CEU MATRIX
THE INSTITUTE FOR ADDICTION & CRIMINAL JUSTICE STUDIES

SUBSTANCE ABUSE TREATMENT AND FAMILY THERAPY (TIP 39) PART IV

4 Continuing Education Credits

Asynchronous Distance Learning Course

Content Level: Intermediate

Course Author: Robert A. Shearer, Ph.D.

Last Updated: 2026

Approved by such credentialing bodies as:

• National Association of Alcoholism and Drug Abuse Counselors (NAADAC) #94564

• National Board of Certified Counselors (NBCC) #6310

All approval bodies are listed at ceumatrix.com/accreditations

For questions or to request accessibility accommodations please email us at: support@ceumatrix.com

© 2026 CEU Matrix. All rights reserved.

CEU MATRIX
THE INSTITUTE FOR ADDICTION & CRIMINAL JUSTICE STUDIES

Welcome to CEU Matrix. We have been committed to supporting the continuing education of behavioral health professionals since 2007. Please reach out with any questions, ideas, or feedback.

Do the best you can until you know better.
Then when you know better, do better.

— Maya Angelou

COPYRIGHT

Original course materials, including the front matter, supplemental research synthesis, post-test, and CEU Matrix-authored content: © Copyright 2026 CEU Matrix. All rights reserved.

This course is based on the SAMHSA Treatment Improvement Protocol (TIP) 39: Substance Abuse Treatment and Family Therapy, in the public domain as a work of the United States Government under 17 U.S.C. § 105.

No portion of the CEU Matrix-authored content may be reproduced in any manner without the written permission of the publisher, in accordance with the U.S. Copyright Act of 1976, Title 17 U.S.C.

ABOUT THE INSTRUCTOR

Dr. Robert A. Shearer is a retired professor of Criminal Justice, Sam Houston State University. He received his Ph.D. in Counseling and Psychology from Texas A & M University, Commerce. Prior to teaching Criminal Justice, he taught Educational Psychology at Mississippi State University on campus and in the extension program across rural Mississippi during the civil rights era.

He has been teaching, training, consulting and conducting research in the fields of Criminal Justice, human behavior, and addictions for over thirty-six years. He is the author of over sixty professional and refereed articles in Criminal Justice and behavior. He is also the author of Interviewing: Theories, techniques, and practices, 5th edition published by Prentice Hall. Dr. Shearer has also created over a dozen measurement, research, and assessment instruments in Criminal Justice and addictions.

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. His interests continue to be substance abuse program assessment and evaluation. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs-crime-social policy, assessment and treatment planning, and educational psychology. He has also taught several university level psychology courses in the Texas Department of Criminal Justice Institutional Division, led group therapy in prison, trained group therapists, and served as an expert witness in various courts of law.

He has been the president of the International Association of Addictions and Offender Counseling and the editor of the Journal of Addictions and Offender Counseling as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

Population-Specific Adaptations: Workforce Diversity, Cultural Context, and LGBTQ+ Populations

Part IV of TIP 39 addresses one of the most clinically demanding aspects of family therapy practice: adapting evidence-based approaches for populations whose needs, cultural contexts, and family structures differ substantially from the populations in which most family therapy models were originally developed. Several bodies of recent research are directly relevant to this challenge -- one examining the structural dimension of workforce diversity and treatment quality, one synthesizing the procedural mechanics of cultural adaptation across dozens of programs, one documenting a successful cultural adaptation for American Indian families, one extending cultural adaptation into integrated perinatal clinical care for Native communities, one detailing how LGBTQ+ individuals experience substance use services and what affirming care requires in practice, one analyzing the structural determinants of substance use among sexual and gender minority adults, and one documenting how rural family members' beliefs about evidence-based treatment can undermine recovery.

Maxey et al. (2025) conducted a systematic review examining how workforce diversity and cultural competency relate to treatment quality for minoritized populations in the United States, analyzing studies published between 2003 and 2023. Nine studies met inclusion criteria. The findings were complex and, at points, contradictory: some studies demonstrated positive associations between workforce diversity or cultural competency and treatment outcomes, while others found no relationship or negative effects. The authors attributed this inconsistency primarily to methodological heterogeneity -- studies used different definitions of cultural competency, different outcome measures, and different analytic frameworks, making direct comparison difficult. Their conclusions point toward urgent structural needs: standardized measures of cultural competency, multi-agency collaboration, and targeted funding to reduce treatment disparities. For counselors implementing Part IV's guidance on culturally adapted treatment, this review is a useful calibration. It does not undermine the case for cultural adaptation; it sharpens the case by identifying what is currently missing from the evidence base and what program-level investments are necessary to demonstrate measurable equity in outcomes.

Corpus-Espinosa et al. (2025) offer a procedural counterweight to the single-site cultural adaptation studies by synthesizing the adaptation processes of 43 evidence-based programs targeting adolescent substance use and mental health. Thirty percent were delivered in family settings, making the review directly relevant to Part IV's family therapy frame. The authors distilled eleven common adaptation steps, beginning with local needs assessment and advisory group establishment and ending with dissemination and monitoring. Most programs used both surface adaptations (translation, local imagery) and deep adaptations (incorporation of cultural values such as "familismo" in Latinx programs). The review's central critique is documentary: despite frequent use of the cultural sensitivity model, detailed adaptation frameworks were often missing from published reports, making replication and evaluation difficult. For counselors applying Part IV, this review functions as a procedural checklist -- advisory groups, pilot studies, surface-plus-deep adaptation -- and as a warning that adaptation quality depends on documentation rigor.

The evidence for cultural adaptation becomes considerably more concrete in Asdigian et al. (2023), who describe the Thiwáhe Gluwáš'akapi Program (TG), a culturally adapted substance use prevention intervention developed for American Indian families on a Northern Plains reservation. The team integrated cultural kinship teachings into the Strengthening Families Program for Parents and Youth

10-14, creating an intervention that embedded local cultural values and contextual realities within an evidence-based prevention framework. Results demonstrated substantial gains across multiple outcomes for youth: improved parental dialogue about substance use, increased resistance capabilities, stronger coping mechanisms, enhanced family connectedness, and improved personal wellness. Parents showed meaningful improvements in multiple parenting competencies and in family relationship indicators. The TG program illustrates a core principle for working with the special populations that Part IV addresses: the process of cultural adaptation is not merely cosmetic translation of existing materials into a different cultural idiom, but a substantive integration of community-specific values and social structures into the therapeutic framework itself. The preservation of the Strengthening Families evidence base while embedding it within kinship and cultural teachings suggests a model for how adaptation can maintain fidelity to proven mechanisms while achieving meaningful relevance for specific communities.

Debbink et al. (2026) extend the cultural adaptation case beyond prevention into integrated clinical care with the CEREMONY project (Culturally Engaged REcovery – MOms connected through Native CommunitY), a 7-year NIH-funded implementation study designed to adapt integrated perinatal SUD care for Native pregnant and postpartum people. The authors ground their rationale in a stark clinical fact: substance use disorders and mental health conditions are leading causes of maternal mortality, particularly in the postpartum window, and Native women have identified stigma, bias, racism, and the absence of culturally responsive care as the primary barriers to entering both prenatal and SUD treatment. CEREMONY operates through a bidirectional partnership between the University of Utah Health and Sacred Circle Healthcare, explicitly acknowledging Native sovereignty, data safety, and the ethics of research with Indigenous communities. The adaptation process uses the ADAPT-ITT model, human-centered design, and the Implementation Research Logic Model. For Part IV practitioners, CEREMONY demonstrates how cultural adaptation functions at the clinical system level -- integrating SUD treatment with prenatal care in a single setting while embedding Indigenous self-determination into governance, consent, and evaluation structures.

LGBTQ+ clients represent a population for whom family therapy carries particular complexity, given that family relationships are often the site of both greatest support and greatest harm. Paschen-Wolff et al. (2024) explored how LGBTQ+ individuals experience substance use treatment services, interviewing 23 LGBTQ+ participants who use opioids and other drugs about their experiences and recommendations. The findings documented discrimination at multiple levels: at the patient level (bullying, name-calling, social exclusion), at the staff level (misgendering, denial of services, inappropriate assumptions about sexuality), and at the organizational level (binary gender structures in programming and housing). These experiences triggered minority stress processes including identity concealment and, critically, substance relapse -- meaning that the treatment environment itself was functioning as a relapse risk factor for this population. Conversely, affirming experiences -- staff advocacy, visible LGBTQ+ symbols, gender-inclusive housing, openly LGBTQ+ personnel -- improved treatment engagement and retention. For counselors applying Part IV's framework to LGBTQ+ clients and their families, this research identifies specific, actionable elements of an affirming treatment environment: non-discrimination policies visibly enforced, LGBTQ+-specific programming options, mandatory sensitivity training for all staff, and program structures that do not presuppose binary gender. Family therapy with LGBTQ+ clients must additionally address the particular dynamics that arise when family of origin is a source of minority stress rather than unconditional support, and when chosen family may carry therapeutic significance that biological relationships do not.

Peasley-Miklus et al. (2024) address a population largely absent from the cultural-adaptation

literature: rural family members whose beliefs about evidence-based treatment can either reinforce or undermine a loved one's recovery. In semi-structured interviews with 20 rural Vermont family members of people with opioid use disorder, four themes emerged. First, family members viewed medication for opioid use disorder (MOUD) as "another form of addiction" that should be used only short-term -- a belief directly at odds with the medical consensus that OUD is a chronic disease and that sustained medication improves survival. Second, families saw residential treatment, mental health services, and a strong support network as essential components of recovery. Third, they framed readiness as a precursor to treatment entry. Fourth, stigma -- both inside healthcare settings and within the community -- was identified as a significant barrier (Peasley-Miklus et al., 2024). For counselors working with rural families, family psychoeducation on MOUD effectiveness is not optional supplementary material but a core intervention.

Mereish et al. (2023) add a further dimension by examining intersectional minority stress among sexual and gender minority adolescents of color, analyzing data from 3,423 participants nationwide. Intersectional minority stress -- discrimination experienced at the intersection of multiple marginalized identities -- correlated with increased odds of recent and heavy alcohol use and recent cannabis use. Family support was independently associated with lower substance use across all categories, confirming its protective function. However, family support did not moderate the relationship between intersectional stress and substance use, meaning it buffered overall consumption but did not neutralize the specific stressors arising from racism within LGBTQ+ communities or heterosexism within racial/ethnic communities. For counselors, this finding has direct clinical implications: family support is necessary but not sufficient for LGBTQ+ youth of color experiencing intersectional stress. Interventions targeting systemic oppression and identity-specific stressors are needed alongside family-based approaches. The work of family therapy with this population must extend beyond communication skills and relationship repair to address the structural conditions shaping the client's experience.

Zhang et al. (2025) bring quantitative reinforcement to Part IV's call for structurally informed LGBTQ+ care, analyzing data from 1,518 sexual and gender minority (SGM) adults in the 2016–2019 Generations Study with interpretable machine-learning methods (SHapley Additive exPlanations). The findings sharply separate structural from individual-level determinants. Hazardous alcohol use was most strongly predicted by past smoking, low social support, cancer history, housing instability, and identity-related stressors. Problematic drug use, in contrast, was driven by a distinct set of structural exposures: conversion-therapy history, housing discrimination, encounters with the legal system, and mental-health indicators including self-harm (Zhang et al., 2025). For family therapy with SGM clients, this taxonomy clarifies where the treatment room ends and structural advocacy begins. Conversion-therapy exposure, housing discrimination, and legal-system contact cannot be resolved through family communication skills training; they require case management, policy-informed referrals, and trauma-focused care. Family-based intervention with this population must therefore operate alongside -- not in place of -- advocacy and structural supports.

Together, these eight sources equip counselors with a differentiated, population-specific lens for Part IV. Workforce diversity matters structurally and requires systemic investment, and the absence of standardized measures continues to limit what the field can demonstrate about equity in outcomes. Cultural adaptation is a documented, multi-step process that works when it is substantive rather than superficial -- and when its steps are rigorously recorded so others can replicate and evaluate them. At the clinical system level, adaptation extends into integrated perinatal care for Indigenous communities, where sovereignty, partnership, and implementation science converge to address a leading cause of

maternal mortality. LGBTQ+ clients need affirming environments before therapeutic content can take hold, and the structural determinants of their substance use -- conversion therapy, housing discrimination, legal-system contact -- demand advocacy and case management alongside family work. For LGBTQ+ youth of color, family support must be complemented by attention to intersectional stressors that family relationships alone cannot resolve. And in rural communities, family members' misunderstandings of evidence-based treatment, particularly MOUD, can become a decisive obstacle to recovery, making family psychoeducation a core clinical intervention rather than an optional add-on. Across cultural adaptation procedure, Indigenous perinatal care, rural OUD, and structural LGBTQ+ determinants, the common thread is that family therapy with special populations cannot be isolated from the systems -- cultural, clinical, structural, and community -- in which families actually live.

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Substance Abuse Treatment and Family Therapy

Treatment Improvement Protocol (TIP) Series 39

Edward Kaufman, M.D.
Consensus Panel Chair

Marianne R.M. Yoshioka, M.S.W., Ph.D.
Consensus Panel Co-Chair
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857

Acknowledgments

Numerous people contributed to the development of this TIP (see pp. ix, xii, and appendices E, F, and G). This publication was produced by The CDM Group, Inc. (CDM) under the Knowledge Application Program (KAP) contract, number 270-99-7072 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Karl D. White, Ed.D., and Andrea Kopstein, Ph.D., M.P.H., served as the Center for Substance Abuse Treatment (CSAT) Government Project Officers. Christina Currier served as the CSAT TIPs Task Leader. Rose M. Urban, M.S.W., J.D., LCSW, CCAC, CSAC, served as the CDM KAP Executive Deputy Project Director. Elizabeth Marsh served as CDM KAP Deputy Project Director. Shel Weinberg, Ph.D., served as the CDM KAP Senior Research/Applied Psychologist. Other CDM KAP personnel included Raquel Witkin, M.S., Deputy Project Manager; Susan Kimner, Managing Editor; Pamela Dronka, former Editor/Writer; Michelle Myers, Editor/Writer; Sonja Easley, Editorial Assistant, and Jason Merritt, Manager of Collateral Products. In addition, Sandra Clunies, M.S., I.C.A.D.C., served as Content Advisor. Jonathan Max Gilbert, M.A., Helen Oliff, B.S., David Sutton, B.A., Catalina Bartlett, M.A., and Randi Henderson, B.A., B.S. served as writers.

Disclaimer

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of CSAT, SAMHSA, or DHHS. No official support of or endorsement by CSAT, SAMHSA, or DHHS for these opinions or for particular instruments, software, or resources described in this document are intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

Public Domain Notice

All materials appearing in this volume except those taken directly from copyrighted sources are in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT or the authors. Do not reproduce or distribute this publication for a fee without specific, written authorization from SAMHSA's Office of Communications.

Electronic Access and Copies of Publication

Copies may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889; or electronically through the following Web site:www.csat.samhsa.gov.

Recommended Citation

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Family Therapy.* Treatment Improvement Protocol (TIP) Series, No. 39. DHHS Publication No. (SMA) 04-3957. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

Originating Office

Practice Improvement Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

DHHS Publication No. (SMA) 04-3957 Printed 2004

What Is a TIP?

Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (DHHS), are best-practice guidelines for the treatment of substance use disorders. CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

CSAT's Knowledge Application Program (KAP) Expert Panel, a distinguished group of experts on substance use disorders and professionals in such related fields as primary care, mental health, and social services, works with the State alcohol and drug abuse directors to generate topics for the TIPs. Topics are based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the TIP. Then recommendations are communicated to a Consensus Panel composed of experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP. The members of each Consensus Panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by the field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet at the URL:www.csat.samhsa.gov. The move to electronic media also means that the TIPs can be updated more easily so that they continue to provide the field with state-of-the-art information.

While each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If research supports a particular approach, citations are provided.

This TIP, *Substance Abuse Treatment and Family Therapy*, addresses how substance abuse affects the entire family and how substance abuse treatment providers can use principles from family therapy to change the interactions among family members. The TIP provides basic information about family therapy for substance abuse treatment professionals and basic information about substance abuse treatment for family therapists. The TIP presents the models, techniques and principles of family therapy, with special attention to the stages of motivation as well as to treatment and recovery. Discussion also focuses on clinical decisionmaking and training, supervision, cultural considerations, specific populations, funding and research. The TIP further identifies future directions for both research and clinical practice.

Contents

Consensus Panel

KAP Expert Panel and Federal Government Participants

Foreword

Executive Summary

Chapter 1 Substance Abuse Treatment and Family Therapy

Chapter 2 Impact of Substance Abuse on Families

Chapter 3 Approaches to Therapy

Chapter 4 Integrated Models for Treating Family Members

Chapter 5 Specific Populations

Chapter 6 Policy and Program Issues

Appendix A: Bibliography

Appendix B: Glossary

Appendix C: Guidelines for Assessing Violence

Appendix D: Resources

Appendix E: Resource Panel

Appendix F: Cultural Competency and Diversity Network Participants

Appendix G: Field Reviewers

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Consensus Panel

Chair

Edward Kaufman, M.D.
Editor in Chief
American Journal of Drug and Alcohol Abuse
Dana Point, California

Co-Chair

Marianne R. M. Yoshioka, M.S.W., Ph.D.
Associate Professor
Columbia University
School of Social Work
New York, New York

Workgroup Leaders

Mary M. Gillespie, Psy.D., CASAC
Professor
Hudson Valley Community College
Saratoga Springs, New York

Gloria Grijalva-Gonzales
Certified Sr. Substance Abuse Case Manager/Counselor
San Joaquin County - Office of Substance Abuse
Allies Project
Stockton, California

I. Andrew Hamid, Ph.D., M.S.W., MFT, CSW
Professor
Columbia University
School of Social Work
New York, New York

David Rosenthal, Ph.D.
Director
La Bodega de la Familia
Family Justice Center (Drop Center)
New York, New York

Daniel Santisteban, Ph.D.
Research Associate Professor
University of Miami
School of Medicine
Miami, Florida

Carol Shapiro, M.S.W.
Executive Director
Family Justice Center
New York, New York

Panelists

Fred U. Andes, D.S.W., M.S.W., M.P.A., LCSW
Associate Professor of Sociology
New Jersey City University
Jersey City, New Jersey

Paul Curtin, M.A., CAC, NCAC II
President
Alcohol Services, Inc.
Syracuse, New York

Jo-Ann Krestan, M.A., MFT, LADC
Family Therapist/Writer
Private Practice

Surry, Maine

Eric E. McCollum, Ph.D., LCSW, LMFT
Professor and Clinical Director
Virginia Tech Falls Church
Marriage and Family Therapy Program
Falls Church, Virginia

Margaret McMahon, M.T.S., M.S., M.S.W.
Clinician
Licensed Certified Social Worker
Private Practice
Washington, DC

Greer McSpadden, M.S.W., LISW
Director, BHS
First Nations Community Health Source
Albuquerque, New Mexico

William Francis Northey, Jr., Ph.D.
Research Specialist
American Association for Marriage and Family Therapy
Alexandria, Virginia

Marlene F. Watson, Ph.D.
Director
Programs in Couple and Family Therapy
Drexel University
Philadelphia, Pennsylvania

Loretta Young Silvia, M.Ed., Ph.D.
Associate Professor of Psychiatry
Wake Forest University School of Medicine
Department of Psychiatry and Behavioral Medicine
Winston-Salem, North Carolina

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: KAP Expert Panel and Federal Government Participants

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina at Wilmington
Carolina Beach, North Carolina

Jacqueline Butler, M.S.W., LISW, LPCC,
CCDC III, CJS
Professor of Clinical Psychiatry
College of Medicine
University of Cincinnati
Cincinnati, Ohio

Deion Cash
Executive Director
Community Treatment and Correction
Center, Inc.
Canton, Ohio

Debra A. Claymore, M.Ed.Adm.
Owner/Chief Executive Officer
WC Consulting, LLC
Loveland, Colorado

Carlo C. DiClemente, Ph.D.
Chair
Department of Psychology
University of Maryland Baltimore County
Baltimore, Maryland

Catherine E. Dube, Ed.D.
Independent Consultant
Brown University
Providence, Rhode Island

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, Maryland

Michael Galer, D.B.A., M.B.A., M.F.A.
Independent Consultant
Westminster, Massachusetts

Renata J. Henry, M.Ed.
Director
Division of Alcoholism, Drug Abuse,
and Mental Health
Delaware Department of Health and Social Services
New Castle, Delaware

Joel Hochberg, M.A.
President
Asher & Partners
Los Angeles, California

Jack Hollis, Ph.D.
Associate Director
Center for Health Research
Kaiser Permanente
Portland, Oregon

Mary Beth Johnson, M.S.W.
Director
Addiction Technology Transfer Center
University of Missouri—Kansas City
Kansas City, Missouri

Eduardo Lopez, B.S.
Executive Producer
EVS Communications

Washington, DC

Holly A. Massett, Ph.D.
Academy for Educational Development
Washington, DC

Diane Miller
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse
and Alcoholism
Bethesda, Maryland

Harry B. Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Espanola, New Mexico

Richard K. Ries, M.D.
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, Washington

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
NJ Department of Health and Senior Services
Trenton, New Jersey

Everett Rogers, Ph.D.
Center for Communications Programs
Johns Hopkins University
Baltimore, Maryland

Jean R. Slutsky, P.A., M.S.P.H.
Senior Health Policy Analyst
Agency for Healthcare Research & Quality
Rockville, Maryland

Nedra Klein Weinreich, M.S.
President
Weinreich Communications
Canoga Park, California

Clarissa Wittenberg
Director
Office of Communications and
Public Liaison
National Institute of Mental Health
Kensington, Maryland

Consulting Members of the KAP Expert Panel

Paul Purnell, M.A.
Social Solutions, L.L.C.
Potomac, Maryland

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.
Director, Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Alhambra, California

Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, Maryland

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission of building resilience and facilitating recovery for people with or at risk for mental or substance use disorders by providing best-practices guidance to clinicians, program administrators, and payors to improve the quality and effectiveness of service delivery, and, thereby promote recovery. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and client advocates debates and discusses its particular areas of expertise until it reaches a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped to bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people who abuse substances. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

Charles G. Curie, M.A., A.C.S.W.
Administrator
Substance Abuse and Mental Health Services Administration

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Executive Summary

Family therapy has a long and solid history within the broad mental health field. Substance abuse treatment, on the other hand, developed in considerable isolation. Indeed, until the 1970s, alcoholism counselors typically outright rejected the predominant view of mental health practitioners that alcohol abuse was a symptom of some underlying disorder rather than a primary disorder on its own account.

Nonetheless, the importance of the family was clear to substance abuse professionals, and substance abuse programs included activities for family members. In this TIP, these types of participation by family members in standard treatment programs are referred to as "family-involved" treatment or techniques. This distinction separates the typically marginal involvement of families in substance abuse treatment programs from the types of family therapy regularly found in the family therapy field. Within the family therapy tradition, the family as a whole is the focus of treatment. Although focusing on the family as a whole has been the mainstay of the family therapy field, such a focus often resulted in inadequate attention to the significant primary features of addictive disease and the need for people with substance abuse problems to receive direct help for their addiction.

Slowly, over the past 20 years or so, sharing has increased between the substance abuse treatment and family therapy fields. The expert practitioners from both fields who served as consensus panel members for this TIP recognize that much greater cross-fertilization, if not integration, is possible and warranted. This TIP represents advice on how both fields can profit from understanding and incorporating the methods and theories of the other field.

The primary audience for this TIP is substance abuse treatment counselors; family therapists are a secondary audience. The TIP should be of interest to anyone who wants to learn more about family therapy. The intent of the TIP is to help counselors and family therapists acquire a basic understanding of each others' fields and incorporate aspects of each others' work into their own therapeutic repertoire.

The consensus panel for this TIP drew on its considerable experience in the family therapy field. The panel was composed of representatives from all of the disciplines involved in family therapy and substance abuse treatment, including alcohol and drug counselors, family therapists, mental health workers, researchers, and social workers.

This TIP includes six chapters. Chapter 1 provides an introduction to substance abuse treatment and family therapy. It introduces the changing definition of "family," explores the evolution of the field of family therapy and the primary models of family therapy, presents concepts from the substance abuse treatment field, and discusses the effectiveness and cost benefits of family therapy.

Chapter 2 explores the impact of substance abuse on families. The chapter includes a description of social issues that coexist with substance abuse in families and recommendations for ways to address these issues. Chapter 3 discusses approaches to therapy in both substance abuse treatment and family therapy. One section, directed at substance abuse treatment counselors, provides basic information about the models, approaches, and concepts in family therapy. Another section for family therapists provides basic information about theory, treatment modalities, and the role of 12-Step programs in substance abuse treatment.

Chapter 4 presents a discussion of integrated models for substance abuse treatment and family therapy. These models can serve as a guide for conjoint treatment approaches. Chapter 5 provides background information about substance abuse treatment for various populations and applications to family therapy for each population.

Chapter 6, aimed at administrators and trainers, presents information about the importance of improving services to families and some policy implications to consider for effectively joining family therapy and substance abuse treatment. In addition, the chapter discusses program planning models developed by the consensus panel that provide a framework for including family therapy in substance abuse treatment.

Throughout this TIP, the term "substance abuse" is used to refer to both substance abuse and substance dependence (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* [DSM-IV-TR] [American Psychiatric Association 2000]). This term was chosen, in part, because substance abuse treatment professionals commonly use the term "substance abuse" to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders described by DSM-IV-TR.

The sections that follow summarize the content in this TIP and are grouped by chapter.

Substance Abuse Treatment and Family Therapy

There is no single, immutable definition of *family.* Different cultures and belief systems influence definitions, and because cultures and beliefs change over time, definitions of what is meant by family are by no means static. While the definition of family may change according to different circumstances, several broad categories encompass most families, including traditional families, extended families, and elected families. The *idea* of family implies an enduring involvement on an emotional level. For practical purposes, family can be defined according to the individual client's closest emotional connections.

Family therapy is a collection of therapeutic approaches that share a belief in the effectiveness of family-level assessment and intervention. Consequently, a change in any part of the system may bring about changes in other

parts of the system. Family therapy in substance abuse treatment has two main purposes: (1) to use family's strengths and resources to help find or develop ways to live without substances of abuse, and (2) to ameliorate the impact of chemical dependency on both the identified patient and family.

In family therapy, the unit of treatment is the family, and/or the individual within the context of the family system. The person abusing substances is regarded as a subsystem within the family, the person whose symptoms have serious implications for the family system. The familial relationships within this subsystem are the points of therapeutic interest and intervention. The therapist facilitates discussions and problemsolving sessions, often with the entire family group or subsets thereof, but sometimes with a single participant, who may or may not be the person with a substance use disorder.

A number of historical models of family therapy have been developed over the past several decades. These include models such as marriage and family therapy (MFT), strategic family therapy, structural family therapy, cognitive–behavioral family therapy, couples therapy, and solution-focused family therapy. Today four predominant family therapy models are used as the bases for treatment and specific interventions for substance abuse: the family disease model, the family systems model, the cognitive–behavioral approach, and multidimensional family therapy.

The full integration of family therapy into standard substance abuse treatment is still relatively rare. Some of the goals of family therapy in substance abuse treatment include helping families become aware of their own needs and providing genuine, enduring healing for family members; working to shift power to the parental figures in a family and to improve communication; helping the family make interpersonal, intrapersonal, and environmental changes affecting the person using alcohol or drugs; and keeping substance abuse from moving from one generation to another (i.e., prevention). Other goals will vary, depending on which member of the family is abusing substances.

Multiple therapeutic factors probably account for the effectiveness of family therapy, including acceptance from the therapist, improved communication, organizing the family structure, determining accountability, and enhancing impetus for change. Another reason family therapy is effective is that it provides a neutral forum where family members meet to solve problems. Additionally, family therapy is applicable across many cultures and religions and is compatible with their bases of connection and identification, belonging and acceptance.

Based on effectiveness data for family therapy and the consensus panel's collective experience, the panel recommends that substance abuse treatment agencies and providers consider how to incorporate family approaches, including age-appropriate educational support services for children, into their programs. In addition, while only a few studies have assessed the cost benefits or compared the cost of family therapy to other approaches (such as group therapy, individual therapy, and 12-Step programs), a small but growing body of data has demonstrated the cost benefits of family therapy specifically for substance abuse problems.

Additional considerations exist for integrating family therapy into substance abuse treatment. Family therapy for substance abuse treatment demands the management of complicated treatment situations. Specialized strategies may be necessary to engage the identified patient in treatment. In addition, the substance abuse almost always is associated with other difficult life problems, which can include mental health issues, cognitive impairment, and socioeconomic constraints, such as lack of a job or home. It can be difficult, too, to work across diverse cultural contexts or to discern individual family members' readiness for change and treatment. These circumstances make meaningful family therapy for substance abuse problems a complex, challenging task for both family therapists and substance abuse treatment providers. Modifications in the treatment approach may be necessary, and the success of treatment will depend to a large degree on the creativity, judgment, and cooperation in and between programs in each field.

Safety and appropriateness of family therapy is another important issue. Only in rare situations is family therapy inadvisable, but there are several considerations of which counselors must be aware. Family or couples therapy should not take place unless all participants have a voice and everyone can raise pertinent issues, even if a dominant family member does not want them discussed. Engaging in family therapy without first assessing carefully for violence may lead not only to poor treatment, but also to a risk for increased abuse. It is the treatment provider's responsibility to provide a safe, supportive environment for all participants in family therapy.

Child abuse or neglect is another serious consideration. Any time a counselor suspects past or present child abuse or neglect, laws require immediate reporting to local authorities. Along the same lines, domestic violence is a serious issue among people with substance use disorders that must be factored into therapeutic considerations. Only the most extreme anger contraindicates family therapy. It is up to counselors and therapists to assess the potential for anger and violence and to construct therapy so it can be conducted without endangering any family members. If, during the screening interview, it becomes clear that a batterer is endangering a client or a child, the treatment provider should respond to this situation first, and if necessary, suspend the rest of the screening interview until the safety of all concerned can be ensured.

Impact of Substance Abuse on Families

People who abuse substances are likely to find themselves increasingly isolated from their families. A growing body of literature suggests that substance abuse has distinct effects on different family structures. The effects of substance abuse frequently extend beyond the nuclear family. Extended family members may experience feelings of abandonment, anxiety, fear, anger, concern, embarrassment, or guilt, or they may wish to ignore or cut ties with the person abusing substances.

Various treatment issues are likely to arise in different family structures that include a person who is abusing substances:

- *Client who lives alone or with a partner.* In this situation, both partners need help. The treatment of either partner will affect both. When one person is chemically dependent and the other is not, issues of codependence arise.
- *Client who lives with a spouse (or partner) and minor children.* Most available data on the enduring effects of parental substance abuse on children suggest that a parent's drinking problem often has a detrimental effect on children. The spouse of a person abusing substances is likely to protect the children and assume the parenting duties not fulfilled by the parent abusing substances. If both parents abuse alcohol or illicit

drugs, the effect on children worsens.

- *Client who is part of a blended family.* Stepfamilies present special challenges under normal circumstances; substance abuse can intensify problems and become an impediment to a stepfamily's integration and stability. Clinicians should be aware of the dynamics of blended families and that they require additional considerations.
- *An older client who has grown children.* An older adult with a substance abuse problem can affect everyone in a household. Additional family resources may need to be mobilized to treat the older adult's substance use disorder. As with child abuse and neglect, elder maltreatment can be subject to statutory reporting requirements for local authorities.
- *Client is an adolescent and lives with family of origin.* When an adolescent uses alcohol or drugs, siblings in the family may find their needs and concerns are ignored or minimized while their parents react to continuous crises involving the adolescent who abuses alcohol or drugs. In many families that include adolescents who abuse substances, at least one parent also abuses substances. This unfortunate modeling can set in motion a combination of physical and emotional problems that can be very dangerous.
- *Someone not identified as the client is abusing substances.* When someone in the family other than the person with presenting symptoms is involved with alcohol or illicit drugs, issues of blame, responsibility, and causation will arise. With the practitioner's help, the family should refrain from blaming, but still be encouraged to reveal and repair family interactions that create the conditions for continued substance abuse.

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

Approaches to Therapy

The fields of substance abuse treatment and family therapy share many common assumptions, approaches, and techniques, but differ in significant philosophical and practical ways that affect treatment approaches and goals. Further, within each discipline, theory and practice differ. Although substance abuse treatment is generally more uniform in its approach than is family therapy, in both cases certain generalizations apply to the practice of the majority of providers. Two concepts essential to both fields are denial and resistance presented by clients.

Many substance abuse treatment counselors base their understanding of a family's relation to substance abuse on a *disease model* of substance abuse. 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. They understand that substance abuse creates negative changes in the individual's 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. It is this focus on the family system, more than the inclusion of more people, that defines family therapy.

Despite these basic differences, the fields of family therapy and substance abuse treatment are compatible. Clinicians in both fields address the client's interactions with a system that involves something outside the self. Multiple systems affect people with substance use disorders at different levels (individual, family, culture, and society), and truly comprehensive treatment would take all of them into consideration. However, some differences exist among many, but not all, substance abuse treatment and family therapy settings and practitioners:

- *Family interventions.* Psychoeducation and multifamily groups are more common in the substance abuse treatment field than in family therapy. Family therapists will focus more on intrafamily relationships, while substance abuse treatment providers concentrate on helping clients achieve and maintain abstinence.
- *Process and content.* Family therapy generally attends more to the *process* of family interaction, while substance abuse treatment is usually more concerned with the planned *content* of each session.
- *Focus.* Substance abuse clinicians and family therapists typically focus on different targets. Substance abuse treatment counselors see the primary goal as arresting a client's substance use; family therapists see the family system as an integral component of the substance abuse.
- *Identity of the client.* Often, the substance abuse counselor regards the individual with the substance use disorder as the primary person requiring treatment. A family therapist might assume 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.* Training in the boundaries related to the therapist's or counselor's self-disclosure is an integral part of any treatment provider's education. Addiction counselors who are in recovery themselves are trained to recognize the importance of choosing to self-disclose their own addiction histories and to use supervision appropriately to decide when and what to disclose. For the family therapist, self-disclosure is not as integral a part of the therapeutic process. It is downplayed because it takes the focus of therapy off of the family.
- *Regulations.* Different regulations also affect the substance abuse treatment and family therapy fields. This influence comes from both government agencies and third-party payors that affect confidentiality, and training and licensing requirements. Federal regulations attempt to guarantee confidentiality for people who seek substance abuse assessment and treatment. Confidentiality issues for family therapists are less straightforward.
- *Licensure and certification.* Forty-two States require licenses for people practicing as family therapists. Although the specific educational requirements vary from State to State, most require at least a master's degree for the person who intends to practice independently as a family therapist. Certification for substance abuse counselors is more varied.

Specific procedures for assessing clients in substance abuse treatment and family therapy vary from program to program and practitioner to practitioner. Assessments for substance abuse treatment programs focus on substance use and history. Some of the key elements examined when assessing a client's substance abuse history include

important related concerns such as family relations, sexual history, and mental health.

In contrast, family therapy assessments focus on family dynamics and client strengths. The primary assessment task is to observe family interactions, which can reveal patterns, along with the family system's strengths and dysfunction. The sources of dysfunction cannot be determined simply by asking individual family members to identify problems within the family. Although most family therapists screen for mental or physical illness, and for physical, sexual, or emotional abuse, issues of substance abuse might not be discovered because the therapist is not familiar with questions to ask or cues that are provided by clients. 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.

Family therapists and substance abuse counselors should respond knowledgeably to a variety of barriers that block the engagement and treatment of clients. While the specific barriers will vary for clients in different treatment settings, basic issues arise in both substance abuse treatment and family therapy. Issues of family motivation/influence, balance of hierarchal power, general willingness for the family and its members to change, and cultural barriers are essential topics to review for appropriate interventions.

Substance abuse counselors should not practice family therapy unless they have proper training and licensing, but they should be sufficiently informed about family therapy to discuss it with their clients and know when a referral is indicated.

The family therapy field is diverse, but certain models have been more influential than others, and models that share certain characteristics can be grouped together. Several family therapy models have been adapted for working with clients with substance use disorders. None was specifically developed, however, for this integration. These models include behavioral contracting, Bepko and Krestan's theory, behavioral marital therapy, brief strategic family therapy, multifamily groups, multisystemic therapy, network therapy, solution-focused therapy, Stanton's approach, and Wegscheider-Cruse's techniques.

A number of theoretical concepts that underlie family therapy can help substance abuse treatment providers better understand clients' relationships with their families. Perhaps foremost among these is the acceptance of systems theory that views the client as a system of parts embedded within multiple systems—a community, a culture, a nation. The elements of the family as a system include complementarity, boundaries, subsystems, enduring family ties, and change and balance. Other concepts include a family's capacity for change, a family's ability to adjust to abstinence, and the concept of triangles.

Family therapists have developed a range of techniques that can be useful to substance abuse treatment providers working with individual clients and families. The consensus panel selected specific techniques on the basis of their utility and ease of use in substance abuse treatment settings, and not because they are from a particular theoretical model. This list of techniques should not be considered comprehensive. These techniques selected by the panel include behavioral techniques, structural techniques, strategic techniques, and solution-focused techniques.

Family therapists would benefit from learning about the treatment approaches used in the substance abuse treatment field. Two of the most common approaches are the medical model of addiction, which emphasizes the biological, genetic, or physiological causes of substance abuse and dependence; and the sociocultural theories, which focus on how stressors in the client's social and cultural environment influence substance use and abuse. In addition, many substance abuse treatment providers add a spiritual component to the biopsychosocial approach. The consensus panel believes that effective treatment will integrate these models according to the treatment setting, but will always take into account all of the factors that contribute to substance use disorders.

Integrated Models for Treating Family Members

In families which one or more members has a substance abuse problem, substance abuse treatment and family therapy can be integrated to provide effective solutions to multiple problems. The term integration, for the purposes of this TIP, refers to 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. This TIP also assumes that, while a substance abuse problem manifests itself in an individual, the solution for the family as a whole will be found within the family system. Four discrete facets of integration along this continuum include staff awareness and education, family education, family collaboration, and family therapy integration.

Clients benefit in several ways from integrated family therapy and substance abuse treatment. These benefits include positive treatment outcomes, increased likelihood of the client's ongoing recovery, increased help for the family's recovery, and the reduction of the impact of substance abuse on different generations in the family. The benefits for the treatment professionals include reduced resistance from clients, more flexibility in treatment planning and in treatment approach, increased skill set, and improved treatment outcomes.

There are some limitations and challenges, however, to integrated models of family therapy and substance abuse treatment. These include the risk of lack of structure and compatibility by integrating interventions from different models, additional training for staff, achieving a major shift in mindset, agencywide commitment and coordination, and reimbursement by third-party payors. In sum, agencies and practitioners must balance the value of integrated treatment with its limitations.

Substance abuse treatment professionals intervene with families at different levels during treatment, based on how individualized the interventions are to each family 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. In some cases, the family may be ready only for intermittent involvement with a counselor. In other cases, as the family reaches the goals set at one level of involvement, further goals may be set that require more intensive counselor involvement. Thus, the family's acceptance of problems and its readiness to change determine the appropriate level of counselor involvement with that family. There are four levels of counselor involvement with the families of clients who are abusing substances:

- Level 1: Counselor has little or no involvement with the family.
- Level 2: Counselor provides the family with psychoeducation and advice.

- Level 3: Counselor addresses family members' feelings and provides them with support.
- Level 4: Counselor provides family therapy (when trained at this level of expertise).

To determine a counselor's level of involvement with a specific family, two factors must be considered: (1) the counselor's level of experience and comfort, and (2) the family's needs and readiness to change. Both family and counselor factors must be considered when deciding a level of family involvement.

Care must be taken in the choice of an integrated therapeutic model. The model must accommodate the needs of the family, the style and preferences of the therapist, and the realities of the treatment context. The model also must be congruent with the culture of the people that it intends to serve. A great number of integrated treatment models have been discussed in the literature. Many are slight variations of others. Those discussed are among the more frequently used integrated treatment models:

- Structural/strategic family therapy
- Multidimensional family therapy
- Multiple family therapy
- Multisystemic therapy
- Behavioral and cognitive–behavioral family therapy
- Network therapy
- Bowen family systems therapy
- Solution-focused brief therapy

Another important consideration in an integrated model is the need to match therapeutic change to level of recovery. The consensus panel decided to view levels of recovery by combining Bepko and Krestan's stages of treatment for families with Heath and Stanton's stages of family therapy for substance abuse treatment. Together, those levels of recovery are

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

Once change is in motion, the individual and family recovery processes generally parallel each other, although they may not be perfectly in synchrony.

Specific Populations

In this TIP, the term *specific populations* is used to refer to the features of families based on specific, common groupings that influence the process of therapy. The most important guideline for the therapist is to be flexible and to meet the family "where it is." It is also vital for counselors to be continuously aware of and sensitive to the differences among themselves and the members of the group they are counseling. Sensitivity to the specific cultural norms of the family in treatment must be respected from the start of therapy.

Family therapy for women with substance use disorders is appropriate, except in cases of ongoing partner abuse. Safety always should be the primary consideration. Substance abuse treatment is more effective for women when it addresses women's specific needs and understands their daily realities. Particular treatment issues relevant to women include shame, stigma, trauma, and control over her life. Women who have lost custody of their children may need help to regain it once stable recovery has been achieved. In fact, working to get their children back may be a strong treatment motivator for women. Finally, childcare is one of the most important accommodations necessary for women in treatment.

A sufficient body of research has not yet been amassed to suggest the efficacy of any one type of family therapy over another for use with gay and lesbian people. Family can be a very sensitive issue for gay and lesbian clients. Therapists must be careful to use the client's definition of family rather than rely on a heterosexual-based model. Likewise, the therapist should also accept whatever identification an individual chooses for him- or herself and be sensitive to the need to be inclusive and nonjudgmental in word choice. Many lesbian and gay clients may be reluctant to include other members of their family of origin in therapy because of fear of rejection and further distancing.

Although a great deal of research has been conducted related to both family therapy and culture and ethnicity, little research has concentrated on how culture and ethnicity influence core family and clinical processes. One important requirement is to move beyond ethnic labels and consider a host of factors—values, beliefs, and behaviors —associated with ethnic identity. Among major life experiences that must be factored into treating families touched by substance abuse is the complex challenge of determining how acculturation and ethnic identity influence the treatment process. Other influential elements include the effects of immigration on family life and the circumstances that motivated emigration, and the sociopolitical status of the ethnically distinct family.

The TIP also explores specific concerns related to age, people with disabilities, people with co-occurring substance abuse and mental disorders, people in rural areas, people who are HIV positive, people who are homeless, and veterans.

Policy and Program Issues

Incorporating family therapy into substance abuse treatment presents an opportunity to improve the status quo; it also challenges these two divergent modalities to recognize, delineate, and possibly reconcile their differing outlooks. Another major policy implication is that family therapy requires special training and skills that are not common among staff in many substance abuse treatment programs. A substance abuse treatment program committed to family therapy will need to consider the costs associated with providing extensive training to line and supervisory staff to ensure that everyone understands, supports, and reinforces the family therapist's work.

Given the complexity of incorporating full-scale family therapy consistently in substance abuse treatment and the

finite resources with which many substance abuse treatment programs are working, family involvement may be a more attractive alternative.

The documented cost savings and public health benefits associated with family therapy support the idea of reimbursement. However, the American health care insurance system focuses care on the individual. Little, if any, reimbursement is available for the treatment of family members, even less so if "family" is broadly defined to include a client's nonfamilial support network.

Including family therapy issues in substance abuse treatment settings at any level of intensity requires a systematic and continuous effort. The consensus panel developed four program planning models—staff education, family education and participation, provider collaboration, and family integration. These models provide a framework for program administrators and staff/counselors. These models cover (1) the issues surrounding staff education about families and family therapy, (2) family education about the roles of families in treatment and recovery from substance abuse, (3) how substance abuse treatment providers can collaborate with family therapists, and (4) methods for integrating family therapy activities into substance abuse treatment programs. The framework identifies key issues: guidelines for implementation, ethical and legal issues, outcomes evaluation, counseling adaptations, and training and supervision. Other program considerations include cultural competence, outcome evaluation procedures and reports, and long-term followup.

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Chapter 1 Substance Abuse Treatment and Family Therapy

This chapter introduces the changing definition of "family," the concept of family in the United States, and the family as an ecosystem within the larger context of society. The chapter discusses the evolution of family therapy as a component of substance abuse treatment, outlines primary models of family therapy, and explores this approach from a systems perspective. The chapter also presents the stages of change and levels of recovery from substance abuse. Effectiveness and cost benefits of family therapy are briefly discussed.

Introduction

The family has a central role to play in the treatment of any health problem, including substance abuse. Family work has become a strong and continuing theme of many treatment approaches (Kaufmann and Kaufman 1992*a*; McCrady and Epstein 1996), but family therapy is not used to its greatest capacity in substance abuse treatment. A primary challenge remains the broadening of the substance abuse treatment focus from the individual to the family.

The two disciplines, family therapy and substance abuse treatment, bring different perspectives to treatment implementation. In substance abuse treatment, for instance, the client is the identified patient (IP)—the person in the family with the presenting substance abuse problem. In family therapy, the goal of treatment is to meet the needs of all family members. Family therapy addresses the interdependent nature of family relationships and how these relationships serve the IP and other family members for good or ill. The focus of family therapy treatment is to intervene in these complex relational patterns and to alter them in ways that bring about productive change for the entire family. Family therapy rests on the systems perspective. As such, changes in one part of the system can and do produce changes in other parts of the system, and these changes can contribute to either problems or solutions.

It is important to understand the complex role that families can play in substance abuse treatment. They can be a source of help to the treatment process, but they also must manage the consequences of the IP's addictive behavior. Individual family members are concerned about the IP's substance abuse, but they also have their own goals and issues. Providing services to the whole family can improve treatment effectiveness.

Meeting the challenge of working together will call for mutual understanding, flexibility, and adjustments among the substance abuse treatment provider, family therapist, and family. This shift will require a stronger focus on the systemic interactions of families. Many divergent practices must be reconciled if family therapy is to be used in substance abuse treatment. For example, the substance abuse counselor typically facilitates treatment goals with the client; thus the goals are individualized, focused mainly on the client. This reduces the opportunity to include the family's perspective in goal setting, which could facilitate the healing process for the family as a whole.

