6

Family Therapy

The family is usually an enduring support system, and improving its ability to support the recovery process is important. The stereotype of alcoholics and addicts as loners, cut off from contact with their families and living an "alley cat existence" is, in fact, incorrect (Stanton & Heath, 2005, p. 680). In reality, substance abusers, especially drug addicts, have more contact with their families than age-comparable individuals in the general population. Systematic research also supports the view that the family should be included in the treatment process. These data are consistent with a pattern of addicted individuals who have failed to thrive and whose family members have become interconnected with them in unhealthy ways. For these reasons family therapy is essential for treatment to be successful. Family therapy can be viewed as an adjunctive or stand-alone treatment.

Chapter 5 focused on the therapist working with the individual patient to assist him or her with admitting the problem and becoming willing to address it, establishing and consolidating abstinence, and changing the lifestyle to support recovery. This chapter deals with how the therapist can support the family through that process. The tasks of the family therapist

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involve engaging, joining, stabilizing, educating, analyzing family systems, developing coping strategies, and developing relapse prevention strategies. Although these tasks are presented sequentially, in reality they are intertwined. The therapist may often go back and forth between education and stabilization interventions within the course of the single session. Likewise, the therapist will probably be educating the family members and the patient in the first session.

ENGAGING: GETTING THE PATIENT INTO TREATMENT

The first task of the therapist working with patients with alcohol or other drug (AOD) use disorders is engaging the patient or family members. *Engaging* refers to techniques or strategies that encourage either the identified patient or other family members to acknowledge that a problem exists and to participate in the therapeutic process. It is an attempt to help the client move through the stages of change from precontemplation to contemplation to action (see Chapter 3, this volume).

Interventions

With adults, the process of engagement often involves what has come to be known as an *intervention.* Although the oldest and best-known intervention method is the Johnson Institute method (Johnson Institute, 1987), it is by no means the only method. There also exist other methods that have greater or lesser degrees of empirical support. These methods include A Relational Intervention Sequence for Engagement (ARISE; Landau & Garrett, 2006), the Pressure to Change (PTC; Barber & Crisp, 1995), and Community Reinforcement and Family Training (CRAFT; Smith & Myers, 2004).

In two types of situations, the therapist in private practice may be asked to help in an intervention. The first is with individuals who are in the precontemplation stage and who are highly resistant to the suggestion that their drinking or drug use is a problem. They are refusing to discuss it and

are certainly not going to talk to a therapist about it. The family members feel frustrated and as if they are at the end of their rope. Negative consequences have accumulated over the years to the point where family members have had enough and are ready to throw the individual out. Or they are scared and fear for this person's life. In this situation, it is probably best to refer the family to an interventionist who is trained in one of the formal intervention techniques mentioned earlier. The therapist can still be involved in the ongoing therapy afterward, if appropriate, but doing the formal intervention is a specialization that takes training. Interventionists must know how to prepare the family in advance, how to transport the patient, and how to prepare for violence or other untoward circumstances.

The second type of intervention is more common. The client may be in the precontemplation or contemplation stage of change but is less hostile and less resistant. The therapist may not need an interventionist and may be able to handle the situation in his or her office. The basic approach is invitational, not confrontational. First, the family meets the therapist without the patient in the office. They discuss their concerns and issues, and the therapist explains the agenda of the coming meeting with the patient as well as the tone of that meeting. The tone should be one of caring, not anger or blame.

The family members write statements to the patient about his or her specific behaviors that have caused them concern. They should let the patient know that they are committed to his or her getting better and prepared to set certain boundaries. The boundaries can include no longer making excuses for the patient or the patient not living at home anymore, depending on how serious the situation has become. These prepared statements should be brief and written. The therapist should review the written statements in advance to be sure they are appropriate. The family then tells the patient that they have met with the therapist and invites the patient to join the next session. The important point is to invite the patient to participate with the other family members in a process of becoming healthy.

With adolescents who refuse to go, a simple approach works well. The parents are instructed to tell the adolescent that there will be a meeting

at a certain date, time, and place, and he or she is invited to attend. They tell the adolescent that decisions will be made about his or her future. If the adolescent refuses to go, the parents are not to argue, but they are to remind the person that he or she will then have no input into the decisions about his or her future. Usually, the adolescent will attend the meeting. If he or she does not, the therapist can meet with the parents, collect background information, and make recommendations. The recommendations can range from restrictions and loss of privileges to residential treatment.

Other Intervention Methods

ARISE is a three-step approach (Landau & Garrett, 2006). The first step involves telephone sessions plus an in-person meeting of family or network members with the therapist to mobilize them to support treatment for the substance abuser. The second step is an "invitational intervention" with the substance abuser (Landau & Garrett, 2006). This intervention is not a surprise and does not involve consequences if treatment is refused. The third step is a surprise intervention similar to the Johnson Institute method (Johnson Institute, 1987).

The *PTC* method was developed for heavy drinkers who refuse to change (Barber & Crisp, 1995). This approach uses learning theory to teach five increasing levels of pressure to encourage the drinker to change. These range from educating the family member about the seriousness of the drinking problem and about PTC, to directly confronting the drinker about the negative effects of his or her drinking and making a simple request to change or seek help.

The *CRAFT* method also uses learning theory in a six- to eight-session program that teaches family members to use positive reinforcement and negative consequences to discourage substance abuse. CRAFT also places emphasis on identifying situations that could lead to violence in the family, by focusing on cues before violence begins. Finally, CRAFT teaches effective ways to suggest treatment options to the substance abuser (Smith & Myers, 2004).

