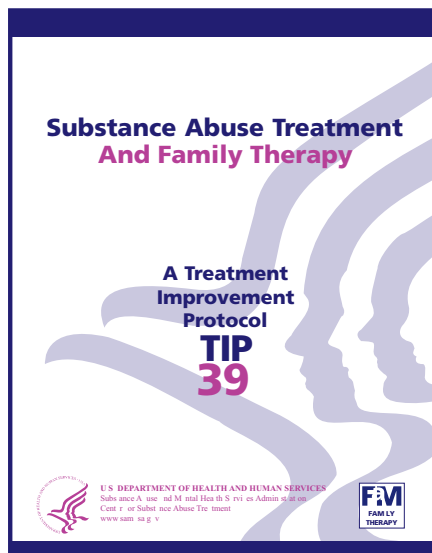


Quick Guide

For Clinicians

Based on TIP 39
***Substance Abuse Treatment
and Family Therapy***



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov



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Quick Guide

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Substance Abuse

Treatment and Family

Therapy

This Quick Guide is based entirely on information contained in TIP 39, published in 2004, and based on information updated through June 2004. No additional research has been conducted to update this topic since publication of the TIP.

WHY A QUICK GUIDE?

This Quick Guide was developed to accompany *Substance Abuse Treatment and Family Therapy*, Number 39 in the Treatment Improvement Protocol (TIP) series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). This Quick Guide is based entirely on TIP 39 and is designed to meet the needs of the busy clinician for concise, easily accessed “how-to” information.

The Guide is divided into nine sections (see *Contents*) to help readers quickly locate relevant material. The *Resources* section beginning on page 52 provides contact and background information for relevant organizations in the fields of substance abuse treatment and family therapy.

For more information on the topics in this Quick Guide, readers are referred to TIP 39.

WHAT IS A TIP?

The TIP series has been in production since 1991. This series provides the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment topics of vital current interest. TIP 39, *Substance Abuse Treatment and Family Therapy*

- Addresses how substance abuse affects the entire family
- Provides basic information about family therapy for substance abuse treatment professionals, and basic information about substance abuse treatment for family therapists
- Presents the models, techniques, and principles of family therapy
- Identifies resources for further information, as well as future directions for both research and clinical practice

See the inside back cover for information on how to order TIPs and other related products.

SUBSTANCE ABUSE TREATMENT AND FAMILY THERAPY

The family has a central role to play in the treatment of any health problem, including substance abuse. Family work has become a strong theme of many treatment approaches, but a primary challenge remains the broadening of the substance abuse treatment focus from the individual to the family.

Though substance abuse counselors should not practice family therapy unless they have proper training and licensing, they can be informed about family therapy in order to discuss it with their clients and know when a referral is indicated. Substance abuse counselors can also benefit from incorporating family therapy ideas and techniques into their work with individual clients, groups of clients, and family groups.

What Is a Family?

There is no single definition of family. However, several broad categories encompass most families:

- Traditional families (two heterosexual parents and minor children all living under the same roof).
- Single parents.

- Foster relationships.
- Grandparents raising grandchildren.
- Stepfamilies.
- Extended families, which include grandparents, aunts, uncles, cousins, and other relatives.
- Elected families, which are joined by choice and not by the usual ties of blood, marriage, and law.
Examples include:
 - Emancipated youth who choose to live among peers
 - Godparents and other nonbiologically related people who have an emotional tie
 - Gay and lesbian couples (and minor children all living under the same roof)

For practical purposes, family can be defined according to the individual's closest emotional connections. A counselor or therapist cannot determine which individuals make up the client's family; rather, counselors can ask, "Who is most important to you?" This allows clients to identify who they think should be included in therapy.

Impact of Substance Abuse on Families

When a family member abuses substances, the effect on the family may differ according to family structure.

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

Client Lives With Spouse (or Partner) and Minor Children. A parent's substance use can have cognitive, behavioral, psychosocial, and emotional consequences for children, including:

- Impaired learning capacity
- A propensity to develop a substance use disorder
- Adjustment problems, including increased rates of divorce, violence, and the need for control in relationships
- Other problems such as depression, anxiety, and low self-esteem

In addition, the children of women who abuse alcohol during pregnancy are at risk for the effects of fetal alcohol spectrum disorders.

Children of those with substance use disorders often feel guilty and responsible for the parent's substance abuse. Older children may be forced prematurely to accept adult responsibilities, especially the care of younger siblings.

Client Is Part of a Blended Family. Many people who abuse substances belong to stepfamilies. Substance abuse can intensify problems and become an impediment to a stepfamily's integration and stability.

When substance abuse is part of the family, unique issues can arise, such as parental authority disputes, sexual or physical abuse, and self-esteem problems for children. Substance abuse by stepparents may undermine their authority, lead to difficulty in forming bonds, and impair a family's ability to address problems and sensitive issues.

The children of blended families often live in two households in which different boundaries and ambiguous roles can be confusing. Without good communication and careful attention to areas of conflict, children may be at increased risk of social, emotional, and behavioral problems.

Older Client Has Grown Children. Older adults often live with or are supported by their adult children because of financial necessity. Whether grown children and their parents live together or apart, the children must take on a parental, care-taking role. Adjustment to this role reversal can be stressful, painful, and embarrassing.

In some cases, grown children may stop providing financial support because it is the only influence they have over the parent. Adult children often will say to “let them have their little pleasure.” In other instances, children may cut ties with the parent because it is too painful to have to watch the parent’s deterioration. Cutting ties only increases the parent’s isolation and may worsen the substance abuse.

What Is Family Therapy?

Family therapy is a collection of therapeutic approaches that share a belief in family-level assessment and intervention. A family is a system, and in any system each part is related to all other parts. Consequently, a change in any part of the system will bring about changes in all other parts. Therapy based on this point of view uses the strengths of families to bring about change in a range of diverse problem areas, including substance abuse.

Note: Family therapy can take place only when the safety of all participants can be guaranteed and no legal constraints preclude it. Counselors should have training in handling families with violence and/or neglect. Guidelines for assessing violence are provided beginning on page 45.

Differences Between Substance Abuse Treatment and Family Therapy

Although compatible in many ways, the fields of substance abuse treatment and family therapy often use different terms, sometimes understand the same terms differently, have different professional requirements and expectations, and are governed by different assumptions. Some of the basic differences are outlined below.

Family-Involved Therapy and Family Therapy. A distinction should be made between *family therapy* and *family-involved therapy*. Family-involved therapy attempts to educate families about the relationship patterns that typically contribute to the formation and continuation of substance abuse. It differs from family therapy in that the family is not the primary therapeutic grouping, nor is there intervention in the system of family relationships. Most substance abuse treatment centers offer such a family educational approach.

Denial. In substance abuse treatment, the term *denial* is generally used to describe a common and complex reaction of people with substance use disorders who, when confronted with the existence of those disorders, deny having the problem. Family therapists' understanding of the term denial will vary more according to the particular therapist's theoretical orientation; some may see it as a strategy for maintaining stability and therefore not a "problem" at all.

Substance Abuse. Many substance abuse treatment counselors base their understanding of a family's relation to substance abuse on a *disease model*. Within this model, practitioners have come to appreciate substance abuse as a "family disease"—that is, a disease that affects all members of a family as a result of the substance abuse of one or more members and that creates negative changes in their own moods, behaviors, relationships with the family, and sometimes even physical or emotional health.

Family therapists, on the other hand, for the most part have adopted a *family systems model*. It conceptualizes substance abuse as a symptom of dysfunction in the family—a relatively stable symptom because in some way it serves a purpose in the family system. It is this focus on the family

system, more than the inclusion of more people, that defines family therapy.

Family Interventions. Family interventions in substance abuse treatment typically refer to a confrontation that a group of family and friends have with a person abusing substances. Their goal is to convey the impact of the substance abuse and to urge entry into treatment. The treatment itself is likely to be shorter and more time-limited than that of a family therapist, who will focus more on intrafamily relationships in an effort to improve family functioning.

Spirituality. In part because of the role of spirituality in 12-Step groups, substance abuse treatment providers generally consider a spiritual emphasis more important than do family therapists. Family therapy developed from the mental health medical field, and as such the emphasis on the scientific underpinnings to medical practice has reduced the role of spirituality, especially in theory and largely in clinical practice.

Process and Content. Compared to substance abuse counselors, family therapists tend to focus more on the *process* of family interactions and the dynamics among family members than on the *content* of each session. For example, a family therapist might comment more on how family

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members ignore or pay attention to one another in conversation, rather than what specifically was being discussed.

Focus. The focus for substance abuse counselors is the substance abuse. For family therapists, it is the family system.

Identity of the Client. Most often the substance abuse counselor regards the individual with the substance use disorder as the primary person requiring treatment (though the family may be involved in treatment to some degree). The family therapy community assumes that if long-term change is to occur, the entire family must be treated as a unit, so the family as a whole constitutes the client.

Self-Disclosure by the Counselor. Many people who have been in recovery for some time and who have experience in self-help groups have become paraprofessional or professional treatment providers. As a result, it is common for substance abuse treatment counselors to disclose information about their own experiences with recovery. Clients in substance abuse treatment often have some previous contact with self-help groups, and usually feel comfortable with counselors' self-disclosure.

The practice of sharing personal history receives much less emphasis in family therapy. For the family therapist, self-disclosure is downplayed because it takes the focus of therapy off of the family.

For more information on differences in theory and practice, see chapter 3 of TIP 39.

Family Therapy Concepts and Techniques That Substance Abuse Counselors Can Use

The field of family therapy has developed a number of theoretical concepts and techniques that can help substance abuse treatment providers better understand clients' relationships with their families.

Complementarity. Complementarity refers to an interactional pattern in which members of an intimate relationship establish roles and take on behavioral patterns that fulfill the unconscious needs and demands of the other. An implication when treating substance abuse is that the results of one family member's recovery need to be explored in relation to the rest of the family's behavior.

Boundaries. Boundaries delineate one family member from another, generations within families, or the family from other systems. Boundaries also regulate the flow of information in the family and between systems outside the family.

Dysfunctional patterns can arise in boundaries ranging from extremes of *enmeshment* (smotheringly close) to *disengagement* (unreachably aloof). When boundaries are too strong, family members can become disengaged and the family will lack the cohesion needed to hold itself together. When boundaries are too weak, family members can become psychologically and emotionally enmeshed and lose their ability to act as individuals.

Appropriate boundaries vary from culture to culture, and the clinician needs to consider whether a pattern of disengagement or enmeshment is a function of culture or pathology.

Subsystems. Within a family system, subsystems are separated by clearly defined boundaries that fulfill particular functions. These subsystems have their own roles and rules within the family system. For example, in a healthy family, a parental subsystem (which can be made up of one or more

individual members) maintains a degree of privacy, assumes responsibility for providing for the family, and has power to make decisions for the family. These subsystem rules and expectations can have a strong impact on client behavior and can be used to motivate or influence a client in a positive direction.