Working out ways for the two disciplines to collaborate also will require a re-examination of assumptions common in the two fields. Substance abuse counselors often focus on the individual needs of people with substance use disorders, urging them to take care of themselves. This viewpoint neglects to highlight the impact these changes will have on other people in the family system. When the IP is urged to take care of himself, he often is not prepared for the reactions of other family members to the changes he experiences, and often is unprepared to cope with these reactions. On the other hand, many family therapists have hoped that bringing about positive changes in the family system concurrently might improve the substance use disorder. This view tends to minimize the persistent, sometimes overpowering process of addiction.

Both of these views are consistent with their respective fields, and each has explanatory power, but neither is complete. Addiction is a major force in people with substance abuse problems. Yet, people with substance abuse problems also reside within a powerful context that includes the family system. Therefore, in an integrated substance abuse treatment model based on family therapy, both family functioning and individual functioning play important roles in the change process (Liddle and Hogue 2001).

What Is a Family?

There is no single, immutable definition of *family.* Different cultures and belief systems influence definitions, and because cultures and beliefs change over time, definitions of family by no means are static. While the definition of family may change according to different circumstances, several broad categories encompass most families:

- Traditional families, including heterosexual couples (two parents and minor children all living under the same roof), single parents, and families including blood relatives, adoptive families, foster relationships, grandparents raising grandchildren, and stepfamilies.
- Extended families, which include grandparents, uncles, aunts, cousins, and other relatives.
- Elected families, which are self-identified and are joined by choice and not by the usual ties of blood, marriage, and law. For many people, the elected family is more important than the biological family. Examples would include
    - Emancipated youth who choose to live among peers
    - Godparents and other non-biologically related people who have an emotional tie (i.e., fictive kin)
    - Gay and lesbian couples or groups (and minor children all living under the same roof)

The idea of family implies an enduring involvement on an emotional level. Family members may disperse around the world, but still be connected emotionally and able to contribute to the dynamics of family functioning. In family therapy, geographically distant family members can play an important role in substance abuse treatment and need to be brought into the therapeutic process despite geographical distance.

Families must be distinguished from social support groups such as 12-Step programs—although for some clients these distinctions may be fuzzy. One distinction is the level of commitment that people have for each other and the duration of that commitment. Another distinction is the source of connection. Families are connected by alliance, but also by blood (usually) and powerful emotional ties (almost always). Support groups, by contrast, are held together by a common goal; for example, 12-Step programs are purpose-driven and context-dependent. The same is true of church communities, which may function in some ways like a family; but similar to self-help programs, churches have a specific purpose.

For practical purposes, family can be defined according to the individual's closest emotional connections. In family therapy, clients identify who they think should be included in therapy. The counselor or therapist cannot determine which individuals make up another person's family. When commencing therapy, the counselor or therapist needs to ask the client, "Who is important to you? What do you consider your family to be?" It is critical to identify people who are important in the person's life. Anyone who is instrumental in providing support, maintaining the household, providing financial resources, and with whom there is a strong and enduring emotional bond may be considered family for the purposes of therapy (see, for example, Pequegnat et al. 2001). No one should be automatically included or excluded.

In some situations, establishing an individual in treatment may require a metaphoric definition of family, such as the family of one's workplace. As treatment progresses, the idea of family sometimes may be reconfigured, and the notion may change again during continuing care. In other cases, clients will not allow contact with the family, may want the counselor or therapist to see only particular family members, or may exclude some family members.

Brooks and Rice (1997, p. 57) adopt Sargent's (1983) definition of family as a "group of people with common ties of affection and responsibility who live in proximity to one another." They expand that definition, though, by pointing out four characteristics of families central to family therapy:

- Families possess *nonsummativity*, which means that the family as a whole is greater than—and different from—the sum of its individual members.
- The behavior of individual members is interrelated through the process of *circular causality*, which holds that if one family member changes his or her behavior, the others will also change as a consequence, which in turn causes subsequent changes in the member who changed initially. This also demonstrates that it is impossible to know what comes first: substance abuse or behaviors that are called "enabling."
- Each family has a pattern of *communication traits*, which can be verbal or nonverbal, overt or subtle means of expressing emotion, conflict, affection, etc.
- Families strive to achieve *homeostasis*, which portrays family systems as self-regulating with a primary need to maintain balance.

The Concept of Family

In the United States the concept of family has changed during the past two generations. During the latter half of the 20th century in the United States, the proportion of married couples with children shrank—such families made up only 24 percent of all households in 2000 (Fields and Casper 2001). The idea of family has come to signify many familial arrangements, including blended families, divorced single mothers or fathers with children, never-married women with children, cohabiting heterosexual partners, and gay or lesbian families (Bianchi and Casper 2000).

Some analysts are concerned about indications of increasing stress on families, such as the increasing number of births to single mothers (from 26.6 percent in 1990 to 33 percent in 1999 [U.S. Census Bureau 2001*c*]). The increase in single-mother families, which typically have greater per-person expenses and less earning power, may help to explain why, in the general prosperity of the last half of the 20th century, the percentage of children living in the poorest families almost doubled, rising from 15 to 28 percent (Bianchi and Casper 2000).

Bengtson (2001) asserts that relationships involving three or more generations increasingly are becoming important to individuals and families, that these relationships increasingly are diverse in structure and functions, and that for many Americans, multigenerational bonds are important ties for well-being and support over the course of their lives.

The Family as an Ecosystem

Substance abuse impairs physical and mental health, and it strains and taxes the agencies that promote physical and mental health. In families with substance abuse, family members often are connected not just to each other but also to any of a number of government agencies, such as social services, criminal justice, or child protective services. The economic toll includes a huge drain on individuals' employability and other elements of productivity. The social and economic costs are felt in many workplaces and homes.

The ecological perspective on substance abuse views people as nested in various systems. Individuals are nested in families; families are nested in communities. Kaufman (1999) identifies members of the ecosystem of an individual with a substance abuse problem as family, peers (those in recovery as well as those still using), treatment providers, non-family support sources, the workplace, and the legal system.

The idea of an ecological framework within which substance abuse occurs is consistent with family therapy's focus on understanding human behavior in terms of other systems in a person's life. Family therapy approaches human behavior in terms of interactions within and among the subsets of a system. In this view, family members inevitably adapt to the behavior of the person with a substance use disorder. They develop patterns of accommodation and ways of coping with the substance use (e.g., keeping children extraordinarily quiet or not bringing friends home). Family members try to restore homeostasis and maintain family balance. This may be most apparent once abstinence is achieved. For example, when the person abusing substances becomes abstinent, someone else may

develop complaints and/or "symptoms." See below for an illustration.

Homeostasis

A young couple married when they were both 20 years old. One spouse developed alcoholism during the first 5 years of the marriage. The couple's life increasingly became chaotic and painful for another 5 years, when finally, at age 30, the substance-abusing spouse entered treatment and, over the course of 18 months, attained a solid degree of sobriety. Suddenly, lack of communication and difficulties with intimacy came to the fore for the non–substance-abusing spouse, who now often feels sad and hopeless about the marital relationship. The non–substance-abusing spouse finds, after 18 months of the partner's sobriety, that the sober spouse is "no longer fun" or still does not want to make plans for another child.

Almost all young couples encounter communication and intimacy issues during the first decade of the relationship. In an alcoholic marriage or relationship, such issues are regularly pushed into the background as guilt, blame, and control issues are exacerbated by the nature of addictive disease and its effects on both the relationship and the family.

The possible complexities of the above situation illustrate both the relevance of family therapy to substance abuse treatment and why family therapy requires a complex, systems perspective. Many system-related answers are possible: Perhaps the non–substance-abusing spouse is feeling lonely, unimportant, or an outsider. With the focus of recovery on the addiction—and the IP's struggles in recovery—the spouse who previously might have been central to the other's drinking and/or maintaining abstinence, even considered the cause of the drinking, is now, 18 months later, tangential to what had been major, highly emotional upheavals and interactions. The now "outsider spouse" may not even be aware of feeling lonely and unimportant but instead "acts out" these feelings in terms of finding the now sober spouse "no fun." Alternatively, perhaps the now sober spouse is indeed no fun, and the problems lie in how hard it is for the sober spouse to relax or feel comfortable with sobriety—in which case the resolution might involve both partners learning to develop a new lifestyle that does not involve substance use.

The joint use of both recovery and family therapy techniques will improve marital communication and both partners' capacity for intimacy. These elements of personal growth are important to the development of serenity in recovery and stability in the relationship.

Family members may have a stronger desire to move toward overall improved functioning in the family system, thus compelling and even providing leverage for the IP to seek and/or remain in treatment through periods of ambivalence about achieving a sober lifestyle. Alternately, clarifying boundaries between dysfunctional family members—including encouraging IPs to detach from family members who are actively using—can alleviate stress on the IP and create emotional space to focus on the tasks of recovery.

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.

Family therapy in substance abuse treatment has two main purposes. First, it seeks to use the family's strengths and resources to help find or develop ways to live without substances of abuse. Second, it ameliorates the impact of chemical dependency on both the IP and the family. Frequently, in the process, marshaling the family's strengths requires the provision of basic support for the family.

In family therapy, the unit of treatment is the family, and/or the individual within the context of the family system. The person abusing substances is regarded as a subsystem within the family unit—the person whose symptoms have severe repercussions throughout the family system. The familial relationships within this subsystem are the points of therapeutic interest and intervention. The therapist facilitates discussions and problemsolving sessions, often with the entire family group or subsets thereof, but sometimes with a single participant, who may or may not be the person with the substance use disorder.

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. It typically is limited to psychoeducation to teach the family about substance abuse, related behaviors, and the behavioral, medical, and psychological consequences of use. Children also need age-appropriate psychoeducation programs prior to being grouped with other family members in either education or therapy. (For more information see chapter 6, under "Family Education and Participation," and see also *Children's Program Kit: Supportive Education for Children of Addicted Parents* [Substance Abuse and Mental Health Services Administration (SAMHSA) 2003], developed by SAMHSA and the National Association for Children of Alcoholics.)

In addition, programmatic enhancements (such as classes that teach English as a second language) also are not family therapy. Although educational family activities can be therapeutic, they will not correct deeply ingrained, maladaptive relationships.

The following discussions present a brief overview of the evolution of family therapy models and the primary models of family therapy used today as the basis for treatment. Chapter 3 provides more detailed information about these models.

Historical Models of Family Therapy

Marriage and family therapy (MFT) had its origins in the 1950s, adding a systemic focus to previous understandings of the family. Systems theory recognizes that

- A whole system is more than the sum of its parts.
- Parts of a system are interconnected.
- Certain rules determine the functioning of a system.
- Systems are dynamic, carefully balancing continuity against change.
- Promoting or guarding against system entropy (i.e., disorder or chaos) is a powerful dynamic in the family system balancing change of the family roles and rules.

The *strategic school of family therapy* "introduced two of the most powerful insights in all of family therapy: that family members often perpetuate problems by their own actions; and that directives tailored to the needs of a particular family can sometimes bring about sudden and decisive change" (Nichols and Schwartz 2001, p. 97).

Based on observations of the relationship between family structure and behavior, along with work with inner-city children and their families, Minuchin (1974) developed another approach, *structural family therapy*. Minuchin and Fishman (1981) believed that families use a limited repertoire of self-perpetuating relational patterns and that family members divide into subsystems with boundaries that regulate family communication and behavior. They sought to shift family boundaries so the boundary between parents and children was clearer. Intervention is aimed at having the parents work more cooperatively together and at reducing the extent to which children assume parental responsibilities within the family.

One major model that emerged during this developmental phase was *cognitive–behavioral family and couples therapy*. It grew out of the early work in behavioral marital therapy and parenting training, and incorporated concepts developed by Aaron Beck. Beck reasoned that people react according to the ways they think and feel, so changing maladaptive thoughts, attitudes, and beliefs would eliminate dysfunctional patterns and the triggers that set them in motion (Beck 1976). This union of cognitive and behavioral therapies in a family setting was new and useful. The therapist considers not only how people's thoughts, feelings, and emotions influence their behavior, but also the impact they have on spouses and other family members. Cognitive–behavioral family therapy and behavioral couples therapy are two models that have strong empirical support.

Through the 1980s and 1990s, newer models of MFT were articulated. In response to the problem-focused strategic and structural family therapies, authors such as de Shazer, Berg, O'Hanlon, and Selkman promulgated *solution-focused family therapy* (e.g., Berg and Miller 1992; de Shazer 1988). They asserted that pinpointing the cause of poor functioning is unnecessary and that therapy focused on solutions is sufficient to help families change.

Soon after the introduction of solution-focused therapy to the MFT landscape, White and Epston's *Narrative Means to Therapeutic Ends* 1990 heralded the *narrative movement* in MFT. This family therapy development has focused on the way people construct meaning and how the construction of meaning affects psychological functioning.

In the early part of the 21st century, MFT seems poised to undergo another change, focused on empirically demonstrating the effectiveness of different approaches to therapy. The few models that have been tested empirically have shown promising results. For example, *functional family therapy*, *multisystemic therapy*, *multidimensional family therapy*, and *brief strategic family therapy* all have been shown to be highly effective in reducing acting-out behavior among adolescents and/or in reducing the risk for problem behavior among their younger siblings. Among the couples therapy models known to have reduced marital distress and psychological problems are *emotionally focused couples therapy*, *cognitive–behavioral couples therapy*, *behavioral couples therapy*, *integrative couples therapy*, and *systemic couples therapy*. (See chapter 3 for further information.)

Primary Family Therapy Models in Use Today

There are numerous variations on the family therapy theme. Some approaches to family therapy reach out to multiple generations or family groups. Some treat just one person, who may or may not be the IP. Usually, though, family therapy involves a therapist meeting with several family members. An expansive concept of family therapy also might spin off group programs that, for example, could treat the IP's spouse, children in groups (children do best if they first participate in groups that prepare them for family therapy), or members of a residential treatment setting.

Most family therapy meetings take place in clinics or private practice settings. Home-based therapy breaks from the traditional clinical setting, reasoning that joining the family where it lives can help overcome shame, stigma, and resistance. It is a return to the practices of social workers who, in the early 20th century, did their work in clients' homes (Beels 2002). Meeting the family where it lives also provides valuable information about how the family really functions.

Four predominant family therapy models are used as the bases for treatment and specific interventions for substance abuse:

1. The *family disease model* looks at substance abuse as a disease that affects the entire family. Family members of the people who abuse substances may develop codependence, which causes them to enable the IP's substance abuse. Limited controlled research evidence is available to support the disease model, but it nonetheless is influential in the treatment community as well as in the general public (McCrady and Epstein 1996).
2. The *family systems model* is based on the idea that families become organized by their interactions around substance abuse. In adapting to the substance abuse, it is possible for the family to maintain balance, or homeostasis. For example, a man with a substance use disorder may be antagonistic or unable to express feelings unless he is intoxicated. Using the systems approach, a therapist would look for and attempt to change the maladaptive patterns of communication or family role structures that require substance abuse for stability (Steinglass et al. 1987).
3. C*ognitive–behavioral approaches* are based on the idea that maladaptive behaviors, including

substance use and abuse, are reinforced through family interactions. Behaviorally oriented treatment tries to change interactions and target behaviors that trigger substance abuse, to improve communication and problemsolving, and to strengthen coping skills (O'Farrell and Fals-Stewart 1999).

4. Most recently, *multidimensional family therapy* (MDFT) has integrated several different techniques with emphasis on the relationships among cognition, affect (emotionality), behavior, and environmental input (Liddle et al. 1992). MDFT is not the only family therapy model to adopt such an approach. Functional family therapy (Alexander and Parsons 1982), multisystemic therapy (Henggeler et al. 1998), and brief strategic family therapy (Szapocznik et al. in press) all adopt similar multidimensional approaches.

Family Therapy in Substance Abuse Treatment

Goals of Family Therapy

The integration of family therapy in substance abuse treatment is still relatively rare. Family therapy in substance abuse treatment helps families become aware of their own needs and provides genuine, enduring healing for people. Family therapy works to shift power to the parental figures in a family and to improve communication. Other goals will vary according to which member of the family is abusing substances. Family therapy can answer questions such as

- Why should children or adolescents be involved in the treatment of a parent who abuses substances?
- What impact does a parent abusing substances have on his or her children?
- How does adolescent substance abuse impact adults?
- What is the impact of substance abuse on family members who do not abuse substances?

Whether a child or adult is the family member who uses substances, the entire family system needs to change, not just the IP. Family therapy, therefore, helps the family make interpersonal, intrapersonal, and environmental changes affecting the person using alcohol or drugs. It helps the nonusing members to work together more effectively and to define personal goals for therapy beyond a vague notion of improved family functioning. As change takes place, family therapy helps all family members understand what is occurring. This out-in-the-open understanding removes any suspicion that the family is "ganging up" on the person abusing substances.

A major goal of family therapy in substance abuse treatment is prevention--especially keeping substance abuse from moving from one generation to another. Study after study shows that if one person in a family abuses alcohol or drugs, the remaining family members are at increased risk of developing substance abuse problems. The single most potent risk factor of future maladaption, predisposition to substance use, and psychological difficulties is a parent's substance-abusing behavior (Johnson and Leff 1999). A "healthy family structure can prevent adolescent substance abuse even in the face of heavy peer pressure to use and abuse drugs" (Kaufman 1990*a*, p. 51). Further, if the person abusing substances is an adolescent, successful treatment diminishes the likelihood that siblings will abuse substances or commit related offenses (Alexander et al. 2000). Treating adolescent drug abuse also can decrease the likelihood of harmful consequences in adulthood, such as chronic unemployment, continued drug abuse, and criminal behavior.

Therapeutic Factors

Because of the variety of family therapy models, the diverse schools of thought in the field, and the different degrees to which family therapy is implemented, multiple therapeutic factors probably account for the effectiveness of family therapy. Among them might be acceptance from the therapist; improved communication; organizing the family structure; determining accountability; and enhancing impetus for change, which increases the family's motivation to change its patterns of interaction and frees the family to make changes. Family therapy also views substance abuse in its context, not as an isolated problem, and shares some characteristics with 12-Step programs, which evoke solidarity, self-confession, support, self-esteem, awareness, and smooth re-entry into the community.

Still another reason that family therapy is effective in substance abuse treatment is that it provides a neutral forum in which family members meet to solve problems. Such a rational venue for expression and negotiation often is missing from the family lives of people with a substance problem. Though their lives are unpredictable and chaotic the substance abuse—the cause of the upheaval and a focal organizing element of family life—is not discussed. If the subject comes up, the tone of the exchange is likely to be accusatory and negative.

In the supportive environment of family therapy, this uneasy silence can be broken in ways that feel emotionally safe. As the therapist brokers, mediates, and restructures conflicts among family members, emotionally charged topics are allowed to come into the open. The therapist helps ensure that every family member is accorded a voice. In the safe environment of therapy, pent-up feelings such as fear and concern can be expressed, identified, and validated. Often family members are surprised to learn that others share their feelings, and new lines of communication open up. Family members gain a broader and more accurate perspective of what they are experiencing, which can be empowering and may provide enough energy to create positive change. Each of these improvements in family life and coping skills is a highly desirable outcome, whether or not the IP's drug or alcohol problems are immediately resolved. It is clearly a step forward for the family of a person abusing substances to become a stable, functional environment within which abstinence can be sustained.

To achieve this goal, family therapy facilitates changes in maladaptive interactions within the family system. The therapist looks for unhealthy relational structures (such as parent-child role reversals) and faulty patterns of communication (such as a limited capacity for negotiation). In contrast to the peripheral role that families usually play in other therapeutic approaches, families are deeply involved in whatever changes are effected. In fact, the majority of changes will take place within the family system, subsequently producing change in the individual abusing substances.

Family therapy is highly applicable across many cultures and religions, and is compatible with their bases of

connection and identification, belonging and acceptance. Most cultures value families and view them as important. This preeminence suggests how important it is to include families in treatment. It should be acknowledged, however, that a culture's high regard for families does not always promote improved family functioning. In cultures that revere families, people may conceal substance abuse within the family because disclosure would lead to stigma and shame.

Additionally, the definition, or lack of definition, of the concept of "rehabilitation" varies greatly across cultural lines. Cultures differ in their views of what people need in order to heal. The identities of individuals who have the moral authority to help (for example, an elder or a minister) can differ from culture to culture. Therapists need to engage aspects of the culture or religion that promote healing and to consider the role that drugs and alcohol play in the culture. (Issues of culture and ethnicity are discussed in detail in chapter 5.)

Effectiveness of Family Therapy

While there are limited studies of the effectiveness of family therapy in the treatment of substance abuse, important trends suggest that family therapy approaches should be considered more frequently in substance abuse treatment. Much of the federally funded research into substance abuse treatment has focused on criminal justice issues, co-occurring disorders, and individual-specific treatments. One reason is that research with families is difficult and costly. Ambiguities in definitions of family and family therapy also have made research in these areas difficult. As a result, family therapy has not been the focus of much substance abuse research. However, evidence from the research that has been conducted, including that described below, indicates that substance abuse treatment that includes family therapy works better than substance abuse treatments that do not (Stanton et al. 1982). It increases engagement and retention in treatment, reduces the IP's drug and alcohol use, improves both family and social functioning, and discourages relapse.

Selected Research Outcomes of Family Approaches to Substance Abuse Treatment

• Bukstein (2000, p. 74) found that "family-focused interventions are empirically well-supported for youth with a conduct disorder or substance use disorder." He notes that 68 percent of adolescents with a substance use disorder also had a comorbid disruptive behavior disorder. Bukstein emphasizes that family therapy interventions can focus on the environmental factors that promote both disorders.

• Catalano et al. (1999) sought to determine whether family-focused interventions for parents on methadone would reduce their drug use and prevent children from starting to use drugs. After studying 144 methadone-treated parents with 78 children for a year, with 33 sessions of family training, the authors found significant improvements in parenting skills, less parental drug use, fewer deviant peers, and better family management.

• Cunningham and Henggeler's 1999 overview of multisystemic therapy, a family-based treatment model, found high rates of substance abuse treatment completion among youth with serious clinical problems.

• Diamond et al. (1996) reviewed advances in family-based treatment research. They cited a growing body of research indicating that family-based treatments are effective for a variety of child and adolescent disorders, including substance abuse, schizophrenia, and conduct disorder. The studies all demonstrated the superiority of brief family treatment over individual and group treatments for reducing drug use.

• Friedman et al. (1995) conducted a study of 176 adolescent drug abuse clients and their mothers in six outpatient drug-free programs with family therapy sessions. The authors found that the more positively the client described the family's functioning and relationships at pretreatment, the more client improvement was reported by client or mother at follow-up. They concluded that the adolescents with better treatment outcomes began treatment with more positive perceptions of their families.

• In a review of controlled treatment outcome research, Liddle and Dakof (1995*a*) found that different types of family intervention can engage and retain people who use drugs and their families in treatment, significantly reduce drug use and other problem behaviors, and enhance social functioning. They also concluded that family therapy was more effective than therapy without families, but cautioned against overgeneralizing this finding because of methodological limitations and the relatively small number of studies.

• McCrady and Epstein (1996) noted that an extensive literature supports family-based models and the effectiveness of treatments based on the family disease, family systems, and behavioral family models. Research knowledge is limited, however, by a lack of attention to cultural, racial, sexual, and gender orientation issues among subjects; the lack of couples treatment research on people using drugs; and the lack of family treatment research on individuals with alcohol abuse disorders.

• O'Farrell and Fals-Stewart (2000) concluded that behavioral couples therapy led to more abstinence and better relationships, decreased the incidence of separation and divorce, reduced domestic violence, and had a favorable cost/benefit ratio compared to individual therapy.

• Shapiro (1999) describes La Bodega de la Familia, a family therapy approach used to reduce relapse, parole violations, and recidivism for individuals released from prison and jail. With intensive family-based therapies, the 18-month rearrest rate dropped from 50 to 35 percent. • In a study using both family and non-family treatments for substance abuse, Stanton and Shadish (1997) concluded that (1) when family–couples therapy was part of the treatment, results were clearly superior to modalities that do not include families, and (2) family therapy promotes engagement and retention of clients.

• Walitzer (1999) analyzed two forms of family therapy (behavioral marital therapy and family systems therapy) for treating substance abuse, concluding that the model of choice depended on the problem at hand. If problems (such as poor communication) centered in the marriage, behavioral marital therapy was the better approach. If the problem involved a whole family organized around alcohol or illicit

drugs, family systems therapy could be a superior strategy. In either case, her review "strongly indicates the critical role family functioning can have in both subtly maintaining an addiction and in creating an environment conducive to abstinence" (Walitzer 1999, p. 147).

Although the effectiveness of family therapy is documented in a growing body of evidence, integrating family therapy into substance abuse treatment does pose some specific challenges:

- Family therapy is more complex than nonfamily approaches because more people are involved.
- Family therapy takes special training and skills beyond those typically required in many substance abuse treatment programs.
- Relatively little research-based information is available concerning effectiveness with subsets of the general population, such as women, minority groups, or people with serious psychiatric problems (O'Farrell and Fals-Stewart 1999).

The balance, however, certainly tips in favor of a family therapy in treating substance abuse. Based on effectiveness data and the consensus panel's collective experience, the consensus panel recommends that substance abuse treatment agencies and providers consider how they might incorporate family approaches, including age-appropriate educational support services for their clients' children, into their programs.

Cost Benefits

Only a few studies have assessed the cost benefits of family therapy or have compared the cost of family therapy to other approaches such as group therapy, individual therapy, or 12-Step programs. A small but growing body of data, however, has demonstrated the cost benefits of family therapy specifically for substance abuse problems. Family therapy also has appeared to be superior in situations that might in some key respect be similar to substance abuse contexts.

For example, Sexton and Alexander's work with functional family therapy (so called because it focuses its interventions on family relationships that influence and are influenced by, and thus are functions of, positive and negative behaviors) for youth offenders found that family therapy nearly halved the rate of re-offending—19.8 percent in the treatment group compared to 36 percent in a control group (Sexton and Alexander 2002). The cost of the family therapy ranged from $700 to $1,000 per family for the 2-year study period. The average cost of detention for that period was at least $6,000 per youth; the cost of a residential treatment program was at least $13,500. In this instance, the cost benefits of family therapy were clear and compelling (Sexton and Alexander 2002).

Other studies look at the offset factor; that is, the relationship between family therapy and the use of medical care or social costs. Fals-Stewart et al. (1997) examined social costs incurred by clients (for example, the cost of substance abuse treatment or public assistance) and found that behavioral couples therapy was considerably more cost effective than individual therapy for substance abuse, with a reduction of costs of $6,628 for clients in couples therapy, compared to a $1,904 reduction for clients in individual therapy.

Similar results were noted in a study by the National Working Group on Family-Based Interventions in Chronic Disease, which found that 6 months after a family-focused intervention, reimbursement for health services was 50 percent less for the treatment group, compared to a control group. While this study looked at chronic diseases such as heart disease, cancer, Alzheimer's disease, and diabetes, substance abuse also is a chronic disease that is in many ways analogous to these physical conditions (Fisher and Weihs 2000). Both chronic diseases and substance abuse

- Are long-standing and progressive
- Often result from behavioral choices
- Are treatable, but not curable
- Have clients inclined to resist treatment
- Have high probability of relapse

Chronic diseases are costly and emotionally draining. Substance abuse is similar to a chronic disease, with potential for recovery; it even can lead to improvement in family functioning. Other cost benefits result from preventive aspects of treatment. While therapy usually is not considered a primary prevention intervention, family-based treatment that is oriented toward addressing risk factors may have a significant preventive effect on other family members (Alexander et al. 2000). For example, it may help prevent substance abuse in other family members by correcting maladaptive family dynamics.

Other Considerations

Family therapy for substance abuse treatment demands the management of complicated treatment situations. Obviously, treating a family is more complex than treating an individual, especially when an unwilling IP has been mandated to treatment. Specialized strategies may be necessary to engage the IP into treatment. In addition, the substance abuse almost always is associated with other difficult life problems, which can include mental health issues, cognitive impairment, and socioeconomic constraints, such as lack of a job or home. It can be difficult, too, to work across diverse cultural contexts or discern individual family members' readiness for change and treatment needs.

These circumstances make meaningful family therapy for substance abuse problems a complex and challenging task for both family therapists and substance abuse treatment providers. Modifications in the treatment approach may be necessary, and the success of treatment will depend, to a large degree, on the creativity, judgment, and cooperation in and between programs in each field.

Complexity

Clinicians treating families have to weigh many variables and idiopathic situations. Few landmarks may be apparent

along the way; for many families, the phases of family therapy are neither discrete nor well defined. This uncertain journey is made less predictable because multiple people are involved. For example, in an adolescent program, a child in treatment might have a parent with alcoholism. As the parent's substance abuse issues begin to surface, the child is withdrawn from treatment. This is why children need to participate in a group of their own. In a family therapy program, the child's and the parent's substance abuse problems would be addressed concomitantly.

Another factor that can complicate any therapy process is external coercion, such as court-mandated treatment or mandates arising out of child protective services requirements. These situations can affect families in varied ways; treatment providers should approach mandated family therapy with heightened vigilance about the role of coercion in family process. Often in substance abuse treatment, a legal mandate or some other form of coercion makes therapy a requirement. The nature of mandated treatment is likely to have an effect on the dynamics of family therapy. It can place constraints on the therapist and raise distracting issues that have a negative effect on treatment, requiring more care, coordination of services, and case management. The legal and ethical thicket is dense in these circumstances. An exception is when the client is a minor, the courts can mandate treatment and family therapy. Practitioners should avail themselves of all relevant resources (e.g., professional associations, supervision, ethical guidelines, local and State legal and consumer organizations) before venturing to treat families under court order or similar situations. Therapists must form a working alliance with each family member and establish trust with the family so that sensitive information can be disclosed. This requires the therapist to demonstrate that she is on the family's side therapeutically, but she also needs to disclose to the family any other obligations she has as a result of her position. For example, by agreeing to treat the family under the particular circumstances at hand, the therapist might be obligated to make progress reports to probation or parole agencies.

Co-occurring problems

Even though an individual with a substance use disorder generally brings a family into treatment, it is possible that more than one person in the family has substance abuse problems, mental illness, problems with domestic violence, or some other major difficulty. Substance abuse, in fact, may be a secondary reason for referral for therapy. Changing the family's maladaptive patterns of interaction may help to correct psychosocial problems among all family members. For more information about co-occurring mental and substance use disorders see the forthcoming TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT] in development *k)*.

Biological aspects of addiction

Other important considerations involve the biological and physiological aspects of addiction and recovery. The recovery process varies according to the type of drug, the extent of drug use, and the extent of acute and chronic effects. Recovery also may depend, at least partly, on the extent to which the drugs are intertwined with antisocial behavior and co-occurring conditions. For the IP, post-acute withdrawal symptoms also will commonly present and interfere with family therapy for a significant period before gradually subsiding.

The biological aspects of addiction also may affect the type of therapy that can be effective. For example, family therapy may not be as effective for someone whose drug use has caused significant organic brain damage or for a person addicted to cocaine who has become extremely paranoid. Severe psychopathology, however, should not automatically exclude a client from family therapy. Even in these cases, with appropriate individual and psychopharmacological treatment, family therapy may be helpful (O'Farrell and Fals-Stewart 1999) since other members of the family might need and benefit from family therapy services.

Socioeconomic constraints

The socioeconomic status of a family in treatment can have far-reaching ramifications. During treatment, poverty has two immediate implications. First, therapy will need to address many survival issues—a therapist cannot explore aspects of family systems or cognitive–behavioral traits if a family is being evicted, is not eating properly, is without financial resources and employment, or is experiencing some other threat to daily life. Second, the reimbursement systems that can be accessed probably will determine how long treatment will continue, irrespective of client needs. Therefore, family therapy treatments for substance abuse must be designed to be relatively brief and to target aspects of the family's environment that may be maintaining the drug abuse symptomatology (e.g., Robbins et al. in press). In addition, family members should be referred to Al-Anon, Alateen, and NAR-Anon to enhance their potential for long-term recovery.

Cultural competence

Cultural competence is an important feature in family therapy because therapists must work with the structures of families from many cultures. Knowledge of and sensitivity to cultures is involved in determining

- To what extent is the family's divergence from mainstream norms a function of pathology or a different cultural background?
- How is the family arranged—hierarchically? Democratically? Within this structure, what are the communication patterns?
- How well is this family functioning? That is, to what extent can the family meet its own goals without getting in its own way?
- What therapeutic goals are appropriate?
- What are the culture's prescribed roles for each family member?
- Who are the appropriately defined "power figures" in the family?

The need for cultural competence does not imply that a therapist must belong to the same cultural group as the client family. It is possible to develop cultural competence and work with groups other than one's own. A sensitive therapist pays attention, senses cultural nuances, and learns from clients. Even when the therapist is from the same culture as the family in treatment, trust cannot be assumed. It must be built. The expectations regarding the therapist's role as an agent of change must be clearly discussed in relation to the developing trust with the family and individual members.

Issues related to cultural sensitivity and appropriateness are considered in greater detail in chapter 5 and in the

forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development *b*).

Stages of change and levels of recovery

The process of recovery is complex and multifaceted. One useful framework for understanding this process involves stages of change (Prochaska et al. 1992), which can be applied to an individual or to the whole family and used as a framework for treatment. The five stages of change are

Precontemplation

Contemplation

Preparation

Action

Maintenance

Individuals typically progress and regress in their movements through these stages (Prochaska et al. 1992). Although these stages can be applied to a whole family, not every family member necessarily will be at the same stage at the same time. The therapist needs to address where each family member is, for these factors play an important role in assessment and treatment matching decisions. For additional information on the stages of change, refer to chapter 3 of this TIP and see also TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).

While Prochaska et al. (1992) conceptualized readiness for change, other researchers have modeled the stages of recovery after treatment has begun. One such model of the path through treatment is Kaufman's (1990*b*) progressive levels of recovery:

- *Dry abstinence* is a time when clients must cope with problems revolving around the cessation of substance use (such as withdrawal, sudden realization of the actual damage intoxication has caused, and the shame that follows).
- *Sobriety*, or *early recovery*, concentrates on maintaining freedom from substances. Bit by bit, the client is helped to substitute health-sustaining behaviors for relationships and circumstances that precipitate substance use.
- *Advanced recovery* shifts from support to examination of underlying personal issues that predispose the client to substance use. Trust and intimacy are re-established, and the client moves through the termination of therapy.

This TIP approaches stages of change for families by combining Bepko and Krestan's stages of treatment for families (1985) and Heath and Stanton's stages of family therapy for substance abuse treatment (1998). Together, the phases of family change are

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

Combining these two models provides a simple, straightforward categorization for a family's progress in recovery regarding attainment of, adjustment to, and long-term maintenance of sobriety. For additional information on these phases of family change, see chapter 4.

Unanswered research questions

At present, research cannot guide treatment providers about the best specific matches between family therapy and particular family systems or substances of abuse. Research to date suggests that certain family therapy approaches can be effective, but no one approach has been shown to be more effective than others. In addition, even though the right model is an important determinant of appropriate treatment, the exact types of family therapy models that work best with specific addictions have not been determined. However, a growing body of evidence over the past 25 years suggests that children benefit from participating in age-appropriate support groups. These can be offered by treatment programs, school-based student assistance programs, or faith-based communities.

Experience and sound judgment can distinguish many situations in which family therapy alone would or would not be a workable modality. Treatment must be customized to the needs of each family and the person abusing substances. An adolescent who is primarily smoking marijuana, for instance, is a good candidate for family systems work. On the other hand, if a youth is mixing cocaine, amphetamines, alcohol, and other drugs, the client is likely to need more extensive services—detoxification, residential treatment, or intensive outpatient therapy--which can be used in addition to family therapy (Liddle and Hogue 2001).

Safety and Appropriateness of Family Therapy

Only in rare situations is family therapy inadvisable. Occasionally, it will be inappropriate or counterproductive because of reasons such those as mentioned above. Sometimes, though, family therapy is ruled out due to safety issues or legal constraints. Family or couples therapy should not take place unless all participants have a voice and everyone can raise pertinent issues, even if a domineering family member does not want them discussed. Family therapy can be used when there is no evidence of serious domestic or intimate partner violence. Engaging in family therapy without first assessing carefully for violence can lead not only to poor treatment, but also to a risk for increased abuse.

A systems approach presumes that all family members have roughly equal contributions to the process and have equity in terms of power and control. This belief is not substantiated in the research on family violence. Hence, family therapy only should be used when one family member is not being terrorized by another. Resistance from a domineering family member can be addressed and restructured by first allying with this family member and then

gradually and gently questioning this person (and the whole family) about the appropriateness of the domineering behavior (Szapocznik et al. 1988). (See also appendix C, Guidelines for Assessing Violence.)

It is the treatment provider's responsibility to provide a safe, supportive environment for all participants in family therapy. Children benefit by attending support groups specifically for them; it is important to create a safe environment in which they can discuss family violence, abuse, and neglect. Usually, a way can be found to include even the family member who has turned to violence as a way of dealing with problems. That person is a vital part of the family and will be pivotal in understanding the nature of the family violence. For example, Johnson (1995) distinguishes between common couple violence and patriarchal terrorism. The former is characterized by occasional violent outbursts by either spouse and is not likely to escalate. It is usually an intermittent response to conflict, and in therapy can be examined and channeled into more positive expression. Patriarchal terrorism, however, is systematic male violence with the goal of control. It may not be possible or advisable to include a chronically violent partner in the family therapy process.

Child abuse or neglect is another serious consideration. Children in violent homes have more physical, mental, and emotional health problems than do children in nonviolent homes. Children of people with alcohol abuse disorders suffer more injuries and poisonings than do children in the general population. Research has shown that when families exhibit both of these behaviors—substance abuse and child maltreatment—the problems must be treated simultaneously to ensure a child's safety. It should be noted that the withdrawal experienced by parents who cease using alcohol or drugs presents specific risks. The effects of withdrawal often cause a parent to experience intense emotions, which may increase the likelihood of child maltreatment. During this time, it is especially important that family support resources be made available to the family (Bavolek 1995), and that children know how to find safe adults to help. Any time a counselor suspects child abuse or neglect, laws require immediate reporting to local authorities. For further information, see TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*).

Domestic violence is a serious issue among people with substance use disorders, and it must be factored into therapeutic considerations. If, for example, a restraining order prohibits spouses from seeing each other, the treatment provider must work within this limitation, using therapeutic configurations that make sure that a client who is abusive is not in a session with the person he or she has been barred from seeing. Often when there is concomitant family violence, the offender is mandated to complete a Batterer's Intervention Program before participating in any couple's work. At the same time, the victim/spouse is engaged in safety planning and sometimes treatment for his or her own issues.

Only the most extreme anger contraindicates family therapy. Kaufman and Pattison (1981) developed the concept of the need for a period of abstinence before sufficient trust can be built to counteract the anger. Including all family members in treatment and providing them a forum for releasing their anger may help to work toward that threshold. Redefining the problem as residing within the family as a whole can help transform the anger into motivation for change. In turn, this motivation can be used to restructure the family's interactions so that the substance abuse is no longer supported. The therapist's ability to reframe proposed obstructions by family members is often the key to creating a positive therapeutic direction.

It is up to counselors and therapists to assess the potential for anger and violence and to construct therapy so it can be conducted without endangering any family members. Because of the life-and-death nature of this responsibility, the consensus panel includes guidelines for the screening and treatment of people caught up in the cycle of family violence. These recommendations, adapted from TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), are presented in appendix C. However, these guidelines are not a substitute for training; counselors and therapists should have training and supervision in handling family violence cases.

If, during the screening interview, it becomes clear that a batterer is endangering a client or a child, 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 can be ensured. The provider should refer the client or child to a domestic violence program and possibly to a shelter and legal services, and should take necessary steps to ensure the safety of affected children. Any outcry of anticipated danger needs to be regarded with the utmost seriousness and immediate precautions taken.

Goals of This TIP

General Goals

Connections

The integration of family therapy into substance abuse treatment is an important development in the treatment of addictions. Historically, barriers have separated the fields, among them differences in credentialing, treatment models, and cost for higher-trained family therapists.

This TIP is intended to provide an opportunity for providers from both disciplines to learn from one another. It provides language that will help both fields talk about family therapy and addiction and facilitate a new and more collaborative way of thinking about substance abuse treatment.

In many States and jurisdictions, credentialing requirements are raising standards for substance abuse counselors and family therapists. These changes, which will require further education, provide opportunities for practitioners to expand their horizons as they upgrade their professional skills. This process can further cross-fertilize the fields by making the practitioners of both fields more familiar with each other's work.

Coverage for family therapy

The consensus panel hopes that substance abuse treatment and family therapy practitioners will be able to use this TIP to help educate insurers and behavioral managed care organizations about the importance of covering family therapy services for clients with substance use disorders.

Goals for Specific Groups

Substance abuse treatment counselors

This TIP will help substance abuse treatment counselors

- Understand the impact of substance abuse on families taken as a whole
- Recognize that family members need treatment in the context of the family as a whole
- Appreciate the value of family therapy in treatment and integrate their interventions with the greater good of the family

Family therapists and other clinicians

This TIP will help family therapists become more aware of the presence and significance of chemical dependency and work with the substance abuse treatment community so family environments no longer contribute to or maintain substance abuse. It also is hoped that family therapists will come to appreciate models of substance abuse treatment and the context in which they are delivered.

Clinical supervisors

Clinical supervisors in substance abuse treatment programs and in family treatment programs can use this information to become aware of and knowledgeable about the potential connections between substance abuse treatment and family therapy. These supervisors will then be better equipped to incorporate appropriate family approaches into their programs and evaluate the performance of personnel and programs in both disciplines.

Treatment program administrators

Realizing how beneficial family therapy can be as an adjunct to or integrated part of substance abuse treatment, program administrators can use the TIP to train and motivate substance abuse treatment clinicians to include family members in treatment. Likewise, program administrators in family treatment programs can use the TIP to motivate and train family therapists to include the exploration of substance use disorders in family treatment.

Since it is difficult to find counselors who are expert in both fields, it is hoped that substance abuse treatment administrators will develop collaborative relationships with family therapy programs and manage necessary logistical issues. For example, finding adequate space is often an issue. Working hours, too, may have to be shifted, because staff will need to work some evenings to meet with family members.

Families

The consensus panel hopes that family therapists will begin to raise the issue of substance use as a critical issue that can negatively impact families and that substance abuse treatment counselors will use information in this TIP to inform families about what they can expect from treatment. The growing consumer health movement can be part of the education that emboldens families to ask for adequate treatment. The IP and family members should be encouraged to identify

- Why is treatment being pursued now?
- What are the costs and benefits of engaging in therapy now?
- How is "change" defined in the structure of "progress" in therapy?
- What are the key components of treatment for the family?

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Chapter 2 Impact of Substance Abuse on Families

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

Introduction

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

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

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

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

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

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

1. *Negativism*. Any communication that occurs among family members is negative, taking the form of complaints, criticism, and other expressions of displeasure. The overall mood of the household is decidedly downbeat, and positive behavior is ignored. In such families, the only way to get attention or enliven the situation is to create a crisis. This negativity may serve to reinforce the substance abuse.
2. *Parental inconsistency*. Rule setting is erratic, enforcement is inconsistent, and family structure is inadequate. Children are confused because they cannot figure out the boundaries of right and wrong. As a result, they may behave badly in the hope of getting their parents to set clearly defined boundaries. Without known limits, children cannot predict parental responses and adjust their behavior accordingly. These inconsistencies tend to be present regardless of whether the person abusing substances is a parent or child and they create a sense of confusion—a key factor—in the children.
3. *Parental denial*. Despite obvious warning signs, the parental stance is: (1) "What drug/alcohol problem? We don't see any drug problem!" or (2) after authorities intervene: "You are wrong! My child does not have a drug problem!"
4. *Miscarried expression of anger*. Children or parents who resent their emotionally deprived home and are afraid to express their outrage use drug abuse as one way to manage their repressed anger.
5. *Self-medication*. Either a parent or child will use drugs or alcohol to cope with intolerable thoughts or feelings, such as severe anxiety or depression.
6. *Unrealistic parental expectations*. If parental expectations are unrealistic, children can excuse themselves from all future expectations by saying, in essence, "You can't expect anything of me—I'm

just a pothead/speed freak/junkie." Alternatively, they may work obsessively to overachieve, all the while feeling that no matter what they do it is never good enough, or they may joke and clown to deflect the pain or may withdraw to side-step the pain. If expectations are too low, and children are told throughout youth that they will certainly fail, they tend to conform their behavior to their parents' predictions, unless meaningful adults intervene with healthy, positive, and supportive messages.

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

Families With a Member Who Abuses Substances

Client Lives Alone or With Partner

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

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

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

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

- They are controlling because they believe that others are incapable of taking care of themselves.
- They typically have low self-esteem and a tendency to deny their own feelings.
- They are excessively compliant, compromising their own values and integrity to avoid rejection or anger.
- They often react in an oversensitive manner, as they are often hypervigilant to disruption, troubles, or disappointments.
- They remain loyal to people who do nothing to deserve their loyalty (CoDA 1998).

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

Client Lives With Spouse (or Partner) and Minor Children

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

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

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

Although, in general, children with parents who abuse substances are at increased risk for negative consequences,

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

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

Client Is Part of a Blended Family

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

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

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

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

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

Clinicians treating substance abuse should know that the family dynamics of blended families differ somewhat from those of nuclear families and require some additional considerations. Anderson (1992) identifies strategies for addressing substance abuse in a stepfamily:

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

Older Client Has Grown Children

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

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

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

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

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

Client Is an Adolescent and Lives With Family of Origin

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

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

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

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

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

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

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

In many families that include adolescents who abuse substances, at least one parent also abuses substances (Alexander and Gwyther 1995). This unfortunate modeling can set in motion a dangerous combination of physical and emotional problems. If adolescent substance use is met with calm, consistent, rational, and firm responses from a responsible adult, the effect on adolescent learning is positive. If, however, the responses come from an impaired parent, the hypocrisy will be obvious to the adolescent, and the result is likely to be negative. In some instances, an impaired parent might form an alliance with an adolescent using substances to keep secrets from the parent who does not use substances. Even worse, sometimes in families with multigenerational patterns of substance abuse, an attitude among extended family members may be that the adolescent is just conforming to the family history.

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

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

Substance Use Disorders (CSAT 1999e).

Someone Not Identified as the Client Abuses Substances

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

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

Other Treatment Issues

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

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

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

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

Chapter 2 Summary Points From a Family Counselor Point of View

•Consider the "family" from the client's point of view—that is, who would the client describe as a family member and who is a "significant other" for the client.

•Assess the "family"—members' effectiveness of communications, supportiveness or negativity, parenting skills, conflict management, and understanding of addictive disease.

•Don't give up, and try, try again—many families or family members at first reject any participation in the treatment process. But, after a period of separation from the client who is abusing substances, family members often become willing to at least attend an initial session with the counselor.

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Chapter 3 Approaches to Therapy

This chapter discusses the fields of substance abuse treatment and family therapy. The information presented will help readers from each field form a clearer idea of how the other operates. It also will present some of the basic theories, concepts, and techniques from each field so they can be applied in treatment regardless of the setting or theoretical orientation.

Substance abuse treatment and family therapy are distinct in their histories, professional organizations, preferred intervention techniques, and focuses of treatment. Training and licensing requirements are different, as are rules (both formal and informal) that govern conduct. The two fields have developed their own vocabularies. These differences have significant and lasting effects on how practitioners approach clients, define their problems, and undertake treatment.

Despite these variations, providers from both fields will continue to treat many of the same clients. It is useful, therefore, for clinicians in each field to understand the treatment that the other field provides and to draw on that knowledge to improve prospects for professional collaboration. The ultimate goal of increased understanding is the provision of substance abuse treatment that is fully integrated with professional family therapy.

Differences in Theory and Practice

Theory

The fields of substance abuse treatment and family therapy share many common assumptions, approaches, and techniques, but differ in significant philosophical and practical ways that affect treatment approaches and goals for treatment. Further, within each discipline, theory and practice differ. Although of the two, substance abuse treatment is generally more uniform in its approach, in both cases certain generalizations apply to the practice of the majority of providers. Two concepts essential to both fields are denial and resistance presented by clients.

Denial and Resistance

The fields of substance abuse treatment and family therapy often use different terms and sometimes understand the same terms differently. For example, the term *denial* can have different meanings for a substance abuse counselor and a family therapist. Two family therapists with different theoretical orientations also may understand the meaning in different ways.

In substance abuse treatment, the term *denial* is generally used to describe a common reaction of people with substance use disorders who, when confronted with the existence of those disorders, deny that they have a substance abuse problem. This is a complex reaction that is the product of psychological and physiological factors, especially those concerned with memory and the influence of euphoria produced by the substance of abuse. It is not a deliberate, willful act on the part of the person who is abusing substances but is rather a set of defenses and distortions in thinking caused by the use of substances. Family therapists' understanding of the term *denial* will vary more according to the particular therapist's theoretical orientation. For example, structural and strategic therapists might see denial as a *boundary issue* (referring to a barrier within the family structure of relationships), which may be necessary for maintaining an alliance or contributing to relationships that are too close or *enmeshed.* On the other hand, a solution-focused therapist might see denial as a strategy for maintaining stability and therefore not a "problem" at all, while a narrative therapist will simply see denial as another element in a person's story.

Resistance is, in contrast, a relatively straightforward negative response to someone expecting you to do something that you do not want to do. The clinician can minimize resistance by understanding the client's stage of change and being prepared to work with the client based on interventions geared to that stage. If clinicians treat individual clients (or their families) at their actual stage of readiness or level of motivation to change, they should encounter minimal client resistance. In other words, clinicians can only do so much when a client is not ready to change or try a new behavior. Still, counselors can help the client move slowly from one stage of change to another. If treatment is in sync with readiness for that treatment, resistance should not become a significant problem.

Resistance may be based on the client not yet being able to do something. When therapists can accept that clients are not always "resisting" because they don't want to do something, but perhaps because they are unable to do something, they are better able to enter the client's world to explore what is causing the resistance.

There is a difference between the therapist saying (or believing) "You refuse to do _____" and saying/believing, "Let's explore what could be in the way of your doing _____." One way of dealing with client resistance is to offer the client some typical reasons for not complying: e.g., "Sometimes, when a client is unable to talk about his early childhood, it is because he is ashamed or embarrassed or afraid of crying or perhaps that I (the therapist) might think the information is bizarre. I wonder if this is something that is going on with you?" The same technique works with resistance to therapeutic suggestions for carrying out a plan constructed during a therapy session: "Sometimes, a client does not carry out the plan we've made because I was moving too fast or perhaps didn't know all

of the dynamics that you find when you get home, or maybe because we didn't talk enough about the potential consequences for carrying out the action, for instance, maybe your child will run away or you need to try some other things first."

Source: Consensus Panel.

Clinical research (e.g., Szapocznik et al. 1988) has demonstrated that *resistance* (whether on the part of the person with a substance use disorder or on the part of another family member) to engaging family members into therapy accurately may reflect the family dynamics that help to maintain the substance abuse problem. Therefore, it may be important to work with the client and family to restructure this resistance in order to bring the family into treatment and correct the maladaptive interactional patterns that are related to the substance abuse problem.

Many substance abuse treatment counselors base their understanding of a family's relation to substance abuse on a *disease model* of substance abuse. 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. In other words, the individual member's substance abuse and the pain and confusion of the family relate to each other as cause and effect. Berenson and Schrier (1998) note that the disease model is pragmatic in orientation, having developed typically through practice and not having been drawn from theory or controlled experimentation. The disease model also views substance use disorders as having a genetic component and as being similar to recurrent medical diseases in that both are "chronic, progressive, relapsing, incurable, and potentially fatal" (Inaba et al. 1997, p. 66).

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. The size of the family system can vary from two (in couples therapy) to an extended family, and may even involve multiple systems (for instance, schools and workplaces) that affect family members (Walsh 1997).

This theoretical perspective emphasizes reciprocal relationships. Substance abuse is believed to interact with dysfunctional family relationships, thereby maintaining both problems. Family therapists believe that interpersonal relationships need to be altered so that the family becomes an environment within which the person abusing substances can stop or decrease use and the needs of family members can be met. Family systems approaches have been developed out of a strong theoretical tradition, but do not have many empirical studies validating their effectiveness (Berenson and Schrier 1998). (See TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* [Center for Substance Abuse Treatment (CSAT) 1999*a*], for more information on the specific approaches to family therapy, all of which draw on a systems model.)

The fields of family therapy and substance abuse treatment, despite their basic differences, are compatible. For example, family therapy may seem to have a monopoly on the systems approach, and substance abuse treatment may appear to focus solely on the individual, with less emphasis on the individual's relationship to any larger system. In fact, however, both family therapy and substance abuse treatment actually understand substance abuse in relation to systems. They simply focus treatment on different systems. Substance abuse treatment providers typically focus on a system consisting of a person with a substance use disorder and the nature of addiction. Family therapists see the system as a person in relation to the family. Clearly, the reaction of the family to the client, the reaction of the client to the family, and the nature of addiction can be mutually reinforcing dynamics.

Clinicians in both fields address client interactions with a system that involves something outside the self. It should be noted that neither substance abuse treatment nor family therapy routinely considers other, broader systems: culture and society. Multiple systems affect people with substance use disorders at different levels (individual, family, culture, and society), and truly comprehensive treatment would take all of them into consideration. Family and substance abuse treatment potentially undervalue the influence and power of gender and stereotypical roles imposed by the culture. Feminist and cultural family therapists caution that by ignoring the power differentials within and between cultures, therapists can potentially harm the client and family. For example, by not recognizing the differences in power between men and women, and advocating for parity and equality in a relationship, the therapist might disrupt the power differential in a family and, if not addressed, cause more conflict and potential harm to the family.

The mental health field in general now recognizes addiction as an independent illness warranting specific treatment on an equal footing with mental health treatment (CSAT in development *k*). So, too, have the majority of family therapists (and group therapists—see CSAT in development *g*) recognized the importance of direct treatment attention for the addictive disorder in addition to family therapy interventions.

Practice

Following is a general overview of the differences that exist among many, but certainly not all, substance abuse and family therapy settings and practitioners.

Family interventions

Substance abuse treatment programs that involve the family of a person who is abusing substances generally use family interventions that differ from those used by family therapists. Psychoeducation and multifamily groups are more common in the substance abuse treatment field than in family therapy. 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 (although some types of family therapy, such as strategic family therapy, are brief).

The understanding of the relative importance of different issues in a client's recovery naturally influences the techniques and interventions used in substance abuse treatment and family therapy. Family therapists will focus

more on intrafamily relationships while substance abuse treatment providers concentrate on helping clients achieve abstinence.

Spirituality

Spirituality is another practice that clinicians in the two fields approach differently. In part because of the role of spirituality in 12-Step groups, substance abuse treatment providers generally consider this 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 reduced the role of spirituality, especially in theory and largely in clinical practice. The lack of emphasis on spiritual life in family therapy continues even though religious affiliation has been shown to negatively correlate with substance abuse (Miller et al. 2000; National Center on Addiction and Substance Abuse 2001; Pardini et al. 2000). Some family therapy is conducted within religious settings, often by licensed pastoral counselors. However, a standard concept of spirituality, whether religious in origin or otherwise, has not yet been clearly agreed on by clinicians of any discipline in the substance abuse treatment field.

Process and content

Family therapy generally attends more to the *process* of family interaction, while substance abuse treatment is usually more concerned with the planned *content* of each session. The family therapist is trained to observe the interactions of family members and employ treatment methods in response to those observations. Some family therapists may even see a client's substance abuse as a content issue (and therefore less significant than the family interactions).

For example, a wife might begin describing how upset and hopeless she felt when her husband had a slip, only to be interrupted by him in a subtly threatening tone and/or condescending manner. The family therapist might zero in on whether the husband regularly interrupts and aggressively changes the course of a conversation whenever his wife expresses emotions—in other words, is what just occurred an instance of a general pattern of interaction (process) between husband and wife? And, what is the purpose/goal of the process—is it the husband's way of avoiding emotions or of avoiding his own disappointment about the slip and inability to have protected his wife from the consequence of illness? On the other hand, a substance abuse counselor might concentrate on the content of the issues raised by the interchange—that is, the counselor might point out to the husband that alcoholism is a family disease, that his slip does have serious consequences, and that his slip and his wife's initial upset and hopelessness are how the disease of alcoholism separates the person with the substance abuse disorder from what is held dear. The counselor might further focus on the content issues of handling slips, learning from them, and recognizing that they are sometimes part of a successful recovery.

A number of essential aspects of addictive disease form the general basis for substance abuse counseling. For addictions, certain themes are essential and are always explored—shame, denial, the "cunning, baffling, and powerful" nature of addiction (Alcoholics Anonymous [AA] 1976, pp. 58–59)—as well as the fact that recovery is a long-term proposition. These are all essential in part because most people with substance use disorders enter treatment with beliefs opposite to the facts. In contrast, these differences support the need for more cross-training between the two disciplines.

Focus

Even when treating the same clients with the same problems, clinicians in the fields of family therapy and substance abuse treatment typically focus on different targets. For instance, if a man who has been abusing cocaine comes with his wife to a substance abuse treatment program, the counselor will identify the substance abuse as the presenting problem. Initially, at least, the substance abuse counselor will see the primary goal as arresting the client's substance use.

A family therapist, on the other hand, will see the family system—which could be just the couple—as an integral component of the substance abuse. The goals of the family therapist will usually be broader than the substance abuse counselor's, focusing on improving relational patterns throughout the family system. Because families change their patterns of interaction over the course of recovery, they are believed to need continued assistance to avoid developing another dysfunctional pattern.

Identity of the client

Most often the substance abuse counselor regards the individual with the substance use disorder as the primary person requiring treatment. While practitioners from both fields would generally agree that a client with a substance use disorder needs to stop using substances, they may not agree on how that end can best be accomplished. A common assumption in substance abuse treatment is that the problems of other family members do not need to be resolved for the client to achieve and maintain abstinence. The substance abuse treatment provider may involve the family to some degree, but the focus remains on the treatment needs of the person abusing substances. 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. Unfortunately, such integrated treatment is not always possible because of lack of funding.

Who is seen in treatment also varies by field. Even though many substance abuse treatment programs feature a component for family members, most counselors and programs will not involve a client's family in early treatment (an exception is the type of interventions that use family and friends to motivate a client to enter treatment). Most substance abuse treatment programs will work with the client's family once a client has achieved some level of abstinence. At the time the client enters treatment, however, substance abuse treatment providers often refer family members, including children, to a separate treatment program or to self-help groups such as Al-Anon, Nar-Anon, and Alateen (see appendix D). While educational support groups offer age-appropriate understanding about addiction as well as opportunities for participants to share their experiences and learn a variety of coping skills, few treatment programs provide such groups. School-age children can also be referred to student assistance programs at their schools.

In contrast, family therapists may not treat clients who are actively abusing substances, but may carry on therapy with other family members. Family therapists do not always meet with all members of the family but with several

subgroups at different times, depending on the issues under discussion. For instance, children would likely not be present when parents are discussing marital conflict issues or struggling with the decision to separate or to stay together. However, when the issues under discussion include the behavior of the children, they would be expected to be present. However, children first need age-appropriate services so they can develop the necessary understanding about addiction, sort through their experiences and feelings, and become prepared to participate in family therapy.

Self-disclosure by the counselor

Training in the boundaries related to the therapist's or counselor's self-disclosure is an integral part of any treatment provider's education. Addiction counselors in recovery themselves are trained to recognize the importance of choosing to self-disclose their own addiction histories, and to use supervision appropriately to decide when and what to disclose. An often-used guide for self-disclosure is to consider the reason for revealing personal addiction history to the client, asking the question, "What is the purpose of the revelation? To assist the client in recovery or for my own personal needs?"

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. Clients, it should be emphasized, must be credited and acknowledged for their ability to effect change in their own lives so that they might lay claim to their own change. 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, where people seek help from other recovering people. As a result, clients usually feel comfortable with the counselors' self-disclosure.

The practice of sharing personal history receives much less emphasis in family therapy, in part because of the influence of a psychoanalytic tradition in family therapy. For the family therapist, self-disclosure is not as integral a part of the therapeutic process. It is downplayed because it takes the focus of therapy off of the family. (More recent post-modern therapies such as narrative therapy and collaborative language systems emphasize the meaning of language and the subjectivity of truth. The therapist's talking about personal experiences to gain some shared truth with the client(s) is part of the process. "Truth" is co-created between therapist and client, so sharing is natural and represents what the client perceives and understands, and the therapist attempts to open up different truths or stories that challenge the client's dominant story.)

Perhaps neither field has taken the best approach to therapist self-disclosure. Research suggests that counselors and therapists need to balance their self-disclosure. If the therapist never discloses anything, the result may be less self-disclosure by the client (Barrett and Berman 2001). Too much self-disclosure, on the other hand, might shut down conversation and decrease client self-disclosure. In addition, such information may be inappropriate for children who are present since they may not be able to process or comprehend the information, therefore adding to their confusion.

Regulations

Finally, different regulations also affect the substance abuse treatment and family therapy fields. This influence comes from both government agencies and third-party payors that affect confidentiality and training and licensing requirements. Federal regulations attempt to guarantee confidentiality for people who seek substance abuse assessment and treatment (42 U.S.C. §290dd-2 and 42 CFR Part 2). Treatment providers should be familiar with regulations in their State that may affect both confidentiality and training and licensing requirements. Confidentiality issues are complex; readers interested in additional information should see TAP 13, *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* (Lopez 1994), and TAP 18, *Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance* (CSAT 1996*a*).

Confidentiality issues for family therapists are less straightforward. For example, family therapists working with adolescents will have more trouble dealing with issues of client–therapist boundaries and confidentiality. Sometimes when treating adolescents who abuse substances, past or planned criminal behavior is evident. A strong interest in family therapy is restoring the authority of parents, yet State law might restrict the therapist's right to divulge information to parents unless the adolescent signs a properly worded release document. Laws differ from State to State, but they can be specific and strict about what therapists are required or permitted to do about reporting crime or sharing information with parents. For more information on this subject see TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999*e*).

Licensure and certification

Forty-two States require licenses for people practicing as family therapists (American Association for Marriage and Family Therapy [AAMFT] 2001). Although the specific educational requirements vary from State to State, most require at least a Master's degree for the person who intends to practice independently as a family therapist. Certain States, such as California, also require particular courses for licensure. Training in substance abuse treatment is generally not required, although the Commission on Accreditation for Marriage and Family Therapy Education of the AAMFT does suggest that family therapists receive some training in substance abuse counseling. (More information on the licensing and certification requirements of the various States is available online at www.aamft.org—this Web site also features links to State agencies that oversee certification.)

The International Certification and Reciprocity Consortium (IC&RC) on Alcohol and Other Drug Abuse is the most far-reaching, providing credentials in prevention and/or counseling to counselors in 41 States, Puerto Rico, three branches of the military, 11 foreign countries, and the Indian Health Service. IC&RC has created standards for credentialing substance abuse counselors that require 270 hours of classroom education (on knowledge of substance abuse, counseling, and ethics, as well as assessment, treatment planning, clinical evaluation, and family services), 300 hours of onsite training, and 3 years of supervised work experience (IC&RC 2002).

NAADAC (The Association for Addiction Professionals, formerly the National Association of Alcohol and Drug Abuse Counselors) also provides certification in many States that also have IC&RC reciprocity. For substance abuse counselors at the most basic level, NAADAC demands less monitoring and fewer requirements than does IC&RC, though its higher-level credentials have many more requirements than those at the basic level. NAADAC offers the only Master's level credential based on education and not experience. NAADAC's Web site is www.naadac.org. In

addition, the Addiction Technology Transfer Centers, which are partially funded by CSAT, provide information at the Web site www.nattc.org with links to State, national, and international bodies that credential counselors. However, there is little training and few credentialing requirements for understanding the impact of addiction on children and effective ways to help them.

Assessment

Specific procedures for assessing clients in substance abuse treatment and family therapy will vary from program to program and practitioner to practitioner. However, an overview of these activities is useful.

Assessment in substance abuse treatment

Assessments for substance abuse treatment programs focus on substance use and history. Figure 3-1 presents an overview of some of the key elements that are examined when assessing a client's substance abuse history —including important related concerns such as family relations, sexual history, and mental health.

Figure 3-1 Overview of Key Elements for Inclusion in Assessment

Standard Medical History and Physical Exam, With Particular Attention to the Presence of Any of the Following

- Physical signs or complaints (e.g., nicotine stains, dilated or constricted pupils, needle track marks, unsteady gait, tattoos that designate gang affiliation, "nodding off")
- Neurological signs or symptoms (e.g., blackouts or other periods of memory loss, insomnia or other sleep disturbances, tremors)
- Emotional or communicative difficulties (e.g., slurred, incoherent, or too rapid speech; agitation; difficulty following conversation or sticking to the point)

Skinner Trauma History

Since your 18th birthday, have you

- Had any fractures or dislocations to your bones or joints?
- Been injured in a road traffic accident?
- Injured your head?
- Been injured in an assault or fight (excluding injuries during sports)?
- Been injured after drinking? *Source:* Skinner et al. 1984.

Alcohol and Drug Use History

- Use of alcohol and drugs (begin with legal drugs first)
- Mode of use with drugs (e.g., smoking, snorting, inhaling, chewing, injecting)
- Quantity used
- Frequency of use
- Pattern of use: date of last drink or drug used, duration of sobriety, longest abstinence from substance of choice (when did it end?)
- Alcohol/drug combinations used
- Legal complications or consequences of drug use (selling, trafficking)
- Craving (as manifested in dreams, thoughts, desires)

Family/Social History

- Marital/cohabiting status
- Legal status (minor, in custody, immigration status)
- Alcohol or drug use by parents, siblings, relatives, children, spouse/partner (probe for type of alcohol or drug use by family members since this is frequently an important problem indicator: "Would you say they had a drinking problem? Can you tell me something about it?")
- Alienation from family
- Alcohol or drug use by friends
- Domestic violence history, child abuse, battering (many survivors and perpetrators of violence abuse drugs and alcohol)
- Other abuse history (physical, emotional, verbal, sexual)
- Educational level
- Occupation/work history (probe for sources of financial support that may be linked to addiction or drug-related activities such as participation in commercial sex industry)
- Interruptions in work or school history (ask for explanation)
- Arrest/citation history (e.g., DUI [driving under the influence], legal infractions, incarceration, probation)

Sexual History: Sample Questions and Considerations

- Sexual orientation/preference—"Are your sexual partners of the same sex? Opposite sex? Both?"
- Number of relationships—"How many sex partners have you had within the past 6 months? Year?"
- Types of sexual activity engaged in; problems with interest, performance, or satisfaction—"Do you have any problems feeling sexually excited? Achieving orgasm? Are you worried about your sexual functioning? Your ability to function as a spouse or partner? Do you think drugs or alcohol are affecting your sex life?" (A variety of drugs may be used or abused in efforts to improve sexual performance and increase sexual satisfaction; likewise, prescription and illicit drug use and alcohol use can diminish libido, sexual performance, and achievement of orgasm.)
- Whether the patient practices safe sex (research indicates that substance abuse is linked with unsafe sexual practices and exposure to HIV).

- Women's reproductive health history/pregnancy outcomes (in addition to obtaining information, this item offers an opportunity to provide some counseling about the effects of alcohol and drugs on fetal and maternal health).

Mental Health History: Sample Questions and Considerations

- Mood disorders—"Have you ever felt depressed or anxious or suffered from panic attacks? How long did these feelings last? Does anyone else in your family experience similar problems?" (If yes, do they receive medication for it?)
- Other mental disorders—"Have you ever been treated by a psychiatrist, psychologist, or other mental health professional? Has anyone in your family been treated? Can you tell me what they were treated for? Were they given medication?"
- Self-destructive or suicidal thoughts or actions—"Have you ever thought about committing suicide?" (If yes: "Have you ever made an attempt to kill yourself? Have you been thinking about suicide recently? Do you have a plan?" [If yes, "What means would you use?"] Depending on the patient's response and the clinician's judgment, a mental health assessment tool such as the Beck Depression Inventory or the Beck Hopelessness Scale may be used to obtain additional information, or the clinician may opt to implement his own predefined procedures for addressing potentially serious mental health issues.)

Source: CSAT 1997*a*.

Substance abuse counselors may not be familiar with ways family therapy can complement substance abuse treatment. Because of their focus on substances of abuse and the intrapsychic dynamics of the identified patient (IP), counselors simply may not think of referral for family therapy. Other counselors may view conflict in a family as a threat to abstinence and a reason to keep that family out of the treatment process. For safety reasons, the seriousness of conflict should be assessed, and the client will need some time to adjust and build rapport with the counselor before being introduced to family therapy.

Eventually, almost all clients with substance use disorders can benefit from some form of family therapy, because the educational sessions for families that are commonly used in substance abuse treatment settings are not always sufficient to bring about necessary, lasting systemic changes in the client's family relationships. A number of factors will influence a decision about the types and relative intensity of treatment the client should receive. The client's level of recovery may have the greatest effect on her ability to participate both in substance abuse treatment and family therapy, as well as the usefulness of that therapy for all members of the family. (See chapter 4 for a discussion of the levels of recovery.)

While family therapy in addition to substance abuse treatment is highly desirable, managed care guidelines and government regulations are certain to affect referrals. The decisions of payors will consequently be a major determinant of the services a program offers and the services a client is willing to seek. If funding agencies do not support family therapy, the counselor may decide to work on family dynamics only through the single symptomatic individual. There is a great need for the training of substance abuse counselors to do family therapy as well. This can be done if the counselor is trained to do family treatment with a single individual. Additionally, family therapists need better preparation in graduate school plus supervised work in order to work effectively in the field of substance treatment specifically. (See chapter 4 for a discussion of integrated treatment.) These are vital first steps toward integrating the two approaches. An integrated approach might well have an important effect on funding policies, allowing more individuals to receive substance abuse treatment integrated with family therapy.

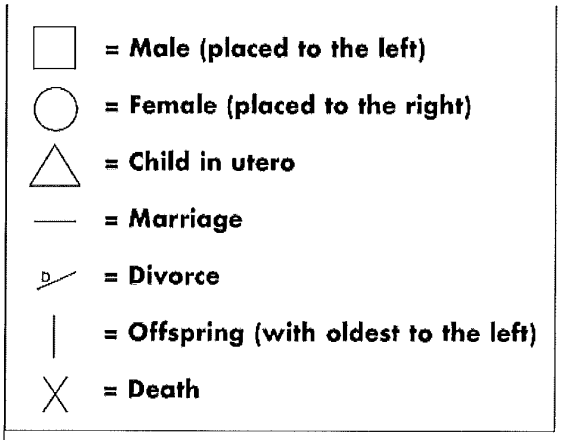
Family therapists and screening, assessment, and referral for substance abuse

Family therapy assessments focus on family dynamics and client strengths. The primary assessment task is the observation of family interactions, which can reveal patterns such as triangulation (which is a means of evading confrontation between two people by bringing a third person into the issue) along with the family system's strengths and dysfunction. The sources of dysfunction cannot be determined simply by asking individual family members to identify problems within the family. The family therapist needs to observe family interactions to determine alliances, conflicts, interpersonal boundaries, communication and meaning, and other relational patterns. Therapists with different theoretical orientations give different degrees of attention to particular aspects of family interaction. Methods for evaluating these interactions also vary with the therapist's theoretical orientation.

In addition to an assessment of dysfunction and strengths, family therapists should be trained and experienced in screening for substance abuse and be familiar with the role that substance abuse plays in family dynamics. Although most family therapists screen for mental or physical illness and physical, sexual, or emotional abuse, issues of substance abuse might not be discovered because the therapist is not familiar with questions to ask or cues provided by clients. Some family therapists may extend the evaluation to how multiple systems (family of origin, family of choice, schools, workplaces) affect the client family at hand.

Genograms

Click on image to enlarge	



Basic Symbols Used in a Genogram

The genogram reproduced in Figure 3-3 depicts five generations in Eugene O'Neill's family. The family history shows a pattern of substance abuse and suicide. O'Neill described his own family, in slightly fictionalized terms, in *Long Day's Journey Into Night*, in which readers can see how the dysfunctional pattern of *fusion* resulted in a family with a "desperate need to distort reality to reassure themselves of their closeness [yet the distortion was] the very thing that prevent[ed] their connection" (McGoldrick 1995, p. 107).

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 (McGoldrick and Gerson 1985). This is typically explained to the client during an initial session and developed as sessions progress, is used for discussion points, and is especially helpful when client and therapist reach a point of being "stuck" in the therapeutic process. Genograms can be used to help identify root causes of behaviors, loyalties, and issues of shame within a family. Working on a genogram can create bonding and increased trust between the therapist and client (seeFigure 3-2).

The genogram has become a basic tool in many family therapy approaches. Significant physical, social, and psychological dysfunction may be added to it. Though the preparation of a genogram is not standardized, most of them begin with the legal and biological relationships of family members. They may also note family members' significant events (such as births, deaths, and illnesses), attributes (religious affiliation, for instance), and the character of relationships (such as alliances and conflicts). Different genogram styles search out different information and use different symbols to depict relationships. In addition, a genogram can show "key facts about individuals and the relationships of family members. For example, in the most sophisticated genogram one can note the highest school grade completed, a serious childhood illness, or an overly close or distant relationship. The facts symbolized on the genogram offer clues to the family's secrets and mythology since families tend to obscure what is painful or embarrassing in their history" (McGoldrick 1995, p. 36). A *family map* is a variation of the genogram that arranges family members in relation to a specific problem (such as substance abuse).

Genograms enable clinicians to ascertain the complicated relationships, problems, and attitudes of multigenerational families. Genograms can also be used to help family members see themselves and their relationships in a new way (McGoldrick and Gerson 1985). The genogram can be a useful tool for substance abuse treatment counselors who want to understand how family relationships affect clients and their substance abuse. Figure 3-2 shows the basic symbols used to construct a genogram.

Screening and assessment issues

When a family therapist refers a client to specialized treatment for a substance use disorder, the client need not be excluded from participation in family therapy. Family therapists instead should be prepared to integrate ongoing family therapy with treatment for substance abuse. When first meeting a family that includes someone who is abusing substances, family therapists can take specific steps to evaluate the situation and prepare the family for involvement in substance abuse treatment. O'Farrell and Fals-Stewart (1999) suggest holding an interview before beginning therapy during which the family therapist can determine whether a family member who is abusing substances is in treatment or what his stage of readiness for treatment is. (TIP 35,*b Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999*b*], has information and instruments for assessing a client's readiness to change substance abuse behavior, and for information on screening for substance abuse, see chapter 2 of TIP 24,*a A Guide to Substance Abuse Services for Primary Care Clinicians* [CSAT 1997*a*].)

Next, the therapist should determine whether an immediate intervention is needed or whether the family can return for a more thorough assessment later. In the former instance, the therapist should refer the individual to a detoxification program or other appropriate treatment. In the latter instance, the therapist should tell the family what will be involved in a more extensive assessment, which will take place at the first therapy session. The therapist also should assess the appropriateness of including any children in the process and when would be the most effective time to include them.

All family therapists should be able to perform a basic screening for substance abuse. In a survey of its membership, the AAMFT found that the great majority (84 percent) reported screening someone for abuse within the previous year (Northey 2002). An overwhelming majority (91 percent) had referred a client to a substance abuse treatment provider, though few of the therapists routinely diagnosed or treated substance abuse (Northey 2002). As part of their professional preparation, AAMFT-certified family therapists are trained to use the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revised (DSM-IV-TR) (APA 2000), which presents standard definitions of substance use disorders. Some simple screening instruments for substance use disorders can be found in TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT 1994*f*), and TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997*a*). More specific information on screening instruments for use with adolescents can be found in TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*c*).

Constraints and Barriers to Family Therapy and Substance Abuse Treatment

Family therapists and substance abuse counselors should respond knowledgeably to a variety of barriers that block the engagement and treatment of clients. While the specific barriers the provider will encounter will vary for clients in different treatment settings, basic issues arise in both substance abuse treatment and family therapy. Issues of family motivation/influence, balance of hierarchal power, and general willingness for the family and its members to change are essential topics to review for appropriate interventions.

Contextual factors that affect motivation and resistance

The differential influence of power

The approaches used by the substance abuse treatment and family therapy fields to motivate clients typically have been different. Traditional substance abuse treatment models often have adopted the 12-Step practice that requires people in recovery to accept their powerlessness over the substance formerly abused—after all, despite repeated efforts to control the substance, it regularly has defeated the person using it and disrupted the user's life and family. Realizing powerlessness over the substance and the damage it causes provides motivation to break free of it. Within the 12-Step tradition, a person is empowered by the program and by "surrendering." Though somewhat paradoxical, the addicted person regains empowerment by giving up the struggle with something he cannot control (the outcome following the use of drugs) for something over which he does have control (the ability to work his program of recovery and do those tasks that strengthen and foster ongoing recovery). Confusion over the use of the 60-year-old term "powerlessness" within 12-Step programs has often led people erroneously to feel that 12-Step programs were antithetical to empowerment points of view.

Family therapy has a tradition of empowerment. Family therapy grew from a perceived need to bring to the therapy session respect and attention to each individual's needs, interests, expressions, and worth. Family therapists have historically accomplished this by making a special effort to "bring out" those members who might remain in the background, such as adolescents and children.

Of course, it is not desirable to cast a person abusing substances as a totally powerless entity. Many clients who abuse substances already may feel economically or socially powerless, and some others may belong to a culture that does not emphasize individual control over destiny. For these clients, especially, it is important to stress that recovery is within their power to accomplish and that it is something that they can choose to accomplish (Krestan 2000).

No simple rule governs the existence and use of hierarchical power relations in therapeutic settings, but clinicians need to be aware that power relationships exist. Therapists always have more power in therapeutic interactions than clients do. This reality has no easy solution. While client autonomy is a primary value in all clinical work, at times therapists must act from a position of overt power to prevent violence or suicide, or to protect an abused child. Clinicians need to be aware that such power differences exist and use these differences in such a way as to establish trust and promote client self-determination and autonomy as much as possible. Clients need to be able to trust clinicians—which involves according them power—but clients also need to believe in their personal capacity to change and to learn to manage their own lives effectively. It is especially important that the client come to feel that she has the power to successfully handle treatment and recovery program activities.

Stages of change

Families with substance abuse problems constitute a vulnerable population with many complicating psychosocial issues. For example, job-related or legal troubles might result in someone being sent for treatment who has never considered the need for or possibility of treatment. In the ideal situation, the family voluntarily seeks help; most frequently, when a family member requests substance abuse help for another member there is great variation in client motivations for substance abuse treatment. Substance abuse treatment can be initiated by the person with a substance use disorder, a family member, or even through mandated treatment by an employer or the legal system.

The stages of change model has been helpful for understanding how to enhance clients' motivation. During the recovery process, individuals typically progress and regress in their movement through the stages. Stages of change have been described in several ways, but one especially helpful concept (Prochaska et al. 1992) divides the process of changing into five stages:

- *Precontemplation*. At this stage, the person abusing substances is not even thinking about changing drug or alcohol use, although others may recognize it as a problem. The person abusing substances is unlikely to appear for treatment without coercion. If the person is referred, active resistance to change is probable. Otherwise, a person at this stage might benefit from non-threatening information to raise awareness of a possible problem and possibilities for change. While families in this stage may think, "This has to stop!" they frequently resort to often-used defenses such as protecting, hiding, and excusing the IP. When the IP is in the precontemplation stage, the therapist works to establish rapport and offer support for any positive change.
- *Contemplation*. A person in this stage is ambivalent and undecided, vacillating over whether she really has a problem or needs to change. A desire to change exists simultaneously with resistance to change. A person

may seek professional advice to get an objective assessment. Motivational strategies are useful at this stage, but aggressive or premature confrontation may provoke strong resistance and defensive behaviors. Many contemplators have indefinite plans to take action in the next 6 months or so. In this stage, families waver between "She can't help it" and "She won't do anything." The level of tension and threat rises. The role of the therapist is to encourage ambivalence. Helping the IP to see both the pros and cons of substance use and change helps her to move toward a decision. Client education is an effective tool for creating ambivalence.

- *Preparation*. In this stage, a person moves to the specific steps to be taken to solve the problem. The person abusing substances has increasing confidence in the decision to change and is ready to take the first steps on the road to the next stage, action. Most people in this stage are planning to take action within the next month and are making final adjustments before they begin to change their behavior. One or more family members in this stage begin to look for a solution. They may seek guidance and treatment options. Here, the therapist's role is to encourage the person to work toward his goal. The goal may be as simple as creating a written record of every drink during the time between sessions.
- *Action*. Specific actions are initiated to bring about change. Action may include overt modification of behavior and surroundings. This stage is the busiest, and it requires the greatest commitment of time and energy. Commitment to change is still unstable, so support and encouragement remain important in preventing dropout and regression in readiness to change. At this point the forces for change in a family reach critical proportions. Ultimatums and professional interventions are often necessary. The role of the therapist is to encourage the person and continue providing client education to reinforce the decision to stop substance abuse.
- *Maintenance*. Day-to-day maintenance sustains the changes prior actions have accomplished, and steps are taken to prevent relapse. This stage requires a set of skills different from those that were needed to initiate change. Alternative coping and problemsolving strategies must be learned. Problem behaviors need to be replaced with new, healthy behaviors. Emotional triggers of relapse have to be identified and planned for. Gains have been consolidated, but this stage is by no means static or invulnerable. It lasts as briefly as 6 months or as long as a lifetime. In maintenance the family adjusts to life without the involvement of substances (Prochaska et al. 1992). During this stage it is important to maintain contact with the family to review changes and potential obstacles to change. Reminding family members that it is a strength, not a weakness, to use support to maintain changes can help them relate to what should be the therapist's enthusiasm for recovery of not only the IP, but for the entire family. The therapist's goal is relapse prevention; to teach the IP and family about relapse, how to prepare for difficult times and places, and to never give up.

During recovery from substance abuse, relapse and regression to an earlier stage of recovery are common and expected—though not inevitable (Prochaska et al. 1992). When setbacks occur, it is important for the person in recovery to avoid getting stuck, discouraged, or demoralized. Clients can learn from the experience of relapse and then commit to a new cycle of action. Treatment should provide comprehensive, multidimensional assessment to explore all reasons for relapse.

Termination (entered from the maintenance stage) is the exit—the final goal for all who seek freedom from dependence on substances. The individual (or family) exits the cycle of change, and the danger of relapse becomes less acute. In the substance abuse field, some dispute the idea that drug or alcohol problems can be terminated and prefer to think of this stage as remission achieved through maintenance strategies.

Confrontation

Generally, substance abuse treatment has relied on confrontation more than family therapy has. For a long time, within the substance abuse treatment community it was believed that confronting clients and breaking through their defenses was necessary to overcoming denial. Some preliminary research has suggested that a confrontational approach is sometimes the least effective method for getting certain clients to change substance abuse behavior (Miller et al. 1998). Treatment of substance abuse has shifted away from confrontational approaches and moved toward more empathic approaches, such as those favored in family therapy. Still, family therapists should be aware of how confrontation has been used and is still used in some substance abuse treatment programs.

Motivation levels

Motivating a person or a family to enter and remain in treatment is a complex task, made all the more complicated by the fact that the IP and the family may have different levels of motivation (as may different members of the family). Many factors related to a client's family, such as maintaining custody of children or preserving a marriage, can be used to motivate clients. All the same, group and family loyalty will affect people differently. These loyalties may motivate some to enter treatment, but the same loyalties can deter others. To some extent, realizing one's powerlessness over the substance and the damage it causes provides motivation to break free of it, although it might be noted that simple awareness may not be enough alone to provide sufficient motivation.

Clinicians in both substance abuse treatment and family therapy also need to consider the motivation level of the family of a person abusing substances. The fact that a person with a substance use disorder is motivated to seek treatment is not evidence that the person's family is equally motivated. The family members may have been discouraged by treatment in the past, and they may no longer believe or hope that any treatment will enable their family member to stop abusing substances. They may also conclude that the treatment system did not respond to their needs.

On the other hand, some or all of the family members might also gain some benefit from the family's continued dysfunction, so they may deny that the whole family needs treatment and urge clinicians to focus only on the problems of the person who abuses substances. It may even be harder to motivate family members than it is to prompt the person with the substance use disorder.

Family members may also fear treatment because there are specific issues in the family (such as sexual abuse or illegal activity) that they do not wish to reveal or change. In such cases, the therapist must be clear with family members about his ethical obligations to reveal information if certain topics are raised. For example, the law and ethics require therapists to report child abuse. Moreover, the therapist must not push family members to talk about difficult issues before they are ready to do so.

A family's resistance to treatment might stem from the treatment system's replication of problems it has encountered at other levels of society. Large agencies and systems may seem untrustworthy and threatening. A family may fear that the system will disrupt it, leading to such consequences as losing custody of a child. Mandated treatment and treatment providers who work in conjunction with the criminal justice system may add a layer to a family's sense of injustice.

Principles of motivational interviewing, which can be used with both the person abusing substance and the family system, are discussed in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*, p. 40).

Psychoeducational groups are also useful for helping family members understand what to expect from treatment. Participation in psychoeducational groups often helps to motivate them to become more involved in treatment (Wermuth and Scheidt 1986) by making them aware of the dynamics of substance abuse and the role the family can play in recovery. Multifamily groups help families see that they can benefit from treatment as others have (even if the family member who uses substances does not maintain abstinence) (Conner et al. 1998; Kaufmann and Kaufman 1992*b*). These two frequently used interventions are particularly useful for involving a family early in treatment and motivating it to continue treatment.

Cultural barriers to treatment

Cultural background can affect attitudes concerning such factors as proper family behavior, family hierarchy, acceptable levels of substance use, and methods of dealing with shame and guilt. Forcing families or individuals to comply with the customs of the dominant culture can create mistrust and reduce the effectiveness of therapy. A knowledgeable treatment provider, however, can work within a culture's customs and beliefs to improve treatment rather than provoke resistance to treatment.

To develop effective treatment strategies for diverse populations, the treatment provider must understand the role of culture and cultural backgrounds, recognize the cultural backgrounds of clients, and know enough about their culture to understand its effect on key treatment issues. This sensitivity is important at every stage of the treatment process, and the clinician's knowledge must continually improve in work with people of different ethnicities, sexual orientations, functional limitations, socioeconomic status, and cultural backgrounds (all of which are considered cultural differences for the purposes of this TIP). (Chapter 5 of this TIP and the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* [CSAT in development *b*] will provide more information on working with people from various cultures and providing culturally competent treatment.)

Integrating Substance Abuse Treatment and Family Therapy

The integration of substance abuse treatment and family therapy may be accomplished at several levels (see chapter 4 for a full discussion of integrated models of treatment). Agencies may opt for full integration that would offer both family therapy and substance abuse treatment in the same location with the same or different sets of staff members. As an alternative, agencies might create a partial integration by setting up a system of referral for services. Regardless of the form integration takes, clinicians working in either field need to be aware of the practices and ideas of the other field. There should be mutual respect and a willingness to communicate between practitioners. They should know when to make a referral and when to seek further consultation with a practitioner from the other field. Clinicians in each field need to tailor their approaches to be optimally effective for clients who have received or are receiving treatment from a practitioner in the other field.

Family Therapy for Substance Abuse Counselors

Substance abuse counselors should not practice family therapy unless they have proper training and licensing, but they should be informed about family therapy 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. In order to promote integrated treatment, training in family therapy techniques and concepts should be provided to substance abuse counselors.

This section builds on content presented in chapter 1 that explained the potential role of family therapy in substance abuse treatment programs. This section presents the basic principles of family therapy models and suggested ways to apply these principles in one's practice. Chapter 4 discusses the specific integrated family therapy models developed for treating clients with substance use disorders.

Traditional Models of Family Therapy

The family therapy field is diverse, but certain models have been more influential than others, and models that share certain characteristics can be grouped together. Family therapy theories can be roughly divided into two major groups. One includes those that focus primarily on problemsolving, where therapy is generally brief, more concerned with the present situation, and more pragmatic. The second major group includes those that are oriented toward intergenerational, dynamic issues; these are longer-term, more exploratory, and concerned with family growth over time. Within these larger divisions, other categories can be developed based on the assumptions each model makes about the source of family problems, the specific goals of therapy, and the interventions used to induce change.

In recent years, calls for the use of evidence-based treatment models have increased. It may be necessary to use evidence-based approaches, especially for adolescents, to get managed care organizations to pay for services. A declaration that a provider is using an evidence-based model, however, may become complicated because the majority of family therapists are eclectic in their use of techniques, and few adhere strictly and exclusively to one approach. Furthermore, evidenced-based approaches may not be appropriate for all cultures or adaptable to practice in all settings. It is important that the research-to-practice issues should be addressed and that research, conducted under conditions that may be artificial to the practice of therapy, be carefully critiqued. The *Journal of Marital and Family Therapy* devoted a full issue (Vol. 28, No. 1, January 2002) to a discussion of "best practice" models and the

challenges of developing research based in practice.

Family Therapy Approaches Sometimes Used in Substance Abuse Treatment

Several family therapy models are presented below. These have been adapted for working with clients with substance use disorders. None was specifically developed, however, for this integration. A number of self-help programs or programs that address issues related to having a family member who has a substance use disorder, such as Adult Children of Alcoholics programs or Al-Anon, are also available (see also appendix D).

Behavioral contracting

Theorist: Steinglass. See Steinglass et al. 1987.

View of substance abuse

- Substance abuse stresses the whole family system.
- Substance abuse is the "central organizing principle" for a "substance-abusing" family (as distinguished from a family with a member who has a substance use disorder, but in which substance use is not yet woven into the family system).
- Families with members who abuse substances are a highly heterogeneous group.

Goals of therapy

- Identify and address the family's problems (including substance abuse by one or more family members) as family problems.
- Develop a substance-free environment.
- Help families cope with the emotional distress (the "emotional desert") that the removal of substance abuse can cause.

Strategies and techniques

- Develop a written contract to ensure a drug-free environment.
- Use enactments and rehearsals to enlighten the family system about triggers of substance use, to anticipate problems, and avoid them.
- Use family restabilization or reorganization to change functioning and organization.

Bepko and Krestan's theory

Theorists: Bepko and Krestan. See Bepko and Krestan 1985.

View of substance abuse

- Focus is on the person who abuses substances and the substance of abuse as a system (while also looking at intrapersonal, interpersonal, and gender systems).

Goals of therapy

- Help everyone in the family achieve appropriate responsibility for self and decrease inappropriate responsibility for others.
- Three phases of treatment, each with a separate set of goals:
- Presobriety: Unbalance the system that was balanced around substance abuse in order to promote sobriety.
- Early Sobriety: Balance the system around a self-help group; maintain people in a corrective context (a zone of right relationship, avoiding overinflated pride and abject self-loathing) with a recognition that no one stays there all the time.
- Maintenance: Rebalance the system in a deep way by going back and working on developmental tasks that were previously missed.
- Clarify adaptive consequences of substance abuse.

Strategies and techniques

(1) Presobriety

- Interrupting and blocking emotional and functional over-responsibility using the pride-system of the spouse and the individual with a substance use disorder.
- Referring to self-help group.

(2) Early sobriety

- Same-sex group therapy with a specific model.
- Reparative and restorative work with children (in order to have children express feelings in a safe environment).

(3) Maintenance

- Anger management; dealing with toxic issues such as sexual abuse.
- Looking at gender stereotypes with respect to sex, power, anger, and control.

Behavioral marital therapy

Theorists: McCrady and Epstein. See Epstein and McCrady 2002.

View of substance abuse

- Developed to treat alcohol problems in a couples counseling framework.
- Uses a social-learning framework to conceptualize drinking (or other substance use) problems and family functioning.
- Examines current factors maintaining substance use, rather than historical factors.
- Cognitions and affective states mediate the relationship between external antecedents and substance use, and expectancies about the reinforcing value of substances play an important role in determining subsequent substance use.
- Substance abuse is maintained by physiological, psychological, and interpersonal consequences.
- Substance use is part of a continuum that ranges from abstinence to nonproblem use to different types of problem use. From this perspective, problems may be exhibited in a variety of forms, some of which are consistent with a formal diagnosis, and some of which are milder or more intermittent. This perspective differs significantly from the psychiatric diagnostic approach of the DSM-IV-TR (APA 2000) in that it does not assume that certain symptoms cluster, nor that an underlying syndrome or disease state is present (although it does not exclude that possibility, either).

Goals of therapy

- Abstinence is the preferred goal for treatment.
- Other goals include
  - Developing coping skills for both partners to address substance abuse.
  - Developing positive reinforcers for abstinence or changed use.
  - Enhancing the functioning of the relationship.
  - Developing general coping skills.
  - Developing effective communication and problemsolving skills.
  - Developing relapse prevention skills.
- Other couple-specific goals may also be identified.

Strategies and techniques

- Intervene at multiple levels, with
  - The individual who is abusing substances
  - The spouse
  - The relationship as a unit
  - The family
  - Other social systems
- Begin with a detailed assessment to determine the primary factors contributing to the maintenance of the substance use, the skills and deficits of the individual and the couple, and the sources of motivation to change.
- Help the client assess individual psychological problems associated with use, potential and actual reinforcers for continued use and for decreased use[2] or abstinence, negative consequences of use and abstinence, and beliefs and expectations about substance use and its consequences.
- Teach individual coping skills (e.g., self-management planning, stimulus control, substance refusal, and self-monitoring of use and impulses to use).
- Teach behavioral and cognitive coping skills individually tailored to the types of situations that are the most common antecedents to use.
- Provide clients with a model for conceptualizing substance abuse and how it can be changed.
- Teach spouses a variety of coping skills based on an individualized assessment of behaviors that may either cue or maintain substance use (for instance, learning new ways to discuss use and learning new responses to partner's use).
- Use substance-related topics (such as how to manage a situation where substances are being used or what to tell family and friends about the treatment) to teach problemsolving and communication skills.
- Help clients identify interpersonal situations and people associated with substance use, and situations and people supportive of abstinence or decreased use.

Brief strategic family therapy

Theorists: Szapocznik and Kurtines. See Santisteban et al. 1996; Szapocznik et al. 2003; Szapocznik and Williams 2000.

Kurtines, Santisteban, Szapocznik, and Williams have researched family therapy for adolescents and their families with specific focus on the family environment. They feel their manualized approach has a strong evidence base for use with such families; however, they do not suggest the use of the approach with adults with addictions, as there have been no efforts to study the approach with adult clients.

View of substance abuse

- Adolescents' lack of success dealing with developmental challenges leads them to substance abuse.
- Rigid family structures can increase substance abuse (as parents need to be able to renegotiate as the adolescent grows).
- Intrafamily and acculturation conflict impact relationships negatively and increase substance abuse.

Goals of therapy

- Change parenting practices (such as leadership, behavior control, nurturance, and guidance).
- Improve the quality of relationship and bonding between parents and the adolescent(s).
- Improve conflict resolution skills.

Strategies and techniques

- Do preliminary phone work to determine who will be resistant to treatment and engagement.
- Identify the normal processes of acculturation and then help families learn to transcend these differences.
- Block or reframe negativity and promote supportive interactions.

- Modify program based on data and research.
- Provide culturally competent treatment.
- Actively work on engaging family.
- Intervene in the family system through the parents rather than directly intervening (and therefore put traditional hierarchies back into place).

Multidimensional family therapy (MDFT)

Theorist: Liddle. See Liddle 1999; Liddle and Hogue 2001.

View of substance abuse

- Developed to treat adolescent drug problems and related behavioral problems such as conduct disorder from a multiple systems perspective.
- Adolescent substance abuse is a multidetermined and multidimensional disorder.
- Uses an integrative developmental, environmental, and contextual framework to conceptualize the beginning, progression, and cessation of drug use and abuse.
- Uses knowledge about risk and protective factors to arrive at a case conceptualization that includes and integrates individual, familial, and environmental factors.
- Both normative (failure to meet developmental challenges and transitions) and nonnormative (abuse, trauma, mental health, and substance abuse in the family) crises are instrumental in starting and maintaining adolescent drug problems.

Goals of therapy

- To facilitate a process of adaptation to the youth's and family's developmental challenges since drug use and other problem behavior will desist when sufficient adaptive developmentally appropriate functioning is restored or created.
- To enhance and bolster the psychosocial functioning of the youth and family in their key developmental domains.
- To improve adolescent functioning in several realms, including individual developmental adaptation, coping skills relative to drug and problemsolving situations, peer relations, and family relationships.
- To improve parents' functioning in several realms including their own personal functioning (e.g., substance abuse or mental health issues) and functioning in their parental role (e.g., parenting practices).
- To improve family functioning as evidenced by changes in day-to-day family environment and family transactional patterns.
- To improve adolescent and parent functioning in the extrafamilial domain, including more adaptive and positive transactions with key systems such as school and juvenile justice.

Strategies and techniques

- The overall therapeutic strategy calls for multilevel, multidomain, multicomponent interventions.
- Treatment is flexible; MDFT is a therapy system rather than a one-size-fits-all model. As such, therapy length, number, and frequency of the sessions is determined by the treatment setting, provider, and family.
- Treatment format includes individual and family sessions, and sessions with various and extra familial sessions.
- Treatment begins with an indepth, multisystems assessment that uses a developmental/ecological and risk and protective factor framework to establish an MDFT case conceptualization.
- The case conceptualization individualizes the treatment system and pinpoints areas of strength and deficit in the multiple and interlocking realms of a teen's psychosocial ecologies.

Multifamily groups

Theorist: Kaufman. See Kaufman and Kaufmann 1992.

View of substance abuse

- Traditional medical model and disease concept.

Goals of therapy

- Work to achieve abstinence for family member(s) with substance use disorders.
- Consolidate abstinence by focusing on resolving dysfunctional rules, roles, and alliances.
- After sobriety is achieved, deepen intimacy through appropriate expression of suppressed feelings (such as mourning of losses or hostility).
- Maintain a sober family core that acts as a central homeostatic organizer for the client who abuses substances, especially during times of stress.

Strategies and techniques

- Therapy begins with an assessment of substance abuse, individual psychopathology, and family systems.
- Address developmental issues and individual Axis I and II disorders, and include these issues as part of a family contract.
- Prepare a family relapse prevention plan.
- Make use of 12-Step and other self-help modalities.

Multisystemic therapy

Theorist: Henggeler. See Cunningham and Henggeler 1999; Henggeler et al. 1998.

View of substance abuse

- Understand fit between substance abuse and the broader systemic context:

- Understand specific problems in a real-world context.
- Serious clinical problems, such as substance abuse, are multi-determined and influenced by variables from multiple systems.

Goals of therapy

- The initial goal is to engage family members and, if necessary, to identify barriers to engagement and develop strategies for overcoming those barriers.
- Examine the strengths and needs of each system and their relationship to the identified problem.
- Address risk and protective factors as they impact the family from a range of sources.
- Family members and caregivers have a major role in defining treatment goals.

Strategies and techniques

- Interventions are designed to promote responsible behavior.
- Interventions are present-focused and action-oriented, targeting specific and well defined problems.
- Provide developmentally appropriate interventions.
- Daily or weekly effort by family members is required.
- Place responsibility on therapist for overcoming barriers.

Network therapy

Theorist: Galanter. See Galanter 1993.

View of substance abuse

- Traditional medical model and disease concept.

Goals of therapy

- Balance the family system in terms of gender, age, relationship, and so on.
- Family and significant others work to help the individual who abuses substances maintain his abstinence and a stable support system that promotes his recovery.
- Focus is on the individual's efforts to maintain abstinence.

Strategies and techniques

- Create secure, stable, substance-free residence.
- Avoid people, places, and things that promote substance use. Encourage self-help group attendance.
- Establish a healthy support system.
- Avoid areas of conflict and negative exchanges.
- Family and significant others work as a team and are coached to help the person abusing substances to achieve and maintain abstinence.

Solution-focused therapy

Theorists: Berg, Miller, and de Shazer. See Berg and Miller 1992; Berg and Reuss 1997; de Shazer 1988.

View of substance abuse

- Emphasis is placed on the solutions that are available to the family, not on how the problem developed or what function it might serve.

Goals of therapy

- A therapeutic relationship needs to be built on trust and respect.
- Help client to realize that she can maintain sobriety and has done so on occasions in the past.
- Goals of therapy are defined by the client.
- Focus on exceptions (such as times when substance abuse does not occur).
- Focus on problems that can be solved and on finding unique solutions to those problems that can enhance optimism.
- The focus is on solution, not problems. Focus on solutions by asking the IP how she will know the problem is improved. What will she be doing? How will she be feeling?

Strategies and techniques

- Use solution-focused techniques to help the family system realize its ability to help the member abusing substances to maintain abstinence.
- Make rapid transitions to identifying and developing solutions intrinsic to the family.

Stanton's therapeutic techniques

Theorist: Stanton. See Stanton et al. 1982.

View of substance abuse

- Substance abuse is part of a cyclical process that takes place between connected people who form an intimate, interdependent, and interpersonal system.
- Substance use often begins in adolescence as an attempt at individuation.
- Within the family there is a "complex homeostatic system" of feedback that serves to maintain stability and in the process maintains substance abuse behavior.

Goals of therapy

- Specific goals are negotiated with the family at the beginning of treatment.
- There are, though, three primary stated goals:
  - The IP should be substance free.
  - The IP should be either gainfully employed or involved in some sort of school or training program.
  - The IP should establish a stable and autonomous living situation.

Strategies and techniques

- Emphasize present situation.
- Alter repetitive behavioral sequences.
- Emphasize process over content.
- Therapist joins with family but takes active role in directing therapy.
- Therapist assigns behavioral tasks.
- Therapist may attempt to "unbalance" the system in order to prompt change.

Wegscheider-Cruse's theory

Theorist: Wegscheider-Cruse. See Wegscheider 1981.

View of substance abuse

- Substance abuse is a progressive family disease affecting every member and every facet of life.
- In the substance-abusing family system, the members, in the interests of their own survival, assume behavioral patterns that maintain a balance. When one member becomes dependent on a substance, it affects the others, causing psychological and/or biological symptoms. As the member who abuses substances progressively experiences a sense of worthlessness, so do all other family members.
- There are six basic roles family members assume:
  - Substance abuser
  - Enabler
  - Hero
  - Scapegoat
  - Lost child
  - Mascot

Goals of therapy

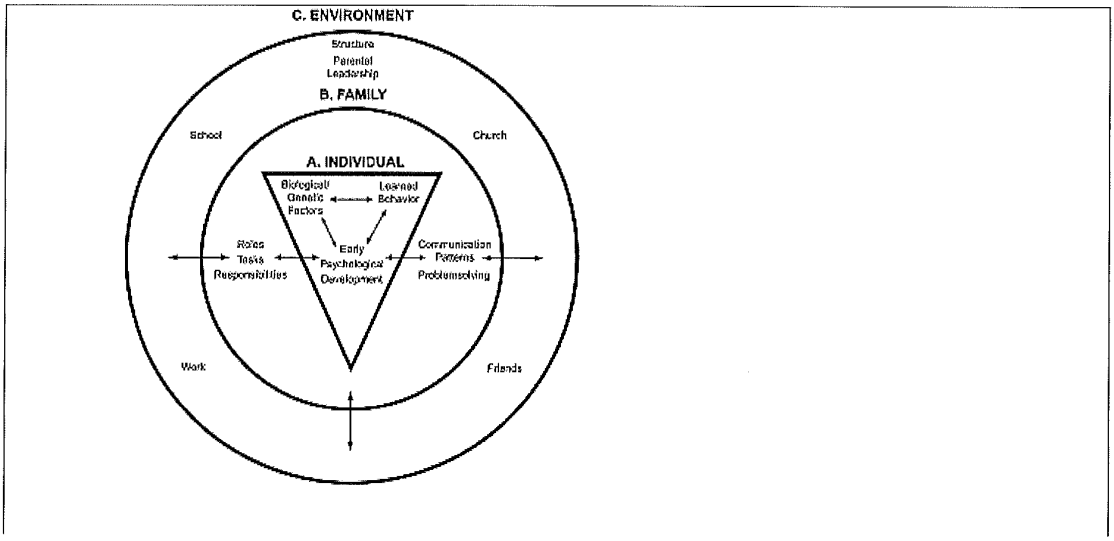
- Make the family system more open, flexible, and whole—as the family system begins to change, other problems will subside as well.

Strategies and techniques

- Educate every family member about the disease.
- Break through the family's denial.
- Confront any crisis.
- Treat the immediate problems of substance abuse.
- Offer concrete recommendations for help, including self-help group attendance.

Family Therapy Concepts That Substance Abuse Counselors Can Use

The field of family therapy has developed a number of theoretical concepts that can help substance abuse treatment providers better understand clients' relationships with their families. In addition, a number of therapeutic practices can assist in the treatment of substance use disorders in the context of family systems. This section provides information about some of these concepts and practices. For more information, refer to citations in the previous section. In addition, Nichols and Schwartz's *The Essentials of Family Therapy* 2001 provides an overview of the background, theory, and practices of family therapy. Also, see appendix D, which lists further sources of information.



Individual, Family, and Environmental Systems

Source: Adapted from Isaacson 1991*a*.

There are a number of theoretical approaches to family therapy, but most of them share many concepts and assumptions. Perhaps foremost among these is the acceptance of the principles of systems theory that views the client as a system of parts embedded within multiple systems—a community, a culture, a nation. (See Figure 3-4 for a graphic depiction of the relationship of these multiple systems.) The family system has unique properties that make it an ideal site for assessment and intervention to correct a range of problems, including substance abuse.

Elements of the family as a system

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. Structural and strategic models of family therapy stress the importance of paying attention to boundaries within the family system, which delineate one family member from another; generational boundaries within families; or boundaries between the family and other systems, and regulate the flow of information in the family and between systems outside the family. Ideally, boundaries should be clear, flexible, and permeable, allowing movement and communication (Brooks and Rice 1997). However, 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 (Richardson 1991). 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 daily interactions. Strong emotional ties connect family members, even when they are separated. Counselors need to address issues, such as family loyalty, that continue to shape behavior even if clients have detached in other ways from their families of origin. With regard to treatment, it is possible to involve a client in a form of family therapy even if family members are not physically present (see below), and the focus of the therapy is on the family system and not the individual client.

Family Therapy With an Individual Client

Szapocznik and colleagues studied a one-person family approach for treating adolescents who abused substances (Szapocznik et al. 1983, 1986). They compared one-person family therapy with a family group; in both treatments therapists used structural and strategic therapy techniques. (There was, however, no nontherapy control group, nor was there a control that used a different therapeutic approach.) After a 6-month follow-up that included 61 percent of original participants, adolescent clients in both groups were found to have decreased their substance use, and the families improved their ability to function. The authors note, however, that one-person family therapy was most effective when carried out by an experienced therapist proficient in strategic family therapy (Robbins and Szapocznik 2000).

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, though, is homeostasis—a state of equilibrium that balances strong, competing forces in families as they tend to resist change so as to maintain the family's balance—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. Flexibility therefore is an important quality for a high-functioning family, although too much flexibility can lead to a chaotic family environment (Walsh 1997).

Capacity for change

Families that have members who abuse substances are more likely to show a lack of flexibility, rather than an excess. In a family organized around substance abuse, the tendency toward homeostasis means that other family members, in a misguided attempt to prevent disruption in the family, may enable continued abuse and keep the person using substances from attaining abstinence. Families that are adjusted to substance use—called an alcoholic family by Steinglass and colleagues (1987)—have found ways to accommodate a person's substance abuse and perhaps gain something from the abuse. Steinglass and colleagues (1987) found that alcoholic families generally have limited ideas of acceptable behavior and are particularly wary of change. In many cases, the presence of alcohol (or other substances of abuse) is necessary for family members to express emotion, communicate with one another, have a short-term resolution of conflicts, or express intimacy. It is important to note that the client maintains a consistent "set point" for a level of success in his role within the family.

Adjusting to abstinence

Mostly because of policy and funding, family interventions in substance abuse treatment often target a client's family for a limited period of time. Family therapists, however, can present a good case for long-term family therapy. In a systems model, a problem such as substance abuse can have both beneficial and harmful effects, and a family will adapt its behavior to the substance abuse. In addition to explaining the phenomenon of enabling, this model also explains why 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 restabilize the family dynamics), or there may be a period of relative harmony that is disrupted when other problems that have been suppressed begin to surface. For example, family members may express resentment and anger more directly to the recovering person. 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 abstinence (Kaufman 1999).

Triangles

Murray Bowen developed the concept of *triangulation,* which 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 (Nichols and Schwartz 2001). 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. In such a triangle, one person, often the child, will actively abuse substances (Brooks and Rice 1997). Triangulation is especially common in families that have low levels of differentiation (that is, high levels of enmeshment), but it does occur to some extent in all families (Brooks and Rice 1997; Nichols and Schwartz 2001).

The third party in a triangle need not be a family member. As Nichols and Schwartz note, "Whenever two people are struggling with conflict they can't resolve, there is an automatic tendency to draw in a third party" (2001, p. 21). 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. Triangulation involving the counselor leaves a client feeling torn between the family and the treatment program, and for this reason, the client often terminates treatment (Stanton 1997). A substance of abuse can also be considered an entity with which the client triangulates to avoid deeper levels of intimacy.

Family Therapy Techniques That Substance Abuse Counselors Can Use

Family therapists have developed a range of techniques that can be useful to substance abuse treatment providers working with individual clients and families. The techniques listed are drawn from the range of family therapy approaches described earlier. The consensus panel selected the techniques on the basis of their usefulness and ease of use in substance abuse treatment settings, and not because they are from a particular theoretical model. This list of techniques should not be considered comprehensive.

Some family therapy techniques are similar to those already used in substance abuse treatment, but they are directed toward a different group of clients. For example, behavioral family therapy uses behavioral contracting, positive reinforcement, and skill building, all of which would be familiar to practitioners who use behavioral and cognitive–behavioral approaches with individual clients. The major difference is that behavioral family therapy focuses on how the family influences one member's substance abuse behaviors and how the family can be taught to respond differently.

Behavioral techniques

Behavioral Marital Therapy (BMT) is a behavioral family approach for the treatment of substance use disorders. BMT attempts to increase commitment and positive feelings within a marriage and improve communication and conflict resolution skills (Walitzer 1999). This is important because marital relationships where one partner abuses substances are typically marked by conflict and dissatisfaction. Improvements in the quality of marital interactions can increase motivation to seek treatment and decrease the likelihood of marital dissolution after abstinence is achieved. In situations where one or both partners are unable to participate sincerely because they are too angry or where there is violence, these techniques may not be suitable. Specific techniques include exercises designed to increase a couple's positive feelings toward one another (see below), improve communication skills by teaching reflective listening techniques (described in more detail in TIP 35,*b Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999*b*]), and teach negotiation skills (Noel and McCrady 1993; O'Farrell 1993). BMT and related approaches have been shown to improve both a client's participation in substance abuse treatment and treatment outcomes (Steinglass 1999), as well as improving relations between partners (Jacobson et al. 1984).

BMT Exercises To Increase Commitment and Goodwill

Catch Your Partner Doing Something Nice: Clients are initially asked to notice and record at least one act each day that shows love or caring from their partners. After the next session, clients are instructed to notice and then tell their partner what they have observed. Each client is then asked to pick a favorite caring behavior from the list and act it out in a role-playing exercise. The therapist gives positive feedback and constructive suggestions based on the role-playing exercise. The person acting out the activity can repeat it, incorporating the therapist's suggestions. This exercise is designed to improve spouses' care-taking and communication skills as well as build appreciation for one another (O'Farrell 1993).

Caring Days: Each partner is told to select 1 day of the week when he or she will shower the other with acts of kindness and caring.At the next session, the other partner is asked to guess which day was selected. This exercise helps partners notice and understand what each does for the other, while increasing positive actions within the relationship.

Shared Rewarding Activities: Conflict or dysfunction resulting from substance abuse can lead to a

significant decline in the amount of time couples spend together in recreational activities. To change this pattern, this exercise first requires couples to list activities they enjoy doing with their partner (either with or without children, inside or outside the home).

At their next session the couple shares their lists, and the therapist points out areas of agreement on both lists. Cotherapists then role-play how they would go about agreeing on and planning a shared activity. The therapist models ways to present activities in a positive manner, plan for potential problems, and learn to agree on activities. Couples subsequently plan and carry out a mutually enjoyable activity (Noel and McCrady 1993).

Source: Adapted from Walitzer 1999.

Structural techniques

In structural family therapy, family problems are viewed as the result of an imbalanced or malfunctioning hierarchical relationship with indistinct or enmeshed, too rigid, or flexible interpersonal boundaries. The complexities of these approaches defy any brief, simple review. Though it well oversimplifies the complexities, one could say that the primary goal is to strengthen or rearrange the structural foundation so the family can function smoothly (Walsh 1997). After an assessment stage, the therapist generally begins by preparing, with the family, a written contract that clearly describes the goals of treatment and explains the steps necessary to reach them. This contract increases the likelihood that the family will return after the first session because they have a clear idea of how they will resolve their problems (Kaufman 1999).

The structural family therapist generally tries to be warm and empathic while at the same time remaining firm and objective (Huycke 2000) in therapeutic relationships with clients. The therapist motivates clients to change through a process of *joining* with the family. During this process, the therapist

- Identifies and adjusts to the family's way of relating to each other, which will make resistance less likely.
- Conveys understanding and acceptance to each person in the family so that everyone will trust the therapist enough to take his or her advice.
- Shows respect to each person by virtue of their family role, which could mean, for example, asking parents first for their views on the problem at hand.
- Listens as each person expresses feelings, because most people in therapy think that no one understands or cares how they feel.
- Makes a special effort to form linkages with family members who are angry, powerful, or doubtful about therapy so that they are engaged (Nichols and Schwartz 2001).

According to Minuchin and Fishman (1981) joining is "more an attitude than a technique" (p. 31), and Kaufmann and Kaufman (1992*a*) indicate that the process is very deliberate at first, becoming more natural as therapy progresses. While joining typically confirms the family's positive traits and supports the family so that members have the confidence and strength to change, it can also mean challenging the family to provide an impetus to change.

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

When appropriate, the therapist will take action necessary to stop behaviors that contribute to enmeshment in the family.

The therapist needs to observe the family closely by tracking family interactions or by having the family enact a dysfunctional behavior pattern within the therapy session. The therapist then acts accordingly either to restructure boundaries that are too rigid or strengthen boundaries that have become enmeshed or fused. For example, in families where substance abuse is present, one parent often becomes over-involved with a child. In such cases, the therapist needs to strengthen boundaries that support the parents as a unit (or subsystem) capable of maintaining a hierarchical relation with their children and able to resist interference from older generations of the family or people outside the family (Kaufman 1999).

Structural therapists motivate and teach a family new ways of behaving using structuralization. Using this process, the therapist sets an example for how family members should behave toward one another. After observing a problem behavior, such as the family's ignoring one family member's thoughts and needs, the therapist acts in a contrary way (paying special attention to what the usually ignored person thinks, feels, or desires). By setting an example in this manner, the therapist provides a model for how the family can behave and applies gentle pressure on family members to change their behavior.

Other important techniques for restructuring family relations include system recomposition, structural modification, and system focusing (Aponte and Van Dusen 1981). System recomposition helps family members build new systems (perhaps outside the family) or remove themselves from existing systems (which can imply physical separation or changing existing patterns of interaction and communication). Structural modification is the process of constructing or reorganizing patterns of interaction (for instance, by shifting triangles to develop better functioning alliances). System focusing, also called reframing or relabeling, is the process of presenting another perspective on an apparent problem so that it appears solvable or as having positive effects for those who look at it as a problem. Relabeling can help family members see their own complicity in one member's relapse by showing them what they might lose if the recovery were to succeed. For example, the therapist might show children that they gain greater freedom if their parents abuse substances. Relabeling also makes new options for solving problems more apparent and can act to provoke family members to change their behavior. Overall, structural intervention techniques may be difficult to use without some further training. However, they can be employed easily in assessment to understand the ways by which the organization of the family may be structured to support the

substance use.

Strategic techniques

Strategic family therapy shares many techniques and concepts with structural family therapy, which are often used together. For example, reframing or relabeling is a process common to both approaches. The structural therapist seeks to alter the basic structure of family relations working on the theory that this will improve the presenting problem. The strategic therapist, however, focuses on solving one specific problem that the family has identified and is concerned only with basic family interactions and behavior that perpetuate the presenting problem. To the strategic therapist, interactions are not the result of underlying structural problems (Walsh 1997).

Different approaches fit into the strategic approach. All of them have in common relabeling/reframing and a focus on sequence of interactions. They differ in the scope (length) of the interaction they observe; however they all look for the sequence of interaction and then develop a directive to modify the sequence.

Directives are part of strategic therapy's emphasis on change taking place outside of therapy sessions. Indirect techniques are specific types of directives that may seem unrelated or contradictory to the task at hand but that actually help the family move toward its goal. Reframing is an indirect technique.

Solution-focused techniques

Solution-focused approaches to family therapy build on many of the ideas and techniques used in strategic therapy (Berg and Miller 1992; Berg and Reuss 1997; de Shazer 1988). This approach is less concerned with the origins of problems and more oriented toward future changes in family interactions. The solution-focused therapist fosters confidence and optimism, so solution-focused approaches do not focus on problems and deficiencies, but rather on solutions and clients' competencies. A variety of solution-focused therapies have been developed specifically for the treatment of substance abuse. Because of its narrow focus on the presenting problem, solution-focused family therapy works well with many existing substance abuse treatment approaches.

Although solution-focused therapy appears to be somewhat at odds with traditional substance abuse treatment approaches, Osborn (1997) found that many alcoholism counselors endorse the fundamental assumptions and approach of solution-focused therapy. Even if one does not completely adopt the solution-focused therapy approach, some of this model's techniques can be used with a variety of other approaches, including a focus on the past. One such technique is to ask the client to remember a time when problem behaviors were not present and then to examine what behaviors occurred during these times. "Can you think of a time when the problem was not happening or happening less? What was happening? What were things like at that point? How can that behavior be repeated now?" The focus on past exceptions, whether deliberate (cases where the clients controlled the problem) or random (cases where the problem disappeared temporarily because of factors beyond the client's control), helps clients to see that change is possible and that at times, the apparent problems abated.

Another technique is to use the "miracle question," which is, "If a miracle occurred, and the presenting problem disappeared, how would you know that the problem had disappeared?" The miracle question is useful because it helps clients see how their lives can be different. This technique is described in greater detail in chapter 4.

Additional information on strategic and solution-focused approaches to the treatment of substance use disorders can be found in TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999*a*).

Substance Abuse Treatment for Family Therapists

The causes of substance abuse are multidetermined, with biological, psychological, social, and spiritual components. Within the substance abuse treatment field, a variety of different approaches are used. Two of the most common are described in this section.

Traditional Theoretical Understandings of Substance Abuse

Two models have contributed to our contemporary understanding of substance abuse and dependence: the medical (or disease) model and the sociocultural model.

Medical model

The medical model of addiction emphasizes the biological, genetic, or physiological causes of substance abuse and dependence. A body of biological research suggesting a genetic component to substance abuse supports this theory (Cloninger 1999), particularly in the case of alcoholism, since it is the type of substance abuse that has been most thoroughly researched (Li 2000) and it is the type involved in the vast majority of substance use disorders. The model is also supported by research that demonstrates how various substances of abuse can cause long-term changes in brain chemistry (Blum et al. 2000; London et al. 1999). From a medical perspective, treatment involves medical care and can include the use of pharmacotherapy to help manage withdrawal and assist in behavior change. (See below for more information on pharmacological treatments for substance use disorders.)

Adjunctive Pharmacotherapy for Substance Use Disorders

A variety of pharmacological interventions have been developed to aid in the treatment of substance use disorders, and many more are in development. The information provided here is merely an introduction to this topic. Further, the information is subject to change as new medications are approved by the Food and Drug Administration.

Medications are available that can help:

- Discourage continued substance use. These include disulfiram (Antabuse) for alcohol use and

naltrexone (Revia) for alcohol and opioid abuse.
- Suppress withdrawal symptoms. These include benzodiazepines for alcohol withdrawal and methadone maintenance for opioid addiction.
- Block or alleviate cravings or euphoric effects. These include methadone, levo-alpha-acetyl-methadol (LAAM), and buprenorphine for opioids, and naltrexone for alcohol and opioids.
- Replace an illicit substance with one that can be administered legally. These include methadone and other forms of opioid replacement therapy.
- Treat co-occurring psychiatric disorders.

Medications should be used in conjunction with other therapeutic interventions (CSAT 1998*c*). Research findings indicate that the use of medication in substance abuse treatment is much more effective when combined with psychosocial interventions (McLellan et al. 1993).

Appendix A of TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997*a*), details specific pharmacological interventions for substance abuse treatment. TIP 28, *Naltrexone and Alcoholism Treatment* (CSAT 1998*c*), is also a reference on this topic. See also the forthcoming TIP *Medication-Assisted Treatment for Opioid Addiction* (CSAT in development *d*).

The ideas of the medical model can be incorporated into family therapy. For example, the model is based in part on a belief in a genetic predisposition to substance abuse, which can just as easily be understood as one element in family therapists' idea of the transgenerational transmission of problems. In family therapy, the recognition is growing, too, that the field needs to develop a better understanding of pharmacological treatments for disorders that affect family dynamics. For this reason, family therapists need some knowledge of the medical issues related to substance abuse and need to know when to refer clients for an assessment of a potential substance use disorder.

Sociocultural theories

Sociocultural approaches to substance abuse focus on how stressors in the social and cultural environment influence substance use and abuse. Theorists from this school propose that environmental influences such as socioeconomic status, employment, level of acculturation, legal penalties, family norms, and peer expectations can have a significant influence on a person's substance use and abuse. Treating substance abuse, according to these theories, requires changing a person's physical and social environment. Particular interventions include economic empowerment, job training, social skills training, and other activities that can improve a client's socioeconomic environment. Other interventions may involve community- and faith-based activities or participation in self-help groups, all of which can help the client regain hope and connect with other people. Sociocultural interventions often stress the strengths of clients and families.

Holistic approach

Each of the two models presented above—medical and sociocultural—has some validity and research to support its credibility. Most treatment providers, however, do not believe that any one of these approaches adequately describes the causes or suggests a single preferred treatment for substance use disorders. The holistic model, a biopsychosocial model, has been presented as a way to understand the multifaceted problem of substance abuse (Wallace 1989).

Many providers also add a spiritual component to the biopsychosocial approach, making it a biopsychosocial-spiritual approach. This is a fourth model for understanding substance abuse, one that regards recovery from substance abuse as, at least in part, a spiritual journey. This fourth model is heavily influenced by the 12-Step approach to recovery. The consensus panel believes that effective treatment will integrate these models according to the treatment setting, but will always take into account all of the factors that contribute to substance use disorders.

Common Treatment Modalities

A variety of treatment modalities are widely used in substance abuse treatment. Family therapists should be familiar with at least the most common of these modalities in order to be able to make effective referrals and understand other components of clients' treatment regimens. When referring a client to a particular substance abuse treatment program, however, a number of factors must be considered in addition to the necessary intensity of treatment and the specific services available. Some main considerations are

- The client's expressed needs and desires
- A recommendation from a substance abuse treatment professional (if there is any doubt about the treatment modality to which the client should be referred)
- The client's insurance or other available funding sources and the types of treatment they cover
- The client's work setting and family arrangements, especially whether they allow the client to leave for an extended period of time

Nonetheless, the consensus panel believes that family therapy (as distinguished from family education programs or visiting programs) has a place in all treatment modalities. The panel has highlighted ways to use family interventions in most of the treatment settings described here.

Detoxification services

People who have a substance use disorder will likely require a period of detoxification before they can begin intensive treatment. Detoxification is not substance abuse treatment, but for many clients it is an essential precursor to treatment. Without subsequent treatment, detoxification is unlikely to have any lasting effect (Gerstein 1999). Not all clients with substance use disorders require the same intensity of detoxification services. Detoxification services range from medically managed inpatient services to services that can take place in outpatient or even social service settings.

The most intensive detoxification service is a medically managed inpatient program set in a facility with medical resources. Medically managed programs can treat a wide range of medical complications that can arise in people detoxifying from dependence on substances of abuse. Inpatient programs have the advantage of allowing clinicians to limit clients' access to substances of abuse and to observe them around the clock if necessary. Clients who require this level of care include those who have had severe overdoses, have acute or chronic medical or psychiatric conditions, are pregnant, or have developed considerable physical dependence (CSAT in development *a*; Inaba et al. 1997). Providers should also be aware that most insurers do not cover this level of service unless the client meets certain clearly defined medical criteria.

Medically managed outpatient programs can provide medication and a range of medical services, but patients are free to leave the premises and are not as closely monitored as are those in inpatient programs. This option is useful for clients who have conditions that require medication and treatment, but not 24-hour observation. Compared to inpatient services, outpatient detoxification is much less expensive and causes less disruption in the client's life.

Many clients do not require medically managed services, and for them, social detoxification programs (either residential or outpatient) may be the best option. Social detoxification programs provide counseling and other forms of nonpharmacological assistance for managing withdrawal, but generally do not have any onsite medical services. Furthermore, most social detoxification is carried out without the use of medications. Staff members do, however, observe a client closely (especially in residential settings) and can contact a physician or nurse if necessary. It is rare, however, to find any of these modalities in their pure form; most are a blend of methods and modalities.

Detoxification programs typically involve families by providing psychoeducational family groups or similar short-term activities, but they lack the time and resources for more extensive family treatment.

For more information on detoxification procedures in both community and hospital settings, see the forthcoming TIP *Detoxification and Substance Abuse Treatment* (CSAT in development *a*), a revision of TIP 19 (CSAT 1995*d*).

Short-term residential

Short-term residential programs provide intensive treatment to clients who live onsite for a relatively short period (usually 3 to 6 weeks). The majority of these programs provide multiple treatment interventions, including group and individual counseling, assessments, the development of a strong connection with self-help groups and instruction in its principles, psychoeducational groups, and pharmacological interventions to reduce craving and discourage use.

Short-Term Inpatient Treatment (SIT) is the therapeutic approach predominantly used in programs oriented toward insured populations (Gerstein 1999). SIT is a highly structured 3- to 6-week inpatient program. Patients receive psychiatric and psychological evaluations, assist in developing a recovery plan based on the tenets of AA, attend educational lectures and groups, meet individually with counselors and other professionals, and participate in family or codependent therapy. Patients also receive intensive follow-up care lasting from 3 months to 2 years, with less intensive follow-up after that.

Many short-term residential programs feature some sort of treatment intervention for clients' family members. The Hazelden Family Center, for example, is a 5- to 7-day residential family program that explores relationship issues common among families with a member who abuses substances. A majority of the family programs used in short-term residential treatment involve psychoeducational family groups. Most such programs do not provide traditional family therapy, even if they offer some other form of family-oriented treatment.

There is no reason family therapy cannot be integrated into short-term residential programs, though the short duration of therapy may require more intensive and longer (than 1 hour) sessions because work with a family will often end when the client with the substance use disorder leaves treatment. Unfortunately, clients may have to become engaged in an entirely different system for their continuing care, as funding for services may not carry over. Further, family therapy would need to be highly structured (as other activities in these programs are) and the therapist would need to work around a schedule of other activities in the treatment program. If family therapy is being added to an inpatient residential program, it should not take the place of family visiting hours. Clients also need recreational time with their families.

Some short-term residential programs may intentionally refrain from including family therapy because providers believe that clients in early recovery are unable to manage painful issues that often arise in family therapy. That may be true in some cases, but even if a client is unable to deal simultaneously with the cessation of substance use and family issues, the family of the client can still benefit from family therapy.

Long-term residential treatment (or therapeutic community)

A long-term residential (LTR) program will provide round-the-clock care (in a nonhospital setting), along with intensive substance abuse treatment for an extended period (ranging from months to 2 years). Most LTR programs consider themselves a form of therapeutic community (TC), but LTRs can make use of additional treatment models and approaches, such as cognitive–behavioral therapy, 12-Step work, or relapse prevention (Gerstein 1999).

The traditional TC program provides residential care for 15 to 24 months in a highly structured environment for groups ranging from 30 to several hundred clients. According to the TC model, substance abuse is a form of deviant behavior, so the TC works to change the client's entire way of life. In addition to helping clients abstain from substance abuse, TCs work on eliminating antisocial behavior, developing employment skills, and instilling positive social attitudes and values (De Leon 1999).

TC treatment is not limited to specific interventions, but involves the entire community of staff and clients in all daily activities, including group therapy sessions, meetings, recreation, and work, which may involve vocational training and other support services. Daily activities are highly structured, and all participants in the TC are expected to adhere to strict behavioral rules. Group sessions may sometimes be quite confrontational. A TC ordinarily also features clearly defined rewards and punishments, a specific hierarchy of responsibilities and privileges, and the promise of mobility through the client hierarchy and to staff positions. The TC has become a treatment option for incarcerated populations (see the forthcoming TIP *Substance Abuse Treatment for Adults in the Criminal Justice*

System [CSAT in development *j*]) and a modified version of the TC has been demonstrated to be effective with clients with co-occurring substance use and other mental disorders (for more information on the modified TC, see the forthcoming TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT in development *k*], a revision of TIP 9 [CSAT 1994*b*]).

Clients in TCs often lack basic social skills, come from broken homes and deprived environments, have participated in criminal activity, have poor employment histories, and abuse multiple substances. For these reasons, the TC process is more a matter of providing habilitation than rehabilitation (De Leon 1999). As Gerstein notes, the TC environment in many ways "simulates and enforces a model family environment that the patient lacked during developmentally critical preadolescent and adolescent years" (1999, p. 139).

Family therapy is not generally an intervention provided in TCs (at least not in the United States), but TC programs can use family therapy to assist clients, especially when preparing them to return to their homes and communities.

Outpatient treatment

Outpatient treatment is the most common modality of substance abuse treatment. It is also the most diverse, and the type of treatment provided, as well as its frequency and intensity, can vary greatly from program to program. Some, such as those that offer walk-in services, may offer only psychoeducation, while intensive day treatment can rival residential programs in range of services, assessment of client needs, and effectiveness (National Institute on Drug Abuse 1999*a*).

The most common variety of outpatient program is one that provides some kind of counseling or therapy once or twice a week for 3 to 6 months (Gerstein 1999). Many of these programs rely primarily on group counseling, but others offer a range of individual counseling and therapy options, and some do offer family therapy. Some outpatient programs offer case management and referrals to needed services such as vocational training and housing assistance, but rarely provide such services onsite, not because they do not see the need, but because funding is unavailable. The services are often offered in specialized programs for clients with co-occurring substance use and other mental disorders.

Outpatient treatment has distinct advantages. Compared to inpatient treatment, it is less costly and allows more flexibility for clients who are employed or have family obligations that do not allow them to leave for an extended period of time. Research has demonstrated, as with many other modalities, that the longer a client is in outpatient treatment the better are his chances for maintaining abstinence for an extended period of time. Studies of outpatient treatment have documented high drop-out rates in this modality, so many clients do not remain in treatment long enough to receive the optimal benefit (Gerstein 1999). For this reason, exit planning, resource information, and community engagement should start in the beginning of treatment.

Because of the great diversity in services offered by outpatient treatment programs it is difficult to generalize about the use of family therapy. Certainly, however, family therapy can be implemented in this setting, and a number of outpatient treatment programs offer various levels of family intervention for their clients. (For more information see the forthcoming TIP *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* [CSAT in development *c*].)

Opioid addiction outpatient treatment

A specific type of outpatient treatment known as opioid addiction treatment or methadone maintenance involves the administration of opioid substitutes, such as methadone and LAAM, to clients who are opioid-dependent. (Methadone requires a daily dosage, but LAAM only needs to be administered every 2 or 3 days.) This pharmaceutical substitute acts to prevent withdrawal symptoms, reduce drug craving, eliminate euphoric effects, and stabilize mood and mental states. The side effects of these prescribed medications are minimal, and they are administered orally, thereby eliminating many of the hazards associated with injection drug use. Methadone maintenance programs require daily attendance for new clients, but many programs allow clients to take doses home if they have complied with treatment requirements for a period of time (for example, if urine tests are negative for illicit drugs and clients have attended counseling sessions regularly).

In October 2002, the Food and Drug Administration (FDA) approved the use of buprenorphine for opioid dependence. Physicians may dispense it or prescribe it to clients in their offices if they (1) obtain a waiver exempting them from Federal requirements regarding prescribing controlled substances and (2) obtain subspecialty board certification or training in treatment and management of patients with opioid dependence. Information and training are available at SAMHSA's Web site (www.buprenorphine.samhsa.gov). A physician locator at this Web site can help clients find qualified physicians in their area (Clay 2003).

SAMHSA's CSAT is engaged with treatment experts, State and other Federal officials, and patient representatives to develop guidelines and other educational materials on the use of medications such as methadone and LAAM and alternative therapies in the treatment of addictions. CSAT's Division of Pharmacologic Therapies manages the day-to-day regulatory oversight activities necessary to implement new SAMHSA regulations (42 C.F.R. Part 8) on the use of opioid agonist medications (methadone and LAAM) approved by the FDA for addiction treatment. These activities include supporting the certification and accreditation of more than 1,000 opioid treatment programs that collectively treat more than 200,000 patients annually (more information can be found at www.dpt.samhsa.gov).

Opioid addiction treatment has been shown to be an effective way to mitigate the harmful consequences of substance abuse, reduce criminal activity, slow the spread of AIDS in the treated population, reduce the client death rate, and curb illicit substance use (Effective Medical Treatment of Opiate Addiction 1997; Gerstein 1999). Despite these findings, approximately 1 in 4 individuals do not respond well to this treatment for a variety of reasons that are not apparent in clients prior to treatment (Gerstein 1999). Retention rates and outcomes are improved, however, if methadone maintenance programs offer more frequent counseling and provide higher doses (an average of 60 to 120 milligrams per day) of methadone (Gerstein 1999). (For more information see the forthcoming TIP *Medication-Assisted Treatment for Opioid Addiction* [CSAT in development *d*]).

Understanding 12-Step Self-Help Programs

Family therapists would benefit from attendance at 12-Step programs to understand the concepts and to see in

action the principles that might be helpful to their clients. Anyone can attend an open 12-Step meeting (see a local telephone directory or AA's Web site at www.aa.org, and click on "contact local AA"), and therapists who attend meetings and process the information with knowledgeable supervisors or colleagues are able to converse with clients about meeting attendance, problems, benefits, and methods of utilizing 12-Step meetings in conjunction with the therapeutic process. Experience with attendance at 12-Step meetings helps therapists to address issues of resistance when clients say that the meetings are not appropriate for them (e.g., "everyone is different from me," or "they make me tell things I don't want to talk about.") Another benefit of therapists' attendance at meetings is the ability to prepare a client for attendance. The therapist can give an overview of what to expect; for example, it is not necessary to put a donation in the basket as it is passed; it is okay to say "pass" if people are taking turns talking by going around the room, seat-by-seat; how people use sponsors, and so on.

Considering how common substance abuse is in our society, all family therapists need to understand the philosophy behind the disease concept of substance abuse; the concepts of 12-Step programs (such as powerlessness and surrender); the signs, symptoms, and stages of substance abuse; and the specific issues, problems, and needs of children. Some evidence suggests that these ties are already strong. For example, Northey (2002) found in a recent survey that 89 percent of family therapists do refer clients to self-help groups. Family therapists also need to understand the language and terminology of the substance abuse treatment field and DSM-IV-TR's definitions of substance use disorders.

It is important that therapists realize that family therapy organized around substance abuse will not be effective unless the substance abuse is dealt with directly. Therapy should also address the substance abuse problem first if other changes are to take place successfully (O'Farrell and Fals-Stewart 1999). Therapists should also understand that substance use disorders are typically chronic, progressive, relapsing conditions. Relapse should be viewed as part of the recovery process and not as a cause for automatic termination of treatment. Family therapists must be apprised of community services for people with substance use disorders and be able to refer clients to them.

Substance abuse treatment providers recognize the importance that spirituality (regardless of the particular faith or spiritual path chosen) can have in recovery. The use of spirituality and self-help principles may seem foreign to some family therapists' conception of treatment, but these ideas are widely used and accepted within the substance abuse treatment community. Family therapists can use spirituality by recommending that families connect (or reconnect) with their spiritual traditions or discuss spiritual beliefs.

Some self-help ideas, such as sponsorship (a mentoring component for clients), can also be applied within a family therapy setting. Connecting a family who is new to treatment with another more experienced family in treatment can help both, encouraging the new family to see the possible gains and helping the more experienced family reaffirm its commitment to treatment and the difference it has made.

12-Step groups are the mutual self-help modality most commonly used, but there are other self-help groups that go beyond the substance abuse field. In fact, some of these groups are called mutual aid groups because they go beyond the traditional AA self-help 12-Step programs. Examples include Deaf and Hard of Hearing 12-Step Recovery Resources (www.dhh12s.com), Depression and BiPolar Support Alliance (www.dbsalliance.org), and the National Alliance for the Mentally Ill (www.nami.org). The Internet can serve as a good point for finding out local information about these kinds of groups. A listing of various mutual aid resources by the Behavioral Health Recovery Management project can be found at www.bhrm.org. See also the National Mental Health Consumer's Self-Help Clearinghouse at www.mhselfhelp.org.

Summary Points From a Family Counselor Point of View

- If background and training are largely within the family therapy tradition, develop an ever-deepening understanding of the subtleties and pervasiveness of denial. If background and training are largely within the substance abuse treatment field, develop an ever-deepening understanding of the subtleties and impact of family membership and family dynamics on the client and the members of the client's family.
- When the going gets tough, get help. Both substance abuse counselors and family therapists are likely to need help from each other with different situations. Consultations and collaboration are key elements in ensuring clients' progress.
- Develop thorough and effective assessment processes.
- Consider specialized training on one or more specific family therapy techniques or approaches.
- Match techniques to stage of change and phase of treatment.

Footnotes

The theories presented in this section are those of the authors and do not necessarily reflect the positions, views, and opinions of the CSAT, the Substance Abuse and Mental Health Services Administration (SAMHSA), or the Department of Health and Human Services (DHHS).
Harm reduction concepts (e.g., reduced or decreased use as opposed to abstinence) discussed in this TIP are those of the authors and do not reflect SAMHSA/DHHS policy or program directions.
Harm reduction concepts (e.g., reduced or decreased use as opposed to abstinence) discussed in this TIP are those of the authors and do not reflect SAMHSA/DHHS policy.

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Chapter 4 Integrated Models for Treating Family Members

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

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

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

Integrated Substance Abuse Treatment and Family Therapy

Most substance abuse treatment agencies serve a variety of clients—men and women, young and old, homeless and affluent individuals, from every racial and ethnic majority and minority group—with a wide range of substance abuse profiles. On any given day, a substance abuse treatment counselor may work with a 15-year-old girl caught with marijuana in her school locker, a 45-year-old woman whose drinking spiraled out of control after her husband's death, and a 35-year-old man faced with legal trouble stemming from his chronic use of crack cocaine. Some clients may be new immigrants with language and cultural barriers that affect treatment. Others with co-occurring medical or psychiatric disorders may require integrated treatment for the two problems. Some clients may have decided to stop abusing substances, while others may wonder "what the big deal is about smoking a little dope." When families are included in substance abuse treatment, the needs, problems, and motivations are exponentially increased.

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

Combining substance abuse treatment and family therapy requires an integrated model. This term, for the purposes of this TIP, refers to a constellation of interventions that takes into account (1) each family member's issues as they relate to the substance abuse (perhaps a spouse who drinks excessively, a spouse who enables the drinking, and a child who acts out in reaction to the drinking), and (2) the effect of each member's issues on the family system. This TIP also assumes that while a substance abuse problem manifests itself in an individual (such as one person smoking crack cocaine), the solution will be found within the family system (for instance, new interactions that support *not* smoking crack cocaine).

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

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

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

Figure 4-1 Facets of Program Integration

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

Family education. Educational opportunities, information, and informal referrals are presented to the

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

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

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

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

Coordinating Services Among Multiple Agencies

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

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

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

Value of Integrated Models for Clients

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

- *Treatment outcomes.* Family involvement in substance abuse treatment is positively associated with increased engagement rates for entry into treatment, decreased dropout rates during treatment, and better long-term outcomes (Edwards and Steinglass 1995; Stanton and Shadish 1997).
- *Client recovery.* When family members understand how they have participated in the client's substance abuse and are willing to actively support the client's recovery, the likelihood of successful, long-term

recovery improves.
- *Family recovery.* When families are involved in treatment, the focus can be on the larger family issues, not just the substance abuse. Both the individual with the substance use disorder and the family members get the help they need to achieve and maintain abstinence (Collins 1990).
- *Intergenerational impact.* Integrated models can help reduce the impact and recurrence of substance use disorders in different generations.

Benefits of an Integrated Substance Abuse and Family Therapy Program

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

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

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

Source: Consensus Panel Member Fred Andes.

Value of Integrated Models for Treatment Professionals

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

- *Reduced resistance.* In addition to the promise of better treatment outcomes, integrated models permit counselors to attend to the specific circumstances of each family in treatment. This focus accommodates the whole family and helps to diminish the family's resistance to treatment.
- *Flexibility in treatment planning.* Integrated models enable counselors to tailor treatment plans to reflect individual and family factors. For instance, each family member's stage of change can be taken into consideration (see chapter 3 for a description of the stages of change). Early in treatment, families may need education about substance abuse and its effects, while families in later stages of treatment may need help as they address such issues as trust, forgiveness, the acquisition of new leisure skills, changing roles, the reestablishment of boundaries within the family and at work, and changing the specific interaction patterns in the family that support substance abuse.
- *Flexibility in treatment approach.* Apart from the freedom to tailor treatment plans, integrated models enable counselors to adjust treatment approaches according to their own personal styles and strengths. For instance, counselors who enjoy working with adolescents and families can choose structural and strategic models that concentrate on family interactions, while those who prefer to capitalize on client competencies and strengths can choose solution-focused therapy. In this way, different treatment models can be used even within the same agency to meet both client and counselor needs.
- *Increased skill set.* Drawing from different traditional therapy models challenges counselors to be creative in their treatment approaches. With integrated models, for instance, substance abuse treatment counselors can work with a client's family members and see how each of their problems reverberates throughout the family system. Similarly, family therapists can experience working with people whose primary problems are substance use disorders.
- *Administration.* Integrated models enable administrators to get more for less. Despite the obvious cost to cross-train family therapists and substance abuse counselors, the improved treatment outcomes more than offset the investment. New Jersey's Division of Addiction Training recently demonstrated this cost-to-benefit relationship (Fishman et al. 2001). In this process, integrated models accommodated the differences in theory, philosophy, and funding across multiple agencies. Further, models with proven efficacy could be duplicated across agencies, which added to the long-term cost-effectiveness.

Collaborating To Treat American Indians

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

Source: Consensus Panel Member Greer McSpadden.

Limitations of Integrated Models

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

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

present, more regimented protocols than usual may be needed to govern therapy selection.

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

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

Levels of Involvement With Families

Substance abuse treatment professionals intervene with families at different levels during treatment (Conner et al. 1998; Levin 1998). The levels vary according to how individualized the interventions are to each family and the extent to which family therapy is integrated into the process of substance abuse treatment (see Figure 4-1). At a low level of involvement, for example, a counselor might undertake an educational intervention, presenting general information about substance abuse that seems applicable to most families. With greater involvement with the family, a counselor might use a family therapy intervention that helps a family to define specific, collective changes it wants to make, which may or may not directly relate to substance abuse.

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

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

Figure 4-2 Levels of Counselor Involvement With Families

Level 1--Counselor has little or no involvement with family

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

Level 2--Counselor provides psychoeducation and advice

Knowledge base

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

Relationship to family system

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

Advising families about how to handle the rehabilitative needs of the client

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

Level 3--Counselor addresses family members' feelings and provides support

Knowledge base

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

Relationship to family system

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

Skills

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

Level 4--Counselor provides systematic assessment and planned intervention

Knowledge base

The counselor understands the concept of family systems.

Relationship to family system

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

Skills

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

Level 5--Family therapy

Knowledge base

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

Relationship to family system

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

Skills

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

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

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

- A Level 1 family intervention in substance abuse treatment may be conducted informally but is carefully thought out and planned to ensure clinical appropriateness. For example, rather than scheduling an appointment, the counselor could speak to a client's family members while they wait for the client attending a group.
- At Level 2, the counselor could provide education or advice to the family in the form of a short discussion

of the stages of substance abuse and recovery.
- At Level 3, the counselor could educate the family on how substance abuse affects parenting, discussing how the mother and father could each improve their parenting skills and supporting them as they made changes.
- At Level 4, a counselor could intervene to define and change the interactional patterns and behavioral sequences around substance abuse or determine the exact behavioral sequence associated with drinking and establish ways to interrupt that sequence.
- At Level 5, the counselor might help the family define specific goals for change--goals that might or might not focus on substance abuse--and then help the family make those changes. The focus at Level 5 is broader than that at Level 4, and the counselor is apt to draw on wider skills and approaches to help the family meet its goals.

Determinants of the level of involvement

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

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

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

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

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

Using the family to engage the client in treatment

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

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

Approaches to engagement

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

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

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

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

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

Selecting an integrated model for substance abuse treatment

Care must be taken in the choice of an integrated therapeutic model. The model must accommodate the needs of the family, the style and preferences of the therapist, and the realities of the treatment context (e.g., in a residential treatment setting one would not select an approach that demanded frequent contact with family members when clients come from a wide geographical area and family members would not be able to visit often).

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

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

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

Integrated Models for Substance Abuse Treatment

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

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

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

Structural/Strategic Family Therapy

Theoretical basis

Structural/strategic family therapy assumes that (1) family structure--meaning repeated, predictable patterns of interaction--determines individual behavior to a great extent, and (2) the power of the system is greater than the

ability of the individual to resist. The system can often override any family member's attempt at nonengagement (Stanton 1981*a*; Stanton et al. 1978).

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

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

Integrated Structural/Strategic Family Therapy for Substance Abuse

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

Techniques and strategies

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

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

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

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

One of the specific techniques used in structural/strategic family therapy is illustrated below.

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

Family: The client is a 22-year-old Caucasian female who abuses prescribed medication and has problems with depression and a thought disorder. She is the younger of two children whose parents divorced when she was 3. She stayed with her mother, while her brother (age 7 at the time) went with their father. Both parents remarried within a few years. Initially, the families lived near each other, and both parents were actively involved with both children, despite ill feelings between the parents. When the client was 7, her stepfather was transferred to a location 4 hours away, and the client's interactions with her father and stepmother were curtailed. Animosity between the parents escalated. When the client was 8, she chose to live with her father, brother, and stepmother, and the mother agreed. The arrangement almost completely severed ties between the parents.

At the time the client entered a psychiatric unit for detoxification, the parents had no communication at all. The initial family contact was with the father and stepmother. As the story unfolded, it became clear that the client had constructed different stories for the two family subsystems of parents. She had artfully played one against the other. This was possible because the birth parents did not communicate.

Treatment: The first task was to persuade the father to contact the mother and request that she attend a family meeting. He, along with the stepmother, agreed, though it took great courage to make the request because the father believed his daughter's negative stories about her relationship with the mother. In the next session, the older brother (the intermediary for the past 4 years) and his wife also

attended.

Because the relationship between the counselor and the paternal subsystem had already been established, it was critical to also join with the maternal subsystem before attempting any family system work. The counselor knew that nothing could be accomplished until the mother and stepfather felt an equal parental status in the group. This goal was reached, granting the mother free rein to tell the story as she saw it and express her beliefs about what was happening.

A second task was to establish appropriate boundaries in the family system.

Specifically, the counselor sought to join the separate parental subsystems into a single system of adult parents and to remove the client's brother and sister-in-law as a part of that subsystem. This exclusion was accomplished by leaving them and the client out of the first part of the meeting. This procedural action realigned the family boundaries, placing the client and her brother in a subsystem different from that of the parents.

This activity proved to be positive and productive. By the end of the first hour of a 3-hour session, the parents were comparing information, routing incorrect assumptions about each other's beliefs and behaviors, and forming a healthy, reliable, and cooperative support system that would work for the good of their daughter.

This outcome would have been impossible without taking the time to join with the mother and father in a way that allowed them to feel equal as parents. Removing the brother from the parental subsystem required the client to deal directly with the parents, who had committed themselves to communicating with each other and to speaking to their daughter in a single voice.

Source: Consensus Panel.

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

- *Culture.* Counselors should become familiar with the roles, boundaries, and power of families from cultures different from their own. These will influence the techniques and strategies that will be most effective in therapy.
- *Age and gender.* Cultural attitudes toward younger people and women can affect how the counselor can best assume the directive role that structural/strategic family therapy requires.
- *Hierarchies.* Certain cultures are very attuned to relative positions in the family hierarchy. Sometimes, children may not ask questions of the parent. Other children will remove themselves from the situation until the parent notices they are not there. The professional needs to be attentive to who is who in the family. Who is revered? Who are friends? What is its history? Place of origin? All these are clues to understanding a family's hierarchy.

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

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

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

Structural/Strategic Family Therapy in the Criminal Justice System

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

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

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

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

Source: Consensus Panel.

Multidimensional Family Therapy

Theoretical basis

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

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

Research basis

MDFT has been developed and refined over the past 17 years (Liddle and Hogue 2001). MDFT has been recognized as one of the most promising interventions for adolescent drug abuse in a new generation of comprehensive, multicomponent, theoretically-derived and empirically-supported treatments (*c* Center for Substance Abuse Treatment [CSAT] 1999*c*; NIDA 1999*a*; Waldron 1997). MDFT has demonstrated efficacy in four randomized clinical trials, including three treatment studies (one of which was a multisite trial) and one prevention study. Investigators have also conducted a series of treatment development and process studies illuminating core mechanisms of change.

Techniques and strategies

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

Core components

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

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

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

intervention modules, and the content and foci of sessions vary by the stage of treatment.

Multiple Family Therapy

Theoretical basis

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

Techniques and strategies

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

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

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

Multisystemic Family Therapy

Theoretical basis

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

Techniques and strategies

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

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

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

Behavioral Family Therapy and Cognitive–Behavioral Family Therapy

Theoretical basis of behavioral family therapy

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

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

Theoretical basis of cognitive–behavioral family therapy

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

Techniques and strategies of behavioral family therapy

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

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

Techniques and strategies of cognitive–behavioral family therapy

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

Example of Behavioral and Cognitive–Behavioral Family Therapy

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

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

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

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

Source: Consensus Panel.

Below is an example of a technique used in behavioral family therapy to improve communication.

Behavioral Family Therapy: Improving Communication

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

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

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

To eliminate the overuse of blaming, the couple instead learned to report how their partner's actions

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

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

Source: Consensus Panel.

Family/Larger System/Case Management Therapy

Theoretical basis

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

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

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

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

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

Techniques and strategies

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

La Bodega de la Familia, New York

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

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

The participants define their "family," and are encouraged to use the broadest definition to capture the entire support network. Participants and their families help design and implement their service plans, increasing the likelihood of compliance with the plan and success in rehabilitation and reconnecting with their communities. La Bodega also serves a prevention function, exposing children, other family

members, and neighbors to the ideas and skills needed to live without alcohol and illicit drugs.

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

Source: Sullivan et al. 2002.

Network Therapy

Theoretical basis

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

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

Techniques and strategies

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

The Counselor as Advocate in the Network

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

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

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

Bowen Family Systems Therapy

Theoretical basis

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

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

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

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

Techniques and strategies

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

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

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

Use of Bowen Family Systems Therapy With Immigrant Populations

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

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

Solution-Focused Brief Therapy

Theoretical basis

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

Rooted in the strategic therapy model, de Shazer and Berg, along with colleagues at the Brief Family Therapy Center in Milwaukee, shifted solution-focused brief therapy away from its original focus, which was how problems are maintained (Watzlawick et al. 1974; Zeig 1985), to its current emphasis on how solutions develop (de Shazer 1988, 1991 1997). SFBT has been increasingly used to treat substance use disorders since the publication of *Working with the Problem Drinker: A Solution-Focused Approach* (Berg and Miller 1992). Berg and Miller challenged the assumptions that problem drinkers want to keep drinking, are unaware of the damage drinking causes, and require an expert's help and information if they are to recover. Quite the contrary, SFBT counselors insist, people who abuse substances can direct their own treatment, provided they participate in the process of developing goals for therapy that have meaning for them and that they believe will make significant change in their lives.

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

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

Techniques and strategies

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

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

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

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

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

The miracle question serves several purposes. It helps the client imagine what life would be like if his problems were solved, gives hope of change, and previews the benefits of that change. Its most important feature, however, is its transfer of power to clients. It permits them to create their own vision of the change they want. It does not require them to accept a vision composed or suggested by an expert (Berg 1995).

Asking the Miracle Question

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

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

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

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

Relational questions. Helping clients set goals that take the views of important others into account can extend the benefits of change into the client's environment. A good relational question is, What will other people notice about you as you move closer and closer to your goal? For instance, an adolescent client might declare that he is completely confident that he will not relapse. In reply, he might be asked, "Do you think your father is that confident?" Being urged to look at his situation from the perspective of the parent, who might only be somewhat confident that the client will not relapse, motivates the client to think about how he must behave to instill more confidence in this important other figure.

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

Case Study of Exceptions to Problem

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

Steve's concern made Darcy feel her independence was threatened. She would get angry, refuse to take Steve's advice, and distance herself even more. Steve would then insist that she call her sponsor, and the tension between them would escalate into an argument. The quarrel often ended when Darcy

stormed out of the house to spend the night with her sister, who was not a healthful influence. She would suggest a drink to calm Darcy's nerves--and then join her in a binge.

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

Matching Therapeutic Techniques to Levels of Recovery

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

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

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

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

Different models of integrated treatment suggest different techniques that can be used at different levels of recovery. As the family addresses its challenges and the client addresses a substance use disorder, they will progress from attainment of sobriety to maintenance. The following summary figures, 4-3, 4-4, and 4-5, list techniques from a variety of treatment models that can be used with families at different levels of recovery in substance abuse treatment and family therapy.

Figure 4-3 Techniques To Help Families Attain Sobriety

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

Multidimensional family therapy (Liddle 1999)

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

Behavioral family therapy (Kirby et al. 1999)

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

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

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

Bowen family system therapy (Bowen 1978)

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

Figure 4-4 Techniques To Help Families Adjust to Sobriety

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

Structural/strategic systems (Stanton et al. 1982)

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

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

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

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

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

Network interventions (Favazza and Thompson 1984; Galanter 1993)

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

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

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

Figure 4-5 Techniques To Help Families in Long-Term Maintenance

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

Family/larger system (Imber-Black 1988)

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

Network therapy (Galanter 1993)

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

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

Chapter 4 Summary Points From a Family Counselor Point of View

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

models.

Footnotes

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

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Chapter 5 Specific Populations

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

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

Introduction

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

It is vital that counselors be continuously aware of and sensitive to the differences between themselves and the members of the group they are counseling. Therapists bring their own cultural issues to therapy, and the therapist's age, gender, ethnicity, and other characteristics may figure in the therapeutic process in some way. Differences within the family also should be explored. Is the family a homogeneous group or one that represents several different backgrounds? What is the significance that family members assign to their own identities and to the identity of the therapist? These considerations and sensitivity to the specific cultural norms of the family in treatment must be respected from the start of therapy. If these factors are not apparent or explicit, the therapist should ask.

Age

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

Children

Background issues

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

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

Application to family therapy

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

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

Approaches to incorporate children in therapy via play—such as family puppet shows, family art projects, and board games with a therapeutic focus—can be modified to fit family therapy, and play therapy can be a valuable component of family sessions. The Association for Play Therapy defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Bratton et al. n.d., p. 1). Cooklin (2001) points out that play therapy does not mean playful interactions in therapy, but refers to more structured and often nonverbal processes such as the use of toys, games, puppets, models, or role playing. Its goal is to reduce the child's anxiety and to facilitate emotional processing. He also emphasizes, though, that when the client is a child, a level of playfulness is helpful in the therapist–client relationship.

Adolescents

Background issues

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

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

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

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

Some specific risk factors for adolescent substance abuse include

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

Application to family therapy

A growing body of evidence supports family therapy's capacity to engage and retain clients in therapy and its efficacy in ameliorating adolescent drug use, as compared to other approaches (Liddle and Dakof 1995*a*). Specific family therapy approaches such as Brief Strategic Family Therapy (Szapocznik and Williams 2000) and Multidimensional Family Therapy (Liddle et al. 2001) have shown great promise in terms of usage reduction in adolescents and improvements in family functioning.

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

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

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

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

Older Adults

Background issues

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

There are two patterns of substance abuse among older adults. The first includes those for whom drug or alcohol abuse has been a chronic, lifelong pattern leading to significant impairment by the time they are older. The second includes older adults who have recently begun misusing alcohol or drugs in response to life transition issues, such as the death of a spouse. Through reduced tolerance and the decrease in the amount of body water (associated with aging) in which to dilute alcohol (Dufour and Fuller 1995; Kalant 1998), alcohol use considered moderate and nonproblematic through a person's middle years can cause intoxication and dysfunction in an older person. In general, treatment is more effective and the prognosis more optimistic for people with later-onset substance disorders.

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

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

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

Application to family therapy

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

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

Even when abuse is not a factor, older adults sometimes are infantilized and trivialized within the family. Likewise, family therapists must be cognizant of their own tendencies to infantilize the elderly (Sluzki 2000). It is helpful to refrain from framing the substance abuse in pejorative terms, such as *heavy* and *problem drinking.* Instead, a less stigmatizing classification system may refer to a person as *at-risk.* Linking at-risk use to existing or potential medical conditions also places the problem in a medical framework and identifies it as a danger to health.

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

Other accommodations that are helpful for many older clients include

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

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

Women

Background Issues

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

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

In some respects, the psychological burden of women's substance abuse is likely to be greater than for men. One of the biggest psychosocial differentials between men and women who abuse substances is stigma. For a man, especially in certain cultures, drinking may be part of manhood. Women with substance use disorders often are referred to in derogatory and sexually charged terms. A mother with a substance abuse problem quickly is regarded as unfit and may be confronted with losing her children. Although 9 out of 10 women stay with male partners who abuse substances, men are more likely to leave relationships with a woman who abuses substances (Hudak et al. 1999).

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

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

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

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

Application to Family Therapy

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

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

Particular treatment issues relevant to women include shame, stigma, trauma, and control over her life. Women tend to hide their drinking and substance abuse because of the shame that is associated with it. It is important that women feel they are being treated with respect and dignity in treatment (Covington 2002; Hudak et al. 1999).

Because of the high rates of victimization in women's lives, it is critical that the therapist addresses trauma in women's therapy in order for it to be successful. Substance abuse recovery and trauma recovery should occur together, and safety must be ensured in therapy (Covington 2002). Related is the issue of control in the woman's life in areas such as sex, money, food, and religion. Some control problems for women are internal and manifested in self-abusive behaviors, such as eating disorders or self-cutting.

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

Race and Ethnicity

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

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

Generalizations about barriers to treatment for racially and ethnically diverse men and women should be made with caution. Nevertheless, some barriers to treatment, particularly among African Americans and Hispanics/Latinos, have been investigated. They include problem recognition or perceptions of problem severity (for example, the belief that one's alcohol use is not a problem, or not a severe one, and that those affected can handle the problem on their own), costs associated with seeking treatment, as well as doubt about the efficacy of treatment (Kline 1996). Other barriers to treatment for these groups include inaccurate perceptions about the cost or availability of treatment (especially for people who lack insurance), a cultural need to maintain dignity, negative beliefs about treatment (such as harsh rules in residential programs), and structural problems (such as too little treatment for people with no or inadequate insurance, inadequate detoxification facilities, and bureaucratic red tape) (Kline 1996). For more information about cultural competency, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development *b*).

African Americans

Background issues

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

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

Application to family therapy

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

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

Within-Group Diversity: Caribbean Black Populations

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

about treatment, alcohol, and other drugs, scheduling individual sessions until clients can comfortably talk about themselves or be assigned to groups with other Caribbean members.

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

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

African-American women

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

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

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

Parenting issues

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

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

Other factors

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

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

Hispanics/Latinos

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

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

Substance use in Hispanic/Latino communities

Substance use and abuse varies between Hispanic and Latino communities. Level of acculturation has a strong

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

The role of acculturation in family functioning

In attempting to navigate their new environment, many immigrants experience a loss in confidence, as well as shame, anger, and confusion. These emotional reactions generally result from poverty, unemployment, social isolation, discrimination, lack of resources, sociopolitical marginality, and cultural shock (Hernandez and McGoldrick 1999). Any of these factors may contribute to substance abuse and impact family functioning.

Cultural characteristics that impact family therapy

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

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

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

Application to family therapy

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

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

Respeto and conflict

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

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

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

Communication styles

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

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

Counseling strategies

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

Clinicians should also explore family members' experiences of migration, cultural transition, and ethnic-minority status. Holding an open discussion about these experiences allows therapists to analyze family stories and leads directly to issues affecting substance abuse. For instance, a discussion concerning how family members reconcile their culture of origin and American culture will reveal differing acculturation levels within the family. Therapists may also explore the issue through the simple exercise of having family members rate how close they feel to their culture of origin on a scale from 1 to 10. Naturally, in all cases, therapists must make arrangements so that language does not impede a family member's participation.

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

Other considerations include the following:

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

Asian Americans

Background issues

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

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

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

Asian family structure

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

Rates of substance abuse in Asian communities

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

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

Application to family therapy

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

Asians may be hesitant to admit to having a substance use disorder, believing that to do so is an imposition and risks shaming the family. Family members are disinclined to confront people with substance use disorders preferring to minimize, deny, reject, or even ostracize the offending individual (Chang 2000). Inevitably, the result is a cycle of enabling that perpetuates the addictive process and leads to advanced stages before coming to outside attention (Chang 2000). Unfortunately, for many Asian Americans with substance use disorders, this is the point at which treatment often commences. The opportunity for the IP to "save face" is a critical element in making therapy an acceptable part of healing.

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

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

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

Issues of acculturation

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

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

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

Communication styles

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

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

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

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

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

Engagement

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

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

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

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

Other considerations in engaging Asian families are noted below:

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

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

American Indians

Background issues

There are 2.5 million American Indians living in the United States and an additional 1.6 million people who reported being American Indian and at least one other race (Ogunwole 2002). American Indians and Alaska Natives are an exceptionally heterogeneous group. The Federal government recognizes 562 distinct tribes in the United States (*Indian Entities Recognized* 2002), and each has its own culture.

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

Mixing spirituality and religion enables American Indians to pull from both sources for recovery (Coyhis 2000).

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

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

Substance abuse patterns

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

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

Other relevant issues

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

Although many American Indians practice abstinence from alcohol and drugs, substance abuse remains a tremendous problem with this population. Nearly one third of people of childbearing age report heavy drinking, a major factor in the development of fetal alcohol syndrome (Sue and Sue 1999).

Application to family therapy

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

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

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

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

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

Acculturation

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

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

Communication styles

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

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

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

Culturally competent approaches

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

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

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

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

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

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

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

Sexual Orientation

Background Issues

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

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

Application to Family Therapy

Research is insufficient to suggest the efficacy of any one type of family therapy over another for use with gay and lesbian people. Possibly more important than the school of therapy is the therapist's knowledge, understanding, and acceptance of gay and lesbian people (Bepko and Johnson 2000). Treatment providers often are not trained in the specific needs of these populations, even though gay and lesbian individuals in treatment for substance abuse often take part in family therapy (CSAT 2001). Lee (2000) suggests a dozen ways for therapists to create a nonthreatening environment for their clients. Tactics range from a sticker on the clinic door that states "This is a lesbian/gay safe place," to explicit assurances of confidentiality, staff education about gay and lesbian issues and resources, and reassurances for gay and lesbian clients that they are not abnormal or deviant. Among Lee's recommendations are, "Do not try to guess who is gay or lesbian" and "Do not try to persuade a client to choose a sexual orientation" (Lee 2000).

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

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

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

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

People With Physical or Cognitive Disabilities

Background Issues

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

- *Physical* impairments are caused by congenital or acquired diseases and disorders or by injury or trauma. For example, spinal cord injury is a disorder that can cause paralysis. Physical disabilities include spina bifida, spinal cord injury, amputation, diabetes, chronic fatigue syndrome, carpal tunnel syndrome, and arthritis.
- *Sensory* impairments may be caused by congenital disorders, diseases such as encephalopathy or meningitis, or trauma to the sensory organs or brain. Sensory disabilities include blindness, deafness, and visual and hearing impairments.
- *Cognitive* impairments are disruptions of thinking skills, such as inattention, memory problems, perceptual problems, disruptions in communication, spatial disorientation, problems with sequencing (the ability to follow a set of steps to accomplish a task), misperception of time, and perseveration (inappropriate repetitions). Cognitive disabilities include learning disability, traumatic brain injury, mental retardation, and AD/HD.
- *Affective* impairments are disruptions in the way emotions are processed and expressed. In this TIP, affective impairments are considered to include problems caused by both affective and mood disorders, such as major depression and mania. These impairments include the symptoms of mental disorders, such as disorganized speech and behavior, markedly depressed mood, and anhedonia (joylessness). Affective disabilities include depression, bipolar disorder, schizophrenia, anxiety, and posttraumatic stress disorder (PTSD) (CSAT 1998e, pp. 3–4).

People with disabilities are at much higher risk than the general population for substance abuse or substance dependence (Rehabilitation Research and Training Center on Drugs and Disability [RRTC] 1996). While 10 percent of the general population has a substance use disorder, studies consistently find that 20 percent of people

qualifying for State vocational rehabilitation services meet diagnostic criteria for substance dependency (Moore and Li 1994; RRTC 1996; Robert Wood Johnson Foundation 1994; Schwab and DiNitto 1993). Other studies have found that the use of prescription medication in combination with alcohol and the use of other people's prescription medications are common for some people with physical disabilities (Moore and Polsgrove 1991). The routine of taking particular medications may itself provide feelings of control, stability, or safety. Additionally, some physicians prescribe medications in a palliative manner in an attempt to assist with disabilities they cannot cure, such as chronic pain or multiple sclerosis.

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

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

Application to Family Therapy

Frequently, people who do not have disabilities are uncertain how best to respond to those who do (Sue and Sue 1999). Family therapists should take care to ensure that the language they use in describing physical and cognitive disabilities is sensitive and appropriate. As a general rule, one should always put people first, before their disabilities, referring to "people with disabilities" rather than "disabled people." One should never refer to the disability in place of the person—not "the schizophrenic" but rather "a person with schizophrenia." A person with a disability should not be called a "patient" or "case," unless the context refers to a relationship with a doctor.

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

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

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

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

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

Most substance use disorder treatment professionals already have extensive knowledge of the complex ways in which psychological denial and substance abuse are intertwined, and they have developed methods of working with clients whose denial presents a significant obstacle to treatment. However, for people with disabilities, denial has additional dimensions. Some people with co-existing disabilities may experience two types of denial at once: denial of the substance use disorder and denial of the disability. The presence of a co-occurring disability can alter how a person manifests denial of his substance use disorder or can cause denial to be focused solely on the disability. For a person with a disability, substance use may also be a form of bargaining. He or she may think that substance use is something that is "allowed" in order to compensate for facing a disability. For clients, recognizing their substance

abuse forces them to cope with all of the often painful emotions typically experienced by any person in recovery, in addition to those related to disability. For most people with severe disabilities, adjustment to this condition is considered a lifelong process (DeLoach and Greer 1981).

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

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

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

Because family members may feel responsible for the individual's condition and present mostly with negativity, family therapists must address guilt and anger (Hulnick and Hulnick 1989). Hulnick and Hulnick (1989) suggest that family therapists assist both the family and the member with a disability to focus on the choices at their disposal. Such questions as "What are you doing that perpetuates the situation?" and "Are you aware of other choices that would have a different result?" can empower clients to understand that they retain the powerful option of making choices (Sue and Sue 1999, p. 325). Another effective strategy is reframing the disability through examination of the ways in which it may afford a learning or growth experience.

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

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

Specific recommendations include the following:

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

that they are no higher than the client. They should be aware of the pace of the interview, and attempt to gauge when clients are becoming fatigued. Counselors should periodically inquire how the client is doing and offer frequent breaks.

- People who use wheelchairs often come to regard the chair as an extension of themselves, and touching the chair may be offensive to them. Therapists should never take control of the wheelchair and push the person without permission.
- For people with cognitive disabilities, providers must systematically address what has been learned in the program and how it will be applicable in the next stage of treatment or aftercare. Some people are very context-bound in their learning, and providers cannot assume that the lessons learned in treatment will be applied in aftercare.
- If a person with a disability has limited transportation options, a therapist may arrange to conduct individual counseling by telephone, go to the person's house, or meet at a rehabilitation center or other alternative site. Going to the residence of an individual with a disability also provides valuable information about a client's lifestyle, interests, and immediate environmental challenges.
- Therapists should recommend literature to families that addresses enabling behavior in general and for people with disabilities in particular. Disability resource agencies may be able to provide helpful literature. For a full discussion of these categories, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998e).

People With Co-Occurring Substance Abuse and Mental Disorders

Background Issues

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

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

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

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

Application to Family Therapy

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

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

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

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

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

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

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

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

Rural Populations

Background Issues

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

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

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

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

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

Patterns of substance abuse

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

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

Although rural communities may have similar substance abuse rates, quite frequently the consequences are more pronounced and severe (CASA 2000). Because rural communities often combine reduced resources with low population density, they often have shortages of trained substance abuse professionals and great challenges

providing accessible treatment programs. In 1993, 55 percent of U.S. counties were without a practicing psychologist, psychiatrist, or social worker, and all of these counties were rural (Pion et al. 1997).

Application to Family Therapy

Overcoming barriers to treatment

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

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

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

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

Use of self-help groups

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

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

- Self-reliance—this feature involves learning how to care for oneself.
- Family system—this element involves learning how one can create healthy families.
- Working with faith-based (religious), community, and spiritual groups is an opportunity to be mutually supportive and let others know about the importance of family therapy in substance abuse treatment. Though no precise definitions distinguish between the terms faith-based, spiritual, self-help, and community initiatives, conventional and practical distinctions do differentiate them. Faith-based programs have clear religious orientations. They may be community-oriented as well. Many churches, for example, coordinate substance abuse services in their communities, and their activities may involve people in the community and include spiritual and faith-based underpinnings as part of the recovery approach. Because of the spiritual focus of 12-Step programs, they are sometimes confused with faith-based programs, but AA does not refer to or promote any religion or denomination. It only encourages connection with a higher power.

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

Other Contextual Factors

HIV Status

The Centers for Disease Control and Prevention (CDC) estimates that between 800,000 and 900,000 people in the United States are living with HIV infection, and about 625,000 are aware of their infection. As of June 2001, more than 457,000 people in this country had died of the disease (CDC 2002). The epidemic has had an impact far

beyond mortality statistics, with far-reaching effects on systems as diverse as health care, food service, economics, and education.

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

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

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

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

Application to family therapy

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

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

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

Homelessness

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

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

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

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

Application to family therapy

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

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

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

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

Veterans

The statistics relating to veterans and substance abuse do little more than provide snapshots that hint at the extent of the problem and the efforts being made to treat it. For example, in fiscal year 2000, the Department of Veterans Affairs (VA), which provides health services for the Nation's veterans, counted 366,429 clients diagnosed with a substance use disorder. In 2000, more than 55,000 veterans were admitted to publicly funded substance abuse treatment facilities (OAS 2003*b*). According to the VA studies, 76 percent of homeless veterans have experienced alcohol, drug, or mental disorders in the past month and 93 percent at some time in their life. Most homeless veterans (98 percent) are male (National Coalition for Homeless Veterans 2002).

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

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

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

Application to family therapy

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

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

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

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

Chapter 5 Summary Points From a Family Counselor Point of View

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

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Chapter 6 Policy and Program Issues

This chapter provides information about the importance of improving services to families and discusses some policy implications for effectively joining family therapy and substance abuse treatment. Of special importance in this effort is the inclusion of key stakeholders in the substance abuse treatment and family therapy fields, among them the Federal government, insurance companies, frontline and executive staff members from both disciplines, researchers, consumers, and others who make decisions about service delivery.

This chapter also presents program planning models developed by the consensus panel that provide a framework for the broad inclusion of family therapy into substance abuse treatment. These models cover (1) the issues surrounding staff education about families and family therapy, (2) family education about the roles of families in treatment and recovery from substance abuse, (3) how substance abuse treatment providers can collaborate with family therapists, and (4) methods for integrating family therapy activities into substance abuse treatment programs.

Considerations for substance abuse treatment program administrators, such as guidelines for implementation, ethical and legal issues, and evaluating outcomes are addressed for each of the four program planning models. The chapter also discusses the counseling adaptations and training and supervision issues that arise for substance abuse counselors and other staff when programs promote attention to family issues and family therapy techniques.

Primary Policy Concerns

Though many substance abuse counselors and family therapists have learned to incorporate aspects of each system's approaches, to be instructive this TIP finds it necessary to proceed as if "family therapy" and "substance abuse treatment" have heretofore existed in isolation from each other and as if each were reducible to a specific limited set of techniques, approaches, attitudes, and points of view. The reader should keep in mind that it is an overly simplified presentation that follows and that the overlap among practitioners and the fields is probably much greater than the artificial separation employed as a vehicle for the presentation of primary policy concerns. With this caveat in mind, the merging of family therapy techniques with substance abuse treatment warrants consideration of three primary policy questions:

- When is family therapy appropriate?
- What are the funding and reimbursement options for family modalities?
- What role does the criminal justice system play in mandating substance abuse treatment with a family focus?

Challenges to Merging Family Therapy and Substance Abuse Treatment

There is considerable evidence to support treatment that taps the power of the family and the community but, at the same time, weaving a different modality with its own distinct values into a treatment program can be a challenge. This may explain in part why many substance abuse treatment programs have been slow to integrate the strengths-based approach essential to effective work with families.

One major impediment to merging the two disciplines effectively is identifying the underlying values of each and then determining whether alternatives would work better. The different values associated with previous forms of substance abuse treatment and family therapy have important implications for combining the two in the future. These implications will affect the entire organizational spectrum. Though the incorporation of family therapy into substance abuse treatment presents an opportunity to improve the status quo, it also challenges these two divergent modalities to recognize, delineate, and possibly reconcile their differing outlooks. At a basic level, for example, agencies can develop common action plans founded on evidence-based research and goals to ensure more success for the client. Such plans could be developed according to the four-tier model described in chapter 4, which guides the development of different levels of family involvement.

Another major policy implication, as noted by O'Farrell and Fals-Stewart (1999), is that family therapy requires special training and skills that are not common among staff in many substance abuse treatment programs. A substance abuse treatment program committed to family therapy will need to consider the costs associated with providing extensive training to line and supervisory staff to ensure that everyone understands, supports, and reinforces the family therapist's work.

For a traditional family therapy approach to be successful, it is necessary to consider how everyone who works in and with a program treats clients and their families. The entire substance abuse treatment program must be examined to verify that the ideas espoused in family therapy are fully integrated into all aspects of the program, including forms, policies, procedures, and mission statement. Further, in providing some level of family involvement or therapy within substance abuse treatment, other problems may need to be resolved, such as

- Substance abuse counselors and family therapists sometimes have different goals.
- Research to support the integration of classic family therapy into substance abuse treatment is not definitive, although recent research studies have shown support for certain types of family-based treatments with certain types of client/family groups.
- Conflicting interests and standards regarding confidentiality must be reconciled.

Given the complexity of incorporating full-scale family therapy consistently in substance abuse treatment and the

finite resources with which many substance abuse treatment programs are working, family involvement may be a more attractive alternative. Family involvement and family therapy are two points on a continuum rather than completely distinct.

What Are the Funding and Reimbursement Options for Family Modalities?

The documented cost savings and public health benefits associated with family therapy support the idea of reimbursement (O'Farrell et al. 1996*a*, *b*). However, like the substance abuse treatment system, the American health care insurance system focuses care on the individual. Little, if any, reimbursement is available for the treatment of family members, even less so if "family" is broadly defined to include a client's nonfamilial support network. For example, under Medicare, family therapy is a covered expense, when done by a licensed and certified Medicare mental health provider, but the system does not certify and therefore does not reimburse family therapists. With Medicaid, administered by States, reimbursement policies vary. Also, the Elementary and Secondary Education Act does not recognize family therapists as qualified mental health or substance abuse services providers.

If a family wants services, and the client is unwilling to participate, the family should not be excluded. Ideally, family members should be able to receive appropriate services, if requested. What must be changed so that families can receive those benefits? Who would fund a more inclusive process? The known and interactive barriers —reimbursement and attitudes—must be resolved in order to include families more fully in the treatment process. Regardless of the context in which family therapy is delivered, if the operational policy of States or insurance companies is not to reimburse, then policy discussions need to develop processes to remove that barrier. Recent evidence of the effectiveness of family involvement, as well as clinical and research evidence that supports family therapy for substance abuse treatment (Liddle et al. 2001; Stanton and Shadish 1997), may eventually move funders to alter payment systems so that families can be included.

What Role Does the Criminal Justice System Play in Mandating Substance Abuse Treatment With a Family Focus?

The criminal justice system is a major source of referrals to substance abuse treatment, especially among people with low incomes. Such legally coerced referrals come with powerful leverage that strongly affects the treatment process. Providers should be prepared to address several issues: If a treatment program requires family member participation and the client refuses to involve them, or the treatment episode is not successful, what are the consequences to both client and family? What happens if a family-focused approach is in place and the family does not show up? Do you punish the client? If such questions are not anticipated and answered adequately, the result may be harm to, rather than assistance for, the client and/or the family.

Program Planning Models

Including family therapy issues in substance abuse treatment settings at any level of intensity requires a systematic and continuous effort. The four program planning models presented in this section—staff education, family education and participation, provider collaboration, and family integration—were developed by the consensus panel and provide a framework for program administrators and staff/counselors. The framework identifies key issues: guidelines for implementation, ethical and legal issues, outcomes evaluation, counseling adaptations, and training and supervision. Some programs may be limited to educating staff about family therapy and how family issues relate to substance abuse, treatment, and recovery.

Many programs already involve families in the treatment process in some way, and those programs might wish both to promote ongoing staff education about family therapies and to increase or improve the ways in which families participate in the substance abuse treatment program and continuing care. A program might decide to create or expand its collaborations with family therapy providers and other social service agencies. Although integrating family therapy into substance abuse treatment might require a significant investment of time and resources, the consensus panel hopes that treatment programs can use the integration models suggested to facilitate such changes.

Staff Education

The goal for educating staff about family therapy and family issues is to increase staff (and therefore client) awareness of the role of family involvement in substance abuse, dependence, treatment, recovery, and relapse. Increasing staff's knowledge of the family as a unit and the influence of the ecological setting within which the substance abuse occurs should be one outcome of the staff education activities. Support for becoming knowledgeable about family therapy issues, as well as for program changes designed to integrate or enhance the delivery of such services to clients and their families, begins with the chief administrative and clinical staff. These staff members need to demonstrate their value of such knowledge and activities and that they are willing to commit the necessary resources in an ongoing fashion.

Issues for substance abuse treatment program administrators

Program administrators must assess the amount of effort and support required to develop staff education activities related to family issues. When the agency does not have in-house resources, it might be best to seek input from the entire staff about any staff knowledge of resources in the community and/or specific providers worth considering for participation in the educational activities. To be sure, program administrators will need to gauge the compatibility of outside presenters' views of addiction against the substance abuse treatment program's viewpoints and materials. Although viewpoints regarding substance abuse and its treatment need not be identical for all family therapy presenters, the program administrator might wish to give advanced thought to how to address issues that could arise over conflicting views. Administrators need to be aware of the costs that are involved; sometimes the resources are not readily available and can be costly, especially in areas where access to care is restricted.

In some locations there might be numerous inexpensive or even free educational activities that relate to family issues and family therapy—from local college courses to evening presentations given by various community organizations. In other locations it may be much more difficult and expensive to access direct presentations, and program administrators may seek resources through e-learning possibilities. Of course, this TIP itself and other State and Federal resources, such as one of the regional Addiction Technology Transfer Centers (www.nattc.org), which receive funding from the Center for Substance Abuse Treatment (CSAT), are good places to start.

Though it is unlikely that there will be any legal or ethical issues associated with providing education on family issues to substance abuse counselors or staff, it is certainly the best practice in terms of credentialing to check with licensing or certification agencies. This will ensure that any professional invited into one's agency is in good standing and has the background and training that are represented in the person's resume. As far as outcome evaluation, many presenters have their own "pre- and post-" questionnaires to demonstrate that participants have acquired certain information from the presentation. Certain accrediting organizations require such program evaluation components in order for a presentation to be eligible for consideration as continuing education credits. Of equal, if not greater, importance would be formal or informal mechanisms for obtaining participants' own assessments of the educational activities.

And finally, some time and attention will need to be devoted to help staff digest the family therapy education they receive, especially in terms of their comfort level about what the training implies as far as their counseling or treatment. Along these same lines, staff might have concerns about the amount of training and supervision necessary to employ any or all of the techniques described or suggested. Again, resources to meet these concerns might be available in-house, in the community, or through distance learning possibilities. Designing a set of educational and training activities so that these activities can help staff satisfy their various education requirements and compensation for any extra time devoted to such endeavors are important ways to support staff interest and appreciation of family therapy educational training. The provision of opportunities for ongoing supervision could be a powerful way to communicate a program's commitment to families and the family's role in treatment and recovery and to show support of staff in becoming familiar with new techniques and approaches.

Issues for staff and trainers

Treatment center staff—from substance abuse counselors to supervisors, nurses, and physicians—are likely to have varied backgrounds in terms of familiarity with family issues and/or family therapy. Therefore, educational activities will need to be appropriate for the participants. Many substance abuse treatment counselors will be familiar with the "family disease model" of substance abuse. Such familiarity is likely to range from being familiar with certain terminology to using the family disease model in individual and group substance abuse treatment, including family involvement. Some counselors or staff will be trained and thoroughly familiar with one or more family therapy treatment systems.

In addition to being sensitive to staff's level of familiarity with the material, trainers must also understand and be sensitive to staff culture. Ways of adapting material for staff to understand and development of new strategies of teaching are the responsibilities of the trainer. Staff may not have the basic knowledge to adapt the new material and might need assistance in understanding how the information is meaningful and applicable to their populations and cultures.

Family Education and Participation

Many substance abuse treatment facilities offer "family counseling" as part of the therapies employed by the treatment program (Office of Applied Studies 2002*a*). However, the nature of such family counseling can vary widely from one facility or treatment provider to another. The consensus panel recognizes that some treatment programs may have no or limited family involvement and other programs may vary in the extent of family participation. The consensus panel's focus is on family education and involvement that is informed by the full range of family therapy information and the possibilities presented throughout the TIP. Consequently, family education and participation stresses the importance of the family in substance abuse treatment and calls for changes in the intake assessment process, education of the family, counselor training and caseloads, confidentiality issues, and special followup and outcome measures.

Assessment is one of the most important components of any substance abuse treatment program. When focused on families, an assessment instrument generates data that can help the substance abuse professional identify resources in the family that may promote treatment success. Collecting data about the client's family serves several purposes:

- It yields a more thorough, and perhaps more accurate, family history.
- It presents an opportunity to confirm and clarify information on the client.
- It can provide insight into the context where substance abuse most often occurs and where it may have started or accelerated.
- It sets the tone for a continuing focus on the family.
- It identifies family resources to help plan long-term care.
- It documents specific information that can determine treatment goals.

The importance of enhancing family involvement can be emphasized by staff. The following types of questions encourage further discussion about family dynamics and involvement, emphasizing a strengths-based model. However, staff should be careful about asking for details in a way that may be experienced by the client as an interrogation:

- Who can support you in treatment?
- Do you know someone who is abstinent who can support you?
- Who in the past has been the most helpful to you?
- Tell me about a safe place where you can live.
- Who is taking care of your children while you are in treatment?
- Does anyone in your family use substances?
- Is anyone in your family recovering from substance abuse?
- Have your family members noticed a decline in your substance use?
- How would your family react to your recovery from substance abuse?

- What does your family think about you being here? Did you tell them? Why or why not?
- Is substance use an important part of your family life?
- Who in your family has jobs? Goes to school?
- Who is the last person in your family who saw you cry?
- Where did you eat dinner last Sunday?

Education of the family proceeds along a continuum that includes strategies such as providing Internet access, informal referral and educational opportunities, and printed materials such as pamphlets, videotapes, and reference books. Some tools can help families understand their importance in substance abuse treatment. Modified genograms, for example, help families understand substance abuse from the focus on its history to the larger context of clients' lives (see chapter 3 for more information on genograms). Another example is psychoeducational groups, which can focus on families' strengths and help family members change common behavior patterns that may contribute to conflicts. A family therapy directed strengths-based perspective may help families learn skills to solve conflicts and identify common feelings or thoughts related to substance abuse and families. Psychoeducation can be conducted in groups with several families in a single session, making the approach highly cost-effective. From a clinical perspective, psychoeducational groups may increase a family's sense of support and reduce stigma within and between families.

Family involvement in treatment can also be construed as a continuum based on the level of background and training required for staff to implement family activities into treatment. From the perspective of the treatment process, the introduction of family activities requires accommodation from traditional program activities and orientation. Minimal family activities, such as the construction of a genogram, require limited counselor training and virtually no changes in any other substance abuse program aspects. Family therapy techniques that require a detailed examination of community influences and contingencies for rewarding recovery activities might require significant staff training, significant shifts in program scheduling, and shifts in the relationships among program staff and community resources.

Issues for substance abuse treatment program administrators

Counselor training and caseloads

If counselors improve their skills and are able to do more complex clinical work with families, such expansion of their roles as counselors will place added burdens on them. Working with families will increase the amount of clinical time for each client so overall adjustments in a counselor's caseload might be necessary, especially when one considers that work with families can at times bring with it a heavy emotional burden. Staff burnout prevention needs to be considered, and difficulties with the stressors associated with additional training, information, and so on need to be monitored.

Confidentiality

Informed consent and confidentiality issues will require careful consideration by program administrators. Ideally, clients in substance abuse treatment will sign informed consent forms, acknowledging their understanding of the potential risks and benefits of family program activities, and family members (including children, when appropriate) will also sign such forms. Informed consent forms can describe in detail, for example, the program or staff responsibilities regarding the reporting of information that is required by law (such as elder abuse, child abuse or neglect, infectious disease, or duty to warn—depending on the particular laws of the State or locale and Federal laws). Additionally, separate confidentiality warnings might be included in the informed consent form so that clients and their families realize and agree that the loss of confidentiality resulting from families meeting in groups is understood and agreed to by all.

In regard to confidentiality, there must be strict adherence to all confidentiality laws, including the specific requirements for any and all releases of information. Substance abuse treatment centers bear a responsibility for ensuring that treatment providers or outside presenters understand the strict requirements of confidentiality imposed by direct Federal laws, State law, and professional ethics within the substance abuse field. For example, if these issues are not clarified, family members may regard sign-up sheets as violating their confidentiality. If family members sign a log sequentially, the program will illegally disclose to client B that client A is in treatment. These issues become especially complicated when a client identifies as "family" people who are neither related by blood nor by law and wishes to include friends or coworkers.

Outcomes

Evaluating the outcome benefits and drawbacks of family education activities and new ways of incorporating family techniques into the treatment process can be qualitative or quantitative, simple or complex. Simple questionnaires and feedback sessions are what many program administrators want to consider; some administrators might want to pursue more intensive analyses that employ focus groups and performance measurement techniques that are developed by outside experts. Such performance measurements might include a change in the percentage of clients who agree to have their families participate in treatment, an increase in the number of contacts counselors have with family members, monitoring the number of requests for the program's free materials related to families and treatment, and a host of other possibilities.

Issues for staff and trainers

Training and supervision issues are similar to those that arise from staff education, but such concerns can reach a higher level of intensity. Being educated about family issues and family therapy might imply certain changes or expectations for counselor behaviors, whereas the inclusion of family education and family involvement in the treatment process brings the responsibilities and expectations for the counselors to a much higher level. Counselors and staff will be expected to know more, explain nuances to family members, and incorporate any new family program activities into their general style and treatment approach. For this level of family participation, substance abuse counselors will require significant training and supervision. The professional associations of staff members may offer guidance in terms of suggested or required background or training to meet acceptable standards; and, of course, organizations that traditionally include family therapy modalities usually have standard curricula and training requirements that they promote.

Provider Collaboration

Collaboration goes beyond referral; it indicates that the substance abuse treatment program and the family social service agency have established an ongoing relationship so that the treatment that takes place at one provider agency is communicated to and influences the course of treatment or services at the other. Such provider collaborations will ensure high-quality referrals, effective outreach, and meaningful partnerships with community resources. Such relationships should encourage family participation in both substance abuse and family-oriented services. Of course, determining what a family needs is a decision to be made in the family and not by the substance abuse treatment provider. From this perspective, the provider encourages empowerment within families to determine their own direction.

Given the complexities of informed consent and confidentiality that arise from adding family education to a program's offerings, developing collaborative relationships with family therapy and related agencies is no easy task. Staff members will be called on to be knowledgeable about family-involved treatment models and services and be familiar with community resources. Matching the resources of various providers with a family's needs and providing the family with information about the pros and cons of various alternatives will require a strong community perspective and resource commitment on the part of the substance abuse treatment agency.

Issues for substance abuse treatment program administrators

Resources need to be provided to monitor and ensure that high-quality referrals, outreach, and partnership components are in place within the agency and community. Examples of such resources include

- Family education sessions where families can learn more about substance abuse and family involvement.
- A comprehensive referral system that can facilitate the participation of families and clients in treatment-based, family therapeutic activities.
- Expanded informed consent, which will often be necessary.
- Client and family education about both the benefits and challenges of using any particular provider or service, and clients should understand the relationships among service systems. In addition, program administrators may need to develop "disclaimers" for clients so they understand that a substance abuse treatment agency cannot be responsible for the actions of another agency's staff or policies.

For many provider collaboration arrangements a memorandum of understanding (MOU) can be developed to help clarify and guide the interrelationships. Coordinated efforts include active involvement of substance abuse staff in the therapeutic process and continuous contact with the family therapist at the external agency. Detailed understanding of each other's processes and protocols, as well as detailed MOUs, can avoid redundancies and improve quality—for example, if each program screens for mental health issues, coordinating the screening processes will avoid duplication and unnecessary confusion on the part of clients, especially if the different screening approaches were to yield different results. Another example is how the MOU establishes separate responsibilities for on-call service provision and responses to crises.

To ensure adequate communication flow to meet the challenges of coordinating provider activities, program administrators face allocating personnel resources for a variety of tasks, from documentation and information coordination to joint public speaking and presentations. Someone could be designated as the provider collaboration coordinator—perhaps as part of quality assurance duties or a position that implements, monitors, evaluates, supervises, updates, and educates staff about the relationships with other providers. Staff could be assigned duties related to cross-training efforts and participate in each other's boards, committees, or multiagency efforts.

Program administrators would also have to consider other costs and the taxing of resources by the responsibilities of collaborating with other providers. Confidentiality and informed consent will be repetitive issues, whether it is how to manage group forms of treatment in the other agency or how to address the Health Insurance Portability and Accountability Act (HIPAA) requirements (for more information on HIPAA see the following Web site: www.hhs.gov/ocr/hipaa). Additional considerations might include policies for non-clients on the treatment premises, space considerations, security, insurance issues to be sure that one's liability protection remains secure, as well as reimbursement issues.

Evaluation and outcome measurement remain challenges for administrators; yet, provider collaboration might offer opportunities to use instruments developed by other providers, gain feedback from other professionals, and offer clients a chance to express themselves to a neutral party by having one agency survey clients about the client's views of the other agencies. Supervisors from each agency are likely to be interested in the views of each other's personnel. The following evaluative questions can be asked in any outcome scenario that involves referring families to other agencies:

- What family members are actually going to the other agency to which they were referred?
- What does the family like about going to the other agency?
- What aspects of treatment from the other agency are helpful?
- What does the other agency provide that this agency also provides?

Issues for staff and trainers

Staff in both agencies can expand their knowledge about substance abuse education and family resources in the community. Staff members should be informed about family-involved treatment models and provide information using collateral resources to build trust with family members. Supervisors are likely to be called on to help staff accommodate the changes and new information generated by collaboration with other providers.

Staff should learn to avoid "splitting"—that is, where a client regards one provider as "good" and the other as "bad," with the implicit attempt to get the "good" provider to agree that the other provider is incompetent, ineffective, or corrupt. Sometimes a variant of triangulation, splitting regularly results in the client becoming upset or attempting to use the "split" to avoid responsibility or consequences for behavior. In any case, staff profit from being as well informed as possible about the details of the programs and resources of collaborative providers, especially in terms of cultural competency issues. For example, it can be important to know the extent to which a collaborating provider can provide accommodations for people with disabilities, from accessible bathrooms to

assistive technologies.

Recommendations for collaboration

Cross-training

Generally speaking, there is a shortage of (1) well-trained substance abuse treatment professionals, (2) well-trained substance abuse treatment professionals knowledgeable about family issues, and (3) well-trained family therapists who are proficient in traditional substance abuse treatment techniques. The integration of family therapy into substance abuse treatment programs will have to address these shortages, a goal that could be accomplished—at least in part—through cross-training. Cross-training needs to be addressed in the educational system as well. Requiring a variety of core class work would enable both substance abuse counselors and family therapists to be better equipped to address both substance abuse and mental health issues.

Though ideally counselors would be adequately trained in both family therapy and substance abuse treatment, that ideal is likely to remain the exception rather than the rule. Family therapists can certainly obtain some training in substance abuse treatment, especially in the areas of screening, assessment, motivational enhancement, and relapse prevention, as well as in specific approaches such as cognitive–behavioral therapy or 12-Step programs. Perhaps the first four levels of involvement with families suggested in chapter 4 could accommodate a training approach for family-oriented substance abuse counselors with various levels of training. Additionally, many family therapy techniques—such as telling family stories—can be of great importance in the process of substance abuse treatment engagement.

Partnerships

A shift from the individual to the family in substance abuse treatment models would necessitate collaboration, partnership, and joint funding at all levels. One such example was announced in July 2002, involving the Department of Housing and Urban Development (HUD), the Department of Health and Human Services, and the Department of Veterans Affairs, who have joined together to end chronic homelessness within 10 years (U.S. HUD 2002). Collaborations such as this one highlight how the Federal government has begun to recognize and address the fragmentation, duplication, and isolation that exist within and among agencies, a model that could be transposed to the family therapy/substance abuse treatment arena.

In the community. One empowering partnership model is a consumer-based collaboration that incorporates community perspectives in the development of substance abuse treatment programs. Inclusion of community members' perspectives can heighten their commitment as key stakeholders, involve them in their own care, and reduce the levels of opposition to substance abuse treatment. It inherently validates the listening process of communities and develops trust. La Bodega de la Familia (see chapter 4 for a more complete description) was the first treatment center accepted unanimously by the community board on the Lower East Side of New York. More than 200 meetings were conducted with community members and police, probation, city council, and community providers, the results of which were used to start the program. This process allowed for the possibility of creating an innovative system of intervention that people want and will use, and does not impose a middle-class family therapy model or a "one-size-fits-all" approach on the community it serves.

It remains to be seen whether a model that shifts the power to the consumer provides reliable outcome or impact data, but it does allow communities to tailor interventions with positive impact. Focus groups and other methods are used to engage communities and learn about how people do or do not use services. A major precaution is that often in an open forum, participants may say what they want, but then do not use the service. It falls on the lead agency to validate the consumer and to operate from the perspective that this is a community-led movement, not a professionally led one. Including consumer voices grounds the validity of the program and shifts the traditional paradigm, while also heeding the voices of substance abuse providers, therapists, and other key stakeholders. An additional benefit is that a consumer-led movement is a strategy that can engage legislators and lay the groundwork for policy shifts related to community-based substance abuse treatment and family involvement.

In the workplace. The workplace is another potential partnership area for family therapy and substance abuse treatment. Many Employee Assistance Programs (EAPs) know and make referrals to family therapists who are also knowledgeable about substance abuse. Ongoing research by EAPs on the effectiveness of such referrals and treatment episodes could stimulate others to be more inclusive of familial involvement in substance abuse treatment.

An ancillary issue to this kind of partnership is the potential need for large numbers of people trained in family-involved or family therapy systems work. For example, if the number of families who are served at Level 4 of the model discussed in chapter 4 increases, there may not be enough well-trained clinicians to provide those services. Also, competencies should be designated to guide training on family issues, general family therapy, and family therapy to treat substance abuse.

Family Integration

Programs at the ideal level are fully functional and culturally competent in their operations, policies, procedures, and philosophical approaches as they relate to the integration of family therapy into substance abuse treatment. At this level, adequate infrastructure, financing, and human resources are available to implement and sustain the integrative project. Program activities are based on the strengths of families and an enhanced view of the family as a positive influence and resource. Social, individual, and family supports are in place to improve family dynamics and prevent relapse.

At this level, a "family culture" is promoted with certain principles about families and substance abuse treatment present throughout the organization and client interactions. Fully integrated programs have multiple staffing patterns with clinical personnel who are educated, comfortable, and competent in substance abuse treatment and family therapy. These programs also have nonclinical staff educated on the importance of family involvement in substance abuse treatment. All clinical staff are cross-trained in family work, substance abuse, and family case management, as well as knowledgeable about social services and other available resources in the community.

Issues for substance abuse treatment program administrators

The total integration of substance abuse treatment and family-based approaches throughout the organization, its policies, and program practices is a challenge at all levels. Ideally, best practice is formed from evidence-based, family-supported therapeutic modalities that have been replicated across a variety of populations, have been evaluated rigorously, and are monitored for adherence. Culturally competent practices are present throughout the organization, its policies, practices, and procedures at this level. In the course of substance abuse treatment and family therapy, close attention is paid to racial and ethnic influences, class, gender, and spiritual values.

Agency administrators prioritize the integration of families into substance abuse treatment and identify model(s) and therapeutic interventions that best address community needs. Throughout the agency, the staff has a thorough understanding of how family will be engaged in the substance abuse treatment and family therapy processes, and implementation of treatment is well coordinated.

A comprehensive range of program activities are available, including

- Screening and assessment for substance abuse and family issues
- Substance abuse treatment
- Family therapy or family-involved interventions
- Information and outreach, using multimedia approaches such as the Internet and videos
- Community partnerships
- Education and psychoeducation
- Therapeutic home-based interventions and family case management services
- Individual and family counseling and parent education
- Process and outcome evaluation

Linkages are established with social services agencies, or those that interact with child welfare agencies, to provide assistance with transportation, housing, health care, food, and childcare. Infrastructural concerns are also addressed, such as the availability and use of physical space; the use of multimedia, including the Internet and videos; and the availability of bilingual informational materials.

With full integration, the notion and practice of informed consent are rigorously implemented and enforced. Fundamentally, this requirement means each family member receives clear, accurate information about what will happen when, or if, they engage in substance abuse treatment and family therapy. Informed consent protects clients before, during, and after treatment. Clients should grant informed consent only when an agreement about treatment objectives has been reached; treatment and available services have been explained; and benefits, risks, possible side effects, and complications are discussed thoroughly (Barker 1998). Clients are also informed of the potential risks of forgoing services, possible alternatives to proposed treatment, and information that links evidence-based support with various services (Marsh 2001). In family therapy, each competent participant gives informed consent for therapy to proceed (Barker 1998).

Confidentiality extends to all individuals in treatment. Exceptions include the need to reveal information to protect clients from harm (such as suicide, homicide, and physical and sexual abuse). Every agency is required to have a formal confidentiality policy to avoid violations of laws, statutes, and accreditation requirements. Policies are also subject to outside mandates. Those agencies that receive Federal funding must comply with Federal regulations, or 42 C.F.R., Part 2, which guarantees strict confidentiality of information about people who have been in treatment for substance abuse. Participant-identifying information must not be disclosed either to other participants (including family members) or to other service providers without a specific release form that complies with the regulations. Program staff may disclose confidential information to other staff members in the same program if it is necessary for the provision of treatment. The regulations stipulate exceptions to the prohibition on disclosure, including medical emergencies, mandated reports of child abuse or neglect, and, in States that mandate it, elder abuse and neglect. The balance between individual needs and those of family members can often turn individual family members against each other during conflict. If staff members are required to divulge such information, all family members should be informed of agency policy and practices.

Issues for staff and trainers

At this level, all staff—from the receptionist to the executive director—are trained about the important role of the family as a positive influence in the substance abuse treatment process. They have varying degrees of familiarity with the models described in chapter 4. Clinical staff are trained more thoroughly in the tools and techniques of traditional family therapy and multisystemic approaches, public speaking and presentation skills, the relationship between substance abuse and families and partners, and relating with the surrounding ecosystem.

Staff understand the cultural, social, political, and economic forces that affect the various racial and ethnic groups (CSAT 1999*b*). A culturally competent model of substance abuse treatment and family therapy addresses the sociocultural factors affecting substance abuse patterns among members of various racial and ethnic groups as a crucial prerequisite in providing adequate treatment (CSAT 1999*b*). From this perspective, adequate treatment is characterized by

- Staff knowledge of the native language of the client, whenever possible
- Staff sensitivity to the cultures of the client populations
- Staff backgrounds representative of those of the client population

Staff are trained in culturally competent strategies that promote respect and dignity for clients and encourage them to discuss issues without inhibition or fear of termination.

At this level, all substance abuse counselors are certified and clinicians are licensed family therapists or licensed professionals with advanced training in family therapy. Continuing education about various approaches to family work and substance abuse treatment is necessary and supported. Ongoing training in other topics such as domestic violence, child abuse and neglect, elder abuse and neglect, posttraumatic stress disorder, and cardiopulmonary resuscitation is also recommended. All staff members are cross-trained in family-based approaches and substance abuse treatment.

Clinical supervisors are licensed family therapists or have completed advanced specialized training and coordinate the work in substance abuse treatment and family therapy. Supervisors should have specific experience in family-based modalities and family therapy. Supervisors also need to be informed about a range of auxiliary topics, including childcare, liability concerns related to children, provision of space, and documentation.

Other Program Considerations

Cultural Competence

An organizational culture that is infused with the values of cultural competence and diversity on every level will highlight and implement such values concretely in staffing patterns, language, and cultural issues related to families and substance abuse. Concerted efforts should be made to hire staff and build an organizational culture that reflects the diversity of the client populations served. Program assessments are achieved by exploring institutional assumptions regarding services for specific racial and ethnic communities. This information is used to reduce bias resulting from institutional misperceptions and cultural ignorance or inexperience. For more information about cultural competence, including organizational cultural competence, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development *b*).

Outcome Evaluation Procedures and Reports

Some outcome evaluation procedures include the development of standard measures to determine the treatment program's efficacy; data collection and database development, which generally require more intensive procedures; and the examination of the relationship between utilization and outcome for every family member treated.

To determine the substance abuse treatment program's efficacy, tracking procedures can be used to record the number of clients returning to the workforce, those involved with medical service providers, and whether treatment correlates with a reduction in the number of client arrests.

Outcomes for family members are examined by the relationship between utilization and outcome, the number of times the client and family members were seen, and the relationship to outcomes. Because the treatment program is in-house, utilization rates can be monitored closely.

Culturally competent evaluation plays a significant role in facilitating outcome evaluation. To be effective, culturally competent evaluation relies heavily on an in-depth understanding of the role that culture plays in substance abuse (Cervantes and Pena 1998). Evaluators should incorporate cultural factors such as acculturation, language, family values, and community attitudes into evaluation design (Cervantes and Pena 1998). Additionally, culturally relevant instruments are critical to the overall evaluation effort. Knowledge of the sociocultural, demographic, and psychological factors specific to the cultural group is necessary. If the evaluation design does not include cultural differences, incorrect conclusions may be drawn about program effectiveness (Cervantes and Pena 1998). An understanding of risk and protective factors as they relate to culture is important in evaluation efforts as well as understanding resiliency factors in a culture.

Long-Term Followup

Monitoring rearrests, recidivism, and readmission to substance abuse treatment programs can serve as measures of long-term functioning. Collection of long-term followup data is difficult and rare in healthcare treatment research in general, and especially in the substance abuse field. Vaillant (1995) provides family related outcome measures such as marital happiness. Though Hser et al. (2001) present significant long-term research outcomes in narcotics treatment, the consensus panel knows of no such long-term followup with a focus on family.

Directions for Future Research

Since its advent in the 1950s, family therapy has been characterized as having theoretical roots that are anecdotal, intuitive, and empirical, rather than scientific (Barker 1998). That opinion may stem mainly from (1) the separation between researcher and therapist, which exists in all mental health disciplines, and (2) the development of family therapy as an outgrowth of studies conducted on family research into schizophrenia, the mostly unscientific results of which were then extrapolated to a wider range of family problems (Barker 1998). In the absence of a well-articulated conceptual framework, it is impossible to draw definitive conclusions about the efficacy of family therapy (Collins 1990). Research in several areas could serve to address this issue.

New Treatment and Therapy Models

Many advances are being made in the field of family-based treatment for adolescent drug abuse that can serve as pilot models for adult treatment. One valuable insight has been the general shift from focusing exclusively on individual or family variables to change or improve treatment outcomes for adolescents and adults to more complex, multicomponent interventions that incorporate more dimensions and domains in and outside the family (Liddle and Dakof 1995*a*). This movement has culminated in the perspective that multicomponent, comprehensive, community-based, multisystemic approaches must be supported to reap the best outcomes. Ideally, such comprehensive coordinated efforts can be meshed with other related ones—domestic violence, for example—to develop a coordinated community response to a variety of issues that can fit well with multisystemic responses to substance abuse and family involvement. Unfortunately, within the family therapy and family-focused intervention domains, the need for more comprehensive strategies is often outweighed by the complexity of making them viable and implementing them within communities. Cultural and linguistic barriers and a lack of trained bilingual and bicultural staff make this task even more challenging.

Another possible research area relates to the critical need to describe, measure, and report on the process of therapy itself. Investigators would have to make sure that the therapy methods chosen are actually being implemented, making it possible to determine outcomes and identify reliable, therapeutic methods that can help families make desirable changes. As newer forms of family therapy emerge, it is unknown whether radically new approaches to research will be required.

Assessment and Classification

A second area for future research is in the assessment and classification process used to determine the type, duration, and intensity of family therapy. Currently, no valid, reliable, acceptable way to categorize families by the way they interact has emerged (Barker 1998). Developing one has been difficult primarily because the diversity of families defies easy categorization. Blended families, gay and lesbian families, adoptive families, as well as those with divergent religious beliefs and cultural norms and values, are just a few variations (Barker 1998). Despite attempts at categorization, classifications have relied typically on uncritical understandings of developmental models that purport to designate the particular stage families *should have* reached, based on the ages of children and the stage the family *has* reached (Barker 1998).

Classical definitions notwithstanding, what researchers and therapists need to classify and assess are *relationships* and the measurement of change in relationships in valid, reliable ways. Should success be measured in terms of the presenting problem of the client or in terms of the change in the family system? Specifying the goals and interventions used would permit clearer comparisons of the two approaches (Collins 1990). Further, how do culturally competent understanding and values regarding the role of families figure into traditional models of family development? The need for more explicit categorizations and assessment methods must be addressed.

Outcome Measurement

A third research area concerns the need for outcome research. Many researchers have proposed guidelines for the design of family therapy research, including the need for studies to have clinical relevance, standardized treatment manuals, and resolve the debate between the reliability of comparative studies and "within-model comparisons" (Barker 1998). Collins (1990) recommends consideration of objective outcomes (not just self-reported information) and the measurement of a wide range of outcomes, such as the ability to hold a job, manage finances, or stay married.

Prevention

Prevention strategy is another area that holds promise for future research. A small but growing number of programs are testing whether family-based interventions can serve as prevention or early intervention strategies (particularly with problem drinking). Family therapy researchers could benefit from more clearly defining what a healthy family is as much as what a dysfunctional family is. All these efforts are important in exploring whether preventive strategies can improve family functioning and prevent family pathology. Prevention opportunities exist in schools (truancy, deviant behaviors, expulsion), in the workplace (poor attendance, identified mental health and substance abuse problems), and in churches (families might ask for help around a specific family problem from a pastor, priest, or other spiritual leader).

Technology

A fifth research area relates to technological advances that have the potential to benefit substance abuse treatment efforts, namely the Internet and e-mail. King and colleagues (1998) explored the use of the Internet as a tool to assist family therapy, especially where family members are geographically separated. The researchers also studied the potential value and use of e-mail and writing to facilitate family therapy.

The advantages of e-mail communication in family therapy include allowing family members to contribute whenever their schedules permit, delay responses until they have been fully thought out, and create a permanent record, which reduces the risk of misunderstanding. One drawback for e-mail communication is possible misinterpretation due to lack of tonal cues. Other uses of writing in family therapy include personal narrative, programmed writing, and letter writing, all of which can be communicated via e-mail. The use of e-mail may make family therapy possible at times when it would otherwise not be feasible.

Another key element that is being used is remote telemedicine. This use of cameras and monitors has been an excellent way to overcome some of the barriers in rural areas where both coverage and transportation have in the past prevented consistent involvement in treatment.

Additional Possibilities

Clear information is also needed in the following areas:

- How effective are various approaches to family therapy in substance abuse treatment?
- How should family therapy be tailored to be appropriate with specific populations?
- How do agencies increase the rate of engagement of families? What role does cultural competence play in the engagement and retention of clients?
- Does the classic family therapy model fit across ethnic groups? If not, what are more feasible options?
- How can competence with families be developed?
- How can the resources of families and communities be identified and mobilized?
- What family differences are important in the treatment of youth, adults, and specifically children?
- What kinds of research and models can increase our understanding of the family role in relapse?
- How will these efforts be funded?
- What changes need to take place for both private and public payment of these services?

The oversimplification of the above might lead some readers to feel as if there is a wide gap between family therapy and substance abuse treatment and that it is a giant leap to move from doing one to doing the other. However, this is not the case. Many people have amended and augmented their customary way of doing their job with input from the other field, and it is certainly not the intent of this TIP to leave the reader with the idea that drawing from the other field requires great change or effort. Rather, the exact opposite is the goal.

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Appendix A: Bibliography

Alcoholics Anonymous World Services. *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*. 3d ed. New York: Alcoholics Anonymous World Services, 1976.

Alexander D.E., Gwyther R.E. Alcoholism in adolescents and their families: Family-focused assessment and management.
Pediatric Clinics of North America. 1995; 42(1): 217–234. [PubMed]

Alexander, J., and Parsons, B.V. *Functional Family Therapy*. Monterey, CA: Brooks/Cole Pub. Co., 1982.

Alexander, J., Waldon, H.B., Newberry, A.M., and Liddle, N. The Functional Family Therapy model. In: Friedman, A.S., and Granick, S., eds. *Family Therapy for Adolescent Drug Abuse*. Lexington, MA: Lexington Books/D.C. Heath and Company, 1990. pp. 183–199.

Alexander J.F., Robbins M.S., Sexton T.L. Family-based interventions with older, at risk youth: From promise to proof to practice.
The Journal of Primary Prevention. 2000; 21(2): 185–205.

Amaro H., Hardy-Fanta C. Gender relations in addiction and recovery.
Journal of Psychoactive Drugs. 1995; 27(4): 325–337. [PubMed]

American Academy of Pediatrics. Inhalant abuse. *Pediatrics* 97(3):420–423, 1996. http://www.aap.org/policy/re9609.html [Accessed February 11, 2004].

American, Academy of Pediatrics.Alcohol use and abuse: A pediatric concern.
Pediatrics. 2001; 108(1): 185–189. [PubMed]

American Association for Marriage and Family Therapy. *Marriage and Family Therapy Licensing and Certification: Directory of State MFT Licensing/Certification Boards*. Alexandria, VA: American Association for Marriage and Family Therapy, 2001. http://www.aamft.org/resources/Online_Directories/boardcontacts.htm [Accessed February 11, 2004].

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th Text Revision ed. Washington, DC: American Psychiatric Association, 2000.

Anderson, J.Z. Stepfamilies and substance abuse: Unique treatment considerations. In: Kaufman, E., and Kaufmann, P., eds. *Family Therapy of Drug and Alcohol Abuse*. 2d ed. Boston: Allyn and Bacon, 1992. pp. 172–189.

Aponte, H.J., and Van Dusen, J.M. Structural family therapy. In: Gurman, A.S., and Kniskern, D.P., eds. *Handbook of Family Therapy: Vol. 1*. New York: Brunner/Mazel, 1981. pp. 310–358.

Ariel J., McPherson D.W. Therapy with lesbian and gay parents and their children.

Journal of Marital and Family Therapy. 2000; 26(4): 421–432. [PubMed]

Atkinson R.M., Tolson R.L., Turner J.A. Late versus early onset problem drinking in older men. *Alcoholism: Clinical and Experimental Research.* 1990; 14(4): 574–579.

Attneave, C. American Indians and Alaska Native families: Emigrants in their own homeland. In: McGoldrick, M., Pearce, J.K., and Giordano, J., eds. *Ethnicity and Family Therapy*. New York: Guilford Press, 1982. pp. 55–83.

Azrin N.H. Improvements in the community-reinforcement approach to alcoholism. *Behaviour Research and Therapy.* 1976; 14(5): 339–348. [PubMed]

Azrin N.H., Donohue B., Besalel V.A., Kogan E.S., Acierno R. Youth drug abuse treatment: A controlled outcome study.
Journal of Child and Adolescent Substance Abuse. 1994; 3(3): 1–16.

Azrin N.H., Donohue B., Teichner G.A., Crum T., Howell J., DeCato L.A. A controlled evaluation and description of individual-cognitive problem solving and family-behavior therapies in dually-diagnosed, conduct-disordered and substance-dependent youth. *Journal of Child and Adolescent Substance Abuse.* 2001; 11(1): 1–43.

Azrin N.H., Sisson R.W., Meyers R., Godley M. Alcoholism treatment by disulfiram and community reinforcement therapy.
Journal of Behavior Therapy and Experimental Psychiatry. 1982; 13(2): 105–112. [PubMed]

Bagarozzi D.A. The family therapist's role in treating families in rural communities: A general systems approach. *Journal of Marital and Family Therapy.* 1982; 8(2): 51–58.

Barker, P. *Basic Family Therapy*. 4th ed. Oxford: Blackwell Science Ltd, 1998.

Barnes, J.S., and Bennett, C.E. *The Asian Population: 2000*. Census 2000 Brief. Washington, DC: U.S. Census Bureau, 2002. http://www.census.gov/prod/2002pubs /c2kbr01-16.pdf [Accessed February 11, 2004].

Barrett M.S., Berman J.S. Is psychotherapy more effective when therapists disclose information about themselves?
Journal of Consulting and Clinical Psychology. 2001; 69(4): 597–603. [PubMed]

Bavolek, S.J. *Alcohol, Anger and Abuse: Understanding the Relationship Between Alcohol and Other Drug Abuse, and Child Abuse and Neglect.* Park City, UT: Family Development Resources, 1995.

Bays J. Substance abuse and child abuse: Impact of addiction on the child.
Pediatric Clinics of North America. 1990; 37(4): 881–904. [PubMed]

Beauvais F. The consequences of drug and alcohol use for Indian youth.
American Indian and Alaska Native Mental Health Research. 1992; 5(1): 32–37. [PubMed]

Beck, A.T. *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press, 1976.

Beels C.C. Notes for a cultural history of family therapy.
Family Process. 2002; 41(1): 67–82. [PubMed]

Bengtson V.L. Beyond the nuclear family: The increasing importance of multigenerational bonds. *Journal of Marriage and the Family.* 2001; 63(1): 1–17.

Bepko C., Johnson T. Gay and lesbian couples in therapy: Perspectives for the contemporary family therapist.
Journal of Marital and Family Therapy. 2000; 26(4): 409–419. [PubMed]

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

Berenson D. Family approach to alcoholism. *Psychiatric Opinion.* 1976; 13(1): 33–38.

Berenson, D., and Schrier, E.W. Current family treatment approaches. In: Graham, A.W., Schultz, T.K., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 2d ed. Chevy Chase, MD: American Society of Addiction Medicine, 1998. pp. 1115–1125.

Berg, I.K. Solution-focused brief therapy with substance abusers: In: Washton, A.M., ed. *Psychotherapy and Substance Abuse: A Practitioner's Handbook.* New York: Guilford Press, 1995. pp. 223–242.

Berg, I.K., and Miller, S.D. *Working with the Problem Drinker: A Solution-Focused Approach*. New York: W.W. Norton, 1992.

Berg, I.K., and Reuss, N. *Solutions Step-By-Step: A Substance Abuse Treatment Manual*. New York: W.W. Norton, 1997.

Bernstein A.C. Straight therapists working with lesbians and gays in family therapy. *Journal of Marital and Family Therapy.* 2000; 26(4): 443–455. [PubMed]

Bhattacharya G. Drug use among Asian-Indian adolescents: Identifying protective/risk factors. *Adolescence.* 1998; 33(129): 169–184. [PubMed]

Bianchi S.M., Casper L.M. American families. *Population Bulletin.* 2000; 55(4): 3–42.

Bijur P.E., Kurzon M., Overpeck M.D., Scheidt P.C. Parental alcohol use, problem drinking, and children's injuries.
Journal of the American Medical Association. 1992; 267: 3166–3171. [PubMed]

Blum K., Braverman E.R., Holder J.M., Lubar J.F., Monastra V.J., Miller D., Lubar J.O., Chen T.J., Comings D.E. Reward deficiency syndrome: A biogenetic model for the diagnosis and treatment of impulsive, addictive, and compulsive behaviors.
Journal of Psychoactive Drugs. 2000; 32(Suppl): 1–112.

Bowen M. Alcoholism as viewed through family systems theory and family psychotherapy. *Annals of the New York Academy of Sciences.* 1974; 233: 115–122. [PubMed]

Bowen, M. *Family Therapy in Clinical Practice.* New York: Jason Aronson, 1978.

Boyd M.R., Mackey M.C. Alienation from self and others: The psychosocial problem of rural alcoholic women. *Archives of Psychiatric Nursing.* 2000; 14(3): 134–141. [PubMed]

Boyd-Franklin, N. *Black Families in Therapy: A Multisystems Approach*. New York: Guilford Press, 1989.

Brady K.T., Randall C.L. Gender differences in substance use disorders. *Psychiatric Clinics of North America.* 1999; 22(2): 241–252. [PubMed]

Brandl B., Horan D.L. Domestic violence in later life: An overview for health care providers. *Women & Health.* 2002; 35(2-3): 41–54.

Bratton, S., Ray, D., Rhine, T., and Jones, L. *A Meta-Analysis of the Play Therapy Outcome Research from 1947 to the Present: A Brief Summary*. Fresno, CA: Association for Play Therapy, n.d. http://www.a4pt.org/Meta-Analysis_Summary.doc [Accessed February 11, 2004].

Brook, D.W., and Brook, J.S. Family processes associated with alcohol and drug use and abuse. In: Kaufman, E., and Kaufmann, P., eds. *Family Therapy of Drug and Alcohol Abuse*. 2d ed. Boston: Allyn and Bacon, 1992. pp. 15–33.

Brooks, C., and Rice, K.F. *Families in Recovery: Coming Full Circle*. Baltimore: Paul H. Brookes Publishing, 1997.

Brown, S. and Lewis, V. *The Alcoholic Family in Recovery: A Developmental Model.* New York: Guilford Press, 1999.

Brown T.G., Kokin M., Seraganian P., Shields N. The role of spouses of substance abusers in treatment: Gender differences. *Journal of Psychoactive Drugs.* 1995; 27(3): 223–229. [PubMed]

Brucker P.S., Perry B.J. American Indians: Presenting concerns and considerations for family therapists. *American Journal of Family Therapy.* 1998; 26(4): 307–320.

Bry B.H. Substance abuse in women: Etiology and prevention. *Issues in Mental Health Nursing.* 1983; 5(1-4): 253–272. [PubMed]

Bucholz, K.K., Sheline, Y., and Helzer, J.E. The epidemiology of alcohol use, problems, and dependence in elders: A review. In: Beresford, T.P., and Gomberg, E., eds. *Alcohol and Aging*. New York: Oxford University Press, 1995. pp. 19–41.

Bukstein O.G. Disruptive behavior disorders and substance use disorders in adolescents. *Journal of Psychoactive Drugs.* 2000; 32(1): 67–79. [PubMed]

Bushy, A. Mental health and substance abuse: Challenges in providing services to rural clients. In: Center for Substance Abuse Treatment, ed. *Bringing Excellence to Substance Abuse Services in Rural and Frontier America*. Technical Assistance Publication Series 20. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997. pp. 45–53.

Caetano R., Clark C.L., Tam T. Alcohol consumption among racial/ethnic minorities: Theory and research. *Alcohol Health and Research World.* 1998; 22(4): 233–238. [PubMed]

Casado-Flores J., Bano-Rodrigo A., Romero E. Social and medical problems in children of heroin-addicted parents: A study of 75 patients. *American Journal of Diseases of Children.* 1990; 144: 977–979. [PubMed]

Catalano R.F., Gainey R.R., Fleming C.B., Haggerty K.P., Johnson N.O. An experimental intervention with families of substance abusers: One-year follow-up of the Focus on Families Project. *Addiction.* 1999; 94(2): 241–254. [PubMed]

Celano M.P., Kaslow N.J. Culturally competent family interventions: Review and case illustrations. *American Journal of Family Therapy.* 2000; 28: 217–228.

Center for Substance Abuse Treatment. *Improving Treatment for Drug-Exposed Infants.* Treatment Improvement Protocol (TIP) Series 5. DHHS Publication No. (SMA) 95-3057. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993*a*.

Center for Substance Abuse Treatment. *Pregnant, Substance-Using Women*. Treatment Improvement Protocol (TIP) Series 2. DHHS Publication No. (SMA) 93-1998. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993*b*.

Center for Substance Abuse Treatment. *Screening for Infectious Diseases Among Substance Abusers*. Treatment Improvement Protocol (TIP) Series 6. DHHS Publication No. (SMA) 95-3060. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993*c*.

Center for Substance Abuse Treatment. *State Methadone Treatment Guidelines*. Treatment Improvement Protocol (TIP) Series 1. DHHS Publication No. (SMA) 93-1991. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993*d*.

Center for Substance Abuse Treatment. *Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients.* Treatment Improvement Protocol (TIP) Series 10. DHHS Publication No. (SMA) 94-3003. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*a*.

Center for Substance Abuse Treatment. *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse*. Treatment Improvement Protocol (TIP) Series 9. DHHS Publication No. (SMA) 95-3061. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*b*.

Center for Substance Abuse Treatment. *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 12. DHHS Publication No. (SMA) 94-3004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*c*.

Center for Substance Abuse Treatment. *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse.* Treatment Improvement Protocol (TIP) Series 8. DHHS Publication No. (SMA) 99-3306. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*d*.

Center for Substance Abuse Treatment. *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 00-3477. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*e*.

Center for Substance Abuse Treatment. *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases.* Treatment Improvement Protocol (TIP) Series 11. DHHS Publication No. (SMA) 94-2094. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*f*.

Center for Substance Abuse Treatment. *Alcohol and Other Drug Screening of Hospitalized Trauma Patients.* Treatment Improvement Protocol (TIP) Series 16. DHHS Publication No. (SMA) 95-3041. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*a*.

Center for Substance Abuse Treatment. *Combining Alcohol and Other Drug Treatment with Diversion for Juveniles in the Justice System*. Treatment Improvement Protocol (TIP) Series 21. DHHS Publication No. (SMA) 95-3051. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*b*.

Center for Substance Abuse Treatment. *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 14. DHHS Publication No. (SMA) 95-3031. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*c*.

Center for Substance Abuse Treatment. *Detoxification from Alcohol and Other Drugs.* Treatment Improvement Protocol (TIP) Series 19. DHHS Publication No. (SMA) 95-3046. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*d*.

Center for Substance Abuse Treatment. *LAAM in the Treatment of Opiate Addiction.* Treatment Improvement Protocol (TIP) Series 22. DHHS Publication No. (SMA) 95-3052. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*e*.

Center for Substance Abuse Treatment. *Matching Treatment to Patient Needs in Opioid Substitution Therapy.* Treatment Improvement Protocol (TIP) Series 20. DHHS Publication No. (SMA) 95-3049. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*f*.

Center for Substance Abuse Treatment. *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System*. Treatment Improvement Protocol (TIP) Series 17. DHHS Publication No. (SMA) 95-3039. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*g*.

Center for Substance Abuse Treatment. *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 13. DHHS Publication No. (SMA) 95-3021. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*h*.

Center for Substance Abuse Treatment. *The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers.* Treatment Improvement Protocol (TIP) Series 18. DHHS Publication No. (SMA) 95-3047. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*i*.

Center for Substance Abuse Treatment. *Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance.* Technical Assistance Publication Series 18. DHHS Publication No. (SMA) 99-3321. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996*a*.

Center for Substance Abuse Treatment. *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing.* Treatment Improvement Protocol (TIP) Series 23. DHHS Publication No. (SMA) 96-3113. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996*b*.

Center for Substance Abuse Treatment. *A Guide to Substance Abuse Services for Primary Care Clinicians*. Treatment Improvement Protocol (TIP) Series 24. DHHS Publication No. (SMA) 97-3139. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997*a*.

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Domestic Violence.* Treatment Improvement Protocol (TIP) Series 25. DHHS Publication No. (SMA) 97-3163. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997*b*.

Center for Substance Abuse Treatment. *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98-3222. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*a*.

Center for Substance Abuse Treatment. *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community*. Treatment Improvement Protocol (TIP) Series 30. DHHS Publication No. (SMA) 98-3245. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*b*.

Center for Substance Abuse Treatment. *Naltrexone and Alcoholism Treatment*. Treatment Improvement Protocol (TIP) Series 28. DHHS Publication No. (SMA) 98-3206. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*c*.

Center for Substance Abuse Treatment. *Substance Abuse Among Older Adults*. Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98-3179. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*d*.

Center for Substance Abuse Treatment. *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities*. Treatment Improvement Protocol (TIP) Series 29. DHHS Publication No. (SMA) 98-3249. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*e*.

Center for Substance Abuse Treatment. *Brief Interventions and Brief Therapies for Substance Abuse.* Treatment Improvement Protocol (TIP) Series 34. DHHS Publication No. (SMA) 99-3353. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*a*.

Center for Substance Abuse Treatment. *Enhancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 35. DHHS Publication No. (SMA) 99-3354. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*b*.

Center for Substance Abuse Treatment. *Screening and Assessing Adolescents for Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31. DHHS Publication No. (SMA) 99-3282. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*c*.

Center for Substance Abuse Treatment. *Treatment for Stimulant Use Disorders.* Treatment Improvement Protocol (TIP) Series 33. DHHS Publication No. (SMA) 99-3296. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*d*.

Center for Substance Abuse Treatment. *Treatment of Adolescents With Substance Use Disorders*. Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA) 99-3283. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*e*.

Center for Substance Abuse Treatment. *Integrating Substance Abuse Treatment and Vocational Services*. Treatment Improvement Protocol (TIP) Series 38. DHHS Publication No. (SMA) 00-3470. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*a*.

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues*. Treatment Improvement Protocol (TIP) Series 36. DHHS Publication No. (SMA) 00-3357. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*b*.

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With HIV/AIDS*. Treatment Improvement Protocol (TIP) Series 37. DHHS Publication No. (SMA) 00-3459. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*c*.

Center for Substance Abuse Treatment. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.* DHHS Publication No. (SMA) 01-3498. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

Center for Substance Abuse Treatment. *Detoxification and Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *a*.

Center for Substance Abuse Treatment. *Improving Cultural Competence in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *b*.

Center for Substance Abuse Treatment. *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *c*.

Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction*. Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *d*.

Center for Substance Abuse Treatment. *Substance Abuse Treatment: Addressing the Specific Needs of Women.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *e*.

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Family Therapy.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *f* .

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Group Therapy.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *g*.

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Men's Issues.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *h*.

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Trauma.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *i*.

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *j.*

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons with Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *k.*

Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report.* 13(1):1–41. Atlanta, GA: Centers for Disease Control and Prevention, 2002. http://www.cdc.gov/hiv/stats/hasr1301.pdf [Accessed February 11, 2004].

Cermak, T.L. *Evaluating and Treating Adult Children of Alcoholics: Volume 2, Treatment (Professional Series).* Minneapolis: The Johnson Institute, 1991.

Cervantes, R.C., and Pena, C. Evaluating Hispanic/Latino programs: Ensuring cultural competence. In: Delgado, M., ed. *Alcohol Use/Abuse Among Latinos: Issues and Examples of Culturally Competent Services.* Binghamton, NY: Haworth Press, 1998. pp. 109–131.

Chaney, R.A., and White, W.L. *Metaphors of Transformation: Feminine and Masculine.* Bloomington, IL: Chestnut Health Systems, 1992.

Chang, P. Treating Asian/Pacific American addicts and their families. In: Krestan, J.-A., ed. *Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment.* New York: Free Press, 2000. pp. 192–218.

Chien, C.P., and Yamamoto, J. Asian American and Pacific Islander patients. In: Acosta, F.X., Yamamoto, J., and Evans, L.A., eds. *Effective Psychotherapy for Low-Income and Minority Patients.* New York: Plenum Press, 1982. pp. 117–145.

Choney, S.K., Berryhill-Paapke, E., and Robbins, R.R. The acculturation of American Indians: Developing frameworks for research and practice. In: Ponterotto, J.G., Casas, J.M., Suzuki, L.A., and Alexander, C.M., eds. *Handbook of Multicultural Counseling.* Thousand Oaks, CA: Sage Publications, 1995. pp. 73–92.

Clay R.A. SAMHSA launches buprenorphine education initiative. *SAMHSA News.* 2003; 11(1): 3.

Cloninger, C.R. Genetics of substance abuse. In: Galanter, M., and Kleber, H.D., eds. *Textbook of Substance Abuse Treatment.* 2d ed. Washington, DC: American Psychiatric Press, 1999. pp. 59–66.

Coco E.L., Courtney L.J. A family systems approach for preventing adolescent runaway behavior. *Adolescence.* 1998; 33(130): 485–496. [PubMed]

Co-Dependents Anonymous. *Patterns and Characteristics of Codependence.* Phoenix, AZ: Co-Dependents Anonymous, 1998. http://www.codependents.org/codapatt.html [Accessed February 11, 2004].

Cohen P., Cohen J., Kasen S., Velez C.N., Hartmark C., Johnson J., Rojas M., Brook J., Streuning E.L. An epidemiological study of disorders in late childhood and adolescence: I. Age- and gender-specific prevalence. *Journal of Child Psychology and Psychiatry.* 1993; 34(6): 851–867. [PubMed]

Collins, R.L. Family treatment of alcohol abuse: Behavioral and systems perspectives. In: Collins, R.L., Leonard, K.E., and Searles, J.S., eds. *Alcohol and the Family: Research and Clinical Perspectives*. New York: Guilford Press, 1990. pp. 285–308.

Conner K.R., Shea R.R., McDermott M.P., Grolling R., Tocco R.V., Baciewicz G. The role of multifamily therapy in promoting retention in treatment of alcohol and cocaine dependence. *American Journal on Addictions.* 1998; 7(1): 61–73. [PubMed]

Cook, P.S., Petersen, R.C., and Moore, D.T. *Alcohol, Tobacco and Other Drugs May Harm the Unborn*. DHHS Publication No. (ADM) 90-1711. Rockville, MD: Office of Substance Abuse Prevention, 1990.

Cooklin A. Eliciting children's thinking in families and family therapy. *Family Process.* 2001; 40(3): 293–312. [PubMed]

Covington, S.S. Helping women recover: Creating gender-responsive treatment. In: Straussner, S.L.A., and Brown, S., eds. *Handbook of Women's Addiction Treatment: Theory and Practice*. San Francisco: Jossey Bass, 2002. pp. 52–72.

Coyhis, D. Culturally specific addiction recovery for Native Americans. In: Krestan, J., ed. *Bridges To Recovery: Addiction, Family Therapy, and Multicultural Treatment*. New York: The Free Press, 2000. pp. 77–114.

Cuadrado M., Lieberman L. Traditionalism in the prevention of substance misuse among Puerto Ricans. *Substance Use and Misuse.* 1998; 33(14): 2737–2755. [PubMed]

Cunningham P.B., Henggeler S.W. Engaging multiproblem families in treatment: Lessons learned throughout the development of multisystemic therapy. *Family Process.* 1999; 38(3): 265–281. [PubMed]

Cutler D.L., Madore E. Community-family network therapy in a rural setting. *Community Mental Health Journal.* 1980; 16(2): 144–155. [PubMed]

De Jong, P., and Berg, I.K. *Interviewing for Solutions*. Stamford, CT: Brooks/Cole, 1997.

De Leon, G. Therapeutic communities. In: Galanter, M., and Kleber, H.D., eds. *Textbook of Substance Abuse Treatment*. 2d ed. Washington, DC: American Psychiatric Press, 1999. pp. 447–462.

DeLoach, C., and Greer, B.G. *Adjustment to Severe Physical Disability: A Metamorphosis*. New York: McGraw Hill, 1981.

de Shazer, S. *Clues: Investigating Solutions in Brief Therapy*. New York: W.W. Norton, 1988.

de Shazer, S. *Putting Difference to Work*. New York: W.W. Norton, 1991.

de Shazer S. Some thoughts on language use in therapy. *Contemporary Family Therapy.* 1997; 19(1): 133–141.

Diamond G., Liddle H.A. Resolving a therapeutic impasse between parents and adolescents in multidimensional family therapy. *Journal of Consulting and Clinical Psychology.* 1996; 64(3): 481–488. [PubMed]

Diamond G.S., Serrano A.C., Dickey M., Sonis W.A. Current status of family-based

outcome and process research.
American Academy of Child and Adolescent Psychiatry Journal. 1996; 35(1): 6–16.

Diaz-Guerrero, R. *Psychology of the Mexican: Culture and Personality*. Austin, TX: University of Texas Press, 1975.

Doherty W.J., Baird M.A. Developmental levels in family-centered medical care.
Family Medicine. 1986; 18(3): 153–156. [PubMed]

Douyon R., Guzman P., Romain G., reland S.J., Mendoza L., Lopez-Blanco M., Milanes F. Subtle neurological deficits and psychopathological findings in substance-abusing homeless and non-homeless veterans.
Journal of Neuropsychiatry & Clinical Neurosciences. 1998; 10(2): 210–215. [PubMed]

Drake R.E., McHugo G.J., Clark R.E., Teague G.B., Xie H., Miles K., Ackerson T.H. Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial.
American Journal of Orthopsychiatry. 1998; 68(2): 201–215. [PubMed]

Dufour M., Fuller R.K. Alcohol in the elderly.
Annual Reviews of Medicine. 1995; 46: 123–132.

Duran, E., and Duran, B. *Native American Postcolonial Psychology*. Albany, NY: State University of New York Press, 1995.

Edwards M.E., Steinglass P. Family therapy treatment outcomes for alcoholism.
Journal of Marital and Family Therapy. 1995; 21(4): 475–509.

Edwards, R.W. Drug and alcohol use among youth in rural communities. In: Robertson, E.B., Sloboda, Z., Boyd, G.M., Beatty, L., and Kozel, N.J., eds. *Rural Substance Abuse: State of Knowledge and Issues*. NIDA Research Monograph 168. NIH Publication No. 97-4177. Rockville, MD: National Institute on Drug Abuse, 1997. pp. 53–78.

Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov 17-19. 1997. http://consensus.nih.gov/cons/108/108_statement.pdf [Accessed February 11, 2004].

Epstein, E.E., and McCrady, B.S. Couple therapy in the treatment of alcohol problems. In: Gurman, A.S., and Jacobson, N.A., eds. *Clinical Handbook of Couple Therapy*. 3d ed. New York: Guilford Press, 2002.

Falicov, C.J. Mexican families. In: McGoldrick, M., Giordano, J., and Pearce, J.K., eds. *Ethnicity and Family Therapy*. 2d ed. New York: Guilford Press, 1996. pp. 169–182.

Falicov, C.J. *Latino Families in Therapy: A Guide to Multicultural Practice*. New York: Guilford Press, 1998.

Falloon, I.R.H. Behavioral family therapy. In: Gurman, A.S., and Kniskern, D.P., eds. *Handbook of Family Therapy: Vol. 2*. New York: Brunner/Mazel, 1991. pp. 65–95.

Fals-Stewart W., O'Farrell T.J., Birchler G.R. Behavioral couples therapy for male substance-abusing patients: A cost outcomes analysis.
Journal of Consulting and Clinical Psychology. 1997; 65(5): 789–802. [PubMed]

Famularo R., Kinscherff R., Fenton T. Psychiatric diagnoses of abusive mothers: A

preliminary report. *Journal of Nervous and Mental Disease.* 1992; 180(10): 658–661. [PubMed]

Famularo R., Stone K., Barnum R., Wharton R. Alcoholism and severe child maltreatment. *American Journal of Orthopsychiatry.* 1986; 56(3): 481–485. [PubMed]

Fang S.R., Wark L. Developing cross-cultural competence with traditional Chinese Americans in family therapy: Background information and the initial therapeutic contact. *Contemporary Family Therapy: An International Journal.* 1998; 20(1): 59–77.

Favazza A.R., Thompson J.J. Social networks of alcoholics: Some early findings. *Alcoholism: Clinical and Experimental Research.* 1984; 8(1): 9–15.

Fields, J., and Casper, L.M. *America's Families and Living Arrangements: March 2000.* Current Population Reports, P20-537. Washington, DC: U.S. Census Bureau, 2001.

Finkelstein N. Treatment issues for alcohol- and drug-dependent pregnant and parenting women. *Health & Social Work.* 1994; 19(1): 7–15. [PubMed]

Finkelstein, N. Using the relational model as a context for treating pregnant and parenting chemically dependent women. In: Underhill, B.L., and Finnegan, D.G., eds. *Chemical Dependency: Women at Risk.* New York: Harrington Park Press/Haworth Press, 1996. pp. 23–44.

Fisher L., Weihs K.L. Can addressing family relationships improve outcomes in chronic disease? Report of the National Working Group on Family-Based Interventions in Chronic Disease. *Journal of Family Practice.* 2000; 49(6): 561–566. [PubMed]

Fishman, H.C. *Intensive Structural Therapy: Treating Families in Their Social Context.* New York: Basic Books, 1993.

Fishman H.C., Andes F., Knowlton R. Enhancing family therapy: The addition of a community resource specialist.
Journal of Marital and Family Therapy. 2001; 27(1): 111–116. [PubMed]

Friedman A.S., Terras A., Kreisher C. Family and client characteristics as predictors of outpatient treatment outcome for adolescent drug abusers.
Journal of Substance Abuse. 1995; 7(3): 345–356. [PubMed]

Friedman, E.H. Bowen theory and therapy. In: Gurman, A.S., and Kniskern, D.P., eds. *Handbook of Family Therapy: Vol. 2.* New York: Brunner/Mazel, 1991. pp. 134–170.

Furstenberg F. F. The sociology of adolescence and youth in the 1990s: A critical commentary. *Journal of Marriage and the Family.* 2000; 62(4): 896–910.

Galanter, M. *Network Therapy for Alcohol and Drug Abuse: A New Approach in Practice.* New York: Basic Books, 1993.

Garcia-Preto, N. Latino families: An overview. In: McGoldrick, M., Giordano, J., and Pearce, J.K., eds. *Ethnicity and Family Therapy.* 2d ed. New York: Guilford Press, 1996. pp. 141–154.

Gay and Lesbian Medical Association. *Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health.* San Francisco: Gay and Lesbian Medical Association, 2001. http://www.glma.org/policy/hp2010

/PDF/HP2010CDLGBTHealth.pdf [Accessed February 11, 2004].

Gerstein, D.R. Outcome research: Drug abuse. In: Galanter, M., and Kleber, H.D., eds. *Textbook of Substance Abuse Treatment*. 2d ed. Washington, DC: American Psychiatric Press, 1999. pp. 135–147.

Giglio J.J., Kaufman E. The relationship between child and adult psychopathology in children of alcoholics. *International Journal of the Addictions.* 1990; 25(3): 263–290. [PubMed]

Gingerich W.J., Eisengart S. Solution-focused brief therapy: A review of the outcome research. *Family Process.* 2000; 39(4): 477–498. [PubMed]

Glover N.M., Janikowski T.P., Benshoff J.J. The incidence of incest histories among clients receiving substance abuse treatment.
Journal of Counseling and Development. 1995; 73(4): 475–480.

Goldberg M.E., Lex B.W., Mello N.K., Mendelson J.H., Bower T.A. Impact of maternal alcoholism on separation of children from their mothers: Findings from a sample of incarcerated women. *American Journal of Orthopsychiatry.* 1996; 66(2): 228–238. [PubMed]

Gomberg E.S. Older women and alcohol: Use and abuse.
Recent Developments in Alcoholism. 1995; 12(4): 61–79. [PubMed]

Goyer P.F., Davis G.C., Rapoport J.L. Abuse of prescribed stimulant medication by a 13-year-old hyperactive boy.
Journal of the American Academy of Child Psychiatry. 1979; 18(1): 170–175. [PubMed]

Green R.J. Introduction to special section: Lesbian, gay, and bisexual issues in family therapy. *Journal of Marital and Family Therapy.* 2000; 26(4): 407–408.

Grieco, E.M. *The Native Hawaiian and Other Pacific Islander Population: 2000*. Census 2000 Brief. Washington, DC: U.S. Census Bureau, 2001. http://www.census.gov /prod/2001pubs/c2kbr01-14.pdf [Accessed February 11, 2004].

Guiao I.Z., Esparza D. Family interventions with "troubled" Mexican American teens: An extrapolation from a review of the literature.
Issues in Mental Health Nursing. 1997; 18(3): 191–207. [PubMed]

Guthmann-Ternus, D.S. "An Analysis of Variables That Impact Treatment Outcomes of Chemically Dependent Deaf and Hard of Hearing Individuals." Ed.D. dissertation, University of Minnesota, Minneapolis, MN, 1995.

Harris-Hastick, E.F. Substance abuse issues among English-speaking Caribbean people of African ancestry. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment*. New York: Guilford Press, 2001. pp. 52–74.

Heath, 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.

Henggeler S.W., Pickrel S.G., Brondino M.J., Crouch J.L. Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy. *American Journal of Psychiatry.* 1996; 153(3): 427–428.

[PubMed]

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., and Cunningham, P.B. *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*. New York: Guilford Press, 1998.

Hernandez, M. Puerto Rican families and substance abuse. In: Krestan, J.A., ed. *Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment*. New York: The Free Press, 2000. pp. 253–283.

Hernandez, M., and McGoldrick, M. Migration and the family life cycle. In: Carter, B., and McGoldrick, M., eds. *The Expanded Family Life Cycle: Individual, Family, and Social Perspectives*. 3d ed. Boston: Allyn and Bacon, 1999. pp. 169–173.

Herrick C.A., Brown H.N. Underutilization of mental health services by Asian-Americans residing in the United States. *Issues in Mental Health Nursing.* 1998; 19(3): 225–240. [PubMed]

Higgins, S.T., and Budney, A.J. Treatment of cocaine dependence through the principles of behavior analysis and behavioral pharmacology. In: Onken, L.S., Blaine, J.D., and Boren, J.J., eds. *Behavioral Treatments for Drug Abuse and Dependence*. NIDA Research Monograph 137. NIH Publication No. 93-3684. Rockville, MD: National Institute on Drug Abuse, 1993. pp. 97–121.

Higgins S.T., Budney A.J., Bickel W.K., Badger G.J. Participation of significant others in outpatient behavioral treatment predicts greater cocaine abstinence. *American Journal of Drug and Alcohol Abuse.* 1994; 20(1): 47–56. [PubMed]

Higgins S.T., Budney A.J., Bickel W.K., Hughes J.R., Foerg F., Badger G. Achieving cocaine abstinence with a behavioral approach. *American Journal of Psychiatry.* 1993; 150(5): 763–769. [PubMed]

Hines, P.M., and Boyd-Franklin, N. African American families. In: McGoldrick, M., Pearce, J.K., and Giordano, J., eds. *Ethnicity and Family Therapy*. 2d ed. New York: Guilford Press, 1996. pp. 66–84.

Hodge, F.S., and Fredericks, L. American Indian and Alaska Native populations in the United States: An overview. In: Huff, R.M., and Kline, M.V., eds. *Promoting Health in Multicultural Populations: A Handbook for Practitioners*. Thousand Oaks, CA: Sage Publications, 1999. pp. 269–289.

Hoffmann J.P. The effects of family structure and family relations on adolescent marijuana use. *International Journal of the Addictions.* 1995; 30(10): 1207–1241. [PubMed]

Hogue A., Liddle H.A., Rowe C., Turner R.M., Dakof G.A., LaPann K. Treatment adherence and differentiation in individual versus family therapy for adolescent substance abuse. *Journal of Counseling Psychology.* 1998; 45(1): 104–114.

Hser Y.I., Hoffman V., Grella C.E., Anglin M.D. A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry.* 2001; 58(5): 503–508. [PubMed]

Hudak, J., Krestan, J.A., and Bepko, C. Alcohol problems and the family life cycle. In: Carter, B., and McGoldrick, M., eds. *The Expanded Family Life Cycle: Individual, Family, and Social Perspectives*. 3d ed. Boston: Allyn and Bacon, 1999. pp. 455–469.

Huff, R., and Kline, M. The Cultural Assessment Framework. In: Huff, R., and Kline, M. *Promoting Health in Multicultural Populations: A Handbook for Practitioners*. Thousand Oaks, CA: Sage Publications, 1999. pp. 481–499.

Hughes T.L., Eliason M. Substance use and abuse in lesbian, gay, bisexual and transgender populations. *Journal of Primary Prevention.* 2002; 22(3): 263–298.

Hulnick M.R., Hulnick H.R. Life's challenges: Curse or opportunity? Counseling families of persons with disabilities.
Journal of Counseling and Development. 1989; 68(2): 166–170.

Human J., Wasem C. Rural mental health in America.
American Psychologist. 1991; 46(3): 232–239. [PubMed]

Hunt G.M., Azrin N.H. A community-reinforcement approach to alcoholism.
Behaviour Research and Therapy. 1973; 11(1): 91–104. [PubMed]

Hunt P.L. Black clients: Implications for supervision of trainees.
Psychotherapy: Theory, Research, Practice, Training. 1987; 24(1): 114–119.

Hurcom C., Copello A., Orford J. The family and alcohol: Effects of excessive drinking and conceptualizations of spouses over recent decades.
Substance Use and Misuse. 2000; 35(4): 473–502. [PubMed]

Hurt R. D., Finlayson, R.E., Morse, R.M., and Davis, L.J., Jr. Alcoholism in elderly persons: Medical aspects and prognosis of 216 inpatients.
Mayo Clinic Proceedings. 1988; 63(8): 753–760. [PubMed]

Huycke, J.D. *Structural Family Therapy*. Racine, WI: SAFE Haven, 2000. http://www.execpc.com/~safehavn/strucfam.htm [Accessed February 11, 2004].

Imber-Black, E. *Families and Larger Systems: A Family Therapist's Guide Through the Labyrinth*. New York: Guilford Press, 1988.

Imber-Black, E. Multiple embedded systems. In: Mirkin, M.P., ed. *The Social and Political Contexts of Family Therapy*. Needham Heights, MA: Allyn and Bacon, 1990. pp. 3–18.

Imber-Black, E. A family-larger-system perspective. In: Gurman, A.S., and Kniskern, D.P., eds. *Handbook of Family Therapy: Vol. 2*. New York: Brunner/Mazel, 1991. pp. 583–605.

Inaba, D.S., Cohen, W.E., and Holstein, M.E. *Uppers, Downers, All Arounders: Physical and Mental Effects of Psychoactive Drugs*. 3d ed. Ashland, OR: CNS Publications, 1997.

Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs. 67 Fed. Reg. 43,328, July 12, 2002.

Indian Health Service. *Trends in Indian Health 1998-99*. Rockville, MD: Indian Health Service, 2002. http://www.ihs.gov/PublicInfo/Publications/trends98/trends98.asp [Accessed February 11, 2004].

Inouye, J. Asian American health and disease: An overview of the issues. In: Huff, R., and Kline, M. *Promoting Health in Multicultural Populations: A Handbook for Practitioners*. Thousand Oaks, CA: Sage Publications, 1999. pp. 337–356.

International Certification and Reciprocity Consortium – Alcohol and Other Drug Abuse. *Standards for Certified AODA Counselors*. Falls Church, VA: International Certification and Reciprocity Consortium – Alcohol and Other Drug Abuse, 2002. http://www.icrcaoda.org/standards_counselor.htm [Accessed February 11, 2004].

Isaacson, E.B. Chemical addiction: Individuals and family systems. *Journal of Chemical Dependency Treatment* 4(1):7–27, 1991*a*.

Isaacson, E.B. Psychodynamics and family systems: A model for chemical addiction counseling. *Journal of Chemical Dependency Treatment* 4(1):41–60, 1991*b*.

Ivey D.C., Wieling E., Harris S.M. Save the young—the elderly have lived their lives: Ageism in marriage and family therapy. *Family Process.* 2000; 39(2): 163–175. [PubMed]

Jacobson N.S., Follette W.C., Revenstorf D., Baucom D.H., Hahlweg K., Margolin G. Variability in outcome and clinical significance of behavioral marital therapy: A reanalysis of outcome data.
Journal of Consulting and Clinical Psychology. 1984; 52(4): 497–504. [PubMed]

Jainchill N., Hawke J., Yagelka J. Gender, psychopathology, and patterns of homelessness among clients in shelter-based TCs.
American Journal of Drug and Alcohol Abuse. 2000; 26(4): 553–567. [PubMed]

Johnson J.L., Leff M. Children of substance abusers: Overview of research findings. *Pediatrics.* 1999; 103(5 Pt 2): 1085–1099. [PubMed]

Johnson M.P. Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family.* 1995; 57(2): 283–294.

Johnson, V.E. *I'll Quit Tomorrow*. New York: Harper and Row, 1973.

Johnson, V.E. *Intervention: How to Help Someone Who Doesn't Want Help. A Step-by-Step Guide for Families and Friends of Chemically Dependent Persons*. Minneapolis, MN: Johnson Institute Books, 1986.

Johnston D. A series of cases of dementia presenting with PTSD symptoms in World War II combat veterans.
Journal of the American Geriatrics Society. 2000; 48(1): 70–72. [PubMed]

Johnston, L.D., O'Malley, P.M., and Bachman, J.G. *Monitoring the Future: National Results on Adolescent Drug Use. Overview of Key Findings, 2001*. Bethesda, MD: National Institute on Drug Abuse, 2002. http://www.monitoringthefuture.org /pubs/monographs/overview2001.pdf [Accessed February 11, 2004].

Kalant, H. Pharmacological interactions of aging and alcohol. In: Gomberg, E.S.L., Hegedus, A.M., and Zucker, R.A., eds. *Alcohol Problems and Aging*. NIAAA Research Monograph No. 33. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 1998. pp. 99–116.

Kao, R.S.-K., and Lam, M.L. Asian American elderly. In: Lee, E., ed. *Working with Asian Americans*. New York: Guilford Press, 1997. pp. 208–226.

Kaufman, E. Adolescent substance abusers and family therapy. In: Friedman, A.S., and Granick, S., eds. *Family Therapy For Adolescent Drug Abuse*. Lexington, MA: Lexington

Books, 1990*a*. pp. 47-61.

Kaufman, E. Critical aspects of the psychodynamics of substance abuse and the evaluation of their application to a psychotherapeutic approach. *International Journal of the Addictions* 25(2A):97–114, 1990*b*.

Kaufman, E. *Psychotherapy of Addicted Persons*. New York: Guilford Press, 1994.

Kaufman, E. Family therapy: Other drugs. In: Galanter, M., and Kleber, H., eds. *Textbook of Substance Abuse Treatment*. 2d ed. Washington, DC: American Psychiatric Press, 1999. pp. 389–400.

Kaufman, E., and Borders, L. Ethnic family differences in adolescent substance use. In: Coombs, R.H., ed. *The Family Context of Adolescent Drug Use*. New York: Haworth Press, 1988. pp. 99–121.

Kaufman, E., and Kaufmann, P., eds. *Family Therapy of Drug and Alcohol Abuse*. 2d ed. Boston: Allyn and Bacon, 1992.

Kaufman E., Pattison E.M. Differential methods of family therapy in the treatment of alcoholism. *Journal of Studies on Alcohol.* 1981; 42(11): 951–971. [PubMed]

Kaufmann, P., and Kaufman, E. From multiple family therapy to couples therapy. In: Kaufman, E., and Kaufmann, P., eds. *Family Therapy of Drug and Alcohol Abuse*. New York: Gardner Press, 1979. pp. 95–103.

Kaufmann, P., and Kaufman, E. From multiple family therapy to couples therapy. In: Kaufman, E., and Kaufmann, P., eds. *Family Therapy of Drug and Alcohol Abuse*. 2d ed. Boston: Allyn and Bacon, 1992*a*. pp. 85–93.

Kaufmann, P., and Kaufman, E. Multiple family therapy with drug abusers. In: Kaufman, E., and Kaufmann, P., eds. *Family Therapy of Drug and Alcohol Abuse*. 2d ed. Boston: Allyn and Bacon, 1992*b*. pp. 72–84.

Kearns, D., and Rosenthal, D. Substance abuse in rural America. In: Moore, R.M., III, ed. *The Hidden America: Social Problems in Rural America for the Twenty-First Century.* Selinsgrove, PA: Susquehanna University Press, 2001, pp. 151–178.

Kelleher K.J., Rickert V.I., Hardin B.H., Pope S.K., Farmer F.L. Rurality and gender: Effects on early adolescent alcohol use.
American Journal of Diseases of Children. 1992; 146(3): 317–322. [PubMed]

Kelley M.L., Tseng H. Cultural differences in child rearing: A comparison of immigrant Chinese and Caucasian American mothers.
Journal of Cross-Cultural Psychology. 1992; 23(4): 444–455.

Kim S.C. Family therapy for Asian Americans: A strategic-structural framework.
Psychotherapy. 1985; 22(2): 342–348.

King S.A., Engi S., Poulos S.T. Using the Internet to assist family therapy.
British Journal of Guidance & Counselling. 1998; 26(1): 43–52.

Kirby K.C., Marlowe D.B., Festinger D.S., Garvey K.A., LaMonaca V. Community reinforcement training for family and significant others of drug abusers: A unilateral intervention to increase treatment entry of drug users.

Drug and Alcohol Dependence. 1999; 56(1): 85–96. [PubMed]

Kleinman, A., and Good, B., eds. *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder*. Berkeley, CA: University of California Press, 1985.

Kline A. Pathways into drug user treatment: The influence of gender and racial/ethnic identity. *Substance Use and Misuse.* 1996; 31(3): 323–342. [PubMed]

Krestan, J.-A. Addiction, power, and powerlessness. In: Krestan, J.-A., ed. *Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment*. New York: Free Press, 2000. pp. 15–44.

Lambert M.J., Okiishi J.C., Finch A.E., Johnson L.D. Outcome assessment: From conceptualization to implementation.
Professional Psychology: Research and Practice. 1998; 29(1): 63–70.

LaSala M. Lesbians, gay men, and their parents: Family therapy for coming-out crisis. *Family Process.* 2000; 39(1): 67–81. [PubMed]

Lee, E. Asian American families: An overview. In: McGoldrick, M., Giordano, J., and Pearce, J.K., eds. *Ethnicity and Family Therapy*. 2d ed. New York: Guilford Press, 1996. pp. 227–248.

Lee R. How to talk about sex with patients who are not heterosexual.
Western Journal of Medicine. 2000; 172(6): 401–402. [PubMed] [Free Full text in PMC]

Leipman, M.R., Wolper, B., and Vazquez, J. An ecological approach for motivating women to accept treatment for drug dependency. In: Reed, B.G., Beschner, G.M., and Mondanaro, J., eds. *Treatment Services for Drug Dependent Women: Vol. 2*. Treatment Research Monograph Series. DHHS Publication No. (ADM) 82-1219. Rockville, MD: National Institute on Drug Abuse, 1982. pp. 1–61.

Leslie, D.R., Perina, B.A., and Maqueda, M.C. Clinical issues with transgender individuals. In: Center for Substance Abuse Treatment, ed. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001. pp. 91–98.

Levin, J.D. *Couple and Family Therapy of Addiction*. Northvale, NJ: Jason Aronson, 1998.

Li T.K. Pharmacogenetics of responses to alcohol and genes that influence alcohol drinking. *Journal of Studies on Alcohol.* 2000; 61(1): 5–12. [PubMed]

Liddle H.A. Theory development in a family-based therapy for adolescent drug abuse. *Journal of Clinical Child Psychology.* 1999; 28(4): 521–532. [PubMed]

Liddle H.A. Adolescent substance abuse derails development.
AAMFT Clinical Update. 2001; 3(3): 1–8.

Liddle, H.A. *Multidimensional Family Therapy for Adolescent Cannabis Users*. Cannabis Youth Treatment (CYT) Series, Vol. 5. DHHS Publication No. (SMA) 02-3660. Rockville, MD: Center for Substance Abuse Treatment, 2002.

Liddle, H.A., and Dakof, G.A. Efficacy of family therapy for drug abuse: Promising but not definitive. *Journal of Marital and Family Therapy* 21(4):511–543, 1995*a*.

Liddle, H.A., and Dakof, G.A. Family-based treatment for adolescent drug use: State of the science. In: Rahdert, E.R., and Czechowicz, D., eds. *Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions*. NIDA Research Monograph 156. NIH Publication No. 95-3908. Rockville, MD: National Institute on Drug Abuse, 1995*b*. pp. 218–254.

Liddle, H.A., Dakof, G.A., and Diamond, G. Adolescent substance abuse: Multidimensional family therapy in action. In: Kaufman, E., and Kaufmann, P., eds. *Family Therapy of Drug and Alcohol Abuse*. 2d ed. Boston: Allyn and Bacon, 1992. pp. 120–171.

Liddle H.A., Dakof G.A., Parker K., Diamond G.S., Barrett K., Tejeda M. Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse.* 2001; 27(4): 651–688. [PubMed]

Liddle, H.A., and Hogue, A. Multidimensional family therapy for adolescent substance abuse. In: Wagner, E.F., and Waldron, H.B., eds. *Innovations in Adolescent Substance Abuse Interventions*. New York: Pergamon, 2001. pp. 229–261.

Liepman M.R., Silvia L.Y., Nirenberg T.D. The use of family behavior loop mapping for substance abuse. *Family Relations.* 1989; 38(3): 282–287.

Linehan, M.M. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press, 1993.

London E.D., Bonson K.R., Ernst M., Grant S. Brain imaging studies of cocaine abuse: Implications for medication development.
Critical Reviews in Neurobiology. 1999; 13(3): 227–242. [PubMed]

Lopez, F. *Confidentiality of Patient Records for Alcohol and Other Drug Treatment.* Technical Assistance Publication Series 13. DHHS Publication No. (SMA) 99-3321. Rockville, MD: Center for Substance Abuse Treatment, 1994.

Madsen, W. *Mexican Americans of South Texas*. New York: Holt, Rinehart, and Winston, 1964.

Makimoto K. Drinking patterns and drinking problems among Asian-Americans and Pacific Islanders. *Alcohol Health and Research World.* 1998; 22(4): 270–275. [PubMed]

Marín, G., and Marín, B.V. *Research with Hispanic Populations*. Newbury Park, CA: Sage Publications, 1991.

Marsh, D.T. *A Family-Focused Approach to Serious Mental Illness: Empirically Supported Interventions*. Sarasota, FL: Professional Resource Press/Professional Resource Exchange, 2001.

Marshak, L.E., and Seligman, M. *Counseling Persons with Physical Disabilities: Theoretical and Clinical Perspectives*. Austin, TX: PRO-ED, 1993.

May Lai, T.-F. Ethnocultural background and substance abuse treatment of Chinese Americans. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse*

Treatment. New York: Guilford Press, 2001. pp. 345–367.

McCollum, E.E., and Trepper, T.S. *Family Solutions for Substance Abuse: Clinical and Counseling Approaches*. Binghamton, NY: Haworth Press, 2001.

McCrady, B.S., and Epstein, E.E. Theoretical bases of family approaches to substance abuse treatment. In: Rotgers, F., and Keller, D.S., eds. *Treating Substance Abuse: Theory and Technique*. New York: Guilford Press, 1996. pp. 117–142.

McGee, G., Johnson, L., and Bell, P. *Black, Beautiful, and Recovering.* Center City, MN: Hazelden, 1985.

McGill, D.W., and Pearce, J.K. American families with English ancestors from the colonial era: Anglo Americans. In: McGoldrick, M., Giordano, J., and Pearce, J.K., eds. *Ethnicity and Family Therapy*. 2d ed. New York: Guilford Press, 1996. pp. 451–466.

McGoldrick, M. Normal families: An ethnic perspective. In: Walsh, F., ed. *Normal Family Processes*. New York: Guilford Press, 1982. pp. 399–424.

McGoldrick, M. *You Can Go Home Again: Reconnecting with Your Family*. New York: W.W. Norton, 1995.

McGoldrick, M., and Gerson, R. *Genograms in Family Assessment*. New York: W.W. Norton, 1985.

McLellan A.T., Arndt I.O., Metzger D.S., Woody G.E., O'Brien C.P. The effects of psychosocial services in substance abuse treatment.
Journal of the American Medical Association. 1993; 269(15): 1953–1959. [PubMed]

McVinney, D. Clinical issues with bisexuals. In: Center for Substance Abuse Treatment, ed. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001. pp. 87–90.

Mercado M.M. The invisible family: Counseling Asian American substance abusers and their families. *Family Journal.* 2000; 8(3): 267–273.

Merikangas K.R., Dierker L.C. Psychopathology among offspring of parents with substance abuse and/or anxiety disorders: A high-risk study.
Journal of Child Psychology and Psychiatry. 1998; 39(5): 711–720. [PubMed]

Meyers, R.J., and Smith, J.E. *Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach*. New York: Guilford Press, 1995.

Miller L., Davies M., Greenwald S. Religiosity and substance use and abuse among adolescents in the National Comorbidity Survey.
Journal of the American Academy of Child and Adolescent Psychiatry. 2000; 39(9): 1190–1197. [PubMed]

Miller, W.R., Andrews, N.R., Wilbourne, P., and Bennett, M.E. A wealth of alternatives: Effective treatments for alcohol problems. In: Miller, W.R., and Heather, N., eds. *Treating Addictive Behaviors*. 2d ed. New York: Plenum Press, 1998. pp. 203–216.

Miller W.R., Benefield R.G., Tonigan J.S. Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles.

Journal of Consulting and Clinical Psychology. 1993; 61(3): 455–461. [PubMed]

Minuchin, S. *Families and Family Therapy.* London: Tavistock, 1974.

Minuchin, S., and Fishman, H.C. *Family Therapy Techniques*. Cambridge, MA: Harvard University Press, 1981.

Moll, L.C., Rueda, R.S., Reza, R., Herrera, J., and Vasquez, L.P. Mental health services in East Los Angeles: An urban community case study. In: Miranda, M.R., ed. *Psychotherapy with the Spanish Speaking: Issues in Research and Service Delivery*. Los Angeles: University of California, Spanish Speaking Mental Health Research Center, 1976. pp. 52–65.

Moncher M.S., Holden G.W., Trimble J.E. Substance abuse among Native-American youth. *Journal of Consulting and Clinical Psychology.* 1990; 58(4): 408–415. [PubMed]

Montalvo B., Gutierrez M. A perspective for the use of the cultural dimension in family therapy. *Family Therapy Collections.* 1983; 6: 15–32.

Moore D., Li L. Substance use among rehabilitation consumers for vocational rehabilitation services. *Journal of Rehabilitation.* 1994; 60(4): 48–53.

Moore D., Polsgrove L. Disabilities, developmental handicaps, and substance misuse: A review. *International Journal of the Addictions.* 1991; 26(1): 65–90. [PubMed]

Moos R.H., Brennan P.L., Moos B.S. Short-term processes of remission and nonremission among late-life problem drinkers.
Alcoholism: Clinical and Experimental Research. 1991; 15(6): 948–955.

Motet-Grigoras C.N., Schuckit M.A. Depression and substance abuse in handicapped young men. *Journal of Clinical Psychiatry.* 1986; 47(5): 234–237. [PubMed]

Mueser K.T., Bond G.R., Drake R.E., Resnick S.G. Models of community care for severe mental illness: A review of research on case management.
Schizophrenia Bulletin. 1998; 24(1): 37–74. [PubMed]

Muetzell S. Are children of alcoholic mothers more psychologically damaged compared with children of mothers from the general population?
Early Child Development and Care. 1995; 109(May): 159–173.

Murphy J.M., Jellinek M., Quinn D., Smith G., Poitrast F.G., Goshko M. Substance abuse and serious child mistreatment: Prevalence, risk, and outcome in a court sample.
Child Abuse and Neglect. 1991; 15(3): 197–211. [PubMed]

Myers J. K., Weissman, M.M., Tischler, G.L., Holzer, C.E., III, Leaf, P.J., Orvaschel, H., Anthony, J.C., Boyd, J.H., Burke, J.D., Jr., Kramer, M., and Stolzman, R. Six-month prevalence of psychiatric disorders in three communities 1980 to 1982.
Archives of General Psychiatry. 1984; 41(10): 959–967. [PubMed]

Napoliello A.L., Sweet E.S. Salvador Minuchin's structural family therapy and its application to Native Americans. *Family Therapy.* 1992; 19(2): 155–165.

National Center on Addiction and Substance Abuse. *No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America*. New York: National Center on Addiction and Substance Abuse, 2000. http://www.casacolumbia.org/publications1456

/publications_show.htm?doc_id=23734 [Accessed February 11, 2004].

National Center on Addiction and Substance Abuse. *So Help Me God: Substance Abuse, Religion and Spirituality*. New York: National Center on Addiction and Substance Abuse, 2001. http://www.casacolumbia.org/usr_doc/Spirituality.pdf [Accessed February 11, 2004].

National Coalition for Homeless Veterans. *Background and Statistics*. Washington, DC: National Coalition for Homeless Veterans, 2002. http://www.nchv.org/background.cfm [Accessed February 11, 2004].

National Coalition for the Homeless. *Who is Homeless?* Washington, DC: National Coalition for the Homeless, 1999. http://www.nationalhomeless.org/who.html [Accessed February 11, 2004].

National Institute on Drug Abuse. *Use of Selected Drugs Among Hispanics: Mexican-Americans, Puerto Ricans, and Cuban-Americans. Findings from the Hispanic Health and Nutrition Examination Survey.* DHHS Publication No. (ADM) 87-1527. Rockville, MD: National Institute on Drug Abuse, 1987.

National Institute on Drug Abuse. *Principles of Drug Addiction Treatment: A Research-Based Guide.* NIH Publication No. 00-4180. Bethesda, MD: National Institutes of Health, 1999*a*.

National Institute on Drug Abuse. *Treatment Medications*. NIDA InfoFax 13560. Rockville, MD: National Institute on Drug Abuse, 1999*b*. http://165.112.78.61/Infofax/treatmed.html [Accessed February 11, 2004].

National Institute on Drug Abuse. *Prescription Drugs: Abuse and Addiction*. National Institute on Drug Abuse Research Report Series. Rockville, MD: National Institute on Drug Abuse, 2001. http://www.nida.nih.gov/PDF/RRPrescription.pdf [Accessed February 11, 2004].

National Institute on Drug Abuse. *Stress and Substance Abuse: A Special Report*. Rockville, MD: National Institute on Drug Abuse, 2002. http://www.nida.nih.gov/stressanddrugabuse.html [Accessed February 10, 2004].

Nelipovich M., Buss E. Alcohol abuse and persons who are blind: Treatment considerations. *Alcohol Health and Research World.* 1989; 13(2): 129–131.

New York State Education Department – Office of Bilingual Education. *Directory of Languages*. Albany, NY: New York State Education Department, Office of Bilingual Education, 1997. http://www.emsc.nysed.gov/ciai/biling/pub/languages.html [Accessed February 11, 2004].

Nichols, M.P., and Schwartz, R.C. *The Essentials of Family Therapy*. Boston: Allyn and Bacon, 2001.

Noel, N.E., and McCrady, B.S. Alcohol-focused spouse involvement with behavioral marital therapy. In: O'Farrell, T.J., ed. *Treating Alcohol Problems: Marital and Family Interventions*. New York: Guilford Press, 1993. pp. 210–235.

Northey W. F. Jr. Characteristics and clinical practices of marriage and family therapists: A national survey.
Journal of Marital and Family Therapy. 2002; 28(4): 487–494. [PubMed]

O'Farrell, T.J. A behavioral marital therapy couples group program for alcoholics and their spouses. In: O'Farrell, T.J., ed. *Treating Alcohol Problems: Marital and Family Interventions*. New York: Guilford Press, 1993. pp. 170–209.

O'Farrell, T.J., Choquette, K.A., Cutter, H.S.G., Brown, E., Bayog, R., McCourt, W., Lowe, J., Chan, A., and Deneault, P. Cost-benefit and cost-effectiveness analyses of behavioral marital therapy with and without relapse prevention sessions for alcoholics and their spouses. *Behavior Therapy* 27(1):7–24, 1996*a*.

O'Farrell, T.J., Choquette, K.A., Cutter, H.S., Floyd, F.J., Bayog, R., Brown, E.D., Lowe, J., Chan, A., and Deneault, P. Cost-benefit and cost-effectiveness analyses of behavioral marital therapy as an addition to outpatient alcoholism treatment. *Journal of Substance Abuse* 8(2):145–166, 1996*b*.

O'Farrell, T.J., and Fals-Stewart, W. Treatment models and methods: Family models. In: McCrady, B.S., and Epstein, E.E., eds. *Addictions: A Comprehensive Guidebook*. New York: Oxford University Press, 1999. pp. 287–305.

O'Farrell T.J., Fals-Stewart W. Behavioral couples therapy for alcoholism and drug abuse. *Journal of Substance Abuse Treatment.* 2000; 18(1): 51–54. [PubMed]

Office of Applied Studies. *Prevalence of Substance Use Among Racial and Ethnic Subgroups in the United States: 1991-1993.* Analytic Series: A-6. DHHS Publication No. (SMA) 98-3202. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998.

Office of Applied Studies. *Summary of Findings from the 2000 National Household Survey on Drug Abuse*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001*a*. http://www.samhsa.gov/oas/NHSDA/2kNHSDA.pdf [Accessed February 11, 2004].

Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1994–1999. National Admissions to Substance Abuse Treatment Services*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001*b*. http://www.samhsa.gov/oas/teds/99TEDS/99Teds.pdf [Accessed February 11, 2004].

Office of Applied Studies. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2000. Data on Substance Abuse Treatment Facilities.* DASIS Series: S-16. DHHS Publication No. (SMA) 02-3668. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002*a*. http://wwwdasis.samhsa.gov/00nssats/nssats2000report.pdf [Accessed February 11, 2004].

Office of Applied Studies. *Prescription and Over-the-Counter Drug Abuse Admissions*. The DASIS Report. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002*b*. http://www.samhsa.gov/oas/2k2/OTCtx/OTCtx.pdf [Accessed February 11, 2004].

Office of Applied Studies. *Results from the 2001 National Household Survey on Drug Abuse: Vol.1. Summary of National Findings.* National Household Survey on Drug Abuse Series: H-17. DHHS Publication No. (SMA) 02-3758. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002*c*.

Office of Applied Studies. *Results from the 2001 National Household Survey on Drug Abuse: Vol. 2. Technical Appendices and Selected Data Tables.* National Household Survey on Drug Abuse Series: H-18. DHHS Publication No. (SMA) 02-3759. Rockville,

MD: Substance Abuse and Mental Health Services Administration, 2002*d*.

Office of Applied Studies. *Overview of Findings from the 2002 National Survey on Drug Use and Health.* (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03-3774). Rockville, MD: Substance Abuse and Mental Health Services Administration, 2003*a*. http://www.samhsa.gov/oas/NHSDA/2k2NSDUH /2k2SoFOverviewW.pdf [Accessed February 11, 2004].

Office of Applied Studies. *Veterans in Substance Abuse Treatment: 1995-2000. The DASIS Report.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2003*b*. http://www.samhsa.gov/oas/2k3/VetsTX/VetsTX.pdf [Accessed March 8, 2004].

Ogunwole, S.U. *The American Indian and Alaska Native Population: 2000*. Census 2000 Brief. Washington, DC: U.S. Census Bureau, 2002. http://www.census.gov /prod/2002pubs/c2kbr01-15.pdf [Accessed February 11, 2004].

Olsen L. Services for substance abuse-affected families: The Project Connect experience. *Child and Adolescent Social Work Journal.* 1995; 12(3): 183–196.

Onken, L.S., Blaine, J., and Boren, J.D., eds. *Beyond the Therapeutic Alliance: Keeping the Drug-Dependent Individual in Treatment*. NIDA Research Monograph 165. NIH Publication No. 97-4142. Rockville, MD: National Institute on Drug Abuse, 1997.

Osborn C.J. Does disease matter? Incorporating solution-focused brief therapy in alcoholism treatment. *Journal of Alcohol and Drug Education.* 1997; 43(1): 18–30.

Oxford M.L., Harachi T.W., Catalano R.F., Abbott R.D. Preadolescent predictors of substance initiation: A test of both the direct and mediated effect of family social control factors on deviant peer associations and substance initiation. *American Journal of Drug and Alcohol Abuse.* 2001; 27(4): 599–616. [PubMed]

Paniagua, F.A. *Assessing and Treating Culturally Diverse Clients: A Practical Guide*. 2d ed. Thousand Oaks, CA: Sage Publications, 1998.

Pardini D.A., Plante T.G., Sherman A., Stump J.E. Religious faith and spirituality in substance abuse recovery: Determining the mental health benefits. *Journal of Substance Abuse Treatment.* 2000; 19(4): 347–354. [PubMed]

Penn N.E., Kar S., Kramer J., Skinner J., Zambrana R.E. Ethnic minorities, health care systems, and behavior. *Health Psychology.* 1995; 14(7): 641–646. [PubMed]

Pequegnat W., Bauman L.J., Bray J.H., DiClemente R., DiIorio C., Hoppe S.K., Jemmott L.S., Krauss B., Miles M., Paikoff R., Rapkin B., Rotheram-Borus M.J., Szapocznik J. Measurement of the role of families in prevention and adaptation to HIV/AIDS. *AIDS and Behavior.* 2001; 5(1): 1–19.

Perez M., Pilsecker C. Family therapy with spinal cord injured substance abusers. *Social Work in Health Care.* 1989; 14(2): 15–25.

Pfeffer C.R., Normandin L., Kakuma T. Suicidal children grow up: Relations between family psychopathology and adolescents' lifetime suicidal behavior. *Journal of Nervous and Mental Disease.* 1998; 186(5): 269–275. [PubMed]

Pinsof W.M., Wynne L.C., Hambright A.B. The outcomes of couple and family therapy:

Findings, conclusions, and recommendations.
Psychotherapy: Theory, Research, Practice, Training. 1996; 33(2): 321–331.

Pion, G.M., Keller, P., and McCombs, H. *Mental Health Providers in Rural and Isolated Areas: Final Report of the Ad Hoc Rural Mental Health Provider Work Group*. DHHS Publication No. (SMA) 98-3166. Rockville, MD: Center for Mental Health Services, 1997. http://www.mentalhealth.org/publications/allpubs/SMA98-3166/default.asp [Accessed February 11, 2004].

Polk G.W. Treatment of problem drinking behavior using solution-focused brief therapy: A single subject design.
Crisis Intervention and Time-Limited Treatment. 1996; 3(1): 13–24.

Popenoe D. The American family crisis. *National Forum.* 1995; 75(3): 15–19.

Prochaska J.O., DiClemente C.C., Norcross J.C. In search of how people change: Applications to addictive behaviors. *American Psychologist.* 1992; 47(9): 1102–1114. [PubMed]

Ray W.A., Thapa P.B., Shorr R.I. Medications and the older driver.
Clinics in Geriatric Medicine. 1993; 9(2): 413–438. [PubMed]

Rehabilitation Research and Training Center on Drugs and Disability. *Substance Abuse, Disability and Vocational Rehabilitation*. Dayton, OH: Rehabilitation Research and Training Center on Drugs and Disability, Wright State University, 1996.

Reid, D.J. Addiction, African Americans, and a Christian recovery. In: Krestan, J.A., ed. *Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment*. New York: The Free Press, 2000. pp. 145–172.

Reilly, D.M. Drug-abusing families: Intrafamilial dynamics and brief triphasic treatment. In: Kaufman, E., and Kaufmann, P., eds. *Family Therapy of Drug and Alcohol Abuse*. 2d ed. Boston: Allyn and Bacon, 1992. pp. 105–119.

Rhoades, J.A., and Chu, M.C. *Health Insurance Status of the Civilian Noninstitutionalized Population: 1999*. Rockville, MD: Agency for Healthcare Research and Quality, 2000. http://www.meps.ahrq.gov/papers/rf14_01-0011/rf14.pdf [Accessed February 11, 2004].

Richardson D. Structural and strategic family therapy techniques: Application to chemically dependent families.
Journal of Chemical Dependency Treatment. 1991; 4(1): 29–39.

Robbins, M.S., Schwartz, S.J., and Szapocznik, J. Structural ecosystems therapy with adolescents exhibiting disruptive behavior disorders. In: Ancis, J.R., ed.
Culturally-Based Interventions: Alternative Approaches to Working with Diverse Populations and Culture-Bound Syndromes. New York: Brunner/Routledge, in press.

Robbins, M.S. and Szapocznik, J. *Brief Strategic Family Therapy*. Juvenile Justice Bulletin. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 2000. http://www.ncjrs.org/html/ojjdp/jjbul2000_04_3/contents.html [Accessed February 11, 2004].

Robert Wood Johnson Foundation. *The Robert Wood Johnson Foundation Annual Report 1994: Cost Containment.* Princeton, NJ: Robert Wood Johnson Foundation, 1994.

Roberts J. How to recognise a therapeutic community.
Prison Service Journal. 1997; 111: 4–7.

Rose L.R. Healing from racism. *Winds of Change.* 1995; 10(2): 14–17.

Rowe D., Grills C. African-centered drug treatment: An alternative conceptual paradigm for drug counseling with African-American clients.
Journal of Psychoactive Drugs. 1993; 25(1): 21–33. [PubMed]

Ryglewicz H. Psychoeducation for clients and families: A way in, out, and through in working with people with dual disorders.
Psychosocial Rehabilitation Journal. 1991; 15(2): 79–89.

Sacks S., Sacks J., De Leon G., Bernhardt A.I., Staines G.L. Modified therapeutic community for mentally ill chemical "abusers": Background; influences; program description; preliminary findings. *Substance Use & Misuse.* 1997; 32(9): 1217–1259. [PubMed]

Sandhu D.S. Psychocultural profiles of Asian and Pacific Islander Americans: Implications for counseling and psychotherapy.
Journal of Multicultural Counseling and Development. 1997; 25(1): 7–22.

Santisteban D.A., Coatsworth J.D., Perez-Vidal A., Mitrani V., Jean-Gilles M., Szapocznik J. Brief structural/strategic family therapy with African American and Hispanic high-risk youth. *Journal of Community Psychology.* 1997; 25(5): 453–471.

Santisteban D.A., Muir J.A., Mena M.P., Mitrani V.B. Integrated Borderline Adolescent Family Therapy: Meeting the challenges of treating borderline adolescents.
Psychotherapy: Theory/Research/ Practice/Training. 2003; 40(4): 251–264.

Santisteban, D.A., Muir-Malcolm, J.A., Mitrani, V.B., and Szapocznik, J. Integrating the study of ethnic culture and family psychology intervention science. In: Liddle, H.A., Santisteban, D.A., Levant, R.F., and Bray, J.H., eds. *Family Psychology: Science-Based Interventions*. Washington, DC: American Psychological Association, 2002. pp. 331–351.

Santisteban D.A., Szapocznik J., Perez-Vidal A., Murray E.J., Kurtines W.M., LaPerriere A. Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness.
Journal of Family Psychology. 1996; 10(1): 35–44.

Sargent A. J., III. The family: A pediatric assessment.
Journal of Pediatrics. 1983; 102(6): 973–976. [PubMed]

Sayger T.V., Heid K.O. Counseling the impoverished rural client: Issues for family therapists. *Psychotherapy Patient.* 1990; 7(1-2): 161–168.

Schaschl S., Straw D. Results of a model intervention program for physically impaired persons. *Alcohol Health and Research World.* 1989; 13(2): 150–153.

Schmidt S.E., Liddle H.A., Dakof G.A. Changes in parenting practices and adolescent drug abuse during multidimensional family therapy.
Journal of Family Psychology. 1996; 10(1): 12–27.

Schuckit, M.A. *Drug and Alcohol Abuse: A Clinical Guide to Diagnosis and Treatment.*

5th ed. New York: Kluwer Academic/Plenum Publishers, 2000.

Schwab A.J., DiNitto D.M. Factors related to the successful vocational rehabilitation of substance abusers. *Journal of Applied Rehabilitation Counseling.* 1993; 24(3): 11–20.

Sexton, T.L., and Alexander, J.F. *Functional Family Therapy*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, 2000. http://www.ncjrs.org/html/ojjdp /jjbul2000_12_4/contents.html [Accessed February 11, 2004].

Sexton, T.L., and Alexander, J.F. Functional family therapy for adolescents and their families. In: Patterson, T., ed. *Comprehensive Handbook of Psychotherapy.* New York: Wiley & Sons, 2002.

Shapiro, C. *Integrating Family-Focused Interventions into the Criminal Justice System*. New York: The Vera Institute of Justice, 1999. http://www.vera.org/publications /bodegafamily.htm [Accessed February 11, 2004].

Sheahan S.L., Coons S.J., Robbins C.A., Martin S.S., Hendricks J., Latimer M. Psychoactive medication, alcohol use, and falls among older adults. *Journal of Behavioral Medicine.* 1995; 18(2): 127–140. [PubMed]

Sheahan S.L., Hendricks J., Coons S.J. Drug misuse among the elderly: A covert problem. *Health Values.* 1989; 13(3): 22–29.

Sheils R., Rolfe T.J. Towards an integrated approach to a family intervention for co-occurring substance abuse and schizophrenia. *Australian & New Zealand Journal of Family Therapy.* 2000; 21(2): 81–87.

Sher K.J. Psychological characteristics of children of alcoholics. *Alcohol Health and Research World.* 1997; 21(3): 247–254. [PubMed]

Shon, S.P., and Ja, D.Y. Asian families. In: McGoldrick, M., Pearce, J.K., and Giordano, J., eds. *Ethnicity and Family Therapy*. New York: Guilford Press, 1982. pp. 208–228.

Simonelli R., Ferrigno B. Alcoholic recovery and the 12 Steps. *Winds of Change.* 1993; 8(3): 41–47.

Sisson R.W., Azrin N.H. Family-member involvement to initiate and promote treatment of problem drinkers. *Journal of Behavior Therapy and Experimental Psychiatry.* 1986; 17(1): 15–21. [PubMed]

Sisson, R.W., and Azrin, N.H. Community reinforcement training for families: A method to get alcoholics into treatment. In: O'Farrell, T.J., ed. *Treating Alcohol Problems: Marital and Family Interventions*. New York: Guilford Press, 1993. pp. 34–53.

Skinner H.A., Holt S., Schuller R., Roy J., Israel Y. Identification of alcohol abuse using laboratory tests and a history of trauma. *Annals of Internal Medicine.* 1984; 101: 847–851. [PubMed]

Sluzki C.E. Social networks and the elderly: Conceptual and clinical issues, and a family consultation. *Family Process.* 2000; 39(3): 271–284. [PubMed]

Spear L. Modeling adolescent development and alcohol use in animals. *Alcohol Research and Health.* 2000; 24(2): 115–123. [PubMed]

Stack, C.B. *All Our Kin: Strategies for Survival in a Black Community*. New York: Harper and Row, 1974.

Stanton, M.D. An integrated structural/strategic approach to family therapy. *Journal of Marital and Family Therapy* 7(4):427–439, 1981*a*.

Stanton, M.D. Strategic approaches to family therapy. In: Gurman, A.S., and Kniskern, D.P., eds. *Handbook of Family Therapy: Vol. 1*. New York: Brunner/Mazel, 1981*b*. pp. 361–402.

Stanton, M.D. Breaking away: The use of strategic and Bowenian techniques in treating an alcoholic family through one member. In: Kaufman, E., ed. *Power to Change: Family Case Studies in the Treatment of Alcoholism*. New York: Gardner Press, 1984*a*. pp. 253–266.

Stanton, M.D. Fusion, compression, diversion, and the workings of paradox: A theory of therapeutic/systemic change. *Family Process* 23(2):135–167, 1984*b*.

Stanton M.D. Coursework and self-study in the family treatment of alcohol and drug abuse: Expanding Heath and Atkinson's curriculum.
Journal of Marital and Family Therapy. 1988; 14(4): 419–427.

Stanton, M.D. The role of family and significant others in the engagement and retention of drug-dependent individuals. In: Onken, L.S., Blaine, J.D., and Boren, J.J., eds. *Beyond the Therapeutic Alliance: Keeping the Drug Dependent Individual in Treatment*. NIDA Research Monograph 165. NIH Publication No. 97-4142. Rockville, MD: National Institute on Drug Abuse, 1997. pp. 157–180.

Stanton M.D., Shadish W.R. Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies.
Psychological Bulletin. 1997; 122(2): 170–191. [PubMed]

Stanton, M.D., Todd, T.C., and Associates. *The Family Therapy of Drug Abuse and Addiction*. New York: Guilford Press, 1982.

Stanton M.D., Todd T.C., Heard D.B., Kirschner S., Kleiman J.I., Mowatt D.T., Riley P., Scott S.M., Van Deusen J.M. Heroin addiction as a family phenomenon: A new conceptual model. *American Journal of Drug and Alcohol Abuse.* 1978; 5(2): 125–150. [PubMed]

Stein, L.I., and Santos, A.B. *Assertive Community Treatment of Persons with Severe Mental Illness*. New York: W.W. Norton, 1998.

Stein L.I., Test M.A. Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation.
Archives of General Psychiatry. 1980; 37(4): 392–397. [PubMed]

Steinglass, P. Family therapy: Alcohol. In: Galanter, M., and Kleber, H.D., eds. *Textbook of Substance Abuse Treatment*. 2d ed. Washington, DC: American Psychiatric Press, 1999. pp. 379–387.

Steinglass, P., Bennett, L.A., Wolin, S.J., and Reiss, D. *The Alcoholic Family*. New York: BasicBooks, 1987.

Stevens M., Youells F., Whaley F., Linsey S. Drug use prevalence in a rural school-age

population: The New Hampshire survey.
American Journal of Preventive Medicine. 1995; 11: 105–113. [PubMed]

Stith S.M., Rosen K.H., McCollum E.E., Coleman J.U. The voices of children: Preadolescent children's experiences in family therapy.
Journal of Marital and Family Therapy. 1996; 22(1): 69–86.

Su S.S., Hoffmann J.P., Gerstein D.R., Johnson R.A. The effect of home environment on adolescent substance use and depressive symptoms.
Journal of Drug Issues. 1997; 27(4): 851–877.

Substance Abuse and Mental Health Services Administration. *Children's Program Kit: Supportive Education for Children of Addicted Parents.* DHHS Publication No. (SMA) 03-3825. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2003.

Sue D. Multicultural training.
International Journal of Intercultural Relations. 1997; 21(2): 175–193.

Sue, D.W., and Sue, D. *Counseling the Culturally Different: Theory and Practice*. 3d ed. New York: John Wiley and Sons, 1999.

Sue S., Zane N. The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist.* 1987; 42(1): 37–45. [PubMed]

Sullivan, E., Mino, M., Nelson, K., and Pope, J. *Families as a Resource in Recovery from Drug Abuse: An Evaluation of La Bodega de la Familia*. New York: Vera Institute of Justice, 2002. http://www.vera.org/publication_pdf/163_250.pdf [Accessed February 11, 2004].

Susser E.S., Lin S.P., Conover S.A. Risk factors for homelessness among patients admitted to a state mental hospital.
American Journal of Psychiatry. 1991; 148(12): 1659–1664. [PubMed]

Sutton, C.T., and Broken Nose, M.A. American Indian families: An overview. In: McGoldrick, M., Giordano, J., and Pearce, J.K., eds. *Ethnicity and Family Therapy*. 2d ed. New York: Guilford Press, 1996. pp. 31–44.

Szapocznik, J., Hervis, O., and Schwartz, S. *Brief Strategic Family Therapy*. Rockville, MD: National Institute on Drug Abuse, in press.

Szapocznik, J., Hervis, O., and Schwartz, S. *Therapy Manuals for Drug Addiction: Brief Strategic Family Therapy for Adolescent Drug Abuse*. Bethesda, MD: National Institute on Drug Abuse, 2003. http://165.112.78.61/pdf/Manual5.pdf [Accessed February 11, 2004].

Szapocznik, J., and Kurtines, W.M. *Breakthroughs in Family Therapy with Drug Abusing and Problem Youth*. New York: Springer Publishing, 1989.

Szapocznik J., Kurtines W.M., Foote F., Perez-Vidal A., Hervis O. Conjoint versus one-person family therapy: Some evidence for the effectiveness of conducting family therapy through one person.
Journal of Consulting and Clinical Psychology. 1983; 51(6): 889–899. [PubMed]

Szapocznik J., Kurtines W.M., Foote F., Perez-Vidal A., Hervis O. Conjoint versus

one-person family therapy: Further evidence for the effectiveness of conducting family therapy through one person with drug-abusing adolescents.
Journal of Consulting and Clinical Psychology. 1986; 54(3): 395–397. [PubMed]

Szapocznik J., Perez-Vidal A., Brickman A.L., Foote F.H., Santisteban D., Hervis O., Kurtines W.M. Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach.
Journal of Consulting and Clinical Psychology. 1988; 56(4): 552–557. [PubMed]

Szapocznik J., Williams R.A. Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review.* 2000; 3(2): 117–134. [PubMed] [Free Full text in PMC]

Tatum, T. Rural women's recovery program and women's outreach: Serving rural Appalachian women and families in Ohio. In: Center for Substance Abuse Treatment, ed. *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas*. Technical Assistance Publication Series 17. DHHS Publication No. (SMA) 99-3339. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995. pp. 13–20.

Teachman J.D., Tedrow L.M., Crowder K.D. The changing demography of America's families. *Journal of Marriage and the Family.* 2000; 62(4): 1234–1246.

Test, M.A. Training in community living. In: Liberman, R.P., ed. *Handbook of Psychiatric Rehabilitation*. New York: Macmillan Publishing, 1992. pp. 153–170.

Thomas, E.J., and Ager, R.D. Unilateral family therapy with spouses of uncooperative alcohol abusers. In: O'Farrell, T.J., ed. *Treating Alcohol Problems: Marital and Family Interventions*. New York: Guilford Press, 1993. pp. 3–33.

Thomas E.J., Santa C., Bronson D., Oyserman D. Unilateral family therapy with the spouses of alcoholics. *Journal of Social Service Research.* 1987; 10(2-4): 145–162.

Thomas E.J., Yoshioka M.R. Spouse interventive confrontations in unilateral family therapy for alcohol abuse. *Social Casework.* 1989; 70: 340–347.

Thomas, E.J., Yoshioka, M., Ager, R., and Adams, K.B. "Experimental outcomes of spouse intervention to reach the uncooperative alcohol abuser: A preliminary report." Paper presented at the Fifth Congress of the International Society for Bio-Medical Research on Alcoholism, Toronto, ON, June, 1990.

Toarmino, D., and Chun, C.-A. Issues and strategies in counseling Korean Americans. In: Lee, C.C., ed. *Multicultural Issues in Counseling: New Approaches to Diversity*. 2d ed. Alexandria, VA: American Counseling Association, 1997. pp. 233–254.

Trepper T.S., Nelson T.S., McCollum E.E., McAvoy P. Improving substance abuse service delivery to Hispanic women through increased cultural competencies: A qualitative study. *Journal of Substance Abuse Treatment.* 1997; 14(3): 225–234. [PubMed]

Tung M.P. Symbolic meanings of the body in Chinese culture and "somatization. *Culture, Medicine, and Psychiatry.* 1994; 18(4): 483–492.

U.S. Census Bureau. *Census 2000 PHC-T-10: Hispanic or Latino Origin for the United States, Regions, Divisions, States, and for Puerto Rico. 2000*. Washington, DC: U.S.

Census Bureau, 2001*a*. http://www.census.gov/population/cen2000/phc-t10/phc-t-10.pdf [Accessed February 11, 2004].

U.S. Census Bureau. *CH-3: Living Arrangements of Black Children Under 18 Years Old. 1960 to Present.* Washington, DC: U.S. Census Bureau, 2001*b*. http://www.census.gov/population/socdemo/hh-fam/tabCH-3.xls [Accessed February 11, 2004].

U.S. Census Bureau. *Statistical Abstract of the United States, 2001: The National Data Book*. Washington, DC: U.S. Census Bureau, 2001*c*. http://www.census.gov/prod/2002pubs/01statab/stat-ab01.html [Accessed February 11, 2004].

U.S. Department of Health and Human Services. *Research Shows Needle Exchange Programs Reduce HIV Infections Without Increasing Drug Use*. Washington, DC: U.S. Department of Health and Human Services, 1998. http://www.hhs.gov/news/press/1998pres/980420a.html [Accessed February 11, 2004].

U.S. Department of Housing and Urban Development. *Martinez Outlines Bush Administration Strategy to Combat Chronic Homelessness: Speech to Homeless Advocates Outlines Coordinated Federal Response to Homelessness*. Washington, DC: Department of Housing and Urban Development, 2002. http://www.hud.gov/news/release.cfm?content=pr02-080.cfm [Accessed February 11, 2004].

Uehara E.S., Takeuchi D.T., Smukler M. Effects of combining disparate groups in the analysis of ethnic differences: Variations among Asian American mental health service consumers in level of community functioning.
American Journal of Community Psychology. 1994; 22(1): 83–99. [PubMed]

Vaillant, G.E. *The Natural History of Alcoholism Revisited*. Cambridge: Harvard University Press, 1995.

Vanderbilt University Institute for Public Policy Studies. *Homeless Families Program Overview*. Washington, DC: Vanderbilt University Institute for Public Policy Studies, 1999. http://www.vanderbilt.edu/VIPPS/CMHP/Public/public.html [Accessed February 11, 2004].

Varley C.K. Schizophreniform psychoses in mentally retarded adolescent girls following sexual assault. *American Journal of Psychiatry.* 1984; 141(4): 593–595. [PubMed]

Vash, C.L. *The Psychology of Disability*. New York: Springer, 1981.

Wagenfeld, M.O., Murray, J.D., Mohatt, D.F., and DeBruyn, J.C. *Mental Health and Rural America: 1980-1993. An Overview and Annotated Bibliography.* NIH Pub. No. 94-3500. Rockville, MD: Health Resources and Services Administration and National Institute of Mental Health, 1994.

Waldron H.B. Adolescent substance abuse and family therapy outcome: A review of randomized trials. *Advances in Clinical Child Psychology.* 1997; 19: 199–234.

Waldron, H.B., Brody, J.L., and Slesnick, N. Integrative behavioral and family therapy for adolescent substance abuse. In: Monti, P.M., and Colby, S.M., eds. *Adolescents, Alcohol and Substance Abuse: Reaching Teens Through Brief Interventions*. New York: Guilford Press, 2000. pp. 216–243.

Walitzer, K.S. Family therapy. In: Ott, P.J., Tarter, R.E., and Ammerman, R.T., eds. *Sourcebook on Substance Abuse: Etiology, Epidemiology, Assessment, and Treatment*.

Needham Heights, MA: Allyn and Bacon, 1999. pp. 337–349.

Wallace J. A biopsychosocial model of alcoholism. *Social Casework.* 1989; 70(6): 325–332.

Walsh, F. Family therapy: Systems approaches to clinical practice. In: Brandell, J.R., ed. *Theory and Practice in Clinical Social Work*. New York: The Free Press, 1997. pp. 132–163.

Watzlawick, P., Weakland, J.H., and Fisch, R. *Change: Principles of Problem Formation and Problem Resolution*. New York: W.W. Norton, 1974.

Weaver, H.N. Native Americans and substance abuse. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment*. New York: Guilford Press, 2001. pp. 77–96.

Wegscheider, S. *Another Chance: Hope and Health for the Alcoholic Family*. Palo Alto, CA: Science and Behavior Books, 1981.

Wermuth L., Scheidt S. Enlisting family support in drug treatment. *Family Process.* 1986; 25: 25–33. [PubMed]

Werner E.E. Resilient offspring of alcoholics: A longitudinal study from birth to age 18. *Journal of Studies on Alcohol.* 1986; 47: 34–40. [PubMed]

Westermeyer J., Neider J. Substance disorder among 100 American Indian versus 200 other patients. *Alcoholism: Clinical and Experimental Research.* 1994; 18(3): 692–694.

White, J.L. Toward a black psychology. In: Jones, R.L., ed. *Black Psychology*. 2d ed. Berkeley, CA: Cobb & Henry Publishers, 1980. pp. 5–12.

White, M., and Epston, D. *Narrative Means to Therapeutic Ends*. New York: W.W. Norton, 1990.

Wilkinson, D. Family ethnicity in America. In: McAdoo, H.P., ed. *Family Ethnicity: Strength in Diversity*. Thousand Oaks, CA: Sage Publications, 1993. pp. 15–59.

Wilkinson, H. Celebrate the new family: Are "supply mums" and "supply dads" such a bad thing? *New Statesman* (August 9):21–23, 1999.

Wolin, S.J., and Wolin, S. *The Resilient Self: How Survivors of Troubled Families Rise Above Adversity*. New York: Villard Books, 1993.

Woods J.H., Winger G. Current benzodiazepine issues. *Psychopharmacology.* 1995; 118(2): 107–115. [PubMed]

Wright, E.M. Substance abuse in African American communities. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment.* New York: Guilford Press, 2001. pp. 31–51.

Yates F.E. The evaluation of a 'co-operative counselling' alcohol service which uses family and affected others to reach and influence problem drinkers. *British Journal of Addiction.* 1988; 83(11): 1309–1319. [PubMed]

Young T.J. Alcoholism prevention among Native-American youth. *Child Psychiatry and Human Development.* 1993; 24(1): 41–47. [PubMed]

Zeig, J.K., ed. *Ericksonian Psychotherapy*. New York: Brunner/Mazel, 1985.

Zitzow, D., and Estes, G. The heritage consistency continuum in counseling Native American children. In: *American Indian Issues in Higher Education*. Los Angeles: American Indian Studies Center, 1981. pp. 133–139.

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Appendix B: Glossary

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

Affective/spiritual acculturation A family's sense of connectedness to its ethnic traditions.

BCT Behavioral couples therapy.

Behavioral acculturation The degree to which a family participates in traditional or dominant-culture activities as opposed to other culture-specific activities.

BMT Behavioral marital therapy.

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 so rigid, inhibiting meaningful interaction so that the people in the relationship are said to be "disengaged" from each other, or so loose that individuals lose a sense of independence so that the "enmeshed" relationship stifles individuality and initiative.

CBT Cognitive–behavioral therapy.

Codependence A state of being overly concerned with the problems of another, to the detriment of one's own wants and needs.

Cognitive acculturation A client's grasp of and the extent of his involvement in the customs, beliefs, values, and language of a given culture.

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.

Ecological view of substance abuse A conception of substance abuse that is analogous to that of an ecological system in nature. Substance abuse occurs within a complex of systems, including families, communities, and societies. It may be assumed that all of the elements of this "ecological" system will have some influence on all the other elements.

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.

Family-involved therapy The programmatic involvement of family members in the substance abuse treatment program to correct family relationships that provoke or support continued substance abuse. Family-involved therapy is distinct from family therapy in that it may not view the entire family as the object of therapeutic interest and may not always intervene in the family's relational system.

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 multigenerational competing forces seek to maintain a state of equilibrium i.e., balance.

Idiopathic Of, relating to, or designating a disease having no known cause.

Integrated models A constellation of interventions that takes into account each family member's issues as they relate to the substance abuse and the effect of each member's issues on the family system.

IP Identified patient.

MFT Marriage and family therapy.

One-person family therapy Therapy incorporating a family focus without treating the whole family.

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.

Psychoeducation A combination of information about substance abuse and recovery, group support, and

examination of interactions that result in conflict. Facilitators collaborate with the family to change these provocative interactions, reduce household stress, and create an atmosphere conducive to recovery.

Social/environmental acculturation A family's patterns of socialization or acquisition of familiarity with its social and environmental elements.

Somatic Of, relating to, or affecting the body.

Stages of change One model of the phases of substance abuse recovery: precontemplation, contemplation, preparation, action, and maintenance.

Traditional family. The nuclear family two parents and minor children all living under the same roof, single parent, and families including blood relatives, foster relationships, grandparents raising grandchildren, and stepfamilies.

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.

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Appendix C: Guidelines for Assessing Violence

It is up to therapists to assess the potential for anger and violence and construct therapy so it can be conducted without endangering any family members. Because of the life-and-death nature of this responsibility, the consensus panel included recommended guidelines for the screening and treatment of people caught up in the cycle of domestic violence. These recommendations are adapted from TIP 25, *Substance Abuse Treatment and Domestic Violence* (Center for Substance Abuse Treatment 1997*b*).

If, during the screening interview, it becomes clear that a batterer is endangering a client, 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 can be ensured. The provider should refer the client to a domestic violence program and possibly to a shelter and legal services.

Screening guidelines for domestic violence and other abusive behavior

1. To determine if someone has endured domestic violence, look for physical injuries, especially patterns of untreated injuries to the face, neck, throat, and breasts. 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
2. 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.
3. As soon as it is clear that a client has been or is being battered, domestic violence experts should be contacted.
4. The provider should contact a forensics expert to document the physical evidence of battering.
5. Referrals should be made whenever 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.
6. A survivor of domestic violence who relocates to another community should be referred to the appropriate shelter programs within that community.
7. Because batterers in treatment frequently harass their partners (threatening them by phone, mail, and messages sent through approved visitors), telephone and visitation privileges of batterers and survivors in residential substance abuse treatment programs should be carefully monitored.
8. The discussion of family relationships, which is an element of all substance abuse screening interviews, can be used to identify domestic violence and gauge its severity.
9. 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 (person), was it a slap or a punch?
    - Do you take car keys away? Damage property? Threaten to injure or kill (person)?
10. 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.
11. The provider should be direct and candid, avoiding vague or euphemistic language, such as, "Is your relationship with your partner troubled?" Instead, ask about "violence," and keep the focus on behavior.
12. Become familiar with batterers' rationalization and excuses for their behavior:
    - *Minimizing:* "I only pushed her." "She bruises easily." "She exaggerates."
    - Claiming *good intentions:* "When she gets hysterical, I have to slap her to calm her down."
    - Blaming *intoxication:* "I was drunk." "I'm not myself when I drink."
    - Pleading *loss of control:* "Something snapped." "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." Substance abuse treatment providers should frame screening questions so that they do not allow a batterer to blame the person battered or a drug.
13. When treating a client who batters, providers should try to ensure the safety of those who have been or may be battered (partners and children, usually) during any crisis that precedes or occurs during the course of his treatment.
14. Treatment providers should mandate that batterers sign a "no-violence contract" stating that the client will refrain from using violence in- and outside the program.
15. Treatment providers should determine the relationship between the substance abuse and the violent

behavior:
    - When you take/drink (substance), exactly when does the violence occur?
    - How much of your violent behavior occurs while you are drinking or on other drugs?
    - What substances lead to violence?
    - What feelings do you have before and during the use of alcohol or other drugs?
    - Do you use substances to get over the violent incident?
16. After identifying the chain of events that precedes or triggers violent episodes, the provider and client should formulate strategies for modifying those behaviors and recognizing emotions that contribute to violent behavior.
17. Providers of services to clients who batter should watch for signs that the clients are misinterpreting the 12-Step philosophy to excuse continued violence. For example, the first step is admitting powerlessness over alcohol. Thus the client may be one short rationalization away from excusing a violent act while intoxicated, which is later justified because the substance "made me do it." Another danger is that batterers will call their partners "codependent" to shift blame for battering to the person harmed.
18. Referrals to self-help aftercare groups such as Batterers Anonymous should be made only after the client has completed a batterers' intervention program and has remained nonviolent for a specified period of time.

Screening for child abuse

1. Inquiries into possible child abuse should not occur until the limits of confidentiality, as defined in Title 42, Part II, of the Code of Federal Regulations (or 42 C.F.R, II) have been explained and the client has acknowledged receipt of this information in writing. Clients also must be informed that mandated reporters (such as substance abuse treatment providers) are required to notify a child protective services agency if they suspect child abuse or neglect.
2. 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?
3. The substance abuse treatment provider should not assess children for abuse or incest. Only personnel with special expertise should perform this delicate function. 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.
4. Indications of child abuse that can crop up in a client interview include:
    - Has a protective services agency been involved with anyone who lives in the home?
    - Do the children's behaviors, such as bedwetting or sexual acting out, indicate abuse?
    - Is extraordinary closeness noted between a child and another adult in the household?
    - Does the client report blackouts? (Batterers often claim to black out during a violent episode.)
5. If a treatment provider suspects that a client's child has been violently 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.
6. 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.
7. 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.

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Appendix D: Resources

The list of resources in this appendix is not exhaustive. The inclusion of selected resources does not necessarily signify endorsement by the Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services.

Addiction Technology Transfer Center National Office

University of Missouri - Kansas City

5100 Rockhill Road

Kansas City, MO 64110

Phone: (816) 482-1200

Fax: (816) 482-1101

E-mail: no@nattc.org

Web site: www.nattc.org

The Addiction Technology Transfer Centers (ATTC) 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 the Center for Substance Abuse Treatment (CSAT), part of SAMHSA, 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 (ACA) is a 12-Step, Twelve 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 55458-6166

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

Al-Anon Family Group Headquarters, Inc.

1600 Corporate Landing Parkway

Virginia Beach, VA 23454-5617

Phone: 1-888-4AL-ANON

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 Twelve Steps, by welcoming and giving comfort to families of alcoholics, and by providing understanding and encouragement to the alcoholic.

Alateen

Al-Anon Family Group Headquarters, Inc.

1600 Corporate Landing Parkway

Virginia Beach, VA 23454-5617

Phone: 1-888-4AL-ANON

Web site: http://www.al-anon.org/alateen.html

Alateen 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

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 (AAMFT) is the professional association for the field of marriage and family therapy. AAMFT represents the professional interests of more than 23,000 marriage and family therapists throughout the United States, Canada, and abroad.

Association for Play Therapy (APT)

2050 North Winery Avenue

Suite 101

Fresno, CA 93703

Phone: (559) 252-2278

E-mail: info@a4pt.org

Web site: www.a4pt.org

The Association for Play Therapy is an organization that was formed to help children and others in need. Its mission is to advance the psychosocial development and mental health of all people through play and play therapy.

Co-Anon Family Groups

Co-Anon Family Groups World Services

P.O. Box 12722

Tucson, AZ 85732-2722

Voice recorder: (520) 513-5028 Tucson, Arizona or (800) 898-9985 Toll Free

E-mail: info@co-anon.org

Web site: http://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 85067-3577

Web site: www.codependents.org

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

Families Anonymous

P.O. Box 3475

Culver City, CA 90231-3475

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 National Association for Children of Alcoholics

11426 Rockville Pike, Suite 100

Rockville, MD 20852

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

Fax: (301) 468-0987

E-mail: nacoa@nacoa.org

Web site: http://www.nacoa.org/

NACoA is the national nonprofit membership organization working on behalf of children of alcohol and drug dependent parents. NACoA's mission is to advocate for all children and families affected by alcoholism and other drug dependencies.

Nar-Anon Family Group

Nar-Anon World Service Office

302 West 5th Street, #301 San Pedro, CA 90731

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 addicted to drugs and alcohol.

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov

SAMHSA is the Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses. SAMHSA is composed of three Centers to carry out this mission: the Center for Substance Abuse Treatment, the Center for Mental Health Services, and the Center for Substance Abuse Prevention.

U.S. Department of Health and Human Services

Families & Children

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), for low-income families, HHS 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 or toll-free at (877) 4-WestEd

Web site: www.WestEd.org

WestEd is a nonprofit research, development, and service agency. The agency traces its history back to 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. The agency's work is far-reaching because its purpose is ambitious: success for every learner.

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Appendix E: Resource Panel

Shirley Beckett, NCAC II
Certification Administrator
National Association of Alcohol and Drug Abuse Counselors
Alexandria, Virginia

Susanne Caviness, Ph.D. (CAPT, USPHS) Senior Program Management Officer
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockville, Maryland

Frank Canizales, M.S.W.
Management Analyst, Alcohol Program
Indian Health Service
Rockville, Maryland

Peggy Clark, M.S.W., M.P.A.
Centers for Medicare and Medicaid Services
Center for Medicaid and State Operations
Baltimore, Maryland

Christina Currier
Public Health Analyst
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockville, MD

James Gil Hill
Director
Office of Evaluation, Scientific Analysis and Synthesis
Center for Substance Abuse Treatment
Rockville, Maryland

Hendree E. Jones, Ph.D.
Assistant Professor
CAP Research Director
Johns Hopkins University Center
Baltimore, Maryland

William (Bill) Francis Northey, Jr., Ph.D.
Research Specialist
American Association for Marriage and Family Therapy
Alexandria, Virginia

Hector Sanchez, M.S.W.
Team Leader
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockville, Maryland

Karen Urbany
Public Health Advisor
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockville, Maryland

Steve Wing
Senior Advisor for Drug Policy
Substance Abuse and Mental Health Services Administration
Office of Policy and Program Coordination
Rockville, Maryland

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Appendix F: Cultural Competency and Diversity Network Participants

Elmore T. Briggs, CCDC, NCAC II President/CEO
SuMoe Partners
Germantown, Maryland
African American Work Group

Frank Canizales, M.S.W.
Management Analyst, Alcohol Program
Indian Health Service
Rockville, Maryland
Native American Work Group

Ting-Fun May Lai, M.S.W., CSW, CASAC
Director
Chinatown Alcoholism Center
Hamilton-Madison House
New York, New York
Asian Work Group

Hector Sanchez, M.S.W.
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, Maryland
Hispanic/Latino Work Group

Ann S. Yabusaki, Ph.D.
Kaneohe, Hawaii
Asian Work Group

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

NATIONAL LIBRARY OF MEDICINE
SAMHSA/CSAT Treatment Improvement Protocols
SAMHSA Substance Abuse & Mental Health Services Administration

TIP 39: Appendix G: Field Reviewers

Stephanie Abbott, M.A.
Adjunct Professor
Marymount University
Arlington, Virginia

Raymond P. Adams, M.P.S., CAP
Drug Court Substance Abuse Counselor
Florida 16th Judicial Circuit Court
Marathon, Florida

David Bergman, J.D.
Director of Legal and Government Affairs
American Association for Marriage and Family Therapy
Alexandria, Virginia

James Bertone, LCSW, LADC
Rehabilitation Specialist II
Bureau of Alcohol and Drug Abuse
Carson City, Nevada

Thomas W. Blume, Ph.D., LPC, LMFT, NCC
Associate Professor
Doctoral Program Coordinator
Oakland University
Rochester, Michigan

Lane Brigham, Ph.D.
Thibodaux, Louisiana

Susanne Caviness, Ph.D. (CAPT, USPHS)
Senior Program Management Officer Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockville, Maryland

Paula Corey
Senior Vice President
Palladia, Inc.
New York, New York

Janice M. Dyehouse, Ph.D., R.N., M.S.N. Professor of Nursing
University of Cincinnati
College of Nursing
Cincinnati, Ohio

Jo-an M. Fox
Nashville, Tennessee

Joel Frank
Milwaukee, Wisconsin

Anne M. Herron, M.S.
Director
New York State Office of Alcoholism and Substance Abuse Services
Albany, New York

M. Kay Keller, M.P.A., SSW
Senior Human Services Program Specialist
Contract Manager Program
Department of Children and Family Services
Substance Abuse Program Office
Tallahassee, Florida

Malcolm V. King
Substance Abuse Program Manager
Virginia Department of Juvenile Justice
Richmond, Virginia

G. Richard Kinsella
Vice President
Syracuse Behavioral Healthcare
Syracuse, New York

Michael Warren Kirby, Jr., Ph.D., M.A., CAC III
Chief Executive Officer

Arapahoe House, Inc.
Thornton, Colorado

Janet M. Lerner, D.S.W., RCSW
Administrator
Narco Freedom, Inc.
New York, New York

Ruby J. Martinez, Ph.D., R.N., CS
Assistant Professor
University of Colorado
Denver, Colorado

Dan A. McRight
Nashville CPE Partnership
Nashville, Tennessee

Jerry Moe, M.A.
National Director
Betty Ford Center's Children's Program
Rancho Mirage, California

Fariha Niazi, LMHC
Brief Therapy Institute
NOVA Southeastern University
Fort Lauderdale, Florida

William (Bill) Francis Northey, Jr., Ph.D.
Research Specialist
American Association for Marriage and Family Therapy
Alexandria, Virginia

Gwen M. Olitsky, M.S.
Founder and C.E.O.
The Self-Help Institute for Training and Therapy
Lansdale, Pennsylvania

Randall W. Phillips, LMFT, LPC/MHSP
Union City Medical Center
Counseling and Consulting Services
Union City, Tennessee

Gerard J. Schmidt, M.A., LPC, MAC
Clinical Affairs Consultant
National Association of Alcoholism and Drug Abuse Counselors
The Association for Addiction Professionals
Morgantown, West Virginia

Thomas L. Sexton, Ph.D.
Professor and Director
Center for Adolescent and Family Studies
Counseling Psychology Program
Indiana University-Bloomington
Bloomington, Indiana

Meri Shadley, Ph.D., MFT, LADC
Associate Professor
Center for the Application of Substance Abuse Technologies
University of Nevada, Reno
Reno, Nevada

Mary K. Shilton
Executive Director
National Treatment Accountability for Safer Communities
Washington, DC

Robert Walker, M.S.W., LCSW
Assistant Professor
University of Kentucky
Center on Drug and Alcohol Research
Lexington, Kentucky

Sis Wenger
Executive Director
National Association for Children of Alcoholics
Rockville, Maryland

Kerry W. Wicks, LAC
Program Director
ND Department of Human Services
Jamestown, North Dakota

Ann S. Yabusaki, Ph.D.
Substance Abuse Director

Psychologist
Coalition for a Drug-Free Hawaii
Substance Abuse Programs and Training
Kaneohe, Hawaii

Copyright and disclaimer
Bookshelf | NCBI | NLM | NIH
Help | Contact Help Desk | Copyright and Disclaimer

REFERENCES

Asdigian, N. L., Tuitt, N., Mousseau, A. C., Ivanich, J. D., Schultz, K., Keane, E. M., Zacher, T., Skinner, L., Richards, F. R. W., Bear Robe, L., & Whitesell, N. R. (2023). Grounding evidence-based prevention within cultural context: Promising effects of substance use prevention adapted for American Indian families. *Substance Use & Misuse, 58*(8), 1004–1013. https://doi.org/10.1080/10826084.2023.2201847 (PMID: 37125477)

Corpus-Espinosa, C., Mac Fadden, I., Del Carmen Torrejón-Guirado, M., & Lima-Serrano, M. (2025). Exploring cultural adaptations: A scoping review on adolescent mental health and substance use prevention programs. *Prevention Science, 26*(2), 204–221. https://doi.org/10.1007/s11121-025-01779-x (PMID: 39888521)

Debbink, M. P., Tanana, H., Murray, J. L., Blosser, P., Horse, L., Monroy, C., Spiess, S., Charles, J. E., Turok, D. K., Smid, M. C., Allshouse, A. A., Smith, J. D., Cohen, S. R., Johnson, E. P., Metz, T. D., & Gordon, A. J. (2026). Culturally Engaged REcovery – MOms connected through Native CommunitY (CEREMONY): An implementation study to evaluate the adaptation and implementation of an integrated perinatal SUD clinical model for pregnant and postpartum Native people. *Substance Use & Addiction Journal, 47*(1), 233–242. https://doi.org/10.1177/29767342251336550 (PMID: 40955087)

Maxey, H. L., Daulton, B. J., Boustani, R., & Binion, K. E. (2025). Substance use disorder, the workforce, and treatment quality for minoritized populations: A systematic review. *Substance Abuse: Treatment, Prevention, and Policy, 20*, 26. https://doi.org/10.1186/s13011-025-00656-8 (PMID: 40537802)

Mereish, E. H., Fish, J. N., & Watson, R. J. (2023). Intersectional minority stress and alcohol, tobacco, and cannabis use among sexual and gender minority adolescents of color: Moderating role of family support. *LGBT Health, 10*(1), 18–25. https://doi.org/10.1089/lgbt.2021.0430 (PMID: 35914084)

Paschen-Wolff, M. M., DeSousa, A., Paine, E. A., Hughes, T. L., & Campbell, A. N. C. (2024). Experiences of and recommendations for LGBTQ+-affirming substance use services: An exploratory qualitative descriptive study with LGBTQ+ people who use opioids and other drugs. *Substance Abuse: Treatment, Prevention, and Policy, 19*(1), 2. https://doi.org/10.1186/s13011-023-00581-8 (PMID: 38172902)

Peasley-Miklus, C. E., Shaw, J. G., Rosingana, K., Smith, M. L., Sigmon, S. C., Heil, S. H., Jewiss, J., Villanti, A. C., & Harder, V. S. (2024). "I don't think that a medication is going to help someone long-term stay off opioids": Treatment and recovery beliefs of rural Vermont family members of people with opioid use disorder. *The Journal of Rural Health, 40*(4), 681–688. https://doi.org/10.1111/jrh.12851 (PMID: 38881521)

Zhang, C., Tang, Y., Kniffen, W., & Liu, Y. (2025). Exploring social and structural determinants of substance use among sexual and gender minority adults in the United States. *Journal of the International Association of Providers of AIDS Care, 24*, 23259582251409855. https://doi.org/10.1177/23259582251409855 (PMID: 41432589)

Appendix A: SUBSTANCE ABUSE TREATMENT AND FAMILY THERAPY

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

Module 4

1. Community and cultural aspects are the broadest components of an _____ approach.
   a. logical
   b. analogical
   c. ecological
   d. phenomenological
   e. eco-dominant

2. The NIDA funded 2001 survey found that more than _____ percent of eighth graders said they had abused inhalants at least once in their lives.
   a. 10
   b. 17
   c. 24
   d. 5
   e. 33

3. More than _____ percent of young people who were classified as heavy drinkers were also using illicit drugs.
   a. 10
   b. 25
   c. 50
   d. 65
   e. 75

4. There are _____ patterns of substance abuse among older adults.
   a. two
   b. three
   c. four
   d. five
   e. six

5. Elder abuse perpetrators are most often _____.
   a. the victim‟s doctor
   b. the victim‟s nursing home caretakers
   c. the victim‟s family members
   d. strangers
   e. the police

6. The OAS 2003 survey found that almost _____ percent of women reported binge drinking in the month preceding the survey.
   a. 50
   b. 40
   c. 30
   d. 20
   e. 10

7. Which of the following ills may influence the children of mothers who abuse substances?
   a. depression
   b. anxiety
   c. conduct disorders
   d. suicide ideation
   e. all of the above

8. Particular treatment issues relevant to women include _____.
   a. shame
   b. stigma
   c. trauma
   d. control over her life
   e. all of the above

9. The practice of _____ is an essential part of extended family life.
   a. inhibition
   b. recycling
   c. recitation
   d. reciprocity
   e. retroaction

10. The mythical role of the African-American _____ prevents many mothers from seeking help.
    a. top dog
    b. underdog
    c. superwoman
    d. superstar
    e. hero

11. Cuadrado and Lieberman assert that English-speaking Mexican Americans are _____ times more likely to use marijuana than their Spanish-speaking peers.
    a. eight
    b. seven
    c. six
    d. five
    e. four

12. Familismo has _____ components.
    a. seven
    b. six
    c. five
    d. four
    e. three

13. Hispanics/Latinos may perceive any type of open disagreement as _____.
    a. rude
    b. insensitive
    c. disrespectful
    d. unacceptable
    e. all of the above

14. Mexican spiritual healers are called _____.
    a. comancheros
    b. curanderos
    c. banderos
    d. holinderos

15. Asian-American families may be characterized by the _____ myth.
    a. modest-minority
    b. modal-minority
    c. model-minority
    d. model-majority
    e. modal-majority

16. Asians may be hesitant to admit to having a substance use disorder. Instead they may prefer to _____.
    a. minimize
    b. deny
    c. reject
    d. ostracize
    e. all of the above

17. Asian culture places a high value on saving _____.
    a. face
    b. eyes
    c. nose
    d. feet
    e. backside

18. Rather than discussing anxiety and depression, Asians may complain about _____.
    a. headaches
    b. fatigue
    c. restlessness
    d. sleep disturbances
    e. all of the above

19. Kim recommends _____ steps to pace the family‟s cultural expectations and limitations.
    a. six
    b. five
    c. four
    d. three
    e. two

20. During 1994-1999, _____ percent of American-Indian men who entered treatment entered because of alcohol abuse.
    a. 70
    b. 60
    c. 50
    d. 40
    e. 30

21. The most important and fundamental constant among American-Indian families is the _____ extended family.
    a. bigenerational
    b. uni-generational
    c. trigenerational
    d. four generation
    e. un-inclusive

22. Historically, the relationship between American Indians and non-Indian therapists has been marked by _____ .
    a. sexism
    b. racism
    c. ethnocentrism
    d. separatism
    e. radicalism

23. The more traditional an American Indian is, the more difficulty he or she will have with _____ concepts.
    a. RET
    b. TA
    c. SOS
    d. RR
    e. AA

24. There are _____ primary disability categories.
    a. four
    b. five
    c. six
    d. seven
    e. eight

25. Affective disabilities include _____.
    a. depression
    b. bipolar disorder
    c. schizophrenia
    d. PTSD
    e. all of the above

26. At least _____ percent of people with alcohol dependency meet criteria for antisocial personality disorder.
    a. 10
    b. 20
    c. 30
    d. 40
    e. 50

27. In 1993, _____ percent of U.S. counties were without a practicing psychologist, psychiatrist, or social worker.
    a. 75
    b. 65
    c. 55
    d. 45
    e. 35

28. AIDS incidence declined in most populations but increases were observed in _____ .
    a. men
    b. women
    c. adolescents
    d. persons with homosexual contact
    e. none of the above

29. Homeless teens are more likely to be female with behaviors that include _____.
    a. sexual promiscuity
    b. prostitution
    c. unplanned pregnancy
    d. suicide attempts
    e. all of the above

30. It is important for the therapist to consider how _____ is defined for the homeless.
    a. realism
    b. responsibility
    c. reintegration
    d. reality
    e. rationality

31. Merging of family therapy techniques with substance abuse treatment warrants consideration of _____ primary policy questions.
    a. 3
    b. 4
    c. 5
    d. 6
    e. 7

32. The documented cost savings and public health benefits associated with family therapy support the idea of _____ .
    a. reinforcement
    b. dispersement
    c. reimbursement
    d. dispersibility
    e. reallocation

33. The four program planning models presented are staff education, family education, family integration, and provider _____ .
    a. collusion
    b. elaboration
    c. collaboration
    d. collectivity
    e. collateralization

34. Education of the family proceeds along a _____.
    a. matrix
    b. continuum
    c. graph
    d. diagram
    e. scale

35. Evaluating the outcome, benefits, and drawbacks of family education activities can be _____.
    a. qualitative
    b. simple
    c. quantitative
    d. complex
    e. all of the above

36. For many provider collaboration arrangements a _____ can be developed to help clarify interrelationships.
    a. MOA
    b. UMO
    c. MOU
    d. MMO
    e. AMA

37. Staff should avoid _____.
    a. ripping
    b. tearing
    c. sparing
    d. splitting
    e. spitting

38. _____ extends to all individuals in treatment.
    a. Confinement
    b. Confidentiality
    c. Confidence
    d. Confluence
    e. Confabulation

39. Measures of long-term functioning can include monitoring _____.
    a. rearrests
    b. recidivism
    c. readmission to substance abuse treatment programs
    d. marital happiness
    e. all of the above

40. One drawback for e-mail communication is possible misinterpretation due to lack of _____ cues.
    a. tonal
    b. trigger
    c. unconscious
    d. sub-lingual
    e. ESP