University of Massachusetts UMASS Boston

Week 5 – **Substance Abuse Systemic & Developmental Assessment**

A Assessment Dimensions & Stages of Recovery

What dimensions influence recovery?

Genograms in Substance Abuse Assessment

Using Genograms to Identify Stories of Substance Abuse.

Activity: Watch the film Divine Secrets of the Ya-Ya Sisterhood

Classical description of the alcoholic family roles (& the ACOA Concept)

Suggestion: UK Addiction Program Website

Ideas you should be familiar with by now

Approaches to Therapy (www.guideline.gov)

The fields of substance abuse treatment and family therapy share many common assumptions, approaches, and techniques, but differ in significant philosophical and practical ways that affect treatment approaches and goals. Further, within each discipline, theory and practice differ. Although substance abuse treatment is generally more uniform in its approach than is family therapy, in both cases certain generalizations apply to the practice of the majority of providers. Two concepts essential to both fields are denial and resistance presented by clients. Many substance abuse treatment counselors base their understanding of a family's relation to substance abuse on a disease model of substance abuse. Within this model, practitioners have come to appreciate substance abuse as a "family disease"—that is, a disease that affects all members of a family as a result of the substance abuse of one or more members. They understand that substance abuse creates negative changes in the individual's moods, behaviors, relationships with the family, and sometimes even physical or emotional health.

Family therapists, on the other hand, for the most part have adopted a family systems model. It conceptualizes substance abuse as a symptom of dysfunction in the family. It is this focus on the family system, more than the inclusion of more people, that defines family therapy. Despite these basic differences, the fields of family therapy and substance abuse treatment are compatible. Clinicians in both

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

Family interventions. Psychoeducation and multifamily groups are more common in the substance abuse treatment field than in family therapy. Family therapists will focus more on intrafamily relationships, while substance abuse treatment providers concentrate on helping clients achieve and maintain abstinence.

Process and content. Family therapy generally attends more to the process of family interaction, while substance abuse treatment is usually more concerned with the planned content of each session.

Focus. Substance abuse clinicians and family therapists typically focus on different targets. Substance abuse treatment counselors see the primary goal as arresting a client's substance use; family therapists see the family system as an integral component of the substance abuse.

Identity of the client. Often, the substance abuse counselor regards the individual with the substance use disorder as the primary person requiring treatment. A family therapist might assume that if long-term change is to occur, the entire family must be treated as a unit, so the family as a whole constitutes the client.

Self-disclosure by the counselor. Training in the boundaries related to the therapist's or counselor's self-disclosure is an integral part of any treatment provider's education. Addiction counselors who are in recovery themselves are trained to recognize the importance of choosing to self-disclose their own addiction histories and to use supervision appropriately to decide when and what to disclose. For the family therapist, self-disclosure is not as integral a part of the therapeutic process. It is downplayed because it takes the focus of therapy off of the family.

Regulations. Different regulations also affect the substance abuse treatment and family therapy fields. This influence comes from both government agencies and third-party payors that affect confidentiality, and training and licensing requirements. Federal regulations attempt to guarantee confidentiality for people who seek substance abuse assessment and treatment. Confidentiality issues for family therapists are less straightforward.

Licensure and certification. Forty-two states require licenses for people practicing as family therapists. Although the specific educational requirements vary from state to state, most require at least a master's degree for the person who intends to practice independently as a family therapist. Certification for substance abuse counselors is more varied.

Specific procedures for assessing clients in substance abuse treatment and

family therapy vary from program to program and practitioner to practitioner. Assessments for substance abuse treatment programs focus on substance use and history. Some of the key elements examined when assessing a client's substance abuse history include important related concerns such as family relations, sexual history, and mental health. In contrast, **family therapy assessments focus on family dynamics and client strengths.** The primary assessment task is to observe family interactions, which can reveal patterns, along with the family system's strengths and dysfunction. The sources of dysfunction cannot be determined simply by asking individual family members to identify problems within the family. Although most family therapists screen for mental or physical illness, and for physical, sexual, or emotional abuse, issues of substance abuse might not be discovered because the therapist is not familiar with questions to ask or cues that are provided by clients. One technique used by family therapists to help them understand family relations is the **genogram**, a pictorial chart of the people involved in a three-generational relationship system.

