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ABSTRACT

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THE ROLE AND RESOURCES OF THE FAMILY DURING THE DRUG REHABILITATION PROCESS

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by

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PROGRAM SUMMARY

Drugs and drug abuse are often viewed in isolation from the social systems of which they are a part. One frequently neglected system is that of the family and its role in the treatment and rehabilitation of the drug abuser. Focusing upon the family as a resource, this program will present selected issues on, approaches to, and difficulties in the establishment, development, and continuance of a family therapy program for a residential treatment center for drug abusers. The initial presentation will be followed by audience reaction and a discussion period.

ABSTRACT

This paper presents a rationale for family involvement in the drug rehabilitation effort. This is based on the significant role the family plays during the process of overcoming the impact of disability. The perspective of this paper is a result of the author's experience over a three-year period with families of drug abusers and their attempts to participate in the rehabilitation process. Discussed also are selected difficulties and challenges faced by these families engaged in a process which requires the acquisition and maintenance of new behaviors. A potent force in this process has been the evolution of a multilevel family therapy program which utilizes the principle of an alternate living arrangement in conjunction with family therapy.

Family Role and Perspective

As a system, the family is not immune to the internal and external stresses of human existence. In concert these forces emerge as both a personifier of the flaws and resources in a particular family unit as well as a magnifier of the limitations and assets of its individual members. Traditionally the family has been responsible for its own welfare and the well-being of its members. However, crisis periods, such as drug addiction, frequently demand new roles and new behaviors on the part of the family. In attempting to engage in this process, families are faced with the reality of their limitations of techniques, the paucity of resources, and the limited availability of expertise to alter such dysfunctional behavior with individual family members or within the family as a whole.

Subsequently, families have by necessity become more reliant upon such external support systems as the helping professions to facilitate their adaptation to these new roles and to provide a structure in which new behaviors may be learned. What a family should be able to cope with is a discussion of the metaphysical unless it is rooted in the dimension of realistic goals, resources, and alternatives. Families that do not demonstrate resources to be responsive to traditional treatment attempts should not necessarily represent barrenness to the helping professions but, rather, a fertile entity that may not have been properly cultivated. There is a vast difference between therapeutic emptiness and therapeutic nothingness. While each in its present state is a deficit, only the former represents the capability of altering that condition to become productive.

Examining the role of the family in relation to the disability process indicates its significance during rehabilitation and highlights the awareness that a person does not function in isolation from the family system. This insight must be taken into account during the diagnostic, treatment, and rehabilitation process. If drug abuse and its concomitant behaviors can be considered as mirrors of a basic systematic dysfunctioning within the family, subsequent intervention must become sensitive to the significance of the family system.

> The interrelations of individual and family contribute to the determinants of mental health at every stage of maturation, infancy, childhood, adolescence, adulthood and old age. Such relations influence the precipitation of illness, its course, the likelihood of recovery and the risk of relapse. Receptivity or resistance to therapy is partly the product of emotional interaction with other family members. Prediction of changes in behavior is accurate only to the extent that family processes are taken into account (Ackerman, 1958, p. 727).

Therefore, since the family is a potent system for causing behavior, and more significantly for modifying it, change must occur by the family unit as well as by individual members if a mutual system of family actualization is to evolve. The need for such family actualization is poignantly apparent when the family is faced with the challenge of the disability of one of its members.

The Family and Disability

The trauma and impact of physical and emotional disability are often unequaled in terms of their impact upon the family. The nature of the disability and the basic resources possessed by those affected determine the extent of this impact on individual and family roles. The occurrence of any disability alters the roles of both the family and the disabled member, subsequently creating demands for which neither are prepared. Not only has the individual been through a traumatic process, but he must face a family that has gone through a similar

experience. As Shellhase and Shellhase (1972) pointed out:

> Just as the traumatic event is usually instantaneous and unheralded for the individual patient, the family also is ill-prepared for the traumatic event and its consequences. Many of the same defensive measures made by the patient himself are made by the family. Just as the patient goes through a process of denial in which he tries to wish away the reality of his disability, so his family also goes through a period of emotional turbulence (p. 548).

The helping professional must bridge the void created by trauma and establish an ongoing, working relationship with the family unit to facilitate the actualization of the treatment and rehabilitation goals. Often the greatest limitations to be overcome are the psychological barriers established by the family as a reaction to the disability and as a manifestation of their fear of being unable to respond to its demands. One approach in reducing these limitations is to involve the family from the beginning of the rehabilitation process:

> Throughout the endeavors to create a positive and working engagement by family members in the future of the severely disabled member, one must remember that the sick member is not in a static condition. He is engaged in a complex process of rehabilitative services. The goal of these services is to return the patient to his family prepared for the maximum resumption of his role within the family.
>
> In summary, it is through the early and continuing attention to the family as a unit during the rehabilitation experience that the patient is never far removed from them, affectively and interactionally. In this way the trip home is never a long one (Shellhase and Shellhase, 1972, p. 550).

