Applying Family Systems Approaches in the Treatment of Substance Abuse and Addiction

INTRODUCTION

It is a rather common observation that individuals who are enslaved by addiction often sacrifice connections with other human beings. This lack of connection is one reason group therapy (discussed in Chapter 8) can be a powerful aspect of substance abuse and addiction treatment: Helping clients reconnect with fellow human beings and learn interpersonal skills along the way breaks the isolation that is the hallmark...
of addiction. If the client has a strong relationship with alcohol and/or other drugs, one set of relationships will invariably suffer: the family. Indeed, the impact on family functioning and resulting effects can be particularly damaging and dramatic (Fisher & Harrison, 2009).

Researchers have documented the myriad of problems that children and the family system itself suffer as a result of members using substances. Other researchers have brought attention to the compromised parenting styles and communication patterns in families where drug and alcohol use are evident (Barrett & Turner, 2006). Chemical addiction problems play a prominent role in the abuse and neglect of children as well as psychological/behavioral problems among children in the United States. For example, Famularo, Kinscherff, and Fenton (1992) found that alcohol abuse was tied to physical maltreatment whereas cocaine was implicated in sexual maltreatment among a sample of parents who mistreated their children. Children of addicted parents were found to experience greater levels of depression and anxiety that resemble diagnostic conditions more frequently than children from nonaddicted families (Earls, Reich, Jung & Cloninger, 1988; Fitzgerald et al., 1993). Clearly, the psychological, emotional, social, and monetary costs of chemical addiction in the family are far greater than the cost of treating the disease.

Traditionally, substance abuse treatment has focused on the individual with the problem without much regard for involving significant others in the treatment process. When clients stop using substances, however, they may be faced with a myriad of relationship problems that suddenly come to the surface. Unfortunately, any progress made during a short time in sobriety cannot offset months or perhaps years of negative consequences. Substance addiction impacts all close relationships with significant others. As Miller, Forcehimes, and Zweben (2011) pointed out, effective therapy approaches to addiction should not only address the client's substance use problem but also the client's relationships with significant others so as to promote a strong, supportive recovery.

Substance abuse clinicians are well aware that addiction has a negative impact not only for the user but also the entire familial and cultural systems. As clinicians become increasingly cognizant of the need to provide therapeutic services to the families of substance abuse clients, proficiency in family conceptualization and family therapy is relevant and needed. Indeed, researchers have found that family therapy is helpful in getting those who abuse substances to enter treatment (Edwards & Steinglass, 1995), is favored over other modes of therapy (e.g., individual, psychoeducation, peer group therapy), and has higher retention rates than nonfamily modalities (Stanton & Stadish, 1997). It is a model of therapy that substance abuse clinicians cannot ignore.

In this chapter, I explore the tenets of family therapy, primarily from a “systems” perspective. Specialized training in family therapy exists, and the interested reader is encouraged to seek such training. This is not meant to be an exhaustive review of family systems therapy in substance abuse counseling practice. For general outpatient counseling, however, knowledge of family issues and treatment approaches is critically important. Addressing family issues in substance addiction reflects the obvious fact that if one family member has a substance addiction problem, the other members are going to be impacted. In addition, comprehensive substance abuse treatment programs usually contain family education and family therapy as part of their programs. My intention is to provide a basic overview of family theory and therapy and general guidelines for how to counsel chemically addicted families.
Before we get into the major concepts and applications of family therapy, it is important to define what is meant by *family*. In the traditional white, Anglo-Saxon Protestant tradition, family refers to the intact nuclear family (Fisher & Harrison, 2009) consisting of a couple, the parents, and their dependent children under one household. However, the definition of *family* varies across cultures (Fisher & Harrison, 2009). For example, many families from different cultures expand the definition to include extended members such as aunts, uncles, grandparents, and cousins. In the West, psychological growth is measured by differentiation, a topic covered in depth later. For other families, such as those with an Asian background, growth may be measured in terms of collectivism, deference to authority, reciprocity, and self-control (Kim & Park, 2008). It is important to note that much of the research on family therapy assumes the traditional Anglo definition of family. Indeed, many of the concepts, terms, and applications in this chapter derive primarily from Western conceptualizations of family and will not fit all situations that clinicians encounter in their daily practice. It is incumbent on the substance abuse clinician to ensure that any family therapy strategy is appropriate for the families they counsel and avoid the trap of forcing one cultural viewpoint onto clients from diverse backgrounds.

**THE MAJOR TENETS OF FAMILY THERAPY: BRIEF OVERVIEW**

To speak of “family therapy” as one overall clinical approach would be mistaken. In actuality, family therapy refers to a multitude of approaches depending on the theoretical perspective and philosophy of the practitioner. Family therapy has grown tremendously over the past several decades and comprises several different approaches the clinician can implement, including Adlerian Family Therapy, Bowenian Family Therapy, Empowerment Family Therapy, Integrative Family Therapy, Narrative Family Therapy, Object–Relations Family Therapy, Satir Family Therapy, Solution-Oriented Family Therapy, Structural Family Therapy, and Value-Sensitive Therapy.

The purpose of this chapter is not to cover each and every family therapy approach as applied to substance abuse counseling (which would be a book in and of itself!). Rather, the approach taken in this chapter rests heavily on *systems theory*, which serves as the foundation for several different family therapy approaches. Perhaps the most prominent and well-known systems theorist is Murray Bowen (Thombs, 2006); as such, I draw many ideas from Bowen's family systems theory. It is important to note that Bowen did not create a theory of addiction but rather a theory of family dysfunction (Thombs, 2006). However, many Bowenian and systems concepts have direct application to families struggling with addiction issues.

In systems theory, the family is seen as an organism with a focus on the relationships among members. Each member is thus impacted by the behaviors and actions of other family members. *System* is defined by *Merriam Webster's Online Dictionary* as “a regularly interacting or interdependent group of items forming a unified whole.” Thus, from a systems perspective, the individual's behavior cannot be understood out of social context. The substance abuse clinician must emphasize the *whole interactions and patterns* that emerge between and among members (patterns that are maintaining the addiction) rather than the specific content the family brings to the session.
Boundaries

Families live by rules of interaction called boundaries (Thombs, 2006). Boundaries can be fixed and rigid or diffuse and loose. Optimal boundary development in a family is somewhere in the middle, and results in what are called clear boundaries (Thombs, 2006). Clear boundaries are characterized by mutual respect for one another, clear communication, the ability of members to individuate and remain intimate and the ability to show genuineness, concern, and love. Clear boundaries mean that family members do not engage in “external control psychology” (Glasser, 1983)—that is, they do not attempt to control or manipulate others, they believe that others do not control them, and they accept responsibility for their behavior, thoughts, and feelings.

An example of a boundary is a family who lives by the rule that emotions are not to be shared between members. If this is a rigid boundary, we can assume that relationships are characterized by little intimacy but much isolation (Thombs, 2006). If emotions are displayed, the boundary has been crossed. As one can imagine, addictive families can have a host of boundaries and rules within these boundaries. According to Lawson, Peterson, and Lawson (1983), alcoholic families have diffuse (i.e., disengaged) boundaries and certain rules of interaction. In alcoholic homes, families generally have three rules: (1) Don’t talk about the alcoholism. (2) Don’t confront the drinking behavior. (3) Protect and shelter the alcoholic so that things don’t become worse (Lawson et al., 1983, p. 42). Notice how each one of these rules perpetuates silence about the problem. Unfortunately, such rules can lead to a vicious cycle where the chemically addicted person embarrasses the family (or acts inappropriately), leading to family isolation, which leads to greater distance between family members, leading to more drinking to cope, and so on, all the while strengthening the addiction (Lawson et al., 1983).

The substance abuse clinician must be cognizant of cultural expectations and norms surrounding family boundaries (Stevens, 2001). Most families fall somewhere between disengaged/rigid boundaries or enmeshed/diffuse boundaries. Substance abuse clinicians must guard against automatically adopting a Western view of what are considered “normal” boundaries. For example, “enmeshment,” or closeness, and emotional expression are valued among many Hispanic mothers (Lawson & Lawson, 1998). Such boundaries need to be respected as part of the family’s cultural background and used to help understand the family’s perspective on the substance abuse problem.

Homeostasis

Homeostasis refers to the tendency among families to maintain a sense of coherence, equilibrium, and structure in the face of change. Thus, change in one family member leads to changes in other family members (Stevens, 2001). From a systems perspective, families resist change, even if it would benefit the system in the long run. It is important to note that families define their own homeostasis or balance points (i.e., there is no set point that is considered “normal”). There is a level of comfort in maintaining the status quo. For example, the family may want the alcoholic family member to keep drinking so as to keep the attention away from internal strife and dysfunction. It is “safer” to maintain the addiction than to confront and address difficult feelings. The introduction of change, then, threatens to disrupt the delicate family balance and throw the system into chaos (Stevens, 2001). Homeostatic mechanisms serve as a natural resistance to change and chaos.
Stanton (1980, as cited in Thombs, 2006) conceptualized family homeostasis as a pathological equilibrium in which nonaddicted members have an emotional investment in the addicted member's drug use. If the addicted member stops using drugs, the family is then thrown out of balance and the nonaddicted members may consciously or unconsciously disrupt the addicted member's recovery to return the family to homeostasis. For example, nonaddicted members may be cynical toward the addicted member's recovery, offer little support, or even act out so as to “drive” the addicted member back to drug use.

In general, alcohol and drug use can “stabilize” a family in several ways, including (a) diverting attention away from marital problems/family crises, (b) establishing emotional distance so that feelings go unexpressed, and (c) as a way to avoid intimacy where addicted and nonaddicted members are ambivalent about feelings, marriage, love, and other family members (Thombs, 2006).

It is important to note that many chemically addicted families operate under rigid rules that make change very difficult. In any system, change is a natural part of life, especially in families: kids get older, parents develop new interests, families move, and so forth. Healthy families strike a balance between change and status quo—not moving too quickly so as to leave needs unmet but not moving too slowly so as to preclude growth. Rigid families cannot adapt when change is thrust upon them. They lack the fluidity to creatively adjust to new environmental demands and consequently remain stuck in a pathological, albeit “comfortable” pattern.

