Family problem, family therapy

Problem drug use can be generated and maintained by family systems

MOST COUNSELLING and therapy services for substance users have been offered on an individual or peer group basis, consistent with the belief that addiction is a problem *within* the individual, either within their body or their personality. This individualistic approach contributes to the popular image of drug users as isolated 'social drop-outs' and to the development of an 'us-and-them' mentality that can leave drug users alienated, stigmatised and ostracised.

Services for drug users developed into this pattern when individual therapy was popular, especially in America. Certainly the illicit nature of some drug use makes more open and shared interventions difficult from the user's point of view. But in focusing on individualistic service provision, specialist drug agencies may be missing an opportunity to confront popular myths and stereotypes about drug use and to raise social awareness of the nature of drug use and drug users.

An alternative to the context-less individual therapy approach is provided by the systems approach. Although applicable to systems such as peer groups, work groups and professional groups, this has found its fullest expression in the field of family groups. As applied to drug use and drug users, it has challenged traditional ideas on at least two main fronts:

Firstly, a systems approach to drug use has given rise to the idea that *drug use can be important for the whole family* and not just for the user.[1,2,3] One of the basic paradigms of family systems therapy is that the family group is of central importance in providing a context within which behaviours originate and are maintained.

Another basic paradigm is that the problem behaviour may serve some function in this social system and thus be supported by it. One view of drug use is that it is important to the continued equilibrium of the family system – the balance of beliefs and behaviours that allow the family to function as a social unit. For example, drug use may distract attention from difficulties elsewhere in the family which may pose a greater threat to its equilibrium.

This model implies that in order to address the problematic use of substances, the rules and patterns of interaction within a family must be examined rather than just the behaviour of the drug user themselves.[4]

Secondly, research has challenged the popular belief that drug users are isolated from their families. It is becoming increasingly apparent that users are often at the centre of a network of intra- and extra-familial relationships. For example, one US study found that most of a sample of opiate users were in regular contact with their families of origin.[5] Two-thirds were either living with their parents or in daily contact with their mothers, and 85 per cent saw one of their parents at least once a week.

At the time, these figures were very similar to those reported by other researchers both in America and Britain. However, a more recent UK study of problem drug users found that just over a third had regular or frequent contact with their parents and only one in ten were actually living with them.[6]

But a reduction in the number of users living with their family of origin may be counteracted by an increase in the proportion living as a 'family' with their partners. The later UK study found that approximately 60 per cent of drug users had partners and about half of these were living with them. Confirmation can be found in another recent UK study of 150 drug users seeking treatment at drug treatment centres in London; 30 per cent were living with parents, and 35 per cent with a spouse or partner.[7]

by

John Fitzgerald & Alistair Sutherland

The authors are clinical psychologists specialising in substance use at the City General Hospital in Stoke-on-Trent.

