# Engaging Family Members Into Adolescent Drug Treatment

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## Introduction

Family members can play an important role in treatment engagement and in treatment outcomes. Although it is not uncommon to hear practitioners and researchers voice skepticism about the feasibility of engaging the families of substance abusing adolescents in treatment, there is considerable evidence, as this monograph will show, to the contrary. The successful engagement of family members into treatment can be a critically important component of the adolescent's successful recovery process.[1]

Family member contributions to the therapy process can take many forms. For example, family relationships may be the primary focus of a more traditional family therapy aimed at improving treatment outcomes for the adolescent, or these same relationships may be one of many targets in a "family-based" treatment.[2] Family members may be enlisted to coax into treatment a substance abusing adolescent who has refused to be involved in treatment.[3] In some types of family treatment, it is assumed that family members will be in most, if not all, of the treatment sessions, while in other treatments, family members participate in more defined ways. Regardless of the specific ways in which family members will be involved, it has become widely accepted that some level of family involvement is critical to successful outcomes, and this is particularly true when the treatment is focused on a child or adolescent.[4]

Counselors have recognized the difficulties inherent in successfully engaging and retaining families in the treatment of children and adolescents despite the benefits of family involvement in treatment.[5] Early work on the difficulties in engaging family members into an adolescent's drug abuse treatment documented that when parents initiated contacts for the treatment of a substance abusing adolescent, only 22% were successful in bringing the entire family through intake completion.[6] Family relationship problems, some of which preceded and contributed to the emergence of the adolescent addiction, and others that did not exist prior to the addiction but emerged as a result, can negatively impact engagement. A father who has become isolated/disengaged from his wife because of disagreements about disciplining strategies might refuse to come to treatment and refuse his wife's request for renewed participation in family matters. A grandmother who has become hurt and hopeless because of the adolescent's pattern of stealing the little money she has may feel too defeated to come to treatment. A mother who has been given the message that she has been inadequate as a parent and is to blame for the adolescent's problem may choose not to be blamed any more. Seen from these perspectives, attainment of higher rates of successful family engagement requires the early identification of key contextual and family issues that may be hindering the engagement process, and the aggressive use of strategies to overcome those obstacles to engagement.

Given these considerations, the purpose of this monograph is to: 1) highlight the importance of including family members in the adolescent recovery process; 2) clarify the meaning of key terms such as family and family involvement; 3) present several of the major obstacles

to engagement; 4) provide helpful strategies for overcoming the engagement obstacles; and, 5) stimulate thinking about the role of cultural factors in the engagement process.

## Why is Family Involvement Critical to the Adolescent Recovery Process?

It is not a coincidence that some of the most successful substance abuse prevention and treatment programs for adolescents are strongly family-based.[7] Any discussion of family involvement in services, however, must ask the question "Which individuals in a person's life constitute family?" For the purposes of helping an adolescent to move forward in treatment and recovery, it may be helpful to be very flexible in the definition of family. A useful distinction has been made between traditional families, extended families and elected families, with elected families representing families self-identified and formed by choice and not by blood, marriage, or law.[8] Elective families may include godparents and other significant but non-biologically-related significant others. The most helpful strategy is that the entire network of support and resources be utilized during treatment and relapse prevention.

It is often the case that important family subsystems are not fully utilized. For example, one of the most helpful and underused family subsystems is the sibling subsystem. Because siblings have often shared similar experiences, they can be used therapeutically to move the adolescent to a higher level of functioning. When parents are divorced, the non-custodial parent is also often left out of treatment in an effort to avoid tension and conflict. This is an unwise decision because this person is often highly important to the adolescent. It is better to take the time to create strategies that will utilize the non-custodial parent to help the adolescent achieve her/his goals even if it requires avoiding conjoint family treatment sessions when these types of sessions cannot be handled successfully.

Major benefits can be gained by engaging family members into the treatment. The following recommendations are key to maximizing the benefits.

*Family interventions can help modify the maladaptive family relationship patterns that can contribute to, or result from, adolescent drug abuse.* The emergence and/or maintenance of overt deviant behaviors among adolescents, including drug/alcohol use and other delinquent behavior, have been well-documented in the research as linked with poor family functioning.[9] Likewise, the lack of bonding and attachment between adolescents and their parents, and the overall quality of their relationship have also been linked to behavior problems in youth.[10] Family interventions are important regardless of whether the maladaptive family patterns are a result of, and not a cause of, the emergence of the adolescent drug problem. Research has shown that family interventions can bring about improvements in overall family functioning and parenting practices by helping parents: create clearer rules and standards for behavior; develop predictable rewards and punishments; and, improve their effectiveness in monitoring school performance and peer relationships. Family interventions can also focus on the repair of relationship ruptures, on improving the trust and cohesion in families, and on fully mobilizing all of the helpers to give support (emotional and instrumental).

*Family members are key to helping with co-occurring disorders.* The treatment of adolescents who use alcohol and drugs is often complicated by the presence of a co-occurring psychiatric disorder. This is supported by the work of Armstrong and Costello[11] which revealed that 60% of youths with substance use, abuse, or dependence had a co-occurring psychiatric diagnosis, often conduct disorder, attention deficit disorder, or depression. Family intervention can help the family of a substance abusing adolescent to understand the signs of co-occurring psychiatric disorders in their children, and the possible interactions between psychiatric disorders and drugs of abuse. Once the therapist suspects that the adolescent may have a co-occurring disorder, it is important to create sensitivity and awareness in the family members about the role of these additional problems in triggering relapses. The ability of family members to observe psychiatric conditions and to support the adolescent in seeking help when psychiatric conditions worsen may be a critical component of the adolescent recovery process.

For adolescents who have a co-occurring psychiatric disorder (i.e. depression, Attention Deficit Hyperactivity Disorder, anxiety, etc.) psychotropic medication may be prescribed within a combined psychosocial-pharmacological treatment. Adherence to a medication regimen, however, is particularly difficult among substance abusing adolescents. The adolescent's family can play an important role in monitoring medications for possible side effects, and facilitating the adolescent's compliance with treatment recommendations, including taking medication as prescribed. Better adherence can be accomplished through medication contracting, in which: the consistent taking of medication is negotiated between parent and adolescent; parents help medications become part of the family routine to avoid forgetting; and, rewards and consequences are linked to medication compliance. Interventions can also help parents and adolescents to identify and process any concerns they have about medication side-effects.

*Family members are needed as change agents in the youth's environment.* In treating adolescents, issues related to school, peer relationships, and legal entanglements are often targets of interventions. Changes needed in schools may involve a closer working relationship between parents and counselors to improve academic performance, increase school attendance, and handle disciplinary actions quickly. At times, a change of school is necessary to give the youth a fresh start. The same may be true when substance abusing youth find themselves in trouble with the legal system. Such large systems as the school and legal system can be complex and intimidating. Interventions that can help parents understand these complex systems, the potential allies that exist within them (e.g., public defenders, school counselors and representatives of regional offices that can serve as advocates for families), and how to change the systems most effectively can have a profound impact on the long-term well being of the adolescent.

*Family interventions can result in beneficial effects long after the "treatment" phase is over.* The amount of time allowed for the addiction treatment phase is typically brief, although current understanding is that recovery from addiction is not a linear process. Recovery is more similar to that of a chronic medical problem, and not necessarily encompassed by discreet symptom and treatment episodes. With this in mind, there is a very real benefit to accomplishing changes during treatment that will continue to have beneficial impacts well after the primary counselor has ceased to meet with the recovering adolescent. Many of the types of changes described in the previous sections (e.g., improving parenting practices, the quality of parent-adolescent relationships, the family members' ability to understand and seek help for adolescent co-occurring psychiatric disorders, and the parents' ability to intervene in the school and other settings) will stay with the adolescent long after the counselor is gone. For example, the changes a counselor makes in an adolescent's school environment may be limited to that school year, but when the counselor helps parents develop these skills, positive impact may continue for many years to come.

*Family interventions can be used to bring an adolescent to treatment for the first time or can help to retain the adolescent in treatment.* Even though the initial engagement of multiple family members can be difficult, successful accomplishment can lead to a higher likelihood that the adolescent will stay until the completion of treatment. Experienced counselors know that the counseling relationship is rarely a smooth one; there tend to be many bumps in the road and many moments in which the adolescents will want to leave treatment. It is helpful to have family members onboard to help navigate these bumps in partnership with the therapist. With the family members serving as allies, the likelihood that an adolescent will continue to participate in treatment is greatly increased.

## Considering Carefully the Desired Level of Family Involvement

A counselor must have a good idea of both the desired level and focus of family involvement prior to the engagement of family members in treatment. A helpful framework for conceptualizing the different levels of family involvement is provided by Doherty and Baird.[12, 13] Although the initial work of these researchers focused primarily on family-centered medical care, the levels are equally helpful here. At the lower levels of family involvement (levels 1 and 2) there may be little family involvement. Family members may simply be brought in to provide information about the client and his/her circumstances, or the family member may be given simple recommendations on how to be helpful to the client. In the middle levels of the framework (levels 3 and 4) interventions become more clearly focused on the family – perhaps addressing some of the stress and distress that the family is experiencing due to the adolescent's addiction and related behaviors, and/or perhaps asking the family members to behave differently so that the recovery process is accelerated. The use of psychoeducational material that can give the family members important information and that can be used to modify the family context of the problem would be seen at these mid-levels of family involvement. At the upper level of family involvement (level 5) one would expect to see the more focused and intensive family treatments. At this level, the focus is on the modification of more dysfunctional and entrenched family dynamics that may be characterized

by high levels of negativity, potential for violence, and past traumas. The adjacent page further delineates the levels of family engagement and the associated counselor competencies at each level.

Careful consideration of the *focus* of family involvement is helpful in many ways. First, there needs to be an appropriate match between the type of services offered to family members and the skills of the counselor. A family session with the aim of information gathering can have unintended negative consequences if the counselor is not skillful in handling a potentially highly charged situations. This type of session is more likely to lead to premature dropping out of treatment than movement toward recovery. Secondly, it is important to establish clear expectations with family members to ensure that their experience in family sessions is in alignment with what they agreed to and understand. Finally, it is important to plan the *depth* and *scope* of the work to avoid the emergence of painful family issues that the counselor cannot possibly address in a treatment that has limited time allocated to the family members. For example, a therapist who is not trained and prepared to handle issues of sexual abuse should not attempt to probe deeply into those experiences but should refer the client to someone trained in this area. Likewise, a counselor who is confronted with issues of marital infidelity during a family session must have a clear sense of whether working in this broader area is within or outside their scope of expertise and the time available to work with the family of the adolescent. Delving only briefly into such highly charged areas, with the purpose of gathering information, may do more damage than good.

## Levels of Family Engagement and Clinician Competencies

*Level 1: Minimal Emphasis on Family*

Interactions with parents are institution centered, not family centered. Families are not regarded as an important area of focus, but parents are dealt with for practical or legal reasons.

*Level 2: Information and Advice*

***Knowledge Base:*** Content information about families, parenting, and child development.

***Personal Development:*** Openness to engage parents in collaborative ways

***Example Skills:***

1. Communicating information clearly and interestingly.
2. Eliciting questions.
3. Engaging a group of parents in the learning process.
4. Making pertinent and practical recommendations.
5. Providing information on community resources.

*Level 3: Feelings and Support*

***Knowledge Base:*** Individual and family reactions to stress, and the emotional aspects of group process.

***Personal Development:*** Awareness of one's own feelings in relation to parents and group process.

*(continued on next page)*

***Example Skills:***

1. Eliciting expressions of feelings and concerns.
2. Empathetic listening.
3. Normalizing feelings and reactions.
4. Creating an open and supportive climate.
5. Protecting a parent from too much self-disclosure in a group.
6. Engaging parents in collaborative problem-solving discussion.
7. Tailoring recommendations to the unique needs, concerns and feelings of the parent and family.
8. Identifying individual and family dysfunction.
9. Tailoring a referral to the unique situation of the parent and family.

### *Level 4: Brief Focused Intervention*

***Knowledge Base:*** Family systems theory.
***Personal Development:*** Awareness of one's own participation in systems, including one's own family, the parents' systems, and larger community systems.
***Example Skills:***

1. Asking a series of questions to elicit a detailed picture of the family dynamics of a parent's problem.
2. Developing a hypothesis about the family systems dynamics involved in the problem.
3. Working with the parent for a short period of time to change a family interaction pattern beyond the one-to-one parent child relationship.
4. Knowing when to end the intervention effort and either refer the parent or return to level three support.
5. Orchestrating a referral by educating the family and the therapist about what to expect from each other.
6. Working with therapists and community systems to help the parent and family.

### *Level 5: Family Therapy*

***Knowledge Base:*** Family systems and patterns whereby distressed families interact with professionals and other community systems.
***Personal Development:*** Ability to handle intense emotions in families and self and to maintain one's balance in the face of strong pressure from family members or other professionals.
***Example Skills:***

1. Interviewing families or family members who are quite difficult to engage.
2. Efficiently generating and testing hypotheses about the family's difficulties and interaction patterns.
3. Escalating conflict in the family in order to break a family impasse.
4. Working intensively with families during crises.
5. Constructively dealing with a family's strong resistance to change.
6. Negotiating collaborative relationships with other professionals and other systems who are working with the family, even when these groups are at odds with one another.[12]

## Strategies for Engaging Family Members

The counselor must *join* the family and *earn* a leadership position in the therapeutic system in order to successfully engage the family and facilitate change. When the therapist joins the family, a therapeutic system is formed, and many of the fears and stereotypes of how a therapist could possibly impact the family emerge. As mentioned earlier, there will be a healthy level of skepticism and reluctance to change on the part of the family and the therapist must earn their trust and confidence. This can be accomplished by: displaying caring, respect, and understanding of all members; by showing competence in conceptualizing the problem; by instilling hope that change is possible; and, by showing that the family session can be under control and not a free-for-all. The counselor and the family establish an alliance around the common goals of the family, usually by reducing the presenting symptom of substance abuse and other behavior problems, by improving adolescent functioning in other key areas such as academic functioning, and by reducing negativity and increasing family support. The counselor thus establishes a facilitative leadership position, making interventions to modify and change the identified therapeutic issues.

A very important part of establishing an alliance or "joining" is to make all family members feel that their participation in the session matters. If a person is not helped to actively participate in the family session she/he will be less likely to return to future sessions. All too often, it is the case that therapists "meet the new members" in the first few minutes and then "get down to work" in the usual way with the usual members. The role that can be played by the new members is not really discussed. To be successful, it is helpful for the counselor and his/her supervisor to think through what each family member may contribute, and to make sure these contributions are not neglected in treatment.

*Challenge your own language, beliefs and habits during the process of engagement.* There is much to be gained from challenging habitual ways of engaging and collaborating with family members. At times, it may be very helpful for the counselor to challenge the negative connotations that are associated with the term "resistance" and to acknowledge that there are also some very healthy reasons for behaviors that commonly carry this label. For example, resistance can be thought of as a person's or family system's natural effort to maintain what they believe is "balance." It is not a simple decision to change course and abandon major rules that have been in place for long periods of time and that were selected based on a belief that they work well. For example, if parents believe that sitting down to negotiate with a substance abusing adolescent is tantamount to being "soft" and refusal to talk is being "tough," they will not readily give up this long-held position.

Counselors need to be able to clearly explain the rationale for approaching family challenges differently in order to help alleviate this tendency to return to the familiar level of "balance." It should not be taken as a given that the

family believes their involvement in treatment is warranted or helpful. It is the responsibility of the counselor to deliver a "logical and engaging" rationale and not become frustrated by tendencies to maintain the same family patterns or equilibrium.

Counselor attitudes can present obstacles to family engagement. An interesting set of issues regarding staff attitudes was raised by the work of Baker, Heller, Blacher, & Pfeiffer.[14] The findings of their study (of 267 staff members in three residential treatment centers) highlight how the perceived advantages of family involvement can often be offset by the staff's perceived disadvantages of family involvