended family members, helps encourage the substance abuser to stop using and remain abstinent. Galanter also points to the importance of the involvement of Alcoholics Anonymous (AA) in network therapy (Galanter, 1993). Similarly, Selekman has involved peer group members in family therapy with adolescent substance users (Selekman, 1991). Piazza and DelValle have developed therapeutic interventions that actively incorporate larger systems available in the community such as churches and schools (Piazza and DelValle, 1992).

The *community reinforcement approach* (CRA) is a brief systemic/family intervention and therapy model that has shown good results through training the significant others, generally spouses, of treatment-resistant clients with alcohol abuse disorders (Hunt and Azrin, 1973; Sisson and Azrin, 1986, 1989). CRA participants learn to encourage sobriety by reinforcing abstinence while allowing the drinker to experience negative consequences from intoxication. Significant others also learn to identify a time when the drinker might be willing to enter treatment, in contrast to the confrontational methods advocated by the Johnson Institute (Johnson, 1986) and Unilateral Family Therapy models (Thomas and Ager, 1993). CRA participants are prepared to contribute to the treatment process when and if the drinker agrees to this. Because domestic violence remains a significant risk throughout this process, spouses and significant others are helped to recognize and respond to warning signs by de-escalating conflict and ensuring their own safety.

Once the drinker agrees to enter treatment, the significant other attends all further sessions and participates in communication-skills training and "reciprocity marriage counseling" to develop mutually reinforcing behaviors (Sisson and Azrin, 1989). The significant other is also asked to monitor the drinker's disulfiram use (Antabuse) on a daily basis and to respond appropriately if the disulfiram is not taken (Sisson and Azrin, 1993). Besides disulfiram and marital counseling, drinkers in the CRA programs receive job and social skills counseling as needed. It is worth noting that some CRA sessions have been held in the family's home (Hunt and Azrin, 1973), recognizing the potential for home-based treatments (Henggeler et al., 1996).

In a study utilizing the CRA approach, 12 significant others of treatment-resistant clients with alcohol abuse disorders were randomly divided to form a CRA group of seven and a control group of five who were referred to Al-Anon. Of the CRA group, six of the seven resistant spouses entered treatment, compared with none of the Al-Anon group partners. The partners of CRA participants reduced their drinking days from 24 per month to 11 before entering treatment, and this rate dropped to 2 drinking days per month once the couple started joint treatment (Sisson and Azrin, 1986). (More information on the CRA model can be found in Chapter 4 of this TIP.)

The CRA has been modified into the *community reinforcement and family training* (CRAFT) procedure (Meyers et al., 1996) with clinical trials under way (Meyers et al., 1998). This brief systemic intervention and therapy model also works through the concerned other to analyze behavior patterns surrounding substance abuse. Substance abuse triggers and consequences are sought, as well as interpersonal cues and positive consequences that support more adaptive, sober behaviors. This analysis can include the Spouse Enabling Inventory or the Spouse Sobriety Influence Inventory (Thomas et al., 1994). The risk of domestic violence is assessed using the Conflict Tactics Scale (Straus, 1979), and strategies, including a safety plan, are developed. Communication skills are an important aspect of this model. The basic rules taught are to be brief, be positive, be specific and clear, label feelings, express understanding for the other's perspective, accept partial responsibility when indicated, and offer to help (Meyers et al., 1998). A treatment setting is also lined up in anticipation that the substance abuser will agree to accept further help at some point.

In one preliminary study of the CRAFT model, 130 significant others of treatment-resistant clients with alcohol abuse disorders were randomly assigned to either the CRAFT program, an Al–Anon-only group, or a Johnson Institute intervention group (Johnson, 1973, 1986). Of the CRAFT participants with alcohol abuse disorders, 67 percent went into treatment, whereas only 13 percent of the Al-Anon group and 23 percent of the Johnson Institute intervention group entered treatment (Meyers et al., 1998).

CRAFT also works with significant others to improve their social and emotional welfare. Significant others are encouraged to decrease stress by taking care of themselves and making changes to enhance their own well-being and positive social supports. Participants in the CRAFT program have reported reductions in anger, anxiety, and depression, regardless of the substance user's treatment status. Although much of the focus of the CRA and CRAFT models centers on getting the substance abuser into treatment, both programs emphasize the importance of ongoing family or couples sessions employing communication skills training and marital reciprocity counseling (Meyers et al., 1998; Sisson and Azrin, 1986).

Family therapy is often applied in the treatment of adolescents with substance abuse disorders, and many specific family therapy models have been developed for this population. These often weave together concepts and techniques from different schools of family therapy. *Multidimensional family therapy* (MDFT) (Liddle et al., 1992) is a brief family therapy model that has demonstrated significant long-term clinical effectiveness in treating adolescent substance abuse and conduct disorders during controlled trials (Schmidt et al., 1996). MDFT integrates structural/strategic family therapy (Stanton, 1981; Todd, 1986) with research findings on adolescent development (Liddle et al., 1992). The MDFT model is designed to enhance a family's ability to buffer adolescents against destructive peer and social influences by nurturing healthy teen

development through supportive rather than strictly authoritarian parent–child relationships. Individual sessions with the adolescent are interspersed with family sessions to allow the therapist an opportunity to form a supportive relationship with the teen and act as an intermediary between parent(s) and child. Besides relationship issues, the MDFT model recognizes the developmental tasks faced by the adolescent, such as learning to manage emotions and impulses, and tries to specifically address them. Therapy sometimes includes representatives of extrafamilial systems such as school and probationary personnel as well as peers.

Recognizing that most substance-abusing teens and their parents are locked in conflict, the MDFT therapist works to find a common ground and create a context where a more trusting relationship can emerge. Adolescents are challenged to identify and articulate their own issues and goals for therapy and to take steps to achieve these. Parents are challenged to listen to their teens and let the parent–child relationship evolve into one of mutual respect, balancing the parental tasks of guidance with support. This involves charging both the adolescent and the parents with responsibility for change while conveying the clear expectation that the family can arrive at this point of reconciliation (Liddle et al., 1992). See TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT, 1999b), for more information on family therapy for adolescent substance users.

In a diverse sample of families (approximately 45 percent African-American or Hispanic), 16 sessions of MDFT led 79 percent of the adolescents to reduce their average alcohol and marijuana use from a daily to a weekly basis. In addition, harder substance use dropped from every other month to zero. Of those who reduced their substance use, 30 percent decided on complete abstinence. There was also a reduction in related conduct disorders among 68 percent of the teens with significant improvements seen in school performance (Schmidt et al., 1996). Most remarkably, these positive outcomes remained at followup 1 year later (Liddle and Dakof, 1995). Based on nonparticipant raters who assessed family therapy videotapes, the reductions in substance use were significantly associated with improvements in the parent–adolescent relationship (Schmidt et al., 1996), a primary goal of MDFT (Liddle et al., 1992). Unfortunately, dropout rates using the MDFT treatment model reached 28 percent, and only 69 percent of the parents were assessed as making progress in modifying their parenting styles (Liddle and Dakof, 1994).

The Institute of Medicine (IOM) recommended that brief couples therapy be included as a treatment option for all alcohol-abusing clients, especially for those still experiencing only mild to moderate problems (IOM, 1990). Based on their review of the treatment outcome literature, Edwards and Steinglass reached a similar conclusion:

> The weight of the evidence...seems so strong at this point as to support a recommendation that family involvement, especially inclusion of non-alcoholic family members in the assessment phase of treatment, be built in as a routine component of alcoholism treatment programs (Edwards and Steinglass, 1995, p. 485).

The brief family therapy approaches reviewed above have all shown positive long-term outcomes in controlled clinical trials. Together these approaches demonstrate the potential for brief family therapy in substance abuse treatment.

Using Brief Family Therapies

Involving family members or concerned others in family therapy can have a number of benefits.

The dynamics of the family are already a factor in the client's substance-abusing behavior in a complex and unique relationship. In the same manner, the family can participate in the positive experience of treatment and recovery.

Duration of Therapy and Frequency of Sessions

The majority of family therapy is conducted on a short-term basis, with some exceptions (Object Relations therapy may take years). Sessions may be 1½ to 2 hours in length. The preferred timeline for family therapy is not more than two sessions per week (except in residential settings) to allow time to practice new behaviors and experience change. Duration of therapy could be 6 to 10 sessions, depending on the purpose and goals of the intervention.