**Subsystems**

Subsystems refer to smaller systems within the larger family system (Stevens, 2001). Multiple subsystems can exist, each with the goal of carrying out the family rules and maintaining boundaries. Within a typical family system, subsystems may include siblings, members who have similar interests, or those who are similar in age (Stevens, 2001). The most obvious subsystem is the marital one, in which both partners assume roles in taking care of each other, financial management, communication patterns, and social activities. The birth of the first child introduces another subsystem—the parental subsystem. Here, the parents are responsible for tending to the needs of the child, instilling the family rules, demonstrating affection, and establishing discipline. In healthy families, subsystems operate smoothly and serve to maintain appropriate family boundaries and rules. In substance-addicted families, where one parent has a drug problem, the nonaddicted spouse often takes on most of the parental power—taking care of everything from washing the kids' clothes to discipline. The addicted parent usurps his power as part of the “bargain” (i.e., “I’ll give up my power if you let me drink or drug”). The trouble with this scenario is that, over time, the nonaddicted spouse often becomes resentful and angry at having to take care of everything (Thombs, 2006). This increased tension increases the addicted person's stress, and the cycle of addiction continues. In some cases, a child might take on a parenting role long before he or she is ready, effectively blurring the subsystem boundaries (Thombs, 2006).

**Rules**

According to Fisher and Harrison (2009), “All culturally and ethnically diverse families as well as Euro-American families have overt and covert contracts between their members that operate as rules governing family interactions” (p. 207). This important point
made by Fisher and Harrison suggests that family rules are an endemic part of the human family. Rules can be spoken but often instead are unspoken codes that develop through interaction and reaction. For example, if Father gets angry every time he is asked about work, then through this interaction the rule, “Don’t talk to Dad about work” has been established. This rule may be part of the larger boundary of “Leave Dad alone.” Barnard (1981, as cited in Fisher & Harrison, 2009) stated that rules can manage when, what, and how to communicate experiences and who has permission to speak.

**Bowen Systems Family Theory**

Murray Bowen was among the first theorists to clarify systems thinking with regard to family relationships. He argued that the complex family patterns into which people are born necessitate that they assume certain roles within the family system (Corsini & Wedding, 1989). Bowen postulated that the family is an organic-living system (Kerr & Bowen, 1988). Therefore, individuals’ emotional functioning can be understood through their relationship systems (i.e., the family), the subsystems within the family, and the individual’s relationship to nature. Indeed, Bowen conceptualized the family unit as a system, but the *modus operandi* of this system was rooted in natural, physical processes. As such, family behavioral patterns can be observed as reactions to the social environment (Kerr & Bowen, 1988). Bowen’s theory of family therapy is based heavily on family systems. Bowenian theory primarily operates from several core principles. These principles are described in the following paragraphs.

**DIFFERENTIATION OF SELF** The well-being of family members depends on one’s level of “differentiation of self” and is the cornerstone of Bowenian theory. Differentiation refers to a person’s ability to separate his emotional and reactive self from his intellectual self. Bowen (1978) described a “differentiated self” as “one who can maintain emotional objectivity while in the midst of an emotional system in turmoil, yet at the same time actively relate to key people in the system” (p. 485)—in other words, one who can effectively separate emotion from intellect.

Bowen (1978) believed that all human beings fall somewhere between complete fusion or undifferentiation to complete differentiation. People who have a low level of differentiation lack the ability to distinguish their emotional processes from their intellectual processes and thus live in an emotionally saturated world; much of their energy is usurped seeking love and approval from others. Low differentiation does not always equate to psychological symptoms as long as one’s need for love, attention, and approval is met and their relational system remains intact (Bowen, 1978). However, when needs are not met or the relational system is thrown in disarray, people with low differentiation may manifest any number of clinical and psychological symptoms (Bowen, 1978).

Low differentiation is represented by a fusion of the emotional system with the intellectual system. Relationally, this fusion occurs when persons with low levels of differentiation have an overly strong bond to a particular family member/spouse. The fusion becomes problematic when one of the fused members wants distance or when anxiety presents itself in the relationship. The fused person is unable to cope with the other’s need for distance or the anxiety that the other may be experiencing. Symptoms emerge when the relationship undergoes a significant amount of stress.
A person with a high level of differentiation has a strong sense of self; he or she is “operationally clear about the difference between feeling and thinking” (Bowen, 1978, p. 474–475). Highly differentiated people are less emotionally reactive and they experience a healthy balance of individuality and closeness with others (Bowen, 1978).

**TRIADS (OR TRIANGLES)** When two people are emotionally close, there is no place or person to transfer anxiety should it develop. Bowen (1978) suggested that within a two-person emotional system, closeness and distance will be in a constant state of fluctuation. This fluctuation leads to an unstable dyad, especially when anxiety becomes overwhelming. To alleviate the anxiety of the dyadic system, dyads sometimes bring in a third member to create a triad (or triangle). The purpose of the triad is to shift the anxiety from the original dyad to one member of the dyad and the new member completing the triad. The other member of the original dyad, then, gets some relief from the anxiety (Brown, 1999). When anxiety begins to overwhelm a particular dyad, the triad will shift so that the other member from the original dyad can take a respite from anxiety. This pattern continues as the triangle gains momentum (Bowen, 1978).

It is important to note that outside individuals, such as teachers, clergy, and clinicians can sometimes serve as the third member of a triad. As such, families may bring outsiders into their conflict as a way to ease tension within the family unit (Bowen, 1978). Understanding the triangulation patterns of the family is a significant aspect of substance abuse therapy and provides the client and clinician a lens from which to observe and understand the degree of fusion/differentiation or cutoff between and among family members (Bowen, 1978). For example, a family member who abuses or is addicted to substances might form a dyad with another member. Because the substance abuse inevitably creates more anxiety in the dyad, a third member may be brought in to ease some of the tension away from the original dyad. Family therapy, then, focuses on helping family members face tension and diffuse it in healthy ways.

**NUCLEAR FAMILY EMOTIONAL SYSTEM** The nuclear family emotional system is “the pattern of emotional forces as they operate over the years in the nuclear family” (Bowen, 1978, p. 425). Several factors contribute to this pattern, such as family stress, differentiation levels, and degree of emotional cutoff between family members (Bowen, 1978). As these factors accumulate, Bowen (1978) theorized that “the emotional problem manifests as (a) emotional distance between the spouses, (b) dysfunction in one spouse that is manifested as physical illness, emotional illness, or social illness, (c) marital conflict, or (d) projection of the problem onto one or more of the children” (p. 425). Therefore, the substance abuse or addiction of a family member is conceptualized as a manifestation of family dysfunction and a result of distress on the emotional system over a span of time.

**FAMILY PROJECTION PROCESS** Bowen observed that parents can pass along levels of differentiation to their children. The family projection process occurs specifically when parents transfer their low differentiation onto one or more children (Bowen, 1978). Undifferentiated parents who are struggling with unresolved issues from their own family of origin repeat the process of projecting their unresolved emotional suffering onto their child/children. In families with more than one child, Bowen theorized that there may be one child who bears the brunt of this projection process: “The
child who is the object of the projection is the one most emotionally attached to the parents and the one who ends up with a lower level of differentiation of self” (Bowen, 1978, p. 477). The effects of the family projection process manifest as psychological and behavioral symptoms of the child or children.

**MULTIPLE GENERATION TRANSMISSION PROCESS** The multigenerational transmission process is a progression of how differentiation increases or decreases over multiple generations in a family. The notion that traits are passed down from generation to generation is not just related to genetics. According to Bowenian theory, families can and do pass down their relational patterns and differentiation levels across multiple generations. This process expands the single family projection process by explaining how families “transmit” their own differentiation levels onto their children, how these children transmit them to their children, and so on, creating multiple generations of similar family patterns and differentiation levels. Bowen (1978) theorized that the manifestation of the most severe clinical, behavioral, and emotional problems, such as schizophrenia, bipolar disorder, and substance abuse, is the result of multiple generations moving further and further away from differentiation.

**EMOTIONAL CUTOFF** Emotional cutoff is a psychological coping mechanism designed to block off or withdraw from intense emotional feelings within family relationships (Brown, 1999). Cutoff can occur both physically and emotionally. It can resemble a sort of “checking out” of a family relationship emotionally; a member may decide to be completely different from her family of origin. Although moving toward autonomy from one’s family of origin is a characteristic of differentiation, emotional cutoff is reactionary and indicative of less differentiation. Because the cutoff family member never truly resolves the emotional attachment issues, differentiation remains unchanged, and family processes for that individual will repeat themselves consistent with the family of origin (Bowen, 1978).

**Does Bowen’s Work Have Any Empirical Support?**

Little research has been conducted to validate many of Bowen’s key theoretical tenets (Nelson, 2003). However, Bowen held that those who attempted to research his theory did not grasp it (Nelson, 2003). Indeed, researchers who have sought to operationalize and quantify Bowenian constructs admit that research lags with regard to Bowen theory because of the complexity of its constructs. In addition, many studies on Bowenian theory have utilized very small sample sizes that have not been representative across cultural groups. Although family systems theory is more advanced since the 1950s, it is still a developing research field, and more remains to be explored (Kerr & Bowen, 1988). Nonetheless, several studies have supported some of the key Bowenian family concepts, including differentiation (Murdock & Gore, 2004; Skowron, 2005), the family projection process (Tuason & Friedlander, 2000), and Nuclear Family Emotional Functioning (Klever, 2001).

Richard Charles (2001), after a review of the empirical research on Bowenian concepts, concluded that many were supported with empirical data. Miller, Anderson, and Keala (2004) also conducted a synthesis of research on Bowenian theory and found that of all the theoretical constructs of Bowen, differentiation of self received the most empirical support.
As noted, Bowen’s theory is not a theory of substance addiction. However, it does provide a systems perspective on how addiction, as well as other behavioral and psychological problems, develop in the context of the family. It also provides an intriguing explanation for how substance abuse and addiction often pass from generation to generation. Entrenched patterns of interaction, particularly those that reflect and promote undifferentiation, are at the heart of symptoms and pathology among family members. Many of the techniques and strategies discussed later are based on Bowenian concepts.