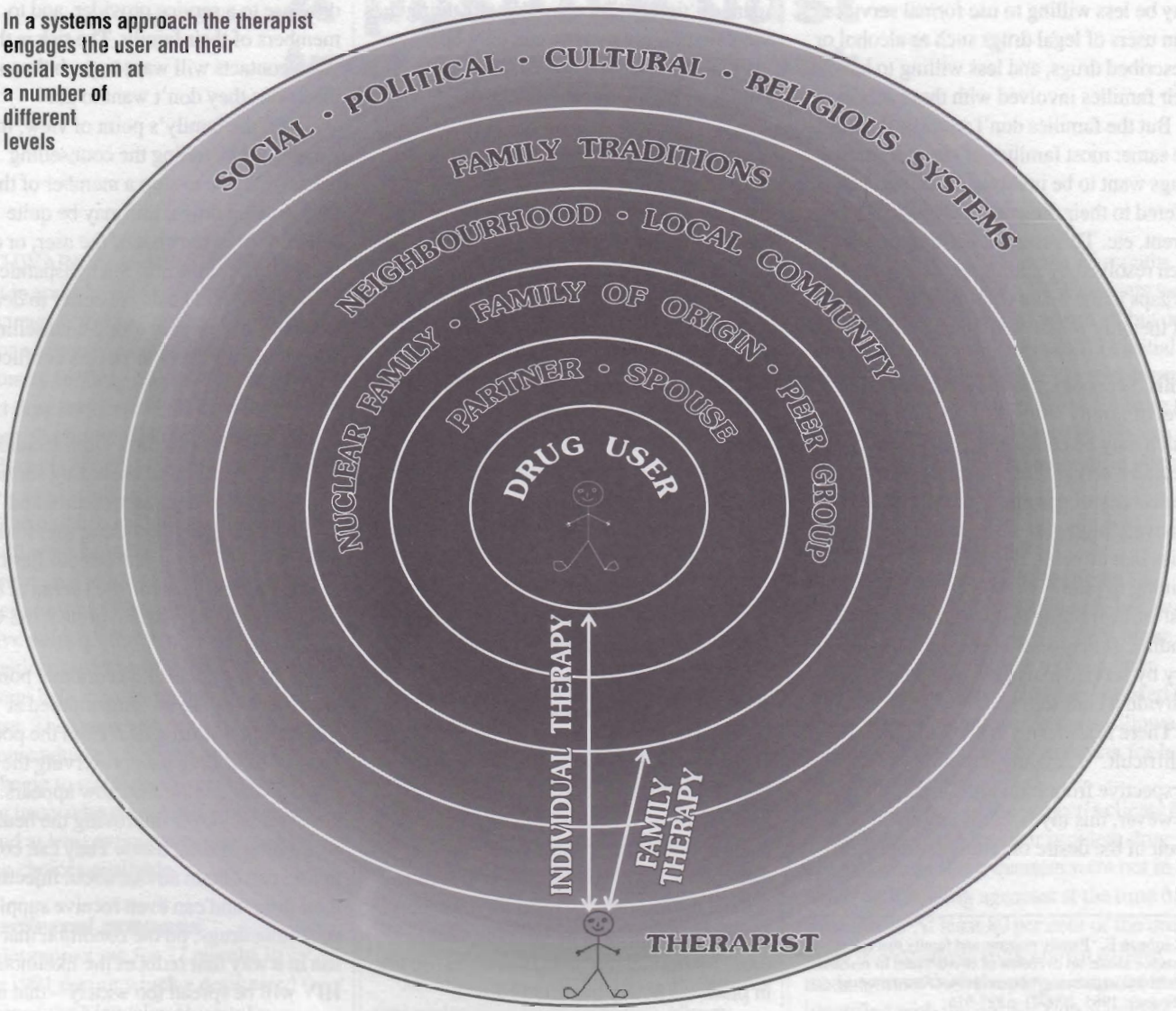
Therapeutic approaches that fail to see problem drug users in their family and social contexts reinforce stereotypes of drug users as social drop-outs. Approaches which recognise the central role of the family in the genesis and maintenance of drug problems have been shown to be effective and are in demand by drug users' families, but have generally not been implemented by drug agencies. Their implementation would require organisational changes which staff may find difficult.

Is family therapy effective?

Stanton and Todd were among the pioneers in the application of a systems approach to working with drug users.[8] Their family therapy project allocated 118 male opiate users and their families to a range of family therapy and non-family therapy treatments. The conclusion was that short-term family therapy can be more effective than other methods in reducing the drug use of adult male opiate users. The evidence was a statistically significant increase in the number of drug-free days reported by users (corroborated by other family members, urinalysis and treatment records) at six- and 12-month follow-up interviews.

More recently, researchers at a London drug dependency clinic reported preliminary results showing a significantly better outcome (measured in drug-free days) from family therapy compared to the standard clinic treatment for opiate users over a 12-month follow-up period.[9] These authors concluded that "family therapy is effective in reducing drug misuse".

Other authors, in an uncontrolled retrospective evaluation of their clients, reported that 31 out of 34 clients using various combinations of alcohol and other drugs were either abstinent or non-problem



In a systems approach the therapist engages the user and their social system at a number of different levels

users at follow-up.[10]

Given the apparent benefits of adopting a systems approach to substance use, how far have drug agencies moved to incorporate it into their service provision?

No place for the family

Two recent surveys shed light on the provision of family services in the UK drugs field. The first covers the 'supply' side of the issue, the second the 'demand' side.

Our recent survey in the West Midlands region revealed that 23 out of 27 specialist drug agencies claimed to be providing a service to drug users' families. However, this generally took the form of a limited information and advice service rather than counselling or family therapy, and was almost exclusively peripheral to the main focus on individual counselling of drug users. Over half of the agencies said they had staff interested in involving families in more aspects of their work.

The level of training in family work was relatively low. Half the agencies had some staff trained in family work, but most had only attended single study days, short courses, or been trained as part of their more general professional training. A high level of interest was expressed in receiving further training specifically on family therapy with drug users.

The agencies' main concern over family therapy was confidentiality. Thirty one per cent of agencies said they would only meet family members if the user was present. Only 36 per cent of the agencies agreed that development of family services was a priority for drug agencies; coping with the increasing demand for individual counselling and other services was generally a more pressing concern.