JOINING: AFFILIATING WITH FAMILY MEMBERS AND THE PATIENT

Joining, another task of the family therapist, refers to the therapist affiliating with each individual family member. The therapist carefully listens and conveys that he or she is interested in what the family members have to say. Also, the therapist attempts to understand each individual's point of view and to address each individual's concerns:

> The quality of the relationship between the counselor and the family is a strong predictor of whether families will come to, stay in, and improve in treatment (M. S. Robbins, [Szapocznik, Alexander, & Miller,] 1998). Studies have found that the therapeutic relationship is a strong predictor of success in many forms of therapy (Rector, [Zuroff, & Segal,] 1999; Stiles, [Agnew-Davies, Hardy, Barkham, & Shapiro,] 1998). (Szapocznik, Hervis, & Schwartz, 2003, p. 25)

Initially it is important for the therapist to respect rather than to challenge the defensiveness of the family. Often these families have led lives centered on the frequent crises created by the behavior of the identified patient (the alcoholic or addict). Sometimes it seems to the family as if the drinking or drug use is the source of the entire problem. Therapists often hear, "If only he or she would stop drinking, then our lives would be fine!" They should challenge this assumption and introduce the idea that once abstinence occurs, other problems will become visible. First, when the alcoholic or user stops drinking or using, family life is often initially more chaotic and more confrontational. Emotions and feelings that have been medicated through the use of alcohol or drugs rise to the surface after these substances been removed. Often family tensions and underlying conflicts that may have contributed to the disorder in the first place are revisited after the person achieves sobriety.

Initially the therapist can acknowledge that drinking has certainly taken its toll on the entire family, and the therapist can sympathize with the family's concern over the patient's continued drinking. The therapist needs to communicate that he or she intends to take this issue seriously by making it a major focus of the therapeutic endeavor. He or she can say,

"Given the involvement of the entire family, including the identified patient, we can jointly develop a plan to address this issue."

Another common misconception poses a greater challenge for the therapist: the notion that alcohol or drugs are not the problem. In this regard, the family therapist does not directly challenge the family rules early in therapy. Instead the therapist works within existing family structures and supports areas of family strength, especially for those family members who are most threatened (Kaufman, 1994). An example of this clinical presentation is the family in which the adolescent is presenting with all the signs of an emerging substance abuse problem.

> The boy's grades have been declining for the past several years. For the past 6 months he has been staying out late, either missing curfew or sneaking out late at night. He has become increasingly isolated, spending more time in his room. He has a new peer group of adolescents who have either had difficulties with juvenile authorities or have dropped out of school. The precipitating event that led to the therapy appointment was the boy's arrest at a party where alcohol and marijuana were being used. The police determined that he had been drinking. Rolling papers but no actual drugs were found in his possession. The young man's story is that he was drinking for the first time and the rolling papers belonged to a friend.
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> The parents begin the session by assuring the therapist that it is not a substance abuse problem. Each parent has a somewhat different perspective on the problem. The mother believes that the father is a workaholic who pays no attention to the children and that this is the source of the problem. She says, "A teenage boy needs a father to keep him in line." She continues, "When he does come home, he is often too tired to bother with the children. He is moody and irritable and has only negative things to say. He puts the boy down all the time." The father, however, thinks that the mother is too soft with the kids. "She is always making excuses for them and never holds them accountable," he explains. "Of course I am irritable," he says. "When I try to intervene and discipline the kids she is always there to undermine what I am doing. She can't stop protecting them for one minute."

> Both parents are united on only one point. They insist that the problem is not drugs, and they do not want alcohol or drugs to be the focus of the intervention. They begin by stating that they took their son to one of those treatment centers, where they were told that he might have an addiction problem. They immediately left and brought their son to see you, the clinician, who would understand that their son is struggling with issues of self-esteem.

Here the therapist is in a bind. The parents have presented a clinical picture that suggests substance abuse but at the same time have given a clear warning that this topic is off-limits and should not be the focus of the therapeutic efforts. In a somewhat controlling way, they have said or implied that the last therapist who tried to focus on the substance abuse issue was fired and in continuing to work with this family it would be unwise to head down that same road. The bind, then, is how to join with this family and acknowledge their concerns without totally accepting the directive to defocus from the teenager's abuse of substances. The underlying family rule is clear: "Don't talk about the substance abuse problem."

Perhaps the mother comes from an alcoholic family herself where there was tremendous family disruption (e.g., constant crisis, chaos, physical or verbal abuse) and where a negative outcome ensued (e.g., death, institutionalization). Perhaps the father has a moral or judgmental view of people with substance abuse problems and cannot tolerate the idea that this problem exists within his family. Perhaps both parents have an overwhelming fear that their son could turn out to be a "druggie," and this would be unthinkable. Whatever the underlying issues, the family is warning the therapist that this is a brittle, sensitive issue that should not be confronted right away and must be dealt with in a sensitive and caring manner only after a trusting bond has been established.

In this instance, the therapist must acknowledge the fears that both parents have. The therapist can say, "Sneaking out at night, declining school grades, and the other symptoms mentioned are all important. We must look at the underlying reasons and try to develop a plan to address the problem." The therapist would also be remiss, however, if he or she did not raise the issue of the importance of the teenager remaining free from

alcohol and drugs as a prerequisite for addressing these other issues. Most parents are willing to support the concept of an alcohol- and drug-free life for their teenager as a positive goal. Helping parents to see the link between regular drug use and low self-esteem, as well as other psychological problems, can help to fortify their resolve on this issue. Requesting their assistance in monitoring this through alcohol and drug screens, and emphasizing that this is a routine part of the procedure in such cases, is often received as a positive, affirming step, even by families with such a rigid defense structure. In this way, the notion of substance abuse as a possible confounding variable in the overall symptom or problem pattern is introduced without identifying substance abuse as the source of the problem. Later, the family's particular sensitivities about substance abuse issues can be examined and perhaps addressed more directly. Also, depending on the outcome of the monitoring process through alcohol and drug screens, the true nature of the problem may become more apparent.