CHARACTERISTICS OF THE ADDICTED FAMILY

Family-systems thinking suggests that the entire family is considered “addicted.” Of course, this doesn’t mean that all family members abuse substances but rather that characteristics, roles, and general ways of interacting within the family are thought to contribute to or exacerbate the addiction problem, whether it is with one member or several. Such characteristics include general traits of an addicted family, as well as more specific family roles, enabling, and codependency issues.

The Addicted Family

In the addicted family, it is a general belief that addicted members use substances as a way to act out family problems. Another camp suggests that members turn to addiction because of the problems inherent in the family (Fisher & Harrison, 2009). In fact, systems theory and the addictions field have traditionally been in disagreement about the genesis of addictive behavior (Stevens, 2001). Much of this disagreement stems from whether substance addiction is considered a family problem or an individual problem (Stevens, 2001). In reality, both camps are probably correct (Fisher & Harrison, 2009) because the chemically addicted family engages in a never-ending circle of acting out, experiencing family discord, greater acting out, and so forth.

Clinical experience and research have shown that chemically addicted families almost always have a negative impact on children, although some children display enough resilience to mitigate these effects (Fisher & Harrison, 2009). In addition, chemically addicted families display shared characteristics such as discouraging change or growth, conditional love and affection, and emotional withdrawal and detachment of members. Boundaries may be quite rigid. Nondependent members typically have a distorted sense of responsibility for the substance abuse. The process of individuation and separation of children and other markers of growth, depending on the family’s cultural background, are thwarted due to the abuse of drugs.

Family Roles

It is probably evident by now that the chemically dependent family is a rigid system that tends to isolate itself, which leads to increased tension (Thombs, 2006). This tension can be quite uncomfortable and must be managed. Families creatively adjust to this tension by adopting certain roles designed to divert attention from the addicted family member, which eases stress and makes day-to-day life easier (Thombs, 2006).
The various roles that family members “play out” depend on their position in the family, personality, motivation, and reactions. The most common role classification scheme comes from the work of Wegscheider (1981), who described children’s roles in chemically addicted families as the hero, scapegoat, lost child, mascot, and enabler. These roles are still used today by family therapists, with slight modifications to fit the particular family. Although these typologies were not generated from empirical research (Thombs, 2006), they are clinically useful to share with families and provide perspective on how roles are adopted to maintain homeostasis and reduce tension. Families also become more aware of these patterns and, as a result, choose to interact in a more preferred way. Each role is briefly described in the following paragraphs.

1. **The Chemically Addicted Person.** The primary role of the chemically addicted member is to divert attention from the family’s dysfunction. He is usually emotionally distant from his spouse and gives up his power to parent. His “first love” becomes alcohol or drugs, or both (Thombs, 2006).

2. **The Chief Enabler.** The enabler is usually the nonaddicted spouse. His or her role in the family is to protect the addicted person from natural and logical consequences of the addictive behavior (Wegscheider, 1981). This person wants to “smooth things over” to reduce tension (Thombs, 2006; see the Enabling section for a more detailed description).

3. **The Family Hero.** The family hero is usually the oldest child, who feels empathy for the other nonaddicted members (Stevens, 2001). He or she tries to work hard around the house by assuming responsibilities the parents have given up (e.g., taking care of younger siblings; Thombs, 2006). He or she will try to divert attention from the addiction by achievement and accomplishment and holds very high self-imposed standards (Wegscheider, 1981). After all, because the hero brings positive recognition to the family, the problem can’t be that bad.

4. **The Scapegoat.** The scapegoat, traditionally the second-born child, often has difficulty with authority figures across multiple settings (Wegscheider, 1981). Also referred to as the problem child, the scapegoat “acts out” to divert attention away from the family strife (Stevens, 2001). He or she engages in opposite behaviors of the hero and enabler and may identify more with the addicted member (Thombs, 2006).

5. **The Lost Child.** The lost child simply disappears. He or she might experience chronic loneliness and anxiety (Wegscheider, 1981). This child may be very quiet so as to not create any more problems with the family. Conflict is avoided. Although well behaved, the lost child may internalize much of the family tension created by the substance abuse.

6. **The Mascot.** The mascot is usually the “baby” of the family and likes to lighten the mood. He or she may be considered the class clown at school. Typically insecure, these children use humor as a way to divert tension away from the addiction and break tension in the family (Wegscheider, 1981).

This typological system probably never happens as neatly as presented here. For example, a family member could be both an enabler and a family hero or a combination of feeling lost and being the mascot. In addition, roles may change over time as circumstances, personalities, and environmental factors change.
Enabling

Doweiko (2009) defined enabling as “knowingly behaving in such a way as to make it possible for another person to continue to use chemicals, without having to pay the natural consequences for his or her substance use disorder” (p. 291). For whatever reason, some family members adopt certain behaviors that seem to let the chemically addicted person off the hook. Enabling behaviors are common among addicted families and include actions such as accepting lies, bailing the substance abuse member out of negative consequences, looking the other way, accepting blame for the problem, covering up the family member’s use, and making excuses for the family member. The key element here is that the person knowingly engages in these behaviors (Doweiko, 2009). As such, the enabling member may misinterpret his or her behavior as a sign of caretaking and affection that is the responsibility of any good spouse (or family member; Perkinson, 2012).

Doweiko (2009) made an important distinction between enabling behavior and codependency. Although the two can go hand in hand, a person might enable another’s chemical dependency but not be in a codependent relationship. Enabling refers to specific behaviors that a person carries out, whereas codependency has to do with a relationship pattern with the dependent spouse. We turn to this concept next.

Codependency

Codependency is a relatively new term that emerged in the late twentieth century and is based on the clinical experience of family therapists working with addicted families. Despite controversy surrounding the concept (Doweiko, 2009), it does seem to characterize certain dynamic patterns in dysfunctional homes where emotional needs are not met (as is often the case of an addicted family). Codependency generally refers to finding an identity in becoming a caregiver to those who appear to be in need, such as an alcohol- or drug-abusing family member. It is generally believed to be an unhealthy pattern of relating to others that results from being too closely involved with an addicted individual. Enabling behaviors, or protecting the addicted family member from consequences of use, are often characteristic of those who are codependent. The following statement from Codependents Anonymous (CoDA) captures the essence of codependency: “We attempted to use others—our mates, friends, and even our children, as our sole source of identity, value and well being, and as a way of trying to restore within us the emotional losses from our childhoods” (Codependents Anonymous, Inc., 2010).

Although differing definitions and perspectives abound (Doweiko, 2009), codependency has certain core aspects, including (a) overinvolvement with the addicted family member, (b) obsessive attempts by the codependent member to control the addicted person’s life, (c) the excessive tendency to turn to others for self-worth, for example, by seeking approval from others, even those who treat the codependent poorly, and (d) to make personal sacrifices in an attempt to cure the addicted family member (Doweiko, 2009).

The traditional codependent relationship is between the nonabusing partner (usually the wife) and the abusing partner (usually the husband). However, codependency is not defined by who comprises the dyad but rather the behavior that occurs between the two individuals. Thus, a codependent relationship can occur between a mother and son, a father and daughter, or between two individuals in a same-sex relationship. It can even be evident in close friendships.
Essentially, codependency is about the loss of self, in the service of protecting the addicted person. Isolation is common to preserve the “family secret” (Thombs, 2006). Psychologically, the codependent family member has a strong emotional need to be needed. They often display the “martyr syndrome,” in which their willingness to suffer is seen as a badge of honor and as a way to strive for superiority above one’s spouse (Thombs, 2006). Co-dependents have a strong need to change and control others, believing they have the power to do so (Thombs, 2006). Struggling with poor self-esteem, they also have an overdeveloped sense of responsibility for the consequences of the addicted person’s behavior (Thombs, 2006).

In clinical settings, spouses or significant others of addicted partners often are unaware of their codependent and enabling behavior. Resistance to change is strong because they see what they are doing as just helping out. It is no surprise that they fear change. After all, a sober loved one might become more assertive, no longer needing his or her needs met in the same way. Abstinence might “upset the apple cart”—disrupt the family system in such a way that problems hidden by the addiction suddenly rise to the surface. Interest in sexual relations by the addicted spouse may instill fear in the nondependent spouse, thus sex is avoided altogether (Thombs, 2006).

**CONTROVERSY** Despite clinical experience and observations, little empirical evidence exists to support the concept of codependency. In addition, controversy has surrounded the concept since it emerged on the scene in the late twentieth century. Lewis (1994) noted that the self-corrective aspects of codependency are particularly biased against women, who now have the extra burden of concentrating on their own growth in addition to keeping the peace in the family. Indeed, behaviors such as caretaking, protecting, and loving, traditional motherly roles are considered dysfunctional according to the codependency concept (Walters, 1993). Whereas these traits are expected when raising healthy children, they are pathological in relations with men. In essence, women are caught in a double bind (Walters, 1993).

Frank and Golden (1992) noted that any concept that includes more than 50 percent of the population must be viewed with skepticism. Indeed, one of the problems of the concept of codependency is that *everyone* is codependent to some extent. Several other authors have raised criticisms of the concept (Lewis, 1994; Webster, 1990). In general, these criticisms have been aimed at how codependency pathologizes traditional, socialized female behavior. In essence, codependency fails to take into consideration the social context of behavior and ignores that idea that many of these characteristics have been considered normal for millennia.