Enduring Family Ties. Another important principle of family therapy is that families are connected through more than physical proximity and frequent interactions. Strong emotional ties connect family members, even when they are separated. It is possible to involve a client in a form of family therapy even if family members are not physically present.

Change and Balance. Family rules and scripts are not unchangeable, but families exhibit different degrees of adaptability when faced with the need to change patterns of behavior. A tendency in all families is homeostasis—a state of equilibrium that balances strong, competing forces in families as they tend to resist change—that must be overcome if change is to occur. In order to function well, families need to be able to preserve order and stability without becoming too rigid to adapt.

Adjusting to Abstinence. The family of a client who has a substance use disorder can be expected to act differently (and not always positively) when the individual with a substance use disorder enters recovery. A family may react negatively to an individual member's cessation of substance use (e.g., children may behave more aggressively or lie and steal to regain homeostasis), or there may be a period of relative harmony that is disrupted when other problems that have been suppressed begin to surface.

If these other problems are not dealt with, the family's reactions may trigger relapse. Family therapy techniques can resolve problems formerly masked by substance abuse to ensure that the family helps, rather than hinders, a client's long-term recovery.

Triangulation. Triangulation occurs when two family members need to discuss a sensitive issue. Instead of facing the issue, they divert their energy to a third member who acts as a go-between, scapegoat, object of concern, or ally. By involving this other person, they reduce their emotional tension, but prevent their conflict from being resolved and miss opportunities to increase the intimacy in their relationship.

In families organized around substance abuse, a common pattern is for one parent to be closely allied with a child while the other parent remains distant. Triangulation is especially common in families that are highly enmeshed, but it does occur to some extent in all families.

The third party in a triangle need not be a family member. Counselors should be aware of the possibility of becoming involved in a triangle with clients by competing with the client's family over the client. This process is especially common in programs that treat only the client without involving the family. A substance of abuse can also be considered an entity with which the client triangulates to avoid deeper levels of intimacy.

See pages 58–60 of TIP 39 for a more detailed discussion of these concepts.

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

Though the preparation of a genogram is not standardized, most of them begin with the legal and biological relationships of family members.

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Different genogram styles search out different information and use different symbols to depict relationships. For instance, a *family map* is a variation that arranges family members in relation to a specific problem (such as substance abuse).

Genograms can help family members see themselves and their relationships in a new way, and can be a useful tool for substance abuse treatment providers who want to understand how family relationships affect clients and their substance abuse.

See chapter 3 of TIP 39 for a more extensive discussion of genograms and how they are developed.

INTEGRATED TREATMENT: BENEFITS, LIMITATIONS, AND LEVELS OF INVOLVEMENT WITH FAMILIES

Benefits to Clients

Examining substance use disorders through the dynamics of the whole family has a number of advantages.

- *Treatment outcomes.* Family involvement in substance abuse treatment is positively associated with increased rates of entry into treatment, decreased dropout rates during treatment, and better long-term outcomes.
- *Client recovery.* When family members understand how they have participated in the client's substance abuse and are willing to actively support the client's recovery, the likelihood of successful, long-term recovery improves.
- *Family recovery.* When families are involved in treatment, the focus can be on the larger family issues, not just the substance abuse.
- *Intergenerational impact.* Integrated models can help reduce the impact and recurrence of substance use disorders in different generations.

Benefits to Providers

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

- *Reduced resistance.* Integrated models permit counselors to attend to the specific circumstances of each family in treatment, thus reducing resistance.
- *Flexibility in treatment planning.* Integrated models enable counselors to tailor treatment plans to reflect individual and family factors.
- *Flexibility in treatment approach.* Integrated models enable counselors to adjust treatment approaches according to their own personal styles and strengths. In this way, different treatment models can be used even within the same agency to meet both client and counselor needs.
- *Increased skill set.* Drawing from different traditional therapy models challenges counselors to be creative in their treatment approaches. With integrated models, for instance, substance abuse treatment counselors can work with family members and see how each of their problems reverberates throughout the family system.

Limitations of Integrating Treatment

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

- *Lack of structure.* If the various modalities in integrated models are not consistent and compatible, the combination can end up as little more than a series of disconnected interventions.
- *Additional training.* Integrated models require greater knowledge of more treatment modalities, so additional training is necessary.
- *Mindset.* The major mindset shift necessary to using integrated models is from an individual model concentrating on pathology to a systemic (relational or behavioral) model focused on changing patterns of family interaction.

Levels of Involvement With Families

Substance abuse treatment professionals intervene with families at different levels during treatment. These levels vary according to how individualized the interventions are to each family, the extent to which the substance abuse treatment provider is trained and supervised in family therapy techniques, and the extent to which family therapy is integrated into the process of substance abuse treatment.

At each level, family intervention has a different function and requires its own set of competencies. The family's acceptance of problems and its readiness to change determine the appropriate level of counselor involvement with that family.

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

- The counselor contacts families for practical and legal reasons and provides no services to them.
- The counselor views the individual in treatment as the only client and may even feel that during treatment, the client must be protected from family contact.

Level 2—Counselor provides psychoeducation and advice.

Typical skills:

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

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

Typical skills:

- Asking questions that elicit family members' expressions of concern and feelings related to the client's condition and its effect on the family
- Empathically listening to family members' concerns and feelings and, where appropriate, normalizing them

- Forming a preliminary assessment of the family's level of functioning as it relates to the client's problem
- Encouraging family members in their efforts to cope with their situation as a family
- Tailoring substance abuse education to the unique needs, concerns, and feelings of the family
- Identifying family dysfunction and fitting referral recommendations to the unique situation of the family

Level 4—Counselor provides systematic assessment and planned intervention.