Kaufman (1994) suggested *mimesis,* or using the family's preferred adaptive mode and styles of communication, as a way to join with the family. In the example of the teenager, for instance, when speaking to the father, the therapist might state in a more authoritative voice, "Yes, I agree rules are important. One of the things we are going to try to do in here is to set up reasonable rules and make sure that they are consistently applied." In speaking to the mother, however, the therapist might say in a somewhat softer, comforting voice, "We must also look at self-esteem. It is important not only for your son to learn how to feel good about himself but also for the whole family to learn how to feel good about this family unit." In this way, the therapist has supported each parent without undermining the other.

STABILIZING: GETTING TO ABSTINENCE

The next task of the family therapist who works with patients with AOD disorders is stabilization. *Stabilization* refers to a set of intervention strategies that are designed to assist the patient in either abstaining from mood-altering drugs completely or, where appropriate, reducing AOD use to the

point at which the patient's functioning is not impaired. Most family therapists, regardless of their theoretical orientation, stress the importance of establishing abstinence before meaningful therapeutic work can be undertaken (S. Brown & Lewis, 1995; Kaufman, 1994; O'Farrell, 1993; Sisson & Azrin, 1993).

> The therapist must structure treatment so that the control of the alcohol abuse is the first priority before attempting to help the couple with other problems . . . [because] the hope that reduction in marital distress will lead to improvement in the drinking is rarely fulfilled. (O'Farrell, 1993, p. 172)

Achieving abstinence often occurs over an extended period of time. During this time, the therapist can help family members to see how their dysfunctional interactions serve to support the patient's substance-using behavior. The therapist should consider discontinuing therapy only when the identified patient and family members continually resist moving toward abstinence, thereby undermining therapeutic progress.

In many cases, however, this focus is the opposite direction from the one in which the family wishes to proceed. The family members have often joined with the alcoholic or drug addict in rigidly maintaining the existence of alternative explanations for the identified patient's problems. Thus, the family member may believe the source of the problem is not the husband's drinking but the stress of his job or perhaps the death of his father 2 years ago. In the clinical example of the adolescent, the source of the problem from the mother's perspective is not the AOD use but the father's parenting; from the father's perspective it is the mother's enabling behavior that creates the difficulties. When these explanations are in danger of breaking down, other explanations can be added or substituted. Therapists frequently hear parents say, "He failed the algebra class because of the bad teacher" or "She drinks because she is under tremendous pressure from her peers."

Faced with these rigid defenses, the therapist's job is to gently but firmly shift the focus back to the drinking and drug use. Fortunately, cracks begin to appear in the defense structure over time. The therapist

highlights these cracks, notes the discrepancies, and focuses the family on the meaning of these episodes. Thus, the adolescent skips school; drinks or uses drugs; and, as a result, misses a test and drops a full letter grade. This event shows the loss of control over AOD use. The therapist needs to highlight the loss of control and define it for what it is: an example of drinking and drug-use behavior that needs to be stabilized. Also, the therapist can suggest that if AOD use is not a problem, it should not be a problem to stop for a period of time. By keeping the focus on the drinking and drug use, by highlighting episodes that illustrate loss of control, and by interpreting the meaning of these episodes, the therapist accelerates the process by which the family's defense structure collapses. The reality of the AOD use becomes too blatant to ignore.

Behavioral contracting is a specific method in which the therapist can help maintain the focus on alcohol and drug use and help move the patient toward abstinence. If in the early stages of therapy an abstinence contract is not achievable, the therapist can use a behavioral contract that will help to move the patient closer to an abstinence contract. The therapist, the family members, and the identified patient jointly agree on certain behavioral goals. For the adolescent these goals might include going to school, passing courses, coming in on time, and so forth. For the adult they might include enhancing performance at work, accepting responsibility at home, increasing involvement with the children, and so forth. The goals might also include complying with a specific therapeutic regimen such as taking disulfiram for the heavy drinker, agreeing to attend group therapy, or going to a certain number of self-help meetings per week.

The therapist and family should create an abstinence contract as soon as they can, because achieving abstinence is a prerequisite for any meaningful therapeutic change. The abstinence contract needs to be long enough to allow the physical and psychological realities of not drinking and using drugs to impinge on the identified patient. These realities include not only the physical withdrawal phase that can often be endured through determination, coping skills, and a good plan but also the waves of psychological craving that are sure to follow. A contract should be for at least 30 days, but a 60- or 90-day contract is preferable.

During the contract period the therapist can see the impact of sobriety on the family members as well as on the patient. Family members may insist that the situation has worsened. In some cases, wives have suggested that the husband return to drinking because he was more likable the old way. Still other family members may find themselves feeling surprisingly empty and lost because the crisis-centered nature of their existence has slowed down. If their role has been that of the rescuer, family members may feel as if their main function in life has been usurped. Most important, during the abstinence contract period, the identified patient has the opportunity to examine feelings that arise that are secondary to sobriety. He or she can focus on dreams, feelings, and thoughts about alcohol and drug use that are indicators of how attached the individual was to the substance.

Establishing a contract allows for the imposition of structure on a previously chaotic existence. It allows the family members and the identified patient to set specific goals by which progress can be measured. Setting specific goals and measuring progress on a weekly basis can help the resistant individual to understand how out of control his or her life has become and the need to move in a different direction. Likewise, contracting for a specific therapeutic regimen also can help to reinforce the need for structure in the lives of the patient and family members. If the patient agrees to attend five self-help meetings a week, and the family members agree to do the same, it soon becomes clear when these goals are not being met. When the patient, for example, misses meetings on a regular basis, this becomes grist for the mill to explore resistance by discussing unpleasant feelings or reactions to the meeting environment.