A major concern is that families are limited in their resources for coping with various illness due to significant changes in the structure and expectancies of society today:

> The primary psychodynamically relevant reasons we find in the special character of the American urban family, which is extremely vulnerable to certain types of strain. Mechanisms have developed which relieve the family of the additional stresses which would be imposed upon it by making the care of the sick one of its principal functions. At the same time, most cases of illness with psychological components are probably more effectively cared for in the special circumstances of our society by professional agencies than they would be in families (Parsons and Fox, 1958, p. 33).

In discussing the issues related to the impact of long-term and fatal illness upon the family, Gordon and Kutner (1965) presented the following consequences which indicate the multitude of problems faced by the family which must struggle with the advent of disability:

> 1. There may be an initial traumatic reaction when the diagnosis is revealed to the parents.
>
> 2. The parents' self attitudes as well as their relationships with other members of their families, friends and neighbors, may be seriously altered.
>
> 3. There may be a difficult adjustment to the medical needs of the sick child.
>
> 4. A variety of relationships with physicians and other medical personnel in clinics and hospitals must be established.
>
> 5. A long term readjustment in way of life depending upon the nature of the illness and the economic, biological and social consequences following in its wake may be required.
>
> 6. Latent emotional problems may be brought to the surface by the demands of the situation (p. 1).

These concerns focus upon the demands made upon the family but they also allude to the consequences if a family is unable to bind its resources during this traumatic period. In discussing family factors in the adjustment of the severely disabled, Deutsch and Goldston (1960) questioned the advisability for home placement in all cases:

> First of all, if home placement is at least partially independent of personal relationship with family members, and at least partially dependent on role and responsibility variables perhaps the emphasis on home placement should be more selective. If it is true that only the unusual family can accept a real role reversal, maybe efforts should be made to understand and then influence the operation of these role variables; but in the meantime, perhaps alternatives to both the hospital and the family unit should be worked out (p. 316).

Being aware that total family participation in the rehabilitation process may not be 100 per cent effective is an aspect of reality that the helping professions must face. However, this reality should never become a rationalization

for not attempting to implement an effective family therapy program. Vincent (1963) discussed "the widespread belief that the stability and harmony of the family are endangered by the presence in the home of old, sick, and retarded, or handicapped family members (pp. 111-112);" however, he concluded that the family must not be isolated from the process of health care:

> The strengths of the family have long been glorified as bases for mental and physical health; its weaknesses have equally long been damned as sources of mental, psychosomatic, and even organic illnesses. Thus, it is encouraging that an increasing number of educators and researchers are emphasizing the total family--nuclear and extended--in relation to health and illness (p. 116).

Similar views were expressed by Benny and Peck (1963) in their discussion of the role of the family in the rehabilitation of the mentally ill:

> The family does, nevertheless, significantly influence aspects of functioning that pertain to a member's level of competence in the world of work. As a consequence we are confronted not with the question of whether the family will influence the rehabilitation process, but rather how feasible and appropriate it may be to engage in direct assessment and intervention into the family problems.
>
> The rehabilitation worker is only too often made painfully aware that without such intervention into the family situations, forward progress at the vocational level may in itself induce reactions in the family which threaten to undermine or block any possible gains with the primary patient (p. 372).

One important family member who can potentially prevent undermining or blocking of gains is the spouse of the disabled, who is also in need of support.

Disability and the Spouse

The spouse of the disabled person often faces a state of loss, a change in role, and a crisis situation.

> . . .illness exerts a significant effect upon the 'well' members of the family. In a way, it may demonstrate that spouses come to the clinic with patients on their first visit because they have a very personal stake in the results of the diagnostic and treatment process. . . . .the development of illness in the family is attended by role failure which leads to interpersonal tension and psychophysio-

> logic distress in both partners (Klein, Dean, and Bogdonoff, 1967, pp. 246-247).

This dual impact is often underemphasized during crisis periods with the spouse being relied upon for strengths which may not exist. In addition, the spouse may feel constrained from making demands to fulfill their own needs due to the expectations of their role in meeting the needs of others. Spouses must be made aware of their importance and the necessity for them to attend to their own needs. One method of establishing a structure for this process to occur is family therapy.

Family Therapy

The current emphasis upon the family and its role in the therapeutic-rehabilitation process has been the result of an evolutionary process from basic psychoanalytic concepts--which did not focus on all members of the family during therapy due to concerns about the effect upon the transference relationship--to orientations that see the family as a key factor in the treatment process which can subsequently effect treatment outcome.

> From the point of view of the therapist, treatment of the family group holds out some attractive brass rings. The therapist may by now be convinced that if a patient is to be changed then his family must also be changed (Parloff, 1961, p. 450).

Centering attention on real life issues of the family focuses upon problems as they relate to potential resources rather than the nebulous issues related to the pathology or the "odd behaviors" of one isolated family member. In their review of the literature on family therapy, Pool and Frazier (1973) concluded that while assessing the results of family therapy is difficult, its potentiality is recognized as a means to educate and support the family. This process, however, must extend beyond definition of problem areas to conceptualization of solutions to them. As Charny (1972) pointed out:

> The fact is that in recent years a powerful new tool for preventing serious emotional disturbance has become increasingly apparent to us in the course of the now established experiments in new techniques of family psychotherapy. Here the whole family group--though at various times it is smaller clusters within the family--is seen together in treatment interviews to tell it like it is, and put it to each other where it's really at, in genuine confrontations of one another, all against the background of the deep reservoirs of family members' love for one another, or, at least, their wishes to love one another that are the blood and guts of the natural family ties of all of us (p. 20).