Typical skills:

- Engaging family members, including reluctant ones, in a planned family conference or a series of conferences
- Structuring a conference with even a poorly communicating family in such a way that all members have a chance to express themselves
- Systematically assessing the family's level of functioning
- Supporting individual members while avoiding coalitions
- Reframing the family's definition of its problem in a way that makes problemsolving more achievable
- Helping family members view their difficulties as requiring new forms of collaborative efforts

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- Helping family members generate alternative, mutually acceptable ways to cope with difficulties
- Helping the family balance its coping efforts by calibrating various roles so that members can support each other without sacrificing autonomy
- Identifying family dysfunction beyond the scope of primary care treatment; orchestrating a referral by informing the family and the specialist about what to expect from each other

Level 5—Family therapy.

Typical skills:

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

For more information on counselor involvement with families, see Figure 4-2 in TIP 39.

INTEGRATED TREATMENT MODELS

Examples of Integrated Treatment Models

A number of integrated treatment models have been discussed in the literature. Those discussed in this section are among the more frequently used integrated treatment models. For a more detailed discussion of these and other models of family therapy, see chapter 4 of TIP 39.

Structural/Strategic Family Therapy

In this model, family structure (defined as repeated patterns of interaction) is the focus of interventions. It is based on two assumptions:

- Family structure largely determines individual behavior.
- The power of the system is greater than the ability of the individual to resist.

This system can be used to

- Identify the function that substance abuse serves in maintaining family stability.
- Guide appropriate changes in family structure (e.g., because the patterns in dysfunctional families are typically rigid, the counselor must take a directive role and coach family members to develop, then practice, different patterns of interaction).

One of the basic techniques of structural family therapy is to mark boundaries so that each member of the family can be responsible for him- or herself while respecting the individuality of others. One of the ways to make respectful individuation possible is to make the family aware when a family member

- Speaks about, rather than to, another person who is present
- Speaks for others, instead of letting them speak for themselves
- Sends nonverbal cues to influence or stop another person from speaking

For more information about structural/strategic family therapy, see pp. 86–90 of TIP 39.

Multidimensional Family Therapy

Multidimensional family therapy (MDFT) was developed as a stand-alone, outpatient therapy to treat adolescent substance abuse and associated behavioral problems of clinically referred teenagers. The model integrates several different techniques with emphasis on the relationships among cognition, affect (emotionality), behavior, and environmental input.

For the adolescent who abuses substances, the goals include

- Positive peer relations
- Healthy identity formation
- Bonding to school and other prosocial institutions
- Autonomy within the parent–adolescent relationship

For parents, the goals are

- Increasing parental commitment and preventing parental abdication
- Improving relationship and communication between parent and adolescent
- Increasing knowledge of parenting practices (e.g., limit-setting, monitoring, and appropriate autonomy granting)

For more information about MDFT, see pp. 90–91 of TIP 39.

Behavioral Family Therapy and Cognitive–Behavioral Family Therapy

Behavioral family therapy (BFT) combines individual interventions within a family problem-solving framework. The approach assumes that

- Families of people abusing substances may have problem-solving skill deficits.

- The reactions of other family members influence behavior.
- Distorted beliefs lead to dysfunction and distorted behaviors.
- Therapy helps family members develop behaviors that support nonusing and nondrinking. Over time, these new behaviors become more and more rewarding, promoting abstinence.

Cognitive-behavioral family therapy views substance abuse as a conditioned behavioral response, one which family cues and contingencies reinforce.

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

- *Contingency contracting*. These agreements stipulate what each member will do in exchange for rewarding behavior from other family members. For example, a teenager may agree to call home regularly while attending a concert in exchange for permission to attend it.
- *Skills training*. The counselor may start with general education about communication or conflict resolution skills, then move to skills practice during therapy, and end with the family's agreement to use the skills at home.

- *Cognitive restructuring.* The counselor helps family members voice unrealistic or self-limiting beliefs that contribute to substance abuse or other family problems. Family members are encouraged to see how such beliefs threaten ongoing recovery and family tranquility. Finally, the family is helped to replace these self-defeating beliefs with those that facilitate recovery and individual and family strengths.

For more information about behavioral family therapy and cognitive-behavioral family therapy, see pp. 93–95 of TIP 39.

Family/Larger System/Case Management Therapy

This model is primarily for families who are or should be involved intensely with larger systems, which include the workplace, schools, health care, courts, foster care, etc. The goal is to empower the family in working with the larger system by designating the family as the major expert on its own needs. Counselors help the family navigate various systems, serving to some extent as a community liaison.

Counselors utilizing this model will need to determine

- What larger systems affect the family?

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- What agencies and agency subsystems regularly interact with family members?
- How is the family moved from one larger system to another?
- Is there a history of significant involvement with larger systems, and if so, regarding what issues?

For example, families with substance abuse problems interact more regularly with the judicial system, because of arrests (e.g., for driving under the influence, loss of parental rights, and domestic violence).

For more information about family/larger system/case management therapy, see pp. 97–98 of TIP 39.

Network Therapy

Network therapy harnesses the potential of therapeutic support from people outside the immediate family, including friends, extended family, and 12-Step groups such as Alcoholics Anonymous (AA). The counselor works to mobilize the client's network, to keep the people in the network informed and involved, and to encourage the client to accept help from the network.

For more information about network therapy, see p. 98 of TIP 39.