These criticisms of codependency are valid. It is somewhat remarkable that we, as a society, turn to the *nonaddicted* spouse as the one with the dysfunction and in need of “correction,” while the addicted spouses continues drinking alcohol or abusing drugs. Yet, at the same time, used with appropriate caution, I believe that frank, open discussions with clients about enabling and codependency can potentially lead to insights and ideas for behavior change. In my clinical experience, I am very careful with the concept of codependency and typically take a middle way approach. I like to educate families about how family systems operate, the roles that each member plays, and that the behavior of one impacts the behavior of others. Without using the term *codependent*, I like to explore communication patterns and relationships within the family. I like to explore with families how their relationships are working and
how they are not working for them. I might point out that calling in to work for one's spouse who is too drunk to do so precludes him from experiencing consequences of his behavior. Eventually, terms like *enabling* and *codependency* may surface and are explored to see if they fit for the particular family. Many nonaddicted spouses are quick to embrace these terms, whereas others are more resistant. The astute substance abuse clinician honors this resistance and realizes the trap of labeling normal, socialized behavior. The clinician avoids using language to disempower clients. Whether codependency becomes a clinical center of attention, *the focus of any substance abuse treatment needs to be on the addicted person's substance use and how the family can assist in his or her recovery.*

**APPLICATION OF FAMILY THERAPY WITH SUBSTANCE ABUSE PROBLEMS AND ADDICTION**

Counseling the family experiencing substance abuse and addiction can look quite different from session to session, depending on who is available to attend, motivation, and commitment by the family to address the substance abuse issue. In addition, substance abuse clinicians can see a variety of clinical issues that manifest during family counseling. Examples of clinical issues include a client with a substance abusing partner, child, or sibling, a child with a substance abusing parent, an adult child of substance-addicted parents, or an adolescent client with substance abuse problems. Other factors that the substance abuse clinician must recognize when formulating an intervention include how the family defines itself, on whom the family leans when in trouble, and what ethnic and cultural considerations need to be made. It may also be helpful to explore the differences in family behavior when substance abuse is present and when it is not present (Stevens, 2001). Needless to say, the extent and variety of issues can be quite complex!

From a family systems point of view, counseling a family in the throes of an addiction involves determining the dysfunctional system that created and maintained the addiction in the first place. For example, enabling, codependency, and denial may be the systemic factors that create and maintain a father's harmful drinking. Many families have little to no understanding of the addiction process, the effect of drugs, or how drug use sabotages family development (Curtis, 1999). In addition, Curtis (1999) argued that there is a common belief that if the substance abuse is stopped, then everything will be “normal.” Clearly, many families fail to comprehend the processes of homeostasis and how members might feel uncomfortable with a sober family member. As such, psychoeducation on the process of addiction, how change happens, and systems thinking becomes an important tool for the substance abuse clinician. The next section provides a brief overview of Bowen family therapy.

**Bowen Systems Family Therapy**

Bowen (1978) stated that the goal of any family therapy is to increase differentiation of self in clients. This, of course, begs the question: How does a clinician use family therapy to facilitate movement toward the theoretical construct of differentiation with substance abuse clients and families? Keep in mind that healthy differentiation refers to developing autonomy *while at the same time* cultivating intimacy (Nelson, 2003). It
is a balance between the two. Bowen (1978) wrote about the importance of orienting the family properly by establishing a working relationship, decreasing anxiety, making sure everyone is heard, and modeling emotional neutrality. After establishing a positive orientation and relationship with the family, the clinician then moves onto issues that feed the family projection process (Bowen, 1978). Discussion of the family projection process begins with psychoeducation: “The goal is to teach the family member about the functioning of emotional systems, to discover the part that [one]self plays in the system and especially towards the other spouse, and to modify the system by controlling the part that [one]self plays” (Bowen, 1978, p. 237).

When working with substance abuse clients individually, the clinician will want to informally conceptualize the differentiation level of the client. From a Bowenian systems perspective, this conceptualization will involve understanding the nature and degree of anxiety and disruption that occurred within the emotional system of the family of origin and how that disruption led to substance abuse to alleviate anxiety. In sessions with all or most family members present, Bowen (1978) believed that both parents are the primary focus of therapy; any symptomology the child or multiple children may exhibit, including substance abuse, is a direct result of the family projection process and unresolved differentiation issues with the parents.

In Bowen family therapy practice, the clinician begins by involving himself in a communication triangle with the parents (or spouses). Bowen (1978) stated, “Conflict between two people will resolve automatically if both remain in emotional contact with a third person who can relate actively to both without taking sides with either” (p. 224). He also contended that specific techniques for the therapist include encouraging the family to take ownership of the substance abuse problem and asking questions that imply it is the family’s problem to solve (e.g., What are some ways that you as a family can solve your substance abuse problem?).

The clinician’s goal is to help develop a healthier triangle with the family by encouraging family members to talk “to and through” the clinician rather than to each other in the initial stages and continue this communication pattern until family members can do so without becoming overly emotional (Nelson, 2003, p. 269). The strategy behind this is to alleviate overly emotional entanglements between parents that hinder growth (and thus avoid cutoff and fusion) and to encourage differentiation at a slow and steady pace. The clinician encourages the use of I statements to encourage individual ownership of thoughts, behaviors, and emotions (Nelson, 2003).

The role of the clinician in the practice of family therapy forces an added triangulated dimension to the family system. Instead of allowing the family to continue the usual patterns of fusion/cutoff/triangulation, the family addresses the clinician and practices forming a “healthy” triangle. Through therapy, the parental (or spousal) dyad stabilizes and moves toward greater differentiation. Problems, disagreements, and arguments are resolved with less reactivity than in the past. According to Nelson (2003), an important characteristic of the clinician is the resistance to being drawn into an unhealthy triangle by keeping a calm presence during intense, emotional discussions, stress, and anxiety. The ability to remain calm in these situations stems from the clinician’s own degree of differentiation. As such, in Bowenian therapy, clinicians are encouraged to work at expanding their own differentiation (Nelson, 2003).

Conceptualizing family work in terms of triangles is particularly important for substance abuse clinicians who operate from the sociocultural model (see Chapter 2).
The primary conceptualization from a Bowenian and systems theoretical orientation is that substance abusing clients are seeking relief from the family emotional system, which involves the triangulation patterns of family members, nuclear family emotional process, and multigenerational transmission processes. Unraveling these facets of a person's differentiation requires intense exploration of family relationships with the substance abusing client. A clinician may want to know in what ways the client finds family relationships stressful and how he reacts when other family members become upset. The clinician may then want to explore how the client reacted when his parents were upset or stressed when he was a child. If the patterns of emotional reactions when one was a child are similar to current reactions, then the family clinician helps the client explore ways to find greater differentiation (i.e., balancing autonomy with intimacy) so as to interrupt the family projection process.

When implementing Bowen and other systems theories into practice, the clinician needs to conduct a thorough assessment of family relationship history. An in-depth review of the multitude of assessment strategies is beyond the scope of this text; however, a few important concepts can be discussed here. Assessing family relationship history using Bowen and other systems approaches is usually done through family mapping or a family genogram. With a family genogram, a client can outline the relational patterns and traits in his or her family, both nuclear and extended, through the use of lines, symbols, and pictures that denote relational aspects (see Juhnke & Hagedorn, 2006 for an excellent review of genograms). The multigenerational transmission process with substance abuse clients can be examined through use of a family genogram. A client can examine his or her family’s relational patterns and symptoms over a period of at least three generations. Helping the client gain insight into family patterns encourages differentiation by allowing the client to step back from the family system and examine patterns without being emotionally embroiled in them. Examining the role that drugs or alcohol may play in multiple family generations can be particularly helpful for substance abuse clients and their families.

Another strategy to assess family relationships is the Adlerian lifestyle assessment, discussed at length in Chapter 11. Aside from assessing individual symptoms and problems, the Adlerian assessment goes in depth about family atmosphere, constellation, and early recollections. Family relationships are explored at length. Although not technically a “systems”-based assessment, the Adlerian lifestyle assessment has the potential to provide a thorough evaluation of rigid family patterns and levels of differentiation among its members.

One of the strengths of a systems approach to substance abuse treatment is placing responsibility on the system rather than the individual client. Emotional suffering and clinical symptoms arise in individuals when the family experiences chronic anxiety and the least-differentiated family member begins to act in ways to alleviate this anxiety. Symptoms manifest in various ways, ranging from schizophrenia, depression, chronic illness, and alcohol and drug use. In counseling families with substance abuse problems, the addicted family member is viewed as the “sick one,” or the member with the least differentiation. However, it is important for the clinician to remain aware that the client’s differentiation level is a reflection of the differentiation of the family system as a whole, and blame is irrelevant.

Despite the differences in the way clinical symptoms manifest, they share one commonality: The purpose is to protect the homeostasis of the family system, the
family’s emotional processes, and guard against the anxiety that threatens to disrupt the family’s emotional system. If this information is conveyed appropriately, the client can be begin to gain insight into the role substance abuse plays in protecting the nuclear family system and how this process may be projected onto his or her current and future family systems.

**Techniques and Strategies**

When substance abuse clinicians meet with the chemically addicted person’s family for the first time, ground rules must be established. For example, who will meet with whom and when, confidentiality, examples of proper communication (e.g., using I statements), norms and expectations, and avoiding argumentation and blaming are common initial ground rules (Stevens, 2001). Families must understand that therapy time is for learning and education, practicing communication, expressing feelings, taking responsibility, and reestablishing boundaries (Stevens, 2001). Several techniques are at the clinician’s disposal when conducting family therapy. It is important to keep in mind that all techniques should be grounded in a systems theory—that is, the focus is more on the process of interaction than content.

**JOINING** Joining refers to making a strong connection with the family and all its members. It entails establishing trust, showing empathy, building rapport, being supportive, and respecting the views of all members and the family as a whole (Edwards, 1990). Of course, there is nothing new about joining because its importance runs across all forms of therapy. However, it is even more important in family therapy because of the greater risk of alienating a member when so many potentially different viewpoints are present (Edwards, 1990). Edwards (1990) outlined several activities that constitute joining: (a) active listening, (b) supporting both individual and family strengths, (c) respecting family values, (d) using the family’s own words, (e) expressing understanding, (f) gently challenging rigid viewpoints, and (g) providing hope.