This approach has certain prerequisites, such as the commitment of the family to the process and their ability to see some benefit from it. Although one may consider permitting families to determine their own courses of action in coping with their own problems, the sad reality is that many families faced with the nightmare of disability cannot make appropriate choices due to the extent of the trauma facing them and the helplessness they feel in doing anything to change their situation. Therefore, for these families the crisis period of disability can potentially evolve into a process of helplessness and hopelessness rather than an exploration of potential solutions.

Family therapy is one vehicle to overcome these feelings of ineffectiveness. While not being able to alter the disability itself, family therapy can alter how people perceive themselves, their role, the disability, its impact, and its implications, thereby providing more control to the family rather than having the family controlled by the disability. The dimensions of this process are vastly expanded when multifamily therapy is initiated, since the isolation of a family is put in the context of other families who have met the challenge of disability or who are attempting to.

Multifamily Therapy

Multifamily therapy is an additional means of providing a format within which families benefit from their mutual exploration and growth:

> One of the goals of the therapeutic process is to help all group members to view the troublemakers as troubled, and to bring out into the open the connection between the problem child and "other family problems (Leichter and Schulman, 1972, p. 268)."

The group interaction therefore becomes a means of crystalizing critical problem areas which may be masked by the overt behavior of an individual member who receives most of the attention and criticism. The multifamily group provides a stage upon which family behavior can be closely examined and more viable roles can be attempted.

Addiction and the Family

Disability makes great demands upon the disabled person and his family. Many of these demands are related to the new role the person must assume within the family. Others are related to the new behaviors the family of the disabled must demonstrate to facilitate the rehabilitation process. Critical to this process is the understanding of the family system and the providing of support to the family members so they have an opportunity to develop those areas in which they may be deficit.

The following section of this paper will be a continuation of the theme of the impact of disability but in the context of drug addiction. The author believes that the drug addiction process has a similar impact upon the client and the family as other disabilities and demands a rigorous rehabilitation process to overcome the limitation of drug dependency and to facilitate family and community reintegration.

Like physical and emotional disability, drug addiction may cause families to fragment, result in financial hardship, and affect the emotional balance of parents, spouses, and siblings. Consequently, understanding the effect of disability on a family, how it is responded to, and how it is coped with facilitates the exploration of the addiction process. Emphasis in this section will be upon

the process of addiction, the significance of the family, and a presentation of an ongoing program which places great importance on the role of the family in the rehabilitation process.

The intensity of the reaction to the condition of drug addiction can be related to the quantitative and qualitative aspects of family relationships. Just as there is variability in the impact of drugs on the life of the drug abuser, so is there an individualistic reaction on the part of the family and its members. One of the most difficult tasks in working with the family of the addicted is to explore the dimensions of the reaction to their drug problem and to transcend the feelings of present failure and impending doom. This fear of the unknown frequently explains the panic reaction of parents and families when initially facing the issue of addiction.

By its nature the awesome power of the addiction process itself is a threat which may consume the drug dependent person and create a state of loss, failure, and helplessness. A person may die, be psychologically destroyed, be imprisoned, or create a variety of personal tragedies for the family. In attempting to control these realities families are faced with the task of self-examination, self-exploration, and often self-incrimination as they attempt to define their role as a causal factor in the addiction process.

In family therapy with the drug dependent person, the challenge is to avoid the task of deficit-focusing as an end in itself and to transform these energies into a process of learning about what can be done "here and now" and to understand the potential impact new behaviors can have upon the future. Vast amounts of energy are frequently expended during the therapeutic process attempting to reconcile the unreconcilable and to alter the unalterable, which has become immortal by virtue of being part of the past and immune to the wishes and desires of the present. This philosophy does not deny the significance of the past but

attempts to use the present as a lever to approximate future gain.

Alcohol Addiction and the Family

Since alcohol is a drug, including it in the discussion of addiction and the family is vital. According to Fort (1973) alcohol is this country's biggest drug problem and consequently has profound implications not only for alcoholics but also for their families. The magnitude of the problem in relation to the family is reflected in a sampling from the vast amounts of research in this area, such as that of Price, 1945; Bensoussen, 1958; Jackson, 1958; Bullock and Mudd, 1959; Bailey, 1961; Cohen, 1966; Esser, 1968; Sands and Hanson, 1971; Catanzaro and Pisani, 1972; and Krimmel, 1973.

The family of the alcoholic is viewed as a necessary component in the process of rehabilitation, and their involvement in the therapeutic process provides an opportunity for family members to understand the addiction of the family member and to clarify their role and responsibility in the cause of this condition or their potential role in its treatment. Meeks and Kelly (1970) found the following factors to be important for intervention with families of recovering alcoholics:

1. Initial attention must be given to helping the family consider why the entire family is in treatment and not just the problem-drinking member. The expectations of therapy by family and therapist should be discussed in this context.