At this point the family may enter a true crisis stage. The identified patient often finds him- or herself in the uncomfortable position of having stopped drinking but having absolutely no coping mechanisms. Physical violence, suicide attempts, and other forms of acting out are not uncommon. The patient is more in touch with issues such as loss of control and is more aware of the destabilizing role that AOD use has played in the overall family problems. As this awareness emerges and behaviors begin to change, the patient is left without access to his or her primary coping mechanism, AOD use. An underlying sense of panic often emerges. The therapist must

be prepared to intervene with other strategies to support, reassure, and guide the patient and family members once the drinking and drug using has stopped.

EDUCATING: WHAT IS NORMAL AND WHAT COMES NEXT

Education can be extremely helpful in the therapeutic process at this stage. It is important to normalize for the family the behaviors that the identified patient is exhibiting. To be helpful, the education must be based on knowledge of the normal pattern that ensues as the patient moves from drinking or using drugs to a recovery lifestyle. Two books by Stephanie Brown are helpful here: *Treating the Alcoholic* (1985) and *Treating Alcoholism* (1995).

The patient's regression in behavior occurs as a normal part of recovery. In early abstinence people often experience intense craving for the drug or alcohol. Often, discussing addictive craving directly with patients and family members is beneficial, comparing it with a primary drive state (see Chapter 2).

Family members, especially parents of adolescents, often become concerned because the patient is not performing to their expectations. "Sure, he's sober, but he still doesn't bring home any books from school. He never studies, and he seems uninterested in playing sports like he used to," is a common refrain. The father of an adolescent patient exclaimed angrily, "He needs to get on with his life. It's his senior year in high school and he has football, he has academics, he has college applications. Why is he so uninterested in all of this?" At this point the therapist can encourage family members to scale back expectations and to keep focused on the target. In the early days of recovery, abstinence is a full-time job.

The therapist should encourage the patient to immerse him- or herself in a recovery program. The therapist should encourage the family members to step back and allow this process to happen, supporting it when they can but certainly not obstructing it. Family members, especially spouses, may become jealous of the time that the husband or wife spends going to self-help meetings. Therapists often hear the refrain, "He spends

more time with them than he spends with me." Family members may feel that the identified patient has become addicted to the program itself.

The answer to the family's questions is that patients' reality in the early days of sobriety is one of hanging on for dear life, trying not to use but not possessing many recovery skills of their own. They are attracted to a support group precisely because they are so desperate. They see others at these meetings who seem happy but who also understand the craving that they are experiencing. These recovering people do not judge or analyze the situation; rather, they provide support and give the patient concrete tools for staying sober "one day at a time." Slowly, patients learn how to structure leisure hours that were previously devoted to drinking and using drugs. They learn to telephone their sponsor in times of crisis. They learn the soothing effects of daily meditation and reading related literature that speaks to their experience. A sponsor is someone who has been abstinent and sober in the 12-step program for a length of time and is now ready to help newcomers and others on their path to sobriety (see Chapter 7). Forming new relationships and new behavior patterns makes it easier to let go of the old. This process is the full-time job of recovery.

At this stage in the process the therapist's knowledge of addiction and recovery stages is vital to the family. They are desperate for information, especially knowledge about the sequencing of recovery-related behaviors and knowledge about what they can expect in the future. They want to know how long before the identified patient is his or her old self again. The patient wants to know how long before he or she will not wake up in the middle of the night dreaming about using. Parents want to know whether their child can return to the old school environment or can be transferred to another one. All family members want to know what is safe to talk about at home. Will they trigger a relapse if they say the wrong thing? The therapist must be prepared to respond to these questions with factual information based on experience.

Especially valuable at this point is referring family members to self-help meetings of their own, such as Al-Anon. This rapidly accelerates the learning curve because they are immediately exposed to other family members who have progressed further through the process and can provide

knowledge and support for them. Soon family members' resentment of the patient's time at self-help meetings lessens because they are deriving nourishment and support from their own recovery programs.

The therapist must also be prepared to address the underlying emotion of fear, which is expressed by the questions "Will he ever get better?" or "Will he survive?" or "Will he ever be normal?" The family is seeking reassurance at this point, and some should be forthcoming. "Of course he can get better, and there is no reason why he should not. Millions of others have gone before him and have recovered, so he can too." By the same token, such questions also provide an opportunity for education. If the patient is truly AOD dependent, recovery is closely tied to remaining abstinent from all mood-altering drugs. Both the patient and family members need to know this principle early in the process.

Another series of questions often posed by family members involves the process of rebuilding trust. Parents wonder, "How can we ever believe anything our child says again?" Often parents will say, "He used drugs for years right under our noses. We are afraid of being burned again." Although their fear is real, the therapist can remind the parents that they are now more educated about this topic than they were in the past. Most appropriately, the therapist can review the warning signs that the family observed but perhaps ignored in the past.

The patient is afraid of relapsing, whereas the family is afraid of returning to the chaos and crisis that permeated their lives for so many years. A frank discussion of this issue is in order. The therapist should support the family members at this point by communicating something such as, "You should never have to return to that type of chaos. Let's develop a plan for dealing with it should it arise." A statement of this type can effectively lead into a discussion of a relapse prevention plan. It is often appropriate at this point for the patient to state what he or she plans to do in the event of a relapse and to discuss some ways of regaining sobriety.

Rather than a rigid plan such as going to long-term treatment, a more flexible plan is preferable, such as, "In the event of a relapse we (the patient and family members) agree to contact you (the therapist) immediately and jointly develop a set of strategies and recommendations." These rec-

ommendations might include increasing the frequency of meeting attendance, increasing the frequency of therapy sessions, or attending a special group for assertiveness training. Another recommendation, according to the nature of the relapse, might be long-term treatment.