The idea in joining is to build rapport and diffuse intense emotions that most likely are present. The strategies of Motivational Interviewing would be quite applicable here because part of the essence of MI is joining with clients.

**ASSIGNING TASKS** Assigning tasks refers to giving families between-session activities to practice to help them apply what they are learning (Edwards, 1990). Assigned tasks can introduce new experiences, provide insight into family patterns, test out new behaviors and change, and keep families in tune from session to session (Edwards, 1990). One of my favorite assigned tasks for both couples and families is to encourage them to have a “miracle day.” A miracle day is a time, preferably a whole day but it can be part of day, in which the family does something together that all members enjoy—going to a movie, going out to eat, traveling, shopping, and so forth. The only rules for the miracle day are (1) to have fun and (2) to engage in absolutely no talk about the problem in any way. The second goal cannot be stressed enough. The family is to avoid talking about dad’s anger, Billy’s drug abuse, or sister Kerrie’s depression. When the family returns to the next session, the miracle day can be explored: What happened? How was it? What were the interactions between everyone like? It is a miracle (no pun intended) that families often rave about how their miracle day was a
success. The clinician’s task is to help the family understand that during the miracle day, there was most likely mutual respect, better communication, and no arguments. In other words, the family created the blueprint for a solution.

Ideas for assigned tasks are numerous and are limited to the creativity of the clinician. However, Edwards (1990) noted that tasks should be kept simple, especially at first, specific, and involve all members, if possible. In addition, exploration of the proposed task should occur before it happens. For example, after the task is planned, the family can explore the questions: “What are some barriers to this plan? How might it fail?” (Edwards, 1990).

**CREATING ENACTMENTS**  It is generally true that clients who talk “to” someone rather than “about” someone have a more powerful experience that can catapult change. Many times in family therapy, individual members talk about another member to the clinician. Whereas this can be useful as an objective analysis of the problem, creating an enactment in which the member talks directly to the other member can be powerful. Usually, dysfunctional communication patterns will emerge in the session and having members talk to each other as they typically do can provide useful information and feedback. Enactments can be formally set up by the clinician or emerge as a natural flow in the session. For example, if a member tells me how she feels about another member, I may gently encourage her to talk to the other member directly.

During the enactment, the clinician is not passive but is an active observer (Edwards, 1990). He or she may stop the communication and point out observations, ask for clarification, or inquire about any reflections that emerged during the communication. I prefer to work within a Gestalt framework when helping families communicate with each other, especially difficult emotions. For example, an enactment exercise might look like this:

**TFL:** Instead of talking to me, how about talking directly to your husband?

**WIFE:** Okay [turning to husband]. I don’t like it when you come home and ignore me, especially after the kids have gone to bed.

**TFL:** And, when I say that, I feel…

**WIFE:** [to her husband] And, when I say that, I feel…frustrated and sad.

**TFL:** [turning to husband] When I hear you say that I feel…

**HUSBAND:** [speaking to wife] When I hear you say that I feel…lost, not sure what to do.

**TFL:** [to husband] I encourage you to tell her more how you feel and what your thoughts are about what she said.

In this example, the husband and wife were able to tune into their feelings and communicate them in the safety of the therapeutic session. Family members are usually unaware how another member feels because communication has been so poor.

Enactments can be used in many, many other ways. For example, they can be used to help parents decide on measures of discipline, help parents encourage their children, and help teens negotiate rules in the home. Parents can be encouraged to talk with each other about how they will discipline Billy should he use substances again while Billy and the clinician listen. Then Billy can negotiate with both parents to set reasonable rules at home. If one parent is enabling Billy’s substance using behavior,
Chapter 9 • Applying Family Systems Approaches in the Treatment 233

she can listen to him and his father talk, resisting the temptation to “jump in and save him.” Enactments keep the focus on the family and preclude putting the responsibility for change on the clinician (Edwards, 1990). Because enactments have the potential to involve intense emotional reactions, they should be considered in the later stages of family therapy when members have learned healthier patterns of communication.

**SEGMENTING** Segmenting refers to dividing the family into smaller groups so that certain goals can be accomplished (Edwards, 1990). Segmenting helps set boundaries among family members. For example, many adolescents in chemically addicted families set their own rules. Such families have dysfunctional structures where the parents have lost all authority over their children (Edwards, 1990). With segmenting, children may be asked to step outside while parents talk about how to better communicate and incorporate discipline. Segmenting can occur as preparation for the next session. Here, the clinician might ask only the parents to attend for the next session, provided that the family agrees with the strategy. Clinicians can also ask the parents to leave the session while they talk with children or adolescents. This might be needed to build rapport with the children and learn their side of things without the oversight of parents. Again, everyone should agree with this strategy and it should be seen as advancing the goals of the family.

**OTHER STRATEGIES** Many other strategies are at the clinician’s disposal to add flexibility and range in family therapy. A brief review of these is presented next.

**Family sculpting** Family sculpting is an effective way to get the family moving, have some fun, and learn a lot. It starts off by having one family member “pretend” he or she is a sculptor and to position the other family members in frozen postures that resemble the day-to-day life of the family. Family members can come up with creative “sculptures” with this technique. For example, I once counseled a family in which the teenage daughter struggled with substance abuse and acting out behavior. In session, I asked her to position the family, including herself, according to how she perceives family life day in and day out. The most remarkable scene from this experience was how she placed her father. He (the father) was leaning forward, arms above his head with a scowl on his face. The daughter was leaning back, with a scared look on her face, as if she wanted to run. I was reminded of the poor cat in the cartoon, Pepe Le Pew, who is always leaning back trying to get out of Le Pew’s grasp (although Le Pew doesn’t typically have the scowl on his face)!

This exercise led to an important and insightful discussion among the family. The father, in particular, was largely unaware of his dominant nature and impact on his daughter. He realized that he was too overbearing, and when he communicated with his daughter, she felt like she wanted to go away. Future work with this family focused on better communication between father and daughter.

**Drawing** Drawing can be an effective way to engage children and adolescents in therapy. It can be done with or without parents being present. With drawing, several options exist. Some possibilities follow:

1. Draw the problem using lines, colors, and shapes.
2. Draw a typical day in your home.
4. Draw how you would like the problem to change.
In any of these examples, clients can be asked to elaborate on their pictures, tell stories related to their pictures, or “become” a character in the picture. The idea is to help clients, especially children, express their feelings related to their family. Parents who are part of the process may become more aware of how they are perceived by their children.

**The solving circle** The solving circle (Glasser, 1999) is a technique from Glasser’s Choice Theory and is effective in eliminating blaming, criticizing, and demanding types of communication that can sabotage therapeutic progress. To start off, the clinician draws an imaginary circle in the room (move tables and chairs) and suggests that the circle represents the family. Each member is invited to step into the circle if they agree that the family’s needs are more important than individual needs. That is, the family relationships are more important than individual wants. Stepping or staying out of the circle suggests that, at the moment, individual needs are more important.

Most family members are willing to step in the circle and work toward the benefit of the family over their individual needs. Once in the circle, the first member states *what he will do to make the family better*. For example, a substance addicted father may state that he will remain abstinent and work hard in his recovery for the benefit of the family. The next person tells what he or she will do to make the family better, and so on, until everyone has a chance to speak. The family can go through as many rounds as needed. The solving circle eliminates blaming and arguing because family members are directed away from worrying about what others will do and instead focus on the self. It also sends the message that trying to control others is futile.

Techniques are an important part of any counseling modality. However, they should always be used within the context and framework of theory. Above all, no single technique is useful to all families or clients. Each family is unique and must be treated individually.

**Sequential Family Addictions Model**

Juhnke and Hagedorn (2006) created a unique synthesis of many theoretical concepts discussed in this chapter (as well as in others) in this text to create the *Sequential Family Addictions Model*. For Juhnke and Hagedorn, family therapy works best if it is organized in an orderly fashion where families begin with non-insight, here-and-now, briefer forms of counseling, and sequentially move to more insightful, long-term, psychodynamic methods. The model includes seven stages, each with a specific focus for the family. If a family plateaus in one particular stage or the intervention proves powerless against the family system, then the next stage of treatment is considered. However, families do not necessarily need to complete the entire seven-stage process. They and the clinician may perceive that they have improved greatly by Stage 4 and no longer need counseling help. The strength of this model is that it provides a road map for clinicians beginning with the least intensive, most cost-effective approaches (Juhnke & Hagedorn, 2006). If these early approaches fail to resolve the family issues, then clinician and family move on to more intensive interventions. We now take a closer look at Stages 1–5. Stages 6 and 7 are given only brief mention because they are more complex and a thorough discussion is beyond the scope of this chapter.
Chapter 9 • Applying Family Systems Approaches in the Treatment  235

STAGE ONE: MOTIVATIONAL INTERVIEWING  My general counseling approach is to always begin with Motivational Interviewing, whether working with individuals or families. In the Sequential Addictions Family Model, the clinician begins with Motivational Interviewing techniques rather than diving right in with other, more advanced approaches. This makes intuitive and clinical sense. After all, if a family is not ready to change, no amount of cognitive, behavioral, systems, or psychodynamic interventions are going to work. Many of the interventions in this stage were discussed in Chapter 5. According to Juhnke and Hagedorn (2006), this stage is completed in one to two sessions.

Juhnke and Hagedorn (2006) also account for the presence of domestic violence in their model. As they noted, nothing is more disruptive to the family therapy process than addictions, domestic violence, and family dysfunction. I could not agree more. In their model, the perpetrating partner, stereotypically the male spouse, is required to receive individual and group counseling separate from family therapy until family therapy is complete.

STAGE TWO: SOLUTION-FOCUSED FAMILY THERAPY  If the family members appear motivated to change their addictive and other dysfunctional patterns, then counseling moves on to solution-focused methods. Here, the emphasis is on examining how their lives would look different if substance abuse and addiction were absent (Juhnke & Hagedorn, 2006). Many of the techniques in Chapter 10, including searching for what is working, the miracle question, and envisioning change would apply here. This stage lasts from three to seven sessions (Juhnke & Hagedorn, 2006).