2. With the families of recovering alcoholics the wish to maintain a present superficial harmony based on the containment of negative feelings (resistance) may defeat the constructive goals of the family as a unit. The therapist must help the family recognize this goal conflict and its sources.

3. The intrusive role of alcohol in the family should not be negated but put into perspective along with other behaviors which affect the relationship of family members to each other and to the family as a whole.

4. "Games" that occur in treatment and mask real conflicts should be related to those that are played at home which distort reality and

sustain conflict. The therapist should intervene in such behaviors and help family members become objective spectators of their own role playing and the rules underlying them.

5. Individual behaviors (extension of individual needs) that reinforce family problems (e.g., drinking) should be opened up and explored. Likewise, the family should be aware of its interaction in relation to the alcoholic member's fears and urges around sobriety and drinking.

6. The therapist should recognize with the family that shifts in its equilibrium (around, for example, dependence, dominance, support, withdrawal) disturb the established patterns of behaving and relating among family members.

7. Periodically these shifts in family equilibrium and their meanings and implications should be reviewed (need for new sources of gratification, role relinquishment, etc.).

8. Family members should be helped to accept compromise and the feelings surrounding compromise so that appropriate reactions are possible and support can be offered on a realistic basis.

9. The family should be helped to apply the problem-solving approaches employed in family therapy to their interaction outside of treatment (pp. 410-411).

The awareness and implementation of these principles enables the family to assume responsibility for its actions and develop the resources to monitor its own dysfunctional behavior. Mueller (1972) also concluded that all problems do not end when drinking stops:

> Because of the all-encompassing nature of the illness, both the alcoholic and his family members tend to associate all their problems with his drinking. Conversely, they assume that once he achieves sobriety, all will revert to normal and there will be no problems. The family will get along smoothly, and there will never be any relapses. Obviously, this rarely happens. When he becomes sober, the alcoholic immediately wants his early role back and tries to accomplish everything at once, at the same time using up most of his energy simply trying not to take a drink (p. 84).

The experience and abilities evolved from attempting to stop drinking behavior becomes the means to solving other problems facing the family and its members. This effort creates a rationale for mutual commitment to the investment in

family therapy and the demands related to this process. This orientation has some similarity to the treatment and rehabilitation of the drug addict and his family.

Drug Addiction and the Family

In a comprehensive review of the literature on the family of the drug addict, Seldin (1972) indicated the basic turmoil within these family systems and the impact this can have upon the family members:

> The family of the addict, typically, provides an unstable environment for emotional growth. The mother's relationship with the addict is particularly critical. The father is detached and uninvolved while the mother, who dominates the family, is viewed as emotionally immature, conflicted, and ambivalent about her family role. This provides poor conditioning for the addict in his own assumption of the roles of husband and father. In marriage there is likelihood of a replication of the original family dynamics--a dominating, psychosexually ambivalent wife who perpetuates the male addict's immature behavior patterns (pp. 105-106).

The challenge in working with drug dependent persons, their problems, and their families is to move beyond the state of behavioral deficits and to begin to mobilize those potential forces which can be facilitators in the deaddiction process. One approach is to develop an awareness of the multitude of factors related to and influencing the behavior of the families of addicts. As Rosenberg (1971) pointed out, there are frequently additional difficulties existing in families of drug dependent persons apart from the secondary diagnosis of drug addiction:

> The study revealed that over one-third of the parents and older siblings of a group of adolescent drug addicts were disturbed to the extent of receiving or requiring psychiatric treatment. Amongst the fathers and brothers behavioural disorders, including the abuse of alcohol and drugs, predominated; but amongst the mothers and sisters neurotic or depressive symptoms were more common. These findings indicate that drug addiction is not only a manifestation of the adolescents' personality disturbance, but is symptomatic of a wider family problem.

Therefore, the helping professional is usually faced with a myriad of dysfunctional behaviors, such as delinquency and alienation, which may either be the

result of the addiction process or a cause of it and which demand commitment, time, and expertise on his part. In discussing some difficulties in working with the student drug user and his family, Kuehn (1970) stated:

> While admittedly family counseling may be the treatment of choice. . . the establishment of a contract is often extremely difficult. Family treatment is also realistically not the cup of tea of many otherwise quite capable counselors. It is common to find that schizophrenogenic scapegoating is taking place. In essence, the family needs the patient sick to maintain its own vital balance. Thus, the family members try subtly to torpedo or organize against the counselor (p. 413).

Working with the family can therefore be as difficult as it is important. However, helping professionals should recognize that initiating and maintaining a meaningful ongoing therapeutic family relationship is not impossible if there is the potential for a mutual gain for all parties involved. However, one situation in which this potential gain may emerge as a potential loss is with the spouse of drug dependent persons.

Spouses of Drug Dependent Persons

An important and sometimes overlooked population is the spouse of the addict, who experiences the impact of drug abuse on the marriage. Compared to working with parents of an addicted child or young adult, dealing with the spouse of the addict creates a different set of demands upon the therapist, the process, and the focus of treatment. The therapeutic process results in the recognition that the spouses do not know each other, since one of them may have been addicted through courtship and marriage and their life together has been lived under the influence of drugs. Frequently during their struggle with addiction, the married couple may believe that a child will become a motivator for the cessation of drug dependency. Upon arrival of the child, the situation usually changes in that there are three people affected instead of two and the drug problem is still there.

The addict, once drug-free, may decide that decisions made in the past were under the effect of drugs and consequently there is no responsibility to the

spouse or the family. The dimensions of the problem make success difficult with this population, since the therapeutic process often becomes a means of evaluating whether or not the couple will remain together after treatment. However, the real value of treatment with this population is the opportunity to interact while drug free and make decisions which are appropriate to both persons.

Issues Related to Treatment of the Family of the Addict

In discussing roles within the family and the resolution of role conflict, Spiegel (1957) referred to the impact of strain on the family system:

> However, there are inevitable strains in any such system, and these give rise to disequilibrium. The strains can be analyzed in terms of the cognitive, goal, allocative, instrumental, and value structures of the roles. A strain represents a discrepancy in the expectations of any ego and alter with respect to these role structures. Thus it can be described in terms of role conflict. Strain gives rise to anxiety because, if left unchecked it will lead to a rupture of the role relations, and thus to a disruption of the system. Without a discussion of the origin of this anxiety in the basic structure and function of the intrapsychic process, it can be said that the role conflict gives rise to defensive processes both in the person and in the family system (p. 16).

If drug addiction is interpreted in the light of the introduction of dissonance into the family system, the process indicates the need for, as Spiegel stated, "re-equilibration," which has similar goals as family therapy; that is, the reestablishment of a functional, dissonance-free or dissonance-controlled state within the family.

The impact of drugs upon the family frequently creates such a state of chaos that the initial efforts toward family reintegration begin on a very basic level, such as attempting to open a channel of communication. This task is compounded by the limited ability of family to respond to tasks which require that they function as a cohesive integrated unit while working toward mutual goals. One explanation for this difficulty is presented by Schuham (1970) in a comparison of the power relations between emotionally disturbed and normal family triads:

> The process and outcome measures are quite consistent in presenting a picture in which psychopathology of a child is associated with a family interaction system which is impaired in its capacity to resolve conflict between its elements, does not demonstrate a clear leadership pattern, could be described as "equalitarian" in the sense that its members share about equally in their power to influence family decisions and support each other (or fail to) at about equivalent rates, is unable to form and maintain coalitions between its members, and shows a weakness in the specific (parental) relationship having the greatest potential for unitary action.
>
> In contrast, the normal family system is associated with an ability to reach decisions which are satisfactory to all its members, and a clear-cut power structure emerges in which the father is in ascendancy, the mother ranks second, and the child last. The ability to form and maintain coalitions among the system members is prominent, and a low but positive rate of support among its members is manifested (p. 36).

This does not mean that all families who are faced with addiction are emotionally disturbed. However, it does imply that during an emotional crisis, appropriate response patterns on the part of the family are limited at best.

Mead and Campbell (1972), in investigating the decision-making and interactional process by families with and without a drug-abusing child, concluded, "Spontaneous agreement or lack of it seems to differentiate normal and abnormal families whether the abnormality within the family manifests itself as emotional maladjustment, delinquency, schizophrenia, or drug abuse (496)." Therefore, the failure to resolve many issues and behaviors related to the addiction process can on occasion be a reflection of a dysfunctional system within the family. Understanding this system is facilitated by the awareness of the process of addiction and its impact upon the family.

Therapeutic Approaches to the Family of the Addicted

In their presentation of a family systems approach to substance abuse, Levy and Joffe (1973) stated:

> The family-systems approach focuses on the dysjunction between people; the interpersonal conflicts and tensions that occur in rela-

> tionships that are associated with pathogenic patterns of relating and self-defeating ways of coping, such as substance abuse. Rather than isolate the individual in an artificial way from his/her social mileau, the family treatment specialist endeavors to understand the individual's behavior within the context of social systems, including friends, family and larger social networks. The focus in on the interpersonal world of the substance abuser. Interest is not so much in "why" one abuses drugs, but rather in what function that behavior serves interpersonally, and how that behavior is maintained within the current family system (p. 2).

Cognitively understanding the addiction process is not sufficient for the family to alter their affect and memories of the effects of addiction (Figure 1). If not resolved, such concerns can create a situation of therapeutic entrapment which can result in the fixation of what was rather than what could be.

Figure 1 goes here.

Therefore, the pain of self-exploration in these cases results in the awareness that there are fears which are not easily alleviated by the empty promise of reform but require demonstrated evidence that behavior change can take place. These concerns are also examples of the frames of reference familiar to the therapeutic setting which inspire the poignant question of what can be done for parents, spouse, and other family members to alter the expectation that what has happened previously will not be an indication of the future.

To attempt to alter the pattern of drug dependency of a family member without dealing with the ongoing process of family reintegration is limited at best and reflects the need for viable treatment goals. Levy and Joffe (1973) stated their treatment goals with families of drug dependent persons as follows:

> 1. Reduction of substance abuse: Therapeutic intervention aimed at alleviating the personal and interpersonal influences which are associated with substance abuse.
>
> 2. Relationship building: The goal is to facilitate a change in the family system so that members relate in a more positive manner. A therapeutic atmosphere is provided which stimulates and encourages new ways of behaving, relating and communicating.