In a residential treatment program, family therapy can take place in a variety of ways depending on program design and length of stay. Some programs have "family weeks" in conjunction with individual treatment. Others may require clients to bring in a significant other one to two nights weekly to work together on recovery issues. Adolescent treatment programs sometimes involve the family continuously throughout treatment.

Certain forms of family therapy have been developed to achieve a high impact in a shorter period of time. One noted derivative of multifamily therapy is the Multiple Impact Model developed by Wegscheider-Cruse (1989), who brought together groups of four or five sober individuals who were previously substance dependent and their families for a concentrated, extended weekend of work. The purpose was to enable the families to support the continued sobriety of their formerly substance-dependent members. Family roles were recast so that each family member could take on a different role, such as who would make family financial decisions. New agreements between family members were written out. Permanent changes often resulted with motivated families. Wegscheider-Cruse's work has been replicated in several residential settings and training institutes (e.g., the On-Site and the Sierra Tucson Treatment Centers in Tucson, Arizona).

Opening Session

A typical opening session for a family in which a member has a substance abuse disorder might involve the following:

- The therapist seeks to clarify the nature of the problem and to identify the family's goals. The therapist asks each family member the same sort of open-ended questions typically used in individual therapy. For example:
  - "What you would like to see happen here?"
  - "What would you like to work on?"
  - "What is your goal in coming here?"
  - "How did you get here?"
- The therapist educates the family in what is needed to participate effectively in the therapeutic process and to understand key biosocial issues related to substance abuse.
- The therapist provides feedback to the family on what was said, demonstrating whose goals are similar or different.
- The therapist can then move on to prioritizing directions for change or, if the direction is sufficiently clear, start work. Some therapists ask the family to engage in a "contract" that identifies the direction of therapy and delineates each member's commitment to the process.

Early on, practitioners of different theoretical models will make choices about what they will focus on and how to proceed, for example:

- Therapists who practice solution-focused therapy would devote more time to gathering information and affirming family members at the first session, which would

probably conclude with the assignment of tasks designed to test the possibility of change in areas where change seems feasible.

- Therapists applying Eriksonian therapy, after asking family members what they want, might ask, "How will you know when you get there?" A followup question would be, "Is there any reason you can think of why it would not be okay to get there?" This question tests for resistance and any constraints, such as the possibility of family violence, which could prevent open and honest communication. The therapist would then try to do something about that constraint in order to create safety (an action referred to as an "ecological check").
- Therapists using the Mental Research Institute (MRI) strategic model would examine solutions that have already been attempted because most families with a member struggling with a substance abuse disorder try a variety of solutions that have not worked before formal treatment. The family's solution may be seen as the problem.

Followup

Therapists should plan for followup and support as part of the termination process. Residential programs, for example, can hold support groups run by alumni or counselors that are available weekly for family members who want to attend on a voluntary, as-needed basis. Some practitioners ask the client and family members to call them after 6 months or 1 year for a followup conversation. Depending on the family's needs, the therapist may be able to provide reinforcement without further meetings, or may suggest one or two followup sessions to address emerging issues.

At a minimum, clients should be assured that they can call the therapist when necessary.

Cultural Issues

It is important that a family therapist understand the family's ethnic and cultural background. (See the example in the text box below.) Failure to do so may be partially responsible for the large dropout rate by ethnic minorities after the first therapy session (Soo-Hoo, 1999). To successfully promote change within a family system, the therapist will need the family's permission to share their closely held secrets. The therapist's approach, however, must vary according to the cultural background of the family. Working with a Filipino family recently settled in the United States, one therapist had to request a letter from the family elder in the Philippines in order to allow members to reveal family matters to an outsider. Once the family opened up, however, the therapist was seen as an "elder" and was accorded the respect he needed to promote