STAGE THREE: COGNITIVE-BEHAVIORAL FAMILY THERAPY  By this stage, we can assume that the family is (a) motivated to change its patterns and, specifically, the addicted member is motivated to change his or her substance use, and (b) the family understands what is working, is doing more of this, and can envision what a life without addictions would be like. In Stage 3 of the Sequential Family Addictions Model, the focus turns to helping families understand the role of thoughts and behaviors in maintaining addictive behavior. In addition, families explore the various consequences of substance addiction, both positive and negative, to get a sense of how these behaviors are reinforced. Finally, family members are taught cognitive restructuring methods to help substitute more adaptive thinking that runs counter to “addictive thinking” patterns (Juhnke & Hagedorn, 2006). Many elements of relapse prevention, which are based on CBT ideas, may be explored here as well. Once again, several of the techniques discussed in Chapter 6 would apply here. This stage typically lasts from three to eleven sessions (Juhnke & Hagedorn, 2006).

STAGE FOUR: STRUCTURAL FAMILY THERAPY  In Stage 4, the focus moves to more formal types of family therapy, beginning with structural family therapy (Minuchin, 1974). Here, family structure and its potential contribution to maintaining addictive behavior are emphasized. The goal is to find a workable structure that creates stability and allows the members to address and work through the addictive behaviors (Juhnke & Hagedorn, 2006).

Structural family therapy is generally concerned with two overarching goals. First, the clinician strives to promote healthy relationships and communication patterns
within the various subsystems of the family. For example, the marital subsystem may be strained due to the substance abuse and addiction, and the sibling subsystem may be fraught with argumentation. If these subsystems are strengthened, then the overall family system will work better (Juhnke & Hagedorn, 2006). The second goal is to assess the power hierarchy and restructure it, if needed. For example, in alcoholic families, a common dysfunctional structure is to have a hierarchy where only the addicted parent holds the power (usually through coercion) and is separated from the other parent and children. The nondependent parent is united with the children as victims in the family (Taibbi, 2011). The goal would be to help the family return to an ideal structure that fits for them and that does not perpetuate the substance abuse. For example, the parents can be encouraged to keep a hierarchy in the family in which they are united but also both involved in the children's lives (Taibbi, 2011)—that is, strengthening and empowering the marital subsystem becomes the foundation for improvement. This stage typically lasts five to ten sessions (Juhnke & Hagedorn, 2006).

**STAGE FIVE: EXTENDED FAMILY SYSTEMS THERAPY** In Stage 5, the clinician and family clearly move into more insight-oriented interventions. The focus in this stage relates to many of the Bowenian concepts discussed in this chapter. Thus, family members are encouraged to strengthen differentiation and converse without emotional entanglements. Triangulation strategies are important techniques for the clinician. Families, through the use of genograms, are encouraged to look closely at multigenerational processes and how addictive behaviors may have been passed down from generation to generation. This stage typically lasts from five to ten sessions (Juhnke & Hagedorn, 2006).

**STAGES SIX AND SEVEN:** Stages 6 and 7 complete the Sequential Family Addictions Model. Stage 6, a Modified Intergenerational Family of Origin Therapy approach, is an optional stage and may not fit with some clients or families (Juhnke & Hagedorn, 2006). The focus here is to help adult clients reconnect with their families of origin and their experiences with addictions while growing up. This reconnection for a client may be an actual meeting with key family-of-origin members. In general, the goal of such meetings is for spouses to enhance differentiation (which is facilitated with adult, mature conversations) and effectively resolve their family-of-origin baggage so as to be more loving and affectionate toward each other (Juhnke & Hagedorn, 2006). Stage 7 of the model is used when families have unsuccessfully resolved their addiction issues via the earlier stages. This final stage, based on psychodynamic object relations principles, is clearly long-term and usually lasts no fewer than 15 sessions (Juhnke & Hagedorn, 2006).

The Sequential Addictions Family Model incorporates many of the theoretical constructs presented throughout this text but applied to family situations—Motivational Interviewing, CBT, relapse prevention, solution-focused counseling, and family systems therapy. The sequential nature of the approach makes it a viable and cost-effective option for substance abuse clinicians working with families. It would be a mistake, for example, to jump right in to psychodynamic work without the prerequisite work of motivation, envisioning change, and healthy thought patterns. It is interesting to note that family systems therapy is not attempted until Stage 5 of the model! Clearly, rushing too far ahead before families are ready can result in frustration for all parties involved.
Other aspects of this model also need brief mention. First, after the seven stages of the model, individual counseling for the addicted family member is encouraged. In addition, throughout the sequencing of therapy, certain family members may get more or less individual attention. Second, some or all of the family members are encouraged to attend Al-Anon (a support a group for family members of addicted individuals) throughout therapy. Finally, if domestic violence is present, the perpetrator is to engage in group and individual counseling as well as a 12-Step batterer's support group. (For a more detailed description of the Sequential Family Addictions Model, see Juhnke & Hagedorn, 2006.)

The Sequential Family Addictions Model provides a road map for how to integrate many ideas and concepts from the family therapy literature into a coherent, stage-by-stage process for working with families struggling with addiction. As a relatively new approach, it has not garnered empirical support to date, although many of its components (e.g., Motivational Interviewing) have been studied extensively. Let's take a quick look at other family-based therapy approaches that have been supported in the empirical literature.

**Other Family Therapy Approaches**

A number of family therapy approaches have emerged to help adolescents and their families address a range of issues when the teenager is the identified client with the addiction problem. Although these approaches have considerable differences, there are a few commonalities. For example, they all rely on cognitive behavioral family therapy as a foundational theory and all have some component of parental skills training. Another commonality and strength is that they have empirical support for their effectiveness (Miller et al., 2011; Robbins et al., 2011). My intention in this section is to provide a brief overview of these approaches, and the interested reader can consult the relevant literature for a more detailed description. The two approaches reviewed are Brief Strategic Family Therapy and Multidimensional Family Therapy.

**Brief Strategic Family Therapy** (BSFT; Szapocznik, Hervis, & Schwartz, 2003) is an evidence-based treatment approach with the overall goal of reducing adolescent behavior problems by strengthening family relationships and connecting the family to outside systems and resources as a way to promote positive youth engagement (Robbins et al., 2011). BSFT targets children and adolescents who show signs of problematic behaviors, including substance abuse and addiction. BSFT is short-term, problem-focused, and includes four primary steps: (1) cultivating a strong therapeutic alliance with each family member, (2) identifying individual and family strengths and patterns of relating that impact the adolescent's behavior negatively or preclude the parents from correcting the behavior, (3) creating a change plan that is problem-focused, direction-oriented, practical, and that focuses on strengths and correcting problematic family relationships, and (4) implementing the change plan and reinforcing family interactions that promote abstinence and competence in communication (Fischer, Pidcock, & Fletcher-Stephens, 2007). Specific strategies include reframing the meaning of interactions, shifting family alliances, clarifying/strengthening interpersonal boundaries (Fischer et al., 2007; Taibbi, 2011), enhancing one's ability to handle and resolve conflict, and strengthening parenting skills via coaching (Fischer et al., 2007). BSFT is endorsed as an effective evidence-based approach by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) and National Institute on Drug Abuse (Fischer et al., 2007).
Multidimensional Family Therapy (MDFT) is an evidence-based outpatient family therapy approach designed to address adolescent substance abuse and delinquent behavior (Liddle, 1995, as cited in Fischer et al., 2007). Its orientation is toward enhancing the development of the adolescent as well as environmental systems in which he or she resides (Fischer et al., 2007). The term multidimensional is fitting for this approach because it is designed to strengthen protective processes and deter growth-inhibiting processes that may come from the family, community, and peers. Thus, MDFT focuses on addressing multiple pathways that contribute to the continuation of substance use (Miller et al., 2011).

MDFT Treatment objectives include shifting the developmental trajectory of the adolescent away from a substance using lifestyle to normal developmental experiences. The resulting shift therefore improves functioning in several domains. Therapy includes promoting positive peer relations, cultivating a strong identity that does not involve drug use, developing healthy relations with institutions such as school, and respecting autonomy within the parent–teenager relationship (Fischer et al., 2007). The MDFT clinician also works with the parents. Here, the focus is on helping parents increase their commitment to their child’s welfare, improve parent-adolescent communication, and increase parenting practices such as limit-setting and striking a balance between granting autonomy and establishing control (Miller et al., 2011). Henderson, Dakof, Greenbaum, and Liddle (2010) found that MDFT was more effective for adolescents with severe substance abuse and addiction problems concomitant with comorbid psychiatric difficulties compared to individually focused cognitive behavioral therapy. According to Fischer et al. (2007), MDFT is cost effective as well, with good results occurring at a cost that is substantially less than residential care.

**FAMILY SYSTEMS THERAPY IN THE TREATMENT OF DIVERSE POPULATIONS**

Family therapy and systems approaches are generally based on white, Anglo-Saxon Protestant ideals, which define the family as an intact, nuclear group (Fisher & Harrison, 2009). However, we must keep in mind that even the definition of family varies from culture to culture (Fisher & Harrison, 2009). For example, the traditional African American culture defines family as a wider network of individuals beyond the nuclear family, such as aunts, uncles, and grandparents. Family may even expand beyond blood relatives to include intimate, longtime friends (Fisher & Harrison, 2009). In Asian American culture, the entire family might include all ancestors and their descendants (Fisher & Harrison, 2009). Thus, it is essential that substance abuse clinicians understand the dynamics of a particular family, especially if that family is from a different ethnic and cultural background. The substance abusing adolescent from a Euro-American family may be encouraged to work on how to better differentiate from his family. On the other hand, the substance-abusing adolescent from an Asian American family may need to strive for other values important to the culture and family, such as empathy, connection, and involvement.