The essential point is that the therapist and the family members as well as the patient are not locked into a predetermined plan that might not be appropriate to the nature of the regression. All relapses are not equal; therefore, it is impossible to specify in advance an appropriate intervention for a given relapse. Once again, these issues are educational points that need to be stressed to the patient and family members during the early stages of the recovery process.

Other questions that family members ask involve signs of knowing when the patient is not doing well. The answers revolve around three essential warning signs. The first warning sign of not doing well is the use of any psychoactive drug. The patient whose drug of choice is cocaine and whose abuse has progressed to the level of dependency cannot drink alcohol and expect to be successful. Therefore, the patient who attempts to use any psychoactive drug on a responsible basis should be considered in relapse. Although conceptually useful for the therapist, it is not helpful to distinguish between a slip, a lapse, or a relapse when talking with patients and their families. These labels inevitably lead to arguments about what this particular incident is. It is more effective to say that any use at all constitutes a relapse while at the same time acknowledging that not all relapses are equal.

The second sign that the patient is not doing well is a failure to comply with the therapeutic plan. The patient may stop attending recovery meetings, refuse to take medication as prescribed, or refuse to attend scheduled psychotherapy sessions. Of particular significance are situations in which a patient does not show for appointments and/or refuses to be monitored by drug and alcohol screens that had previously been agreed on.

The third major warning sign is a return to old habits and patterns. For adults the signs may be staying out late, becoming isolated from the family, experiencing increased irritability and moodiness, and/or failing to fulfill responsible duties in the family (e.g., parenting duties, chores around the house). For adolescents the signs may be declining school

grades, running away, sneaking out at night, and a declining interest in extracurricular activities. For both adults and adolescents, returning to old friends who use AODs and frequenting old AOD places sends a strong signal of increased relapse potential.

Both the patient and the family members feel a sense of relief and satisfaction when these warning signs are discussed openly. Patients sometimes describe it as feeling that a safety net has been erected. Although they (especially adolescents) tend to protest, they know that those who love and care for them will never again be so easily manipulated. They know that their conning and deceiving is not likely to go unnoticed. As one alcoholic put it, "If I ever relapse again, I hope someone will stop me."

For family members, knowing the warning signs can sometimes free them from trying to control the patient so much. "If he is using, we are all going to know about it sooner rather than later" is a therapeutic statement that relieves some of the family's and patient's anxieties.

Although these interventions are described as educational in nature, they also serve a psychotherapeutic purpose. They address underlying insecurities, anxieties, trust issues, and fears that are common to family members and patients alike. They begin to help the family members and patients feel a sense of control over a previously unmanageable situation.

ANALYZING FAMILY SYSTEMS

Once abstinence has been achieved, the task of the family therapist becomes that of analyzing the family system and structures that may have contributed to the AOD problem. In some cases, the family dysfunction precedes the alcohol and drug abuse; in others, it comes in response to the substance abuse. In either case, the family therapist can help the family members see how their own dysfunctional behavior has contributed to or sustained the substance abuse problem.

Sometimes family behaviors serve to perpetuate the substance use (Stanton & Heath, 2005, p. 681). An example is when the addicted individual begins to improve, the parents begin to fight and develop a distance from each other. When the addicted person returns to using behavior, the

parents become united in attempts to deal with the new crisis, thus shifting attention away from their problems.

The alcohol or drug use plays an increasingly dominant role in the lives of the patient and other family members. Daily routines of sleeping, waking, mealtimes, and shopping are changed to get some semblance of normal family life (Steinglass, Bennett, Wolin, & Reiss, 1987, p. 63). Family rituals also change over time. The alcoholic who is drinking may disrupt family vacations. As a result, the family plans vacations that are less stressful to the alcoholic or stops vacations altogether. Thanksgiving dinner may be eaten at home rather than at a relative's house so that the alcoholic can be brought to the table at least for a few minutes (Steinglass et al., 1987, p. 73).

Family problem solving is affected. Reactions to problems are often disproportionate and overly aggressive in relation to the magnitude of the problem (Steinglass et al., 1987, p. 69). Family rules and problem solving become rigid. In some families, the expression of certain behaviors (e.g., expression of affect) occurs only in the presence of intoxication. Other behaviors may occur only in the presence of sobriety. Over time, the patient's drinking or drug use becomes the central organizing principle of family functioning.

Individuals who are involved with alcoholics or drug users sometimes live a reactive lifestyle in which they are enmeshed in the day-to-day activities of the addict. This is referred to as *codependence.*

> As a result of this emotional enmeshment, the codependent tends to lose all sense of "self" or identity and to become emotionally dependent upon the addict. The addict's mood dictates the codependent's mood. In a sense the codependent becomes an appendage to the addict and the substance abuse. (Thombs, 1994, p. 161)

The codependent and other family members are encouraged to develop a sense of detachment. To "detach with love" is the way out of the trap. Detachment comes by acknowledging one's powerlessness over the behavior of the addicted individual and by stopping the controlling and enabling behavior patterns.

S. Brown and Lewis (1995) explained that during the initial stages of therapeutic work it is often necessary for the alcoholic and the family to

both hit bottom and thus allow the alcoholic system to collapse. As this process proceeds, the therapist must work with each family member to shift focus away from the identified patient and toward a personal program of recovery. The family members "must disengage from their unhealthy addictive attachment to the alcoholic and focus on themselves" (S. Brown & Lewis, 1995, p. 295). The therapist must work closely with the entire family to help them tolerate the separation of different recovery programs and to support their ongoing involvement in this process.