1. How should families react when one of its members backs a truck into the driveway and empties their home of all their worldly possessions and sells them for several hundred dollars to purchase drugs?

2. How should families react when the psychiatric treatment and hospitalization of the addicted member cost $75,000.00; and after this investment, he returned to the streets and resumed his pretreatment behaviors?

3. How should a family react when as a result of the drug-abusing behavior of one of its members, the mother has a nervous breakdown and is hospitalized for a year?

4. How should a family react when they have spent many nights wondering whether their loved one has overdosed again and will be found dead or alive?

5. How should parents react when their fifteen-year-old daughter has rejected them, their life style, and their morals, and openly informs them her vocational goal is to be a prostitute, and leaves to assume that role?

6. How should a family react when they realize the drug-abusing member is a felon who may spend seven years in prison for drug-related crimes?

7. How should a parent react, having buried a child who died from a drug overdose, when faced with the emergence of drug-taking behavior on the part of younger siblings?

8. How should a wife react when she is faced with the loss of her husband when he stops using drugs, since he married while addicted and has never known her or his children while being drug free?

Fig. 1. Frames of reference for families of the addicted

> 3. Positive community involvement: Substance abuse families typically experience conflictual and frustrating interactions with social agencies and institutions (legal, correctional, vocational, educational and social service). The family treatment specialist must understand and confront problems at the interface of family and community so that the family as a social unit experiences more positive and self-enhancing interactions with their community as well as with each other (p. 4).

Such treatment goals demand a comprehensive understanding of the needs of the addicted and their families and require the establishment of a treatment mechanism to facilitate this process.

Multiple Family Therapy

Multifamily therapy is a vehicle by which behavior change can occur and basic coping skills can be learned. Laquer (1970) stated that family competition and group interaction can produce more rapid change than single-family therapy. Because the key point of this interaction is learning how learning takes place, one family can often become a model for other families. Therefore, multifamily group therapy becomes an experience in incidental learning and modeling as well as a vehicle for facilitating therapeutic interaction. However, there are some basic difficulties encountered when attempting to initiate a multifamily therapy program. Pitkin, Bates, and Brown (1973) discussed their experience as follows:

> The families rigidly insisted that all their problems would be solved if the patient would stop being a drug addict and become a "dutiful son", surrogate father, or a "good daughter". We saw the addict as being scapegoated for whatever else had gone wrong in their lives and family situation. The families were adamant in their stance that the only thing wrong with their family was their drug addicted son or daughter (p. 10).

The aspects of learning during multiple family therapy are most critical when the drug problem moves beyond the crisis intervention stage and enters the realm of prolonged treatment and rehabilitation.

Alternate Living Arrangements

Realistically, the expectations are limited for a family lacking the resources for controlling the behavior of a drug-dependent person who remains at home and lives in a crisis-oriented environment. The alternate living arrangement has great potential in drug rehabilitation because it is a facilitative alternative rather than a punitive placement. The value of the residential placement in conjunction with family therapy is discussed by Dell Orto and Zibbell (1974):

> One of the primary strengths of a residential therapeutic program for the resident has been removal from the drug environment. This encapsulation enables the resident to insulate himself from many destructive influences in his life and provides him with the opportunity to develop new skills and behaviors. This separation relieves the family from a constant state of crisis which existed while the person was involved with drugs. Placement in the therapeutic environment, along with individual and family therapy, allows a new perspective to be attained by all members (p. 57).

This does not mean that via professional consultation and intervention by the school or other agencies that change cannot take place. It does mean, however, that many families when faced with the trauma of the addiction process are unable to respond facilitatively due to the presence and immediacy of their problem.

Program Model

The following model evolved from the needs of a residential drug treatment program for adolescents and young adults.* The drug dependent person is referred to this treatment program in various ways: Court referral, self-referral, parental or spouse-referral, and community/agency referral. In most of these cases,

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*The author wishes to acknowledge the role of Peter Petit, whose leadership solidified the family program; Robert Zibbell, Ph.D., whose dedication made it viable; and Gene Bocknek, Ph.D., who conceived it.

drug abuse is concomitant with a crisis situation with which the family cannot cope. Theoretically, the goal of treatment is to terminate drug use, develop alternatives, and facilitate community and family reintegration. In order to do this, the family involvement must be more than superficial and include an ongoing feedback system so family members who have been separated from each other during the rehabilitation process are not faced with an irreconcilable psychological time lag. The structure and format of this program are presented in Figure 2.

Figure 2 goes here.

Structure

Families perceive the alternate living arrangements in a therapeutic community as an opportunity for the drug dependent person to demonstrate that he or she is capable of and willing to change. This in turn results in modification of the family's expectancies regarding the person's potential for change. One interpretation of this alteration in these expectancies is that the act of giving up drugs is a major step in the drug rehabilitation process but, more significantly, it is a demonstration of faith to the family which is substantiated by overt behavior as compared to meaningless verbalizations of the past which promised a great deal but delivered nothing.

Participation in the residential treatment program demands a certain degree of ego resources which enable the client and his family to begin the long, difficult process which may test their limits. Many families take refuge in the hope that once a drug-dependent person has begun to do something positive, the situation will change. They are often unaware of potential difficulties and are unrealistic in their expectations both for the process and for its outcome. At this point the family group therapy program emerges as a dimension of reality to

Treatment Components		Community Components	
Detoxification:	To safely eliminate psychological dependence, usually at a local hospital; programs vary in having or not having a methadone component.	Intervention Procedures:	To handle crisis situations through a hotline and consultation center.
Psychological Evaluation:	To determine individualized treatment goals oriented toward the nature and extent of each patient's dysfunctional behavior.	Rap Groups:	To provide alternatives to those who are pre-drug users and information and help to those who are using drugs through youth groups in the community.
Concept/Self-help:	To focus upon the individual and his relationship to himself, others, and the world around him via heavy reality/encounter therapy, individual and group therapy, the goal being foundation-building and personality rebuttressing.	Community Education:	To assist the community via consultation, lectures, and advice concerning drug-related problems.
Group Counseling:	To provide peer evaluation and support in a therapeutic setting.	Family Therapy:	To enable the staff and the family to explore solutions and alternatives available in coping with drug usage as well as providing an opportunity for the family to become more aware of their mutual concerns and to work on them during a mutual therapeutic effort.
Individual Therapy:	To enable the client to work on selected areas of concern which demand individual attention.	Consultation Center:	To provide a liaison between young people and drug centers, free health clinics, and other services they might need.
Educational:	To provide the resident with educational skills necessary for improved functioning which enable him to profit from educational opportunities.	Volunteer Groups:	To provide support of the program by contribution and creating an awareness of needs both in the community and of the treatment program.
Vocational:	To provide the resident with marketable assets which will facilitate entry into a labor market.	Family Support Group:	To provide a cohesive unit which can direct itself toward areas of consumer needs.
Phase-out:	To facilitate a satisfactory vocational and personal adjustment in the community through a transitional period characterized by more freedom and responsibility.	Follow-up:	To provide the support system necessary to keep a person functioning during the crises and subsequent periods that follow phase-out.

Fig. 2. Format of Drug Treatment Program

clearly define the challenges that lie ahead and to offer support during the joy and heartbreak which is eminent.

Attempting to create a family of families, a program for the family was established which has two basic components:

Family Support Group

The family support group provides an opportunity for families to continue the role as supporters by contributing toward financial and material needs of the family member during treatment. One of the basic tenets of rehabilitation is self-sufficiency and independence within reason. However, many drug rehabilitation programs are totally reliant upon Federal and state support and are not supported by the family or the local community. By having the family involved in the support of the treatment program, the value of the program gains credence within the community and, in turn, is frequently supported by it.

Family Therapy Group

The family therapy program is facilitated by having the family support group meet prior to the family therapy group. In this way, families are able to get together, work on mutual concerns, and share a common ground upon which the therapy program is built (Figure 3).

Figure 3 goes here.

Heterogeneity of Group Members

During the initial year of developing the family therapy program, concern was expressed regarding whether the heterogeneity of the group members would be a hindrance to the group process. This concern was resolved by the original group in 1971, consisting of an older couple, a middle-aged couple, a divorced

Weekly Meetings		
	Monday night	Other nights
7:00-7:30	Parent executive meeting	Family orientation groups--new families are oriented to the total program and are prepared for the family therapy group.
7:30-8:00	Support	
	Treasury report	Individual family or multifamily therapy groups to focus on individual needs
	Business	
	Fund Raising	
	Staff presentation	
8:10	Family therapy group	

Fig. 3. Family Support and Therapy Program

mother, and a wife, whose positive interaction and resources for helping each other set the format for the subsequent family therapy groups.

Residents Without Families

On occasion there are residents who either do not have families or whose family has disowned them and refused for a variety of reasons to participate in the treatment process. The significance of the family program in a therapeutic community is clearly seen in such situations. Since one basic principle in such a community is that all members are responsible for the well-being of others, those who have families automatically extend them to those who do not. By the nature of the interactional process during treatment, all families get to know the other residents. Through this interaction many residents are exposed to families who care about them, invite them into their homes, and thereby establish a sense of belonging which facilitates the efforts the resident makes during the treatment program. Such extending behavior on the part of families may also be motivated by the awareness of the impact other residents can have upon the progress of their own family member.

Role of Multiple Therapist

Due to the structure of the residential program, during the family therapy program accurate input must be available. To facilitate this process, the following model was implemented. A team of four therapists, two professionals and two paraprofessionals, co-lead each multiple family group. One professional works with both the families and the residents. The other works just with the family in the group and with total families during individual or multiple family therapy. The two paraprofessionals are staff members who work closely with the residents and who are aware of the problems the resident has had and are having with the family. Family therapy therefore becomes a vital resource for

both the family group and the residential program, since they are closely related in focus and in process via direct input to each other and by exploration of selected issues which emerge within either group.

Summary and Implications

The philosophy of the family group program is not to focus on the limitations of the family but to build upon its assets. The commonality between families is that all have serious problems and many do not know what to do about them. By being presented with a model and a format to deal with their difficulties, families immediately feel they have an opportunity to begin to resolve their problems because they have met other families in similar situations who have succeeded.

Families functioning within this context emerge as role models for each other and create a forum in which incidental learning and active participation and mutual accountability can take place. The group process is vitalized by the constant input of how a family is coping with its problems and why some have been successful and why others have failed. Since the therapeutic process in a residential program is ongoing and dynamic, families have the opportunity to come to group with problems related to how they are progressing with their particular problems and goals.

By working toward a goal of eventual family integration, especially for adolescents, families are faced with the awareness that if they want things to change, they must be willing to make the commitment, effort, and investment in the process of change. The goal of change is not an end in itself but is a means to modify and enhance the family's behavioral repetoire so it can better understand and cope with its own process as well as that of the drug-dependent member. This approach creates a much different climate than constantly focusing

on the pathology of a family or a particular member because it is futuristically oriented rather than fixated in the past.

It does happen, however, that some families or family members are not suitable for the family therapy program due to the extent of their limitations. However, in a three-year period of working with over one hundred families, only one family was not workable due to psychological difficulties. An explanation for this is that those families who do participate have the resources to do so while those who do not self-select themselves out via nonparticipation.

The opportunity to evaluate the functioning of a client in several environments is a resource of the alternate living arrangement. The therapeutic environment attempts to approximate reality by making demands upon a resident which often far exceed those of family/community living. By approaching the functioning of a person within the therapeutic environment, growth must be measured in terms of a controlled environment. The realistic reading takes place when a person returns home, for this is the testing point for the skills acquired during treatment for both the family and the individual.

Sometimes the result of this application is successful, but often there is failure and disappointment. However, failure and disappointment are seen within the context of the treatment program as an opportunity to learn. The concept of attempting to succeed within the family treatment program is important because it puts the present effort into perspective. For family and client alike, the concept that what we want and what we are willing to do to obtain it are different dimensions. This approach creates a task oriented process during which all members attempt to define what their goals are, how they are going to attain them, and how they will be accountable for their performance, both to the family group and to themselves.

The value of defining basic objectives of treatment and rehabilitation is that it focuses on tasks which are to be accomplished in the present in order to facilitate the attainment of future goals. The present process must attend to the acquisition of those skills which can be generalized to and utilized in the future. The therapeutic alternate living arrangement therefore becomes an opportunity to resolve crisis, to develop intrapersonally and interpersonally, to acquire prevocational skills and to prepare for self-sufficiency. An examination of why many drug rehabilitation efforts fail indicates that the deficiency has been in what has not been done rather than what has been accomplished. Levy (1972), in a five-year follow-up study of narcotic addicts, discussed the good and poor outcomes attained:

> Subjects with a good outcome most often mentioned support from and responsibility to abstinent relatives and friends, treatment programs, and self-help groups, a feeling of self-respect, moving away from their previous associates and environment, and interest in their work as factors that were helpful in decreasing their drug use. Subjects with a poor outcome often said that mental addiction to the drug way of life, reinforced by identification with other addicts, was more difficult to break than physical addiction to drugs. Some saw their drug use as a means of escape or self-destruction and others as a result of domestic-sexual problems or lack of money and work skills (p. 105).

Those issues related to perception of poor outcome are areas that should be resolved prior to reentry. To focus on the termination of drug abuse without the development of viable alternatives to drugs is to create a void which is often coped with by the reinstatement of drugs in the life of the client. This is a very profound issue because a client who makes a commitment to treatment often assumes that when the program is completed, there is a chance to survive. If the therapeutic skills are not generalizable, failure and readdiction become realities and those involved in the therapeutic process in many cases must bear the burden for failure.

The creation of the futuristic perspective is a means of avoiding the pitfalls of the unknown. When the treatment-rehabilitation process is perceived as an ongoing one over a period of time, the client and the family become realistic in their expectations. The saying that life is a journey and not a destination is most applicable, particularly when referring to the adolescent or young adult who must continue the process of conflict resolution without the potential disastrous effect of drug abuse and its concomitant pathology.

Within this context the community begins to emerge as a responsible agent both in the creation of opportunities for rehabilitation and the alleviation of obstacles which can deter this process. It is not sufficient or ethical to design a rehabilitation model which can detoxify and treat a drug dependent client, bring this person to a maximal level of functioning, and abandon him to discover that there are no vocational or educational opportunities due to a past history of drugs and legal problems. When the drug rehabilitation effort is concentrated at the community level and integrates the drug abuser, the family, support services, and industry, a sense of community awareness and responsibility is created.

> The problems related to drugs are very real and very complex. However, their existence should not preclude positive action being taken to eliminate them. Often misdirection and inappropriate focal points account for the meager returns of large investments in the area of drug rehabilitation. The community and its resources represent a potential foundation from which the significant problem related to drug rehabilitation can not only be defined but also resolved (Dell Orto, 1973, p. 6).

A major factor in this process is the family, due to its significant role in the present, past, and future for many drug dependent persons. The family is a most potent rehabilitation force. The challenge is to actualize this potential and to explore what has not been done as compared to being satisfied with what has been accomplished.

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