Bowen Family Systems Therapy

Bowen family systems therapy often works through one person, on the premise that a change on the part of just one family member will affect the family system. The model attempts to reduce anxiety throughout the family by encouraging people to become more differentiated, more autonomous, and less enmeshed in the family emotional system.

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

- *Creating distance.* Alcohol and drugs are used to manage anxiety by creating distance in the family.
- *Triangulation.* As previously discussed, triangulation is an emotional pattern that can involve either three people or two people and an issue (such as the substance abuse). In the latter situation, the substance is used to displace anxiety that exists between the two people.
- *Coping.* Substance abuse is used to mute emotional responses to family members and to create a false sense of family equilibrium.

For more information about Bowen family systems therapy, see pp. 98–100 of TIP 39.

Solution-Focused Brief Therapy

Rather than focusing on an extensive description of the problem, solution-focused brief therapy (SFBT) encourages client and therapist to focus instead on what life will be like when the problem is solved. The emphasis is on the development of a solution in the future, rather than on understanding the development of the problem in the past or its maintenance in the present. Exceptions to the problem—that is, times when the problem does not happen and a piece of the future solution is present—are elicited and built on.

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

The Miracle Question

Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens: The problem that brought you here is solved. Because you are sleeping, however, you don't know that the miracle has happened. When you wake up tomorrow morning, what will be different that will tell you a miracle has happened, and the problem that brought you here has been solved?

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

For more information about solution-focused brief therapy, see pp. 100–105 of TIP 39.

Matching Therapeutic Techniques to Points of Family Recovery

TIP 39 combines Bepko and Krestan's stages of treatment for families (1985)¹ and Heath and Stanton's stages of family therapy for substance abuse treatment (1998)² to describe how families cope at different points in the progression of treatment. Three points are described:

- **Attainment of Sobriety:** The family system is unbalanced but healthy change is possible.
- **Adjustment to Sobriety:** The family works on developing and stabilizing a new system.

¹Bepko, C., and Krestan, J.A. *The Responsibility Trap: A Blueprint for Treating the Alcoholic Family*. New York: Free Press, 1985.

²Heath, A.W., and Stanton, M.D. Family based treatment: Stages and outcomes. In: Frances, R.J., and Miller, S.I., eds. *Clinical Textbook of Addictive Disorders*. 2d ed. New York: Guilford Press, 1998. pp. 496–520.

- **Long-Term Maintenance of Sobriety:** The family must rebalance and stabilize a new and healthier lifestyle.

The following summary lists techniques from the previously summarized treatment models that can be used with families at these different recovery points.

Attainment of Sobriety

Multidimensional Family Therapy

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

Behavioral Family Therapy

- Conduct community reinforcement training interviews (e.g., with area clergy to help them develop ways to impact the community).

Network and Family/Larger System

- Use the network (including courts, parole officers, employer, team staff, licensing boards, child protective services, social services, lawyers, schools, etc.) to motivate treatment.

- Interview the family in relation to the larger system.
- Interview the family and people in other larger systems that assist the family.
- Interview larger system representatives (e.g., school counselors) without the family present (provided that issues of confidentiality have been addressed).

Bowen Family Systems Therapy

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

Adjustment to Sobriety

Structural/Strategic Systems

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

Multidimensional Family Therapy

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

Cognitive–Behavioral Family Therapy

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

Network Interventions

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

Solution-Focused Family Therapy

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

Long-Term Maintenance of Sobriety

Family/Larger Systems/Case Management

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

Network Therapy

- Employ Al-Anon, spousal support groups, and multifamily support groups.

For more information on matching therapeutic techniques to points of family recovery, see pages 103–106 of TIP 39, including Figures 4-3, 4-4, and 4-5.

SPECIFIC POPULATIONS

Women

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.

Racial and Ethnic Minorities

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 core family and clinical processes.

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
- Doubt about the efficacy of treatment

- 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 (e.g., harsh rules in residential programs)
- Structural problems (e.g., too little treatment for people with no or inadequate insurance, inadequate detoxification facilities, bureaucratic red tape)

Gay, Lesbian, and Bisexual Clients

Available data suggest that lesbian and gay sexual orientation increases a person's risk for substance use and abuse. However, research is insufficient to suggest the efficacy of any one type of family therapy over another for use with gay and lesbian clients.

Possibly more important than the school of therapy is the therapist's knowledge, understanding, and acceptance of differing sexual orientations. Treatment providers often are not trained in the specific needs of these populations, even though gay, lesbian, and bisexual individuals in treatment for substance abuse often take part in family therapy.

People With Physical or Cognitive Disabilities

The life challenges facing family members with disabilities increases their risk of substance use, makes treatment more complex, and heightens the possibility of relapse.

Because family members may feel responsible for the individual's condition and present mostly with negativity, providers must address guilt and anger. Researchers suggest that a therapist 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.

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.

Children and Adolescents

TIP 39 indicates several possible approaches to treatment involving an adolescent or child and her family.

- Providers will need to make accommodations for children in therapy (e.g., 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).
- Parents can be taught techniques to decrease reactivity and ways to provide real and acceptable choices for their children.
- Children can 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 an adolescent is familiar and comfortable can be helpful. Conducting sessions at an adolescent's home may promote a more open and sharing tone than sessions in an office.
- Scheduling of sessions must be sensitive not only to school obligations, but to extracurricular and social activities as well.
- Gender also may have implications in family groupings, particularly in families where abuse has occurred. There may be cases where father/son or mother/daughter sessions will be helpful.

Ultimately, treatment for adolescents and children is challenging and may require referral.

Older Adults

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. At the same time, 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.

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.

Rural Populations

The geographic dispersion of families in rural areas may require them to travel great distances in order to access treatment. A provider has several options for addressing distance barriers:

- Contract with the family for a limited number of sessions and be very focused in the work.

- 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).
- Schedule extended sessions that allow bigger chunks of therapeutic work to occur every 2 or 3 weeks instead of weekly.

Homeless Clients

Many homeless people do not have a family group to bring into therapy, even by the most inclusive interpretations. 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 that a family genogram would yield little useful information, but constructing one can 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.

Veterans

Little specific family therapy research about veteran populations exists. The therapist can help the veteran locate services, including benefits to which they are entitled. Therapists also need to

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know where local veteran centers are. If treatment is difficult to access, it may be hard to get families involved.

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.

The issue of abandoned children may also be difficult for veterans. A number of veterans fathered children while in the service, and these lost families often need to be addressed in family therapy.

For more information about these and other specific populations as they relate to family therapy, see chapter 5 of TIP 39.

GUIDELINES FOR FAMILY VIOLENCE AND CHILD ABUSE SCREENING

Therapists must assess the potential for anger and violence and construct therapy so it can be conducted without endangering any family members. Because of the critical nature of this responsibility, included here are guidelines for the screening of families for violence and neglect

These guidelines have been adapted from a more extensive version included in TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997), and in appendix C of TIP 39. Providers who encounter family violence issues in practice should refer to these more comprehensive discussions for further guidance.

If during the screening interview, it becomes clear that a batterer is endangering a client or other abuse is occurring in the family, the treatment provider should respond to this situation before any other issue, and if necessary, suspend the rest of the screening interview until the safety of the client or family member can be ensured. The provider should refer the client to a domestic violence program and possibly to a shelter and legal services.

Screening for Domestic Violence and Other Abusive Behavior

- To determine if someone has endured domestic violence, look for physical injuries, especially patterns of untreated injuries to the face, neck, and throat. Other indicators may include
 - Inconsistent explanations for injuries and evasive answers when questioned about them
 - Complications in pregnancy, including miscarriage, premature birth, and infant illness or birth defects
 - Stress-related illnesses and conditions such as headache, backache, chronic pain, gastrointestinal distress, sleep disorders, eating disorders, and fatigue
 - Anxiety-related conditions, such as heart palpitations, hyperventilation, and panic attacks
 - A sad, flat affect or talk of suicide
 - History of relapse or noncompliance with substance abuse treatment plans
- Always interview clients about domestic violence in private. Ask about violence using concrete examples and hypothetical situations rather than vague, conceptual questions. Screening questions should convey to survivors that no battering is justified and that substance abuse is not an acceptable excuse for violent behavior.
- Referrals should be made when appropriate for psychotherapy and specialized counseling. Staff

training in domestic violence is important so that substance abuse treatment counselors can respond effectively to a domestic violence crisis.

- Because batterers in treatment frequently harass their partners, telephone and visitation privileges of batterers and survivors in residential substance abuse treatment programs should be carefully monitored.
- A good initial question to investigate the possibility that a client is abusing family members is, “Do you think violence against a partner is justified in some situations?” A third-person example may be used, followed by specific, concrete questions that define the extent of the violence:
 - What happens when you lose your temper?
 - When you hit [name of family member], was it a slap or a punch?
 - Do you take car keys away? Damage property? Threaten to injure or kill [name of family member]?
- Once it has been confirmed that a client has been abusive—whether physically, sexually, or psychologically—the provider should contact a domestic violence expert, either for referral or consultation. Treatment providers should ensure that the danger the batterer poses is carefully assessed.

- Become familiar with batterers' rationalizations and excuses for their behavior:
 - *Minimizing*: “I only pushed her.” “She exaggerates.”
 - Claiming *good intentions*: “When she gets hysterical, I have to slap her to calm her down.”
 - Blaming *intoxication*: “I’m not myself when I drink.”
 - Pleading *loss of control*: “I can only take so much.” “I was so angry, I didn’t know what I was doing.”
 - *Faulting* the partner: “She drove me to it.” “She really knows how to get to me.”
 - *Shifting blame* to someone or something else: “I was raised that way.” “My probation officer is putting a lot of pressure on me.” “I’ve been out of work.”

Screening for Child Abuse

- Federal and State laws require health care providers, and in some cases “any person,” to report suspected child abuse or neglect. Consequently, substance abuse treatment providers must notify a child protective services agency if they suspect child abuse or neglect. Providers that fail to carry out this mandate are subject to loss of license, fines, or imprisonment, as well as civil liability. In order to avoid any client feeling that they have been betrayed,

notification regarding Federal and State reporting requirements should be clearly stated during the admission process, and should be prominently written or stated for those parts of any treatment program that involve participation of the client's family, friends, or others.

- When discussing the limits of confidentiality as set forth in Title 42, Part 2, of the Code of Federal Regulations (or 42 C.F.R, Part 2), treatment programs should be sure that clients understand that those requirements do not affect the absolute reporting requirement of suspected child abuse or neglect. Clients should understand that their permission is not needed in any way, as child abuse or neglect reporting laws must be adhered to regardless of the concerns of the client or others.
- During initial screening, the interviewer should attempt to determine whether a client's children have been physically or emotionally harmed and whether their behavior has changed. Have they become mute? Do they scream, cry, or act out? [See also TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues*, p. 79, "Clues That the Client May Be Endangering Children," for additional guidance.]
- The substance abuse treatment provider should not assess children for abuse or incest. Only personnel with special expertise should perform

this delicate function (e.g., a psychologist, psychiatrist, social worker, or other care provider authorized by State child protective services). The treatment provider should, however, note any indications of child abuse occurring in a client's household and pass these suspicions on to the appropriate agency.

- Indications of child abuse that can crop up in a client interview include:
 - A protective services agency has been involved with anyone who lives in the home
 - The children's behaviors are indicative of abuse (e.g., bedwetting, sexual acting out)
 - Extraordinary closeness is noted between a child and another adult in the household
 - The client reports blackouts (batterers often claim to black out during a violent episode)
- If a treatment provider suspects that a client's child has been abused, the provider must immediately refer the child to a health care provider. If the parent will not take the child to a doctor (who is required by law to report suspected abuse), the provider must contact home health services or child protective services.
- If the treatment provider reports suspected or definite child abuse or neglect, the provider must assess the impact on any client also being

battered and develop a safety plan if one is deemed necessary.

- Providers should be aware that if a child has been or is being abused by the mother's partner, it is likely that the mother is also being abused.

RESOURCES

This list of resources is not exhaustive, and does not necessarily signify endorsement by CSAT, SAMHSA, or the U.S. Department of Health and Human Services (DHHS).

Addiction Technology Transfer Centers (ATTCs)

National Office

University of Missouri, Kansas City
5100 Rockhill Road
Kansas City, MO 64110
Phone: (816) 482-1200
Fax: (816) 482-1101
Web site: www.nattc.org

The Addiction Technology Transfer Centers are a nationwide, multidisciplinary resource that draws upon the knowledge, experience, and latest work of recognized experts in the field of addictions. Launched in 1993 and funded by CSAT, the Network today is composed of 14 independent Regional Centers and a National Office.

Adult Children of Alcoholics (ACA)

World Services Organization, Inc.

P.O. Box 3216

Torrance, CA 90510

Phone: (310) 534-1815

Web site: www.adultchildren.org

Adult Children of Alcoholics is a 12-Step, 12 Tradition program of men and women who grew up in alcoholic or otherwise dysfunctional homes.

Adult Children Anonymous

ACA General Service Network

P.O. Box 25166

Minneapolis, MN 55458

Web site: www.12stepforums.net/acoa.html

Adult Children Anonymous is a 12-Step program modeled after Alcoholics Anonymous. It is a spiritual program designed to help adults raised in families where either substance addiction, mental illness, or generalized dysfunction was present.

Al-Anon and Alateen

Al-Anon Family Group Headquarters, Inc.
1600 Corporate Landing Parkway
Virginia Beach, VA 23454
Phone: (757) 563-1600
Fax: (757) 563-1655
Web site: www.al-anon.org

Al-Anon is a group of relatives and friends of alcoholics who share their experience, strength, and hope to solve their common problems. The purpose of Al-Anon is to help families of alcoholics by practicing the 12 steps, by welcoming and giving comfort, and by providing understanding and encouragement.

Alateen, which can be contacted through Al-Anon, is a group made up of young Al-Anon members, usually teenagers, whose lives have been affected by someone else's drinking.

American Association for Marriage and Family Therapy (AAMFT)

112 South Alfred Street
Alexandria, VA 22314
Phone: (703) 838-9808
Fax: (703) 838-9805
Web site: www.aamft.org

The American Association for Marriage and Family Therapy represents the professional interests of more than 23,000 marriage and family therapists throughout the United States, Canada, and abroad.

Co-Anon Family Groups

Co-Anon Family Groups World Services
P.O. Box 12722
Tucson, AZ 85732
Phone: (800) 898-9985
Voice recorder: (520) 513-5028
Web site: www.co-anon.org

Co-Anon Family Groups are a fellowship of men and women who are husbands, wives, parents, relatives, or close friends of someone who is chemically dependent.

Co-Dependents Anonymous, Inc. (CoDA)

P.O. Box 33577

Phoenix, AZ 85067

Web site: www.codependents.org

Co-Dependents Anonymous, Inc. is a fellowship of men and women whose common purpose is to develop healthy relationships. CoDA relies on the 12 Steps and 12 Traditions for knowledge and wisdom.

Families Anonymous

P.O. Box 3475

Culver City, CA 90231

Infoline: (800) 736-9805

Fax: (310) 815-9682

Web site: www.familiesanonymous.org

Families Anonymous is a nonprofit organization that provides emotional support for relatives and friends of individuals with substance or behavioral problems using the 12 steps.

The International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse (IC&RC)

6402 Arlington Boulevard, Suite 1200

Falls Church, VA 22042

Phone: (703) 294-5827

Fax: (703) 875-8867

Web site: www.icrcaoda.org

The IC&RC is a not-for-profit voluntary membership organization composed of certifying agencies involved in credentialing alcohol and drug abuse counselors, clinical supervisors, and prevention specialists.

IC&RC member boards are currently located in 40 States, the District of Columbia, and 10 countries outside the United States. Members also include the U.S. Army, U.S. Air Force, U.S. Navy, U.S. Marine Corps, the Indian Health Service, and the U.S. Administrative Office of the Courts.

There are currently five reciprocal certifications offered through IC&RC including Alcohol and Drug Counselor, Advanced Alcohol and Drug Counselor, Certified Clinical Supervisor, Criminal Justice Addictions Professional, and Certified Prevention Specialist.

NAADAC (The Association for Addiction Professionals)

901 N. Washington Street, Suite 600

Alexandria, VA 22314

Phone: (703) 741-7686

or Toll-Free (800) 548-0497

Fax: (703) 741-7698

or Toll-Free (800) 377-1136

Web site: www.naadac.org

Formerly the National Association of Alcohol and Drug Abuse Counselors, NAADAC provides certification in many States that also have IC&RC reciprocity. NAADAC offers the only Master's level credential based on education and not experience.

Nar-Anon Family Group

Nar-Anon World Service Office

22527 Crenshaw Boulevard, Suite 200B

Torrance, CA 90505

Phone: (310) 547-5800

Web site: www.naranon.com

Nar-Anon Family Group is a 12-Step recovery program for the families and friends of individuals with substance use disorders.

The National Association for Children of Alcoholics (NACoA)

11426 Rockville Pike, Suite 100

Rockville, MD 20852

Phone: (888) 55-4COAS or (301) 468-0985

Fax: (301) 468-0987

Web site: www.nacoa.org

NACoA is a national nonprofit membership organization working on behalf of children whose parents have substance use disorders. NACoA's mission is to advocate for all children and families affected by alcoholism and other drug dependencies.

National Center on Substance Abuse and Child Welfare (NCSACW)

Web site: www.ncsacw.samhsa.gov

E-mail questions to ncsacw@samhsa.gov

The National Center on Substance Abuse and Child Welfare is an initiative of DHHS and jointly funded by SAMHSA, CSAT, and the Administration on Children, Youth and Families, Children's Bureau's Office on Child Abuse and Neglect.

One of NCSACW's primary goals is to develop materials and resources that serve to advance knowledge and practice in the linkages among substance abuse, child welfare, and family court systems. A wealth of products and services—including curricula, tutorials, and training materials, publications, technical assistance, and presentations—can be accessed via its Web site.

U.S. Department of Health and Human Services

Families & Children Web Site

Web site: www.dhhs.gov/children/index.shtml

This Web site provides information and resources for and about families and children under several categories, including adoption, babies, children, family issues (child support, child care, domestic violence, child abuse), low-income families, DHHS agencies, immunizations/vaccinations, kids' Web sites, pregnancy, safety and wellness, teenagers, teen Web sites, and other resources.

WestEd

730 Harrison Street

San Francisco, CA 94107

Phone: (415) 565-3000

Toll-Free (877) 4-WestEd

Web site: www.WestEd.org

WestEd is a nonprofit research, development, and service agency formed in 1966 when Congress created a network of Regional Educational Laboratories. WestEd is committed to improving learning at all stages of life—from infancy to adulthood, both in school and out.

GLOSSARY

Affect: Feeling or emotion, especially as manifested by facial expression or body language.

Boundary: An invisible though often effective barrier within a relationship that governs the level of contact. Boundaries can appropriately shape and regulate relationships. Two dysfunctional types of boundaries are those that are (1) so rigid, inhibiting meaningful interaction so that the people in the relationship are said to be “disengaged” from each other, or (2) so loose that individuals lose a sense of independence so that the “enmeshed” relationship stifles individuality and initiative.

Complementarity: A pattern of human interactions in which partners in an intimate relationship establish roles and take on behavioral patterns that fulfill the unconscious needs and demands of the other.

Disengagement: The state of being unreachably aloof or distant from others.

Enmeshment: The state of being in which two people are so close emotionally that one perceives the other as “smothering” him or her with affection, concern, attention, etc. Enmeshment also can occur without a conscious sense of it.

Family Structure: Repeated, predictable patterns of interaction between family members that influence individual behavior to a considerable extent.

Family Therapy: An approach to therapy based on the idea that a family is—and behaves as—a system. Interventions are based on the presumption that when one part of the system changes, other parts will change in response. Family therapists therefore look for unhealthy structures and faulty patterns of communication.

Genogram: A pictorial chart of the people involved in a three-generational relationship system, marking marriages, divorces, births, geographical location, deaths, and illness. Significant physical, social, and psychological dysfunction may be added. A genogram assists the therapist in understanding the family and is used to examine a family's relationships.

Homeostasis: A natural process in which multi-generational competing forces seek to maintain a state of equilibrium (i.e., balance).

Integrated Models: A constellation of interventions that takes into account (1) each family member's issues as they relate to the substance abuse and (2) the effect of each member's issues on the family system.

Phases of Family Change: A model of family change that includes three elements occurring in a series: attainment of sobriety, adjustment to sobriety, and long-term maintenance of sobriety.

Triangulation: This occurs when two family members dealing with a problem come to a place where they need to discuss a sensitive issue. Instead of facing the issue, they divert their energy to a third member who acts as a go-between, scapegoat, object of concern, or ally. By involving this other person, they reduce their emotional tension, but prevent their conflict from being resolved and miss opportunities to increase the intimacy in their relationship.

For additional terms, see appendix B of TIP 39.

Ordering Information

TIP 39

Substance Abuse Treatment and Family Therapy

TIP 39-Related Products

Quick Guide for Administrators
Training Manual

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Three Ways to Obtain FREE Copies of All TIPs Products:

1. Call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at **800-729-6686**, TDD (hearing impaired) **800-487-4889**.
2. Visit NCADI's Web site at **www.ncadi.samhsa.gov**.
3. You can also access TIPs online at:
www.kap.samhsa.gov.



Other Treatment Improvement Protocols (TIPs) that are relevant to this Quick Guide:

TIP 25: *Substance Abuse Treatment and Domestic Violence* **BKD139**

TIP 32: *Treatment of Adolescents With Substance Use Disorders* **BKD307**

TIP 35: *Enhancing Motivation for Change in Substance Abuse Treatment* **BKD342**

TIP 36: *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* **BKD343**

TIP 41: *Substance Abuse Treatment: Group Therapy* **BKD507**

See the inside back cover for ordering information for all TIPs and related products.