The task of the family therapist at this point is first to help the family members see how alcohol has invaded the routines and rituals and, second, to help the family restructure daily functioning so as to not reinforce drinking and drug-using behavior. This point is a difficult one in the therapeutic process because the therapist's suggestions are usually those that the family has already considered and rejected. For example, the therapist may suggest behaviors that allow the substance user to experience the consequences of his or her behavior. The therapist might suggest that a wife allow her husband to sleep on the floor after he has passed out drunk or not call his boss in the morning to make excuses when he is unable to appear for work on time. The therapist might suggest allowing the adolescent to experience the consequences of the juvenile court system when he has been arrested for possession of marijuana.

The family members might view these suggestions with astonishment, thinking that the therapist has taken leave of his or her senses. Sometimes it helps to start with small steps such as encouraging the family to plan a night out together. The therapist might reinforce the notion that this outing is to take place with or without the participation of the identified patient.

Once again, Al-Anon or Nar-Anon can be helpful. Contact with other families of recovering addicts allows family members to see their problems in a different light. Family members often note the remarkable similarity between their issues and those discussed at meetings. They begin to see the role that alcohol and drug abuse has played in organizing family life. They hear about concepts such as enabling, codependence, and detachment. They learn that by not allowing the alcoholic or drug addict to experience the consequences of his or her behavior, they are enabling the process to

continue. They learn that allowing the substance-abusing individual to hit bottom provides the best hope for positive outcomes. They also learn that by allowing patients to experience consequences, the family members are constructing a "higher bottom" for the addict so that the patient will reach for help sooner.

Family members initially view this advice and new learning with skepticism because it runs so contrary to their thinking. Through support, sharing, and confrontation by other group members, the family members begin to see the value of this new behavior. They then become more amenable to the restructuring suggestions of the therapist. Because both the therapist and the support group are giving a consistent message, the strength of that message assumes greater power. The family slowly begins to change behavior patterns and with great fearfulness awaits the results.

Now the therapist must be willing to provide extra support. Telephone calls after hours are common as family members need to be reassured that they are doing the right thing. One particular situation occurred with the mother of a substance-abusing young adult who refused to stop using and was eventually asked to leave the home. Over the next 6 months this young man would periodically appear at the mother's doorstep and request readmission to the family. As the weather turned colder his requests were more urgent and forceful. The advice to the mother was always the same: Offer the young man treatment and tell him that he could return home after 1 month's sobriety in a halfway house. The mother called each time the young man appeared at the door, and she asked the same question: "Is it okay to do the same thing and stick with the plan?" The answer was always in the affirmative, and the mother would say, "Thanks. I just needed to hear that." After 6 months the young man entered treatment.

The therapist must be able to openly acknowledge the fears of the family members as they move toward new ways of dealing with the patient's drinking or drug using. At the same time, the therapist must stay firm in the resolve that the family "stay the course" even when it looks as if things might not work out. Frequently, family members object at this point because of the possible negative results of the person leaving home. Getting arrested, overdosing, or contracting HIV are possibilities. The therapist

cannot minimize these concerns or even suggest that the family is resisting setting limits, even if that is partially correct. Rather, the therapist can acknowledge these concerns and point out that the risks are high either way. The choice may be whether the addicted person stays at home, continually sheltered from the consequences of drug use, or leaves to face the consequences of using AODs. It should be emphasized that the family should not make the decision to set limits until they are ready and that they should not threaten to set boundaries if they are not prepared to follow through. The therapist should stress that this is the family's decision; he or she can support them in the process but not make the decision for them.

Families nearly always experience this stage of recovery as a destabilizing time. Once enabling behaviors have been reduced or stopped and the alcoholic or addicted individual is allowed to hit bottom, the work of the family therapist is to help the family tolerate the stress. The introduction of sobriety into the lifestyle of the family is expected to be positive but rarely is. The therapist now begins the next task: helping the family to develop new coping mechanisms that will better serve them in their new lifestyle.

DEVELOPING COPING STRATEGIES

The next stage in the therapeutic process involves helping the patient and the family to tolerate the anxiety that inevitably goes with change. The next stage involves the development of new coping strategies, such as enhanced communication skills and dealing with conflict, so as to sustain the therapeutic gains that they have fought so hard to achieve.

One of the first coping skills that the family needs to learn is how to explore and talk about affective material. Although uncovering affective material is an important part of therapy with addicts, as with other psychiatric disorders, timing is of the essence with patients with AOD use disorders. S. Brown and Lewis (1995) explained the importance of timing in the use of psychodynamic concepts in the treatment of addicts and alcoholics. They observed that uncovering deep-seated affective material too early in the treatment of alcoholics can often lead to relapse. If too much painful affective material is uncovered, it can trigger overwhelming anxi-

ety and depression for the alcoholic in the early stages of recovery. Because these individuals usually have no coping skills other than the use of alcohol and drugs, they are likely to drink or use drugs to blot out the painful affective experience.

Family members of patients who are addicted are also often threatened by the emergence of affective material too soon in the therapeutic process. In many instances, alcoholic families have developed rigid boundaries with inflexible rules. These rules typically include prohibitions against speaking about affectively laden material. The family often believes that talking about conflicts could trigger more drinking or drug using on the part of the addicted patient. As the family accommodates itself to the invasion of alcohol (Steinglass et al., 1987), they attempt to completely dampen or suppress affective material. Thus, painful feelings fester beneath the surface for years.

For these reasons the therapist should uncover affective material gingerly at first. Inevitably, painful feelings and discussions of traumatic events emerge as the patient and the family move toward greater recovery. In the early stages of family therapy, however, the focus is not an in-depth discussion of traumatic events or a deep exploration of affective material but rather on how these issues are likely to affect abstinence and the recovery programs of the other family members. The therapist encourages the family to keep on course and to push ahead with their individual personal programs of recovery. The emphasis is on the maintenance of therapeutic gains (e.g., abstinence for the patient and a personal program of recovery for all family members).