Most of the empirical research on substance abuse and families is with Euro American clients who struggle with alcoholism. Culturally and ethnically diverse families are at risk for developing alcohol and drug problems. Unfortunately, there is a dearth of empirical research on addiction problems within these diverse families and
methods of intervention. However, there appears to be a growing body of literature as researchers strive to conduct more studies on diverse family systems and substance abuse and addiction (Fisher & Harrison, 2009).

Inclan and Hernandez (1992) criticized the concept of codependency, citing concerns with how it reflects white, Anglo-Saxon perspectives on what is healthy in a family. The codependence concept is based on the Bowenian systems idea of separation and individuation. However, Incan and Hernandez made the point that individuation might look quite different depending on culture and society. The risk in family therapy, according to the authors, is that healthy recovery will be defined for the clients and they may be forced to adopt cultural values that reflect only white Anglo-Saxon culture.

As an example, Inclan and Hernandez (1992) discussed the concept of familism that is central to Hispanic family culture. Familism refers to remaining loyal to the family and honoring family traditions and interdependence. As with many cultures around the world, familism from the Hispanic perspective extends beyond the nuclear family to include extended family, especially in times of crisis. Elders are held with great respect. As the authors pointed out, the description of familism seems to match closely with the main concepts of codependency. The obvious concern is that a Hispanic family may be labeled as codependent, when in reality, the family is expressing its deeply held cultural and societal values.

Inclan and Hernandez (1992) suggested that family therapy based on codependence as the organizing dysfunction may inadvertently pathologize normal cultural processes in the Hispanic family. The Western emphasis on differentiation, individuation, equality, and mastery run counter to the Hispanic notions of child rearing and family roles. This is not to say that differentiation does not occur in Hispanic culture; in fact, differentiation occurs in most cultures (Corey, 2009). However, how differentiation is manifest depends largely on culture. The culturally sensitive substance abuse clinician needs to be aware of these cultural family dynamics and issues surrounding relationships among members and work within the family's cultural lens.

Considerable focus was placed on Bowenian theory as an example of one systems theory earlier in the chapter and its potential to be a useful approach for substance abuse intervention. However, it must be acknowledged that significant gaps in the empirical evidence support the effectiveness of Bowen theory in practice, particularly as it pertains to specific diagnoses and populations. For instance, no investigations seem to have been conducted regarding Bowenian theory's effectiveness when used with minority clients as well as clients with a range of psychological issues.

Honoring and respecting cultural differences of our clients is paramount to effective clinical work. In no therapeutic milieu is this more necessary than family therapy. This is because the parameters of family are defined differently depending on a multitude of cultural, ethnic, racial, and gender factors. In their work with families from different cultural backgrounds, Breunlin, Schwartz, and Mackune-Karrer (1997) noted the importance of adopting a multicultural perspective that emphasized a range of cultural contexts of which families are a part. These contexts contribute to attitudes, perspectives, behaviors, and values (Breunlin et al., 1997). For example, one context might be religious practice and beliefs, whereas another might be the family's economic situation. Within each context are similarities and differences between clinician and client (e.g., clinician from privilege and client from poverty; Breunlin et al., 1997).
Ultimately, the clinician strives to assess the degree of cultural fit between himself or herself and the client and the “relevance and salience” of these contexts in the clients’ lives (Breulin et al., 1997, p. 208). Following are the cultural contexts, including sample questions to assess their relevance and salience, as outlined in Breulin et al. (1997).¹ These questions can be incorporated within the initial interview:

1. **Immigrant**: What is the fit between the clinician and the family regarding cultural context? Do some family members defend the old country’s values? (p. 208)
2. **Economics**: What is the fit between the clinician and the family regarding economic background? What do members of this family think about their current economic state? (p. 214)
3. **Education**: What is the fit between the clinician and the family regarding education? What are the educational aspirations of the members of the family? (p. 216) What is the highest level of education within the family? What are the barriers, if any, to education?
4. **Ethnicity**: What is the fit between the family and clinician regarding ethnicity? What is their ethnic diversity? (p. 218)
5. **Religion**: What is the fit between the clinician and family regarding religion? How do religious beliefs enrich or estrange families? (p. 220)
6. **Gender**: What meaning do members of the family attribute to being a woman? A man? Who is in control of the relationships? (p. 221)
7. **Age**: How does age impact family process and functioning? Is there a hierarchical system based on age? (p. 223)
8. **Race**: What is the fit between the clinician and family regarding race? Is any member of the family experiencing racial oppression? (p. 225)
9. **Minority/Majority Status**: What meaning do the members of the family attribute to their being a minority? Majority? If the family is a minority, do any members experience discrimination and/or ethnocentrism? (p. 226)

These broad assessment contexts help the clinician understand the experiences that the family as a whole, as well as individual members, has endured. It is important to note that even within families disagreements may occur. For example, parents of an African American family might speak of a particular religious belief system, yet their children may hold differing views on religion. This speaks to the importance of understanding each member’s viewpoint across a range of important sociocultural variables.

Consider the Asian American family where the teenage son is experimenting with drugs. It is tempting to work with the son independently to enhance motivation, develop skills, and change self-defeating thoughts. Whereas these goals may be necessary and useful at some point, the substance abuse clinician must look at the cultural and family context that contributes to the substance use. Using the assessment guidelines of Breunlin et al. (1997) discussed earlier, it was discovered that the family members are recent immigrants to the United States, they have not yet reached economic security, and the parents are struggling in a society in which individuation/differentiation are the prominent goals for children. Because of these significant

¹Only two sample questions from Breulin et al. (1997) are provided here, with relevant page numbers for interested readers. For a complete listing of possible questions related to each domain, see Breulin et al. (1997).
contextual factors, the family is under considerable stress manifested by continual parental arguments, bouts of depression between mother and father, and limited time to enjoy life. The substance abuse seems to be a way for the son to cope with these difficult circumstances and maybe even “protect” the family by drawing attention away from these issues. The substance abuse clinician in this case must be sensitive to these cultural challenges and strive to build rapport, generate understanding, and brainstorm interventions that fit within the family’s culture and circumstances.

Barón’s Integrative Cross-Cultural Model (ICM; Barón, 2000) is a comprehensive metamodel designed to help clinicians integrate multifaceted personal, cultural, and familial factors that influence the cognitions and behaviors implicated in one’s behavior. It is a particularly useful model to follow when making an initial assessment because of its comprehensiveness in determining both internal and external experiences that impact minority families. Barón (2000) proposed that four domains of inquiry can help clinicians understand the multitude of factors that contribute to behavioral problems within culturally diverse families. Briefly, these domains are the following:

1. **Individual/Systemic Variables and Dynamics.** In this domain, the clinician inquires about typical assessment items such as mental health issues, developmental history, childhood experiences, level of education, and so forth. Related to substance abuse, the clinician queries individual use patterns, quantity of use, frequency of use, presence of tolerance and/or withdrawal, age of first use, and so on (Barón, 2000).

2. **Cultural and Ethnic Variables.** This domain includes cognitive mechanisms (beliefs, values, and thoughts) that have been influenced by one’s native culture. Related to substance abuse, items such as cultural viewpoints on addictive behaviors, cultural norms regarding substance use, how one seeks help within one’s cultural context, familial boundaries, gender roles, and parenting influences all comprise this domain (Barón, 2000).

3. **Dominant Group Influences.** This domain includes how strongly a family incorporates the beliefs and values of the dominant culture (Barón, 2000). Related to substance abuse, the clinician assesses the correspondence between the client’s cultural beliefs regarding alcohol and drug use and the dominant culture’s beliefs. For example, does the family (or client) believe that abstinence is the only option in substance abuse treatment as espoused by proponents of the disease model of addiction? How are their conceptualizations of substance abuse different and similar to the dominant dialogue?

4. **Minority Group Experiences.** In this domain, the clinician inquires about the minority family’s experiences of how they are treated by the majority group. Differential treatment might include elements of discrimination, prejudice, and oppression, which can have a profound impact on personality development, beliefs, and the maintenance of the substance abuse problem. The clinician must avoid generalizations; each client is unique and the effect of negative experiences with the dominant group differs for each person and family (Barón, 2000).

Bruenlin et al.’s (1997) and Barón’s (2000) assessment models provide a comprehensive outline for substance abuse clinicians to incorporate with minority clients. As one can see, there is far too much complexity for the substance abuse clinician to blindly adopt a certain therapy without thoroughly vetting the client’s worldview, perceptions, experiences, and motivations.
Many ethnic and cultural groups place much emphasis on the extended family. This must be acknowledged and incorporated into substance abuse family therapy. If a family from a diverse background respects aunts, uncles, grandparents, and cousins, then it would be worthwhile to incorporate them into therapy (Corey, 2009). With substance abusing children and adolescents, I have noticed that several admire some extended family member, such as an aunt or grandparent. Even if extended family members cannot attend sessions, it is worthwhile to tap into their wisdom in an imagined way. For example, I might ask a client, “What would your uncle say about how to better handle peer pressure?”

The job of the family clinician is to explore the unique culture of the family (i.e., rituals, rules, boundaries, celebrations, etc.) as well as the wider culture to which the family belongs and the dominant culture that impacts them every day (Corey, 2009). How does culture and its aspects inform as well as mediate members’ behaviors? Systems theory helps clinicians think about the processes and factors outside the family (and within the family) that impact the substance abuse problem. However, techniques cannot be administered universally (Corey, 2009). Assessment and intervention must be individually tailored to each unique family.

One final point regarding the application of family therapy with diverse clients: Our Western view of what constitutes healthy human growth is being able to separate from our families while at the same time maintaining intimacy—striking a balance between the two. Preference seems to be given, however, to differentiation. Immigrant children coming to the United States often adapt a Western view of differentiation and want to separate from their families in a way inconsistent with their culture of origin (Corey, 2009). Family clinicians who insist on and promote the Western view of differentiation may inadvertently disrespect the family’s cultural roots, and the family may not embrace family therapy as a result. Substance abuse clinicians must be open to cultural variations in family processes, structures, rituals, and beliefs and broaden their views of healthy family functioning (Corey, 2009).