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

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

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

A number of theoretical concepts that underlie family therapy can help substance abuse treatment providers better understand clients' relationships with their families. Perhaps foremost among these is the acceptance of systems theory that views **the client as a system of parts embedded within multiple**

systems—a community, a culture, a nation. The elements of the family as a system include complementarity, boundaries, subsystems, enduring family ties, and change and balance. Other concepts include a family's capacity for change, a family's ability to adjust to abstinence, and the concept of triangles.

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

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

"What Works" in Drug and Alcohol Treatment? National Institute on Drug Abuse (2000). Principles of Drug Addiction Treatment. Washington, D.C.: NIDA

Treatment of substance problems is "big business" in the United States. The data say, however, that it is cost-effective. For every dollar spent on treatment, four to seven are saved in the cost of drug-related crimes, criminal justice costs, and theft. Now, the NIDA has just released the first ever science-based guide to the treatment of drug addiction. Based on a 30 year review of the data, this guide identifies 13 core principles of effective practice. Here they are:

- No single treatment works for everyone
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual, not just his or her drug use.
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.

- Remaining in treatment for an adequate period of time is critical for effectiveness.
- Counseling is critical for the treatment of addictions.
- Medications are an important element of treatment for many.
- People with mental health and substance problems should be treated in an integrated way.
- Medical detox does little to change long-term drug use.
- Treatment need not be voluntary to be effective.
- Possible drug use must be monitored during treatment.
- Treatment should include assessment for HIV/AIDS, Hepatitis, TB, and other infectious diseases.
- Recovery frequently requires multiple treatment episodes.

Student comments

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The focus of this week's readings is the stages that families and individuals experience as they travel through the drinking and recovery process and the functioning of the family during recovery. There were a few poignant factors that I identified. Looking at the individuals within the family during recovery is important in working with families and ensuring that each individual's needs are understood and considered at each moment. Also, I realized that the substance abusing families I have worked with have never reached a stage of recovery past "early recovery." I have one family in which the children completed matched the criteria that was presented on the LSS website. I found this very helpful in how I perceive this family and understanding who they are.

As the recovery process proceeds, each individual in the family plays a role, as they always have, in the change that is taking place and experiences the effects of the change. I found it interesting the similarities between the alcoholic and the co-alcoholic. This raised some thoughts concerning the underlying personalities of these two individuals and the attraction that originally brought them to each other. I see these dynamics in the families that I work with. They type of partner that individuals choose to be with is many times based on unhealthy perceptions and needs. It is evident how difficult it will be to preserve such relationship as it progresses through the recovery process because the foundation of the connection must be re-evaluated. If the both individuals in the relationship reach the "ongoing recovery" state, which usually takes a lot of time, I wonder how often the couple remains together and if they do, is it truly a healthy relationship, because who are they then without the unhealthy needs is different than who they once were.

I realized from studying the stages of recovery how much time, energy, effort, and commitment it takes on the part of the clients. I have two clients that have reached stages of early recovery. You can see a stark difference between clients who are being honest about their abuse issues and those who are in denial and not ready to begin the recovery process. I have been a social worker for three years and substance abuse is the most prevalent issue I see in my clients and families. I wonder what the success rates are for recovery, and the different averages of time spent at each stage of the process. I can imagine that being a substance abuse therapist can be very frustrating at times. I often feel frustrated as a social worker dealing with this. I think patience and understanding is crucial in working with this population.

The website, Lutheran Social Services in Wisconsin and Upper Michigan, that we discussed in our chat I found to be very helpful. I have a family in which the three children from eldest to youngest match the descriptions in this website accordingly. I believe that not all families will fit exactly to a theory or description such as this instance; however, I believe that having these outlines are important for clinicians working with individuals and families. We must have a foundation to learn from and to organize the information about our families, even though they will often deviate from the exact data given.