Of course, issues of abuse, abandonment, or other painful affective topics do emerge during family therapy sessions. The skilled therapist knows how threatening the emergence of this material can be for the patient and family members. At the end of a difficult therapy session the therapist might state, "I know this has been a difficult time for the family. Sometimes this may trigger cravings or a desire to use. Let's talk about how we can address these cravings if they should occur." The individuals might sustain themselves and handle the cravings by increasing the frequency of self-help meetings and sponsor contact. In this way self-help meetings and

family psychotherapy work in conjunction with each other to support the family's ongoing process of recovery. For example, here is what happened for one adolescent patient:

> This young man had been dealing with the reality that his parents were on the verge of divorce. Even as the adolescent was progressing through treatment and getting sober, the parents were planning to separate. At the time of the session, the parents were still living together, and the tension was heavy in the air at home. The patient was attempting to deal with his sadness and frustration over the divorce by isolating himself in his room. The patient's mother, a recovering alcoholic with 10 years of sobriety, went to the boy in his room and encouraged him to go to a meeting. The patient and his mother went to the meeting together. By talking in the meeting, the patient gained support and came home feeling more relieved and relaxed. Through this simple experience, the boy realized for the first time that he could relieve his feelings of sadness and frustration without the use of psychoactive drugs. He began to see feelings more like waves that would pass over him rather than like a permanent fixture that needed to be blotted out through pharmacological means.

With experiences such as these, it becomes safer to begin exploring affective material in a more meaningful way. As therapy progresses, abstinence becomes more secure. The therapist can then begin the work of traditional psychodynamic uncovering because the family no longer views this work as a threat to recovery.

In addition to uncovering painful affective material and working through traumatic family events, the family psychotherapist can offer other specific skills to the family members to help them cope with the stresses of living a sober lifestyle. Many of these interventions, such as communication skills and stress reduction mechanisms, originate from behavioral or learning theory models of family psychotherapy such as O'Farrell's (1993) behavioral marital therapy.

Other programs teach similar behavioral skills to enhance marital satisfaction and decrease the probability that the identified patient will return to drinking or drug use. Noel and McCrady (1993) and Sisson and Azrin

(1993) have also developed programs that focus on learning communication and stress reduction techniques that help the early stage recovering person.

Although O'Farrell's (1993) techniques are used in his couples program, many of these techniques can be altered and used in a more traditional individual family psychotherapy setting. The therapist who wishes to work with patients with AOD disorders should become familiar with these techniques as a means of enhancing effectiveness with this population. The therapist who is most effective in working with addicted families is generally not locked into one ideological model (e.g., disease model, social learning model, psychodynamic model) but knows and uses an assortment of tools to achieve the desired outcome.

DEVELOPING RELAPSE PREVENTION STRATEGIES

The final task of the family therapist who works with patients with AOD disorders is to assist the family in formulating and implementing a relapse prevention strategy. On a basic level, a relapse prevention plan addresses how each family member, including the identified patient, intends to address relapse if and when it occurs. On a more complex level, the plan should identify what steps the identified patient and the family members can take to prevent relapse from occurring in the first place. The plan should address not only what to do once the relapse has occurred but also what concrete steps can be undertaken to prevent it.

For the purposes of the plan, the definition of *relapse* is expanded to include not only the use of psychoactive drugs by the identified patient but also the return to dysfunctional behaviors by the individual family members. These dysfunctional behaviors signal a regression of the family toward more primitive, dysfunctional coping strategies. For example, after having worked at a recovery program successfully for a number of months, a wife may find herself returning to controlling behaviors such as searching through her husband's car and possessions to find evidence of whether he has returned to drinking. Sometimes these behaviors reappear at the point at which the identified patient is beginning to make real therapeutic

gains. Many family members feel threatened by these gains, especially when the patient begins to behave in a more autonomous manner.

> Perhaps an adolescent girl is beginning to develop new friendships within the recovering community. She wants to go on a weekend camping trip to the mountains. She will go with her new recovering friends, and the trip will be properly supervised by adults. The parents unfortunately associate this type of fun with using behaviors and become increasingly suspicious. "Why does she want to go camping? What are they doing out in the woods? Can they be trusted? Will there be girls and boys together?" As they become increasingly suspicious, the parents move to reassert control. They cancel the plans for the camping trip, thus undermining the adolescent's attempts to bond with other recovering peers.

The family therapist should identify and address these behaviors as relapse behaviors. Although the parents' fears must be validated, it is important to identify for them how they have allowed their fears to propel them into relapse behavior. In this case, however, relapse is defined not as the use of psychoactive drugs but as a regression out of recovery and into dysfunctional, controlling behavior patterns.

Handling Triggers

The relapse plan needs to begin to focus on the dysfunctional behaviors that often precede relapse for the identified patient and for the family members. Often a good place to start with the relapse prevention plan is to discuss triggers for the identified patient. For adult patients the most common relapse triggers include negative affect states. For adolescent patients the most common triggers involve peer interactions. The therapist can assist the patient and family members to identify triggers, the obvious ones being, for example, returning to old using friends, frequenting places where using occurred, and unanticipated situations and events. For example, major life changes, such as moving to another city or changing jobs, are potential triggers.

A move to another city involves establishing a new support network, meeting with a new therapist, and attending new outside support meetings. These situations involve a large amount of planning. Contacting a new therapist prior to the move is an important step. Perhaps the family can make advance contact with existing self-help support groups while visiting the city so that the process of bonding with a new group can begin before the move actually occurs. Changing jobs may mean that the patient's meeting schedule is disrupted. In addition, the new environment may be less conducive to recovery (e.g., coworkers who frequent bars after work). The therapist should also discuss the timing of these changes. Is it wise to undertake a change of jobs early in the recovery process? It is wise to discuss issues like these.