Native Americans in Brief Family Therapy

A 26-year-old Native American man sought treatment for his alcohol abuse. In a residential treatment setting, the therapist learned that the client's father was a fanatically religious ex-drinker who tried to force his son to go to church. As a result, the client began drinking heavily on Sunday mornings in order to avoid going to church. The client was torn between a culturally based belief that he should respect his elders and his own desire for independence. The therapist encouraged father and son to express both their resentment and their appreciation of each other in letters read aloud to each other. Through this process, the client began to remember what his father had been like as an alcoholic and saw that he himself was in danger of making the same mistake. This motivated the client to accomplish abstinence and to move out of his father's home in order to establish his own household.

positive change. In another example, a therapist working with a client who belonged to the Southern Baptist fundamentalist movement found that the client was immobilized by the shame that surrounded drinking in her family and the difficulty of talking about it. The client approached the family's minister to help frame the situation so that the family could face the problem together and find a solution. (For more information on family therapy for those from unfamiliar cultures, see McGoldrick et al., 1996; Sue and Sue, 1990.)

The language used to describe dynamics within the family system is charged with specific cultural meaning. For example, if a client belongs to a culture that values lifelong interdependence among family members, the therapist would be ill advised to encourage greater independence from the family. However, the therapist might encourage the client to become more effective within his family and explain ways that would allow some freedom within the cultural parameters of the family.

Ablon (with middle-class Catholic families) and Kaufman and Borders have drawn attention to the importance of ethnic and cultural differences to understand and treat families with substance abuse problems (Ablon, 1980; Kaufman and Borders, 1988). Many substance abuse treatment programs have developed culturally specific family therapy models for Latino families (Flores-Ortiz and Bernal, 1989; Laureano and Poliandro, 1991; Panitz et al., 1983; Szapocznik et al., 1991), African-American families (Aktan et al., 1996; Ziter, 1987), and Native American families (Hill, 1989), among others.

A family therapy approach that has been successful with substance-using Hispanic adolescents combines elements from structural, strategic, and Milan therapies (Szapocznik and Kurtines, 1989; Szapocznik et al., 1988, 1991). This approach focuses considerable effort on overcoming initial resistance to treatment because the process embodies the family's issues around the adolescent's substance use (Santisteban and Szapocznik, 1994; Szapocznik and Kurtines, 1989).

9 Time-Limited Group Therapy

Group psychotherapy is one of the most common modalities for treatment of substance abuse disorders. Group therapy is defined as a meeting of two or more people for a common therapeutic purpose or to achieve a common goal. It differs from family therapy in that the therapist creates open- and closed-ended groups of people previously unknown to each other. The lessons learned in therapy are practiced in the normal social network. Although efficacy research on group therapy for substance abuse disorder clients has been limited, there is substantial anecdotal and clinical evidence that it can have a dramatic impact on participating clients. In TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* (CSAT, 1994a), group therapy is cited as the treatment modality of choice for a variety of reasons. In clinical practice, group psychotherapy offers individuals suffering from substance abuse disorders the opportunity to see the progression of abuse and dependency in themselves and in others; it also gives them an opportunity to experience their success and the success of other group members in an atmosphere of support and hopefulness. The curative factors associated with group psychotherapy, defined by Yalom, specifically address such issues as the instillation of hope, the universality experienced by group members as they see themselves in others, the opportunity to develop insight through relationships, and a variety of other concerns specific to the support of substance-abusing clients and their recovery (Yalom, 1995). For many years, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have recognized the importance of breaking the isolation associated with substance abuse, while at the same time connecting individuals with others whose common purpose is to dramatically change their lives through connection and community. From these perspectives, time-limited group psychotherapy offers potent opportunities to maximize the treatment energies of both therapist and client.

Research suggests that most client improvement as a result of group therapy occurs within a brief span of time—typically, 2 or 3 months (Garvin et al., 1976). This research implies that short-term therapy can be as successful as long-term therapy in promoting change. Short-term group therapy should be more goal-oriented, more structured, and more directive than long-term group therapy. Some therapists also believe the experience should be intensified through the use of high-impact techniques such as psychodrama (see discussion later in this chapter).

Appropriateness of Group Therapy

Groups can be extremely beneficial to individuals with substance abuse problems. Levine and Gallogly have noted that groups for alcohol-dependent clients

- Help reduce denial, process ambivalence, and facilitate acceptance of alcohol abuse

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