The materials that we have studied in this course thus far have given me a much clearer understanding of families with substance abuse problems. I do not feel prepared to be an expert or a therapist on such matters though. I believe this is a skill separate from the ones acquired to be a therapist dealing with different issues. I have always believed that this issue is complex, especially since my employment as a DSS social worker. I can now see that this is based on the difficult dynamics of this topic. I hope that I will feel more prepared at the end of the semester; however, I know that understanding with come over time and with a combination of the knowledge and hands-on experience.

Brown, S. & Lewis, V. The Alcoholic Family in Recovery. New York: The Guilford Press, 1999, pp. 81-122.

www.winnipeg.freenet.mb.ca/iphome/a/aca/lit/alcfam.html

Kelly Moltedo Spring 2003

This week's lecture focused mainly on stages of recovery and family functioning. As I read through Chapters 5 and 6 of Brown and Lewis, I tried to apply the stages of recovery to those that I have known personally and found the stages and the dimensions within each stage to be easily applied to my own

experiences; however, I don't think that I've known anyone who has reached the stage of ongoing recovery.

The most vivid personal recollection of alcoholism and family functioning that stands out in my mind is that of my friend Melissa, who I met as a freshman in High School. The first time she brought me home to her house, we were welcomed by her mother who was clearly intoxicated and asked us to have a drink with her. Melissa and her mother lived by themselves, there were no other family members present. In this home, the functions of mother and daughter were clearly reversed. Instead of the parent holding most of the responsibility for the family's survival, this function was performed by the child—Melissa held down two jobs in addition to going to school in order to pay rent and support herself and her mother. According to Brown and Lewis, "In some alcoholic families, neither parent is competent and the child's attachment and relationship are characterized by role reversal. The child assumes a caretaking role with childlike, out-of-control parents" (p. 89). Every weekend, Melissa's mother would call her from a bar, claiming that she was getting harassed by the men there, and she would ask Melissa to pick her up. And so Melissa would drive her mother's car (without a license) to the bar, go in, talk to the patrons whom she had gotten to know well, and carry her mother out to the car.

Although I was often there to witness these happenings, I cannot imagine being in Melissa's shoes. Melissa knew that her enabling actions were not helping her mother toward abstinence. But on the other hand, I can understand why she did what she did. If I received a phone call from a parent/family member/friend who was intoxicated and stranded at a bar I don't think I would be able to refuse them either. I think that some enabling behaviors are more difficult to drop than others. The preceding example of picking someone up when you feel as though they may be in trouble is a good example of a behavior that would be difficult to put an end to. Other behaviors that may be easier to curtail would be giving in to the alcoholic's request for money or a request for a ride to the bar/liquor store.

In reflecting on the dynamic that existed within Melissa's home, I found the Lutheran Social Services of Wisconsin and Upper Michiganwebsite (http://www.winnipeg.freenet.mb.ca/iphome/a/aca/lit/alcfam.html) to be quite insightful and applicable to Melissa's situation. According to the site, I think Melissa would fit quite nicely into two roles—that of the "Chief Enabler" and that of the "Family Hero". The Chief Enabler is the person with the closest relationship to the abuser and is the responsible and nurturing member of the family. This behavior can also lead to feelings of anger and resentment. This was true for Melissa—she was angry and resentful toward her mother because she (Melissa) was forced to grow up too fast and take on responsibilities that

she was not ready for. She was taking on an adult role as a child. The Family Hero tries to hold the family together which in turn leads to feelings of loneliness and hurt.

Presently, Melissa's mother is in early recovery. As is characteristic in this stage, there are a lot of anxieties and doubt within the family dynamic. Melissa doesn't trust her mother enough to leave her alone for long periods of time and she constantly calls and checks in on her when she is away from home. As is stated in the Lutheran Social Services website, the Family Hero tends to be an overachiever. Now happily married and living around the corner from her mother, Melissa has one full-time job and two part-time jobs. Her husband makes a respectable amount of money and it is not necessary for Melissa to have to hold down three jobs; however, this is the role that she grew up in and will most likely remain in, at least until her mother reaches a stage of ongoing recovery.