Some triggers cannot be avoided. These include serious illnesses or deaths. Although it is impossible to develop specific plans for unforeseen catastrophes, it is often important to mention that they are a possibility and to underscore the necessity of the patient connecting with his or her sponsor (see Chapter 7), therapists, and other support systems in time of crisis.

Handling Cravings

In addition to discussing triggers, the therapist should openly discuss the nature of cravings and how the patient intends to handle them. Craving is normal for addicts and alcoholics. To deny the existence of craving is to ask the patient to suppress powerful urges and feelings and thus to shut down communication within the family. Although it is scary for family members to hear that the patient is craving, it is an important realization that needs to be acknowledged and validated by the therapist. The relapse plan helps because it gives the therapist and family members specific tasks to do when cravings occur and gives them a sense of mastery over the situation. The patient can call his sponsor or go to a meeting. The family can assist the patient by providing transportation or taking over responsibilities, thus freeing the patient to deal with the cravings in a healthy way.

Another goal of the relapse prevention plan is to specify specific behaviors that the family members can practice that will minimize the possibility

of a relapse for each family member. Family members and patients may commit to practicing stress reduction techniques such as exercise, meditation, or breathing exercises on a daily basis. The therapist can remind the family members of the new communication patterns that they have developed and incorporate them into the relapse prevention plan.

Relapse Prevention for Couples

The therapist should encourage the family to commit to handling troubling new situations and issues by reengaging in the therapeutic process. Frequently, sexual issues emerge after some months of sobriety. As these issues emerge, the couple needs to reengage with the therapist to resolve them as part of the relapse plan. After developing a 10-session behavioral marital therapy (BMT) protocol, O'Farrell (1993) discovered that although patients often reported increased marital satisfaction a year later, their rates of relapse did not differ significantly between the BMT group and the control group. After adding a 12-month relapse prevention component to his program, drinking outcomes improved considerably.

O'Farrell's relapse prevention component consists of 15 couples sessions over the course of a year, with a gradually decreasing frequency. The relapse prevention component has three goals. The first goal is to help the couple maintain the gains achieved in the BMT group during the initial phase of the program. The couple is asked to list the specific goals that were achieved and to examine any problems that might arise in regard to maintaining these goals. The couple is encouraged to develop a written plan that involves specific therapeutic interventions, such as continuing with disulfiram, attending Alcoholics Anonymous and Al-Anon meetings, and implementing new coping strategies such as improved communication skills.

The second goal of the relapse prevention phase is to deal with unresolved issues that emerge during the first year of recovery. Difficulty often arises when the identified patient attempts to assume a more assertive or dominant role in the family after having been labeled as the "sick" person for so long (O'Farrell, 1993). Other issues include substance abuse by other family members and sexual issues. Couples are

encouraged to apply the communication and coping skills that they were taught during the initial phase of the program.

The third goal of the relapse prevention phase is to develop and rehearse cognitive–behavioral strategies for dealing with relapse. The strategies involve a framework or method for discussing relapse, identification of high-risk situations and early warning signs, plans for preventing drinking, and plans for minimizing the intensity and duration of any relapse. The identified patient and spouse are encouraged to specify what they will do if they encounter high-risk situations and how they will deal with any drinking that might occur.

After the 15 sessions over the course of a year, couples also participate in quarterly follow-up visits either in the clinic or at home for an additional 18 months. As stated previously, the outcomes regarding drinking were significantly improved and marital satisfaction remained high after the implementation of the relapse prevention plan. O'Farrell's program is an example of one specific relapse prevention plan or program within the context of family or couples therapy. More general discussions of relapse prevention and relapse plans can be found in Chapter 8 of this volume, Marlatt and Gordon (1985), and Gorski (1989).

Although a formal relapse prevention plan including contracts and agreements is an essential component of the relapse prevention process, the therapist's attitude and skill in keeping the family focused around sobriety and recovery-related issues are of paramount importance in helping to prevent relapse. Good psychotherapy with patients with AOD disorders, whether in a family, individual, or group context, involves a focus on recovery alternating with a focus on interpersonal and psychodynamic issues. S. Brown (1985) described this process of shifting between an alcohol/drug/recovery focus and a psychodynamic or cognitive–behavioral focus as *cyclotherapy* (p. 271).

The question that beginning therapists ask is, "When is it safe to shift to a psychodynamic or interpersonally oriented focus and move away from the abstinence or recovery focus?" The skilled therapist who works with patients with AOD disorders realizes that relapse behavior may potentially be just on the horizon no matter the length of sobriety achieved

by the patient. As painful affective material is uncovered, the risk of relapse or at least craving may increase. The therapist should be mindful that addiction is a chronic condition that although seemingly dormant for weeks, months, even years, is quite capable of surfacing at any time.

The patient views such questions as "So how are things with your recovery program?" as a sign of caring and an indication that the therapist is sensitive to the ever-present struggle with sobriety. Returning to this line of questioning periodically is always a good idea. Staying in touch with the patient's recovery focus allows the therapist to be sensitive to the ebb and flow of the patient's inner process. It helps to remind patients that they need to maintain this same sensitivity. Of all the specific relapse prevention skills that a therapist can bring to the process, this focus is perhaps the most important.

CONCLUSION

Family therapy techniques have added a new richness and depth to the treatment of substance abuse patients. For years clinicians have stated that returning addicts to dysfunctional families sets them up for relapse. Although they acknowledged the importance of family dynamics for several decades, it was not until the family therapy movement became popular in the 1980s that family therapists developed the structured family therapy programs that support and reinforce this view. Since then, substantial research has indicated that family therapy enhances treatment outcomes in terms of both sobriety and overall life satisfaction for recovering people and family members.