**CASE STUDY**

**Using Family Systems Therapy in the Case of Michael**

There are many possibilities to explore and ways to work in family therapy. It is important to note, however, that no one right way exists to do family systems work. Thus, the case with Michael illustrates one possibility.

At the initial intake with Michael, it becomes clear that he is experiencing significant issues related to his substance abuse, especially with alcohol. He noted several consequences that he could no longer ignore. He and his wife, Julie, were constantly arguing. Their son, Zach, began acting out in school. Zach and his sister, Maria, were arguing daily. The clinician, thinking that Michael's drinking might have systemic roots, proceeded to conduct a genogram.

Michael’s genogram (see Figure 9.1) revealed several interesting insights that solidified the clinician's belief of a generational transmission process related to alcohol and substance abuse. It appears that alcohol problems have been an issue on his side of the family, especially for the men. His father, Jeff, struggled with alcoholism as
did his grandfather, Joseph. Michael also grew up in a disruptive home, as evidenced by significant conflict between his mother, Marilyn, and father. Michael noted that these conflicts and arguments usually revolved around his father's drinking. Michael is still close to his sister Amanda. It is interesting to note that there appears to be friction between Michael and his mother, and this pattern seems to have emerged between (Continued)
CASE STUDY (continued)

him and Julie. Michael and Julie have some conflict, and he stated that it has escalated recently. He is afraid it is just going to get worse unless something is done.

Due to the probable projection process within Michael's family, as well as the systemic and relationship variables that seem to play into his drinking and substance use, the clinician suggested that Michael and his family attend the next session.

For the next several sessions, Michael, Julie, Zach, and Maria were present. Marilyn and Jeff could not attend counseling because they lived ten states away. The following excerpt is from a session in which the clinician discussed the various family roles with the family and how these roles might change to improve relationships. This led to an insightful discussion among members through the clinician (i.e., using triangulation).

CLINICIAN: Zach, could it be that maybe you act out to divert attention away from Mom and Dad, or perhaps your dad's drinking? (assessing Zach's role as the scapegoat)

ZACH: Hmm, haven't thought about it that way before. I guess that could be the case. I mean, sometimes they are so stupid with rules and stuff, I just want to get away. But, yeah, dad's drinking bothers me.

MICHAEL: [getting defensive and angry] That's the first time I've heard you say that, Zach.

CLINICIAN: Michael, go ahead at this point and talk to me about how you feel and any other comments you want to make. Zach, can you say specifically how your dad's drinking bothers you? (creating a triad between Zach and Michael to diffuse tension)

ZACH: I mean, it just does. He comes home late, yells at Mom. It just makes me uncomfortable. I feel like I want to get away. And then Mom just covers it up. I’m sick of it—she covers everything up, and he treats her like crap.

CLINICIAN: [ensuring all members have a voice] Julie, what are your thoughts about what Zach has to say?

JULIE: [becoming teary] I don’t know. I might protect Michael a little bit. I wasn’t aware that Zach had such strong feelings about it. I just want to keep the peace. If I didn’t, then who would?

CLINICIAN: [ensuring all members have a voice] Michael, what is it like, hearing this from Zach and then Julie for the first time?

MICHAEL: I had no idea. But now, I can see how Zach has handled my drinking. He hasn’t talked to me, but he has gotten into trouble as a way to talk to me. I love Julie. I don’t want her to get hurt.

CLINICIAN: [ensuring all members have a voice] This is new to you, and may take some time to digest. What about you Maria, where do you fit in all of this?

MARIAN: I don’t know. I just like to disappear. I don’t cause as much trouble as Zach, or any trouble for that matter.
CLINICIAN: Do you think, Maria, that disappearing protects your family or you in some way? (assessing Maria’s role as the lost child)

MARIA: I know if I keep my mouth shut, then I can’t get in trouble. But it is like walking on eggshells around the house.

JULIE: I think Maria has slowly withdrawn from her friends and school—it has been more noticeable this year.

CLINICIAN: Michael, I’m hearing some feedback from Zach and Maria that they want to distract everyone from the drinking. That seems to be the common denominator here.

MICHAEL: Yeah, maybe so. Look, I have said that I will stop drinking. Isn’t that enough?

CLINICIAN: Well, as I said before, from a systems perspective, sobriety may bring about other changes that may be uncomfortable at first. For example, if you, as a family, continue to fight, even without alcohol, Zach might continue to act out because the family still cannot communicate. [To the family] How can you all communicate in a more effective way—so that Zach doesn’t have to act out, Maria doesn’t have to disappear, and Julie doesn’t have to protect?

MICHAEL: We can start by practicing in here. (all nodding their heads)

CLINICIAN: Okay, how about if all of you pay attention to when you are acting out in the session, Zach, or if you are disappearing, Maria, or if you are protecting, Julie, and then we can explore what you are really feeling, really trying to do? How does that sound? (ensuring ownership of the problem; all nod their heads)

ZACH: What a minute! Why do we have to do all this work, as if we are the reason dad is using?

CLINICIAN: I hear you loud and clear, Zach. You are concerned that you and the family are being blamed when the substance use is not your problem, and wonder why you should change. I would like to make two points related to this: First, as we have discussed, the member who struggles with substance use, in this case your father, is responsible for his own treatment and care, and the family is invited to support him in his recovery. There is no place for blaming here. Second, as a family, you may be stuck in some interaction patterns that are not as healthy as they could be. When communication and interactions among all of you improve, everyone benefits.

ZACH: I guess that makes some sense. I just think living in our house has got to change!

CLINICIAN: For next session, I would like you all to notice what roles you are playing in the family and what purpose they serve to maintain balance in your family, including you, Michael. You don’t have to change roles at this point, but just be aware. Just notice. (providing an assigned task)

(Continued)
CASE STUDY (continued)

This session was designed to help Michael's family think about the roles they play and the reasons they play them. There is nothing wrong with roles; however, if they are used in ways that sabotage growth or preclude awareness, then they probably need to change. Notice how the clinician engaged in joining, encouraged the family to talk through him (forming triads/triangulation), and gave the family an assigned task. Also, Zach presented some initial resistance to the idea that he needs to pay attention to his behavior, when he is not the one addicted to substances. This is a common sentiment among nonaddicted family members. It is important for the clinician to validate these concerns and then educate the family on the systemic nature of addiction and the importance of support. At the same time, the clinician should emphasize that, when you boil it down, it is ultimately the addicted member's choice to use or not use chemicals.

The sky is the limit in terms of where to go from here. Based on Michael's genogram, additional sessions might need to focus on strengthening the marital dyad, exploring Julie's enabling behaviors, and giving the children a chance to further express their emotions. Improving communication between family members also seems paramount.

STRENGTHS, LIMITATIONS, AND ETHICAL ISSUES RELATED TO FAMILY THERAPY

Family therapy is an effective, viable treatment component when working with clients struggling with substance abuse and addiction issues. From a systems perspective, working on individual symptoms without taking into account the systemic variables that maintain the addiction may result in less-than-adequate treatment results. When possible, family work should be a part of every substance abuse client's recovery. This chapter reviewed the major tenets of family therapy with systems theory serving as the foundation. Numerous family therapy strategies and interventions were offered for the substance abuse clinician to consider. Even if the primary mode of intervention is individual therapy, occasional focus on the family can provide a powerful adjunct to therapy.

Despite being an effective mode of therapy, skilled family work takes considerable training and supervision to apply competently as a sole form of therapy. However, substance abuse clinicians need not be licensed marriage and family therapists to provide basic family interventions. Still, care must be exercised in the provision of family-based assessment, interpretation, and intervention. In addition, whereas individual counseling requires only one person to attend sessions, family therapy requires more than one member to attend counseling and commit to change, which can be difficult in today's busy, fast-paced society. Ethical concerns may arise if clinicians operate solely from a traditional, Western conceptualization and definition of the family. A summary of the strengths, limitations, and ethical issues related to family therapy is provided in Table 9.1.
Table 9.1 Summary of Strengths, Limitations, and Ethical Concerns of Family Therapy in the Treatment of Substance Use Problems

**Strengths**
- Family therapy is as effective, and in some cases more effective, than individual therapy.
- Family therapy addresses the systemic factors that serve to create and maintain the symptom of substance abuse.
- Much of family therapy rests on systems theory, which holds that psychological symptoms are a function of dysfunctional systems. Looking for and correcting faulty relationship patterns among family members can go a long way to alleviating substance abuse problems.
- Family therapy offers a range of techniques to help families differentiate, communicate better, and develop mutual caring and respect.
- In family systems therapy, neither the individual or family is blamed for the family problems (Corey, 2009); rather, the focus is on learning and adjusting the system to live more happily.

**Limitations**
- Family therapy can be a complex process that requires attention to multiple processes, patterns, and content. Substance abuse clinicians can easily get confused without sufficient training and supervision.
- Systems approaches do not focus exclusively on the substance abuse problem but rather on the patterns of relationships that maintain the problem. Some clients might view family interventions as addressing tangential issues rather than the main issue of substance abuse.
- In systems thinking, the individual perspective within the system can sometimes get lost by overzealous family therapists who cling to systems terminology and concepts. The family is not a “car” that can be tweaked and adjusted. Clinicians should not forget to communicate with the individuals in the family as real people with real human emotions (Corey, 2009).

**Ethical Issues**
- Despite its effectiveness in substance abuse counseling, family therapy takes considerable skill and understanding to use competently. There is potential risk that some clinicians’ lack of skill and theoretical understanding, as well as confusion as to its application, could constitute unethical practice.
- Family therapy can present several ethical issues for the clinician, including how confidentiality of the family is maintained, psychological risks of confronting family members, misuses of family strategies, and clinician competence. Substance abuse clinicians must constantly be mindful of these issues and clarify their values as they apply to ethical practice.
- Multicultural family counseling may pose ethical issues for leaders who do not consciously acknowledge the reality of our multiracial society. Given the diversity of families that may enter treatment, clinicians must maintain a stance of broad sensitivity to client differences. Ethical issues arise if the clinician’s perspective of what constitutes a healthy family is imposed on diverse clients.

**References**