The second survey was of 50 relatives of drug users in south-west England.[11] It showed that a large proportion wanted some kind of counselling, support or advice, but that just under half of these felt they had received a satisfactory service.

Obstacles to systems thinking

There are several practical reasons why services are not being developed in ways attentive to the social context within which drug use originates, is maintained, and may be reduced.

Understanding. Firstly, as highlighted in the surveys reported above, there seems to be little understanding of the central role the family can play in drug use and little appreciation of the level of need for family therapy services. It's true that the illicit

nature of some substances is likely to influence the types of services offered to and demanded by users. Illegal drug users may be less willing to use formal services than users of legal drugs such as alcohol or prescribed drugs, and less willing to have their families involved with these services.

But the families don't necessarily feel the same: most families of users of illicit drugs want to be involved in the services offered to their drug using spouse, child, parent, etc. This conflict has traditionally been resolved by putting the user first, perhaps in the belief that this is the best if not the only way to help them.

Skills. Secondly, there is a generally low level of family work skills in the agencies which may be called on to provide such a specialist service. This is partly a result of the scarcity of specific training and the relatively high cost of the training opportunities that do exist. For most drug workers, training in family work is considered to be post-basic training that is a low priority for funding. It may also be considered unnecessary by service managers raised on a diet of individual counselling.

There is also a myth that family therapy is difficult.[12] Certainly it requires a different perspective from individual counselling. However, this myth seems largely to be the result of the desire of family therapists to establish family therapy as a *bona fide* therapeutic approach through the attainment of academic respectability and the development of 'tight' clinical models, fostering the view that family therapy can only be adequately practised within specialist clinics by highly trained therapists.

Resources. Finally, there is a common belief that family therapy is resource-intensive, usually reckoned to involve team working with special facilities such as video recording equipment and a one-way screen: these may be helpful, but they are not pre-requisites.

Practical difficulties such as these may influence the type of services offered, but can be overcome by training, appropriate research and adequate resourcing. However, there are perhaps more deeply rooted reasons why family services have been slow in developing.

Introducing family therapy can challenge traditional work structures

Organisational change. Introduction of family therapy, perhaps more than any other form of therapy, necessitates organisational change within the service which may be difficult for both workers and management. It may, for instance, be difficult to accommodate the approach in agencies where more traditional hierarchies of expertise are in place – a newly qualified clinical psychologist or nurse specialist may know more about family therapy than the consultant psychiatrist with 20 years experience, who is the clinical director of the service.

Family work may also be viewed as divisive. Workers within a typically egalitarian drug agency may find it difficult to accept the establishment of sub-teams within their agency team, and that membership of these teams will be relatively fixed to facilitate the development of particular styles of working.

Conflicting motivations. One difficulty frequently encountered when working with any group, including family groups, is the often disparate motivations, aims, fears and expectations of those present. Such dynamics may influence the demand and supply of services to drug users.

Users of socially sanctioned drugs will not expect the service provider to act as an agent of social control; after all, their behaviour is legal and not seen as threatening social values. In contrast, the illicit drug user may perceive some risk in revealing drug use to a service provider, and to members of their family. The risk is that these contacts will want to push the user in directions they don't want to go.

From the family's point of view, their reasons for attending the counselling agency may be to stop a member of their family using drugs; this may be quite different from the goal of the user, or even of the drug counsellor. Such disparate motivations and goals are easier to deal with in one-to-one or peer group counselling where there is likely to be less conflict of interests.

Public health priorities. Until recently the acknowledged aim of most drug services was to help the drug user control and eventually abstain from drug use. In the field of illicit drug use, the focus has been modified in response to the spread of HIV and the perceived need to protect the wider population.

From a political and economic point of view, services are no longer aimed at 'protecting' the drug user from the potential harm of their drug use; preserving the health of the wider community now appears to have primacy over improving the health and well-being of drug users. They can continue to use, can obtain advice about injecting their drug, and can even receive supplies of substitute drugs, on the condition that they use in a way that reduces the likelihood that HIV will be spread too widely – that is, to you and me. Therapies aimed at resolving drug problems are no longer a priority, making it less likely that a developing therapy such as family therapy would be widely adopted.

SYSTEMS THEORY, the basic building block of system therapy, is a theory of family interaction. It is also a social theory which can be used to explore relationships between as well as within the various sub-systems of society. Theories of individual therapy emphasise to varying degrees the responsibility of the individual for the development, maintenance and resolution of their problems. The alternative presented by systems theory is an examination of the actions and beliefs of the family, the local community and society at large towards the problematic use of drugs – certainly a more difficult and challenging proposition than restricting the focus of attention to the drug user alone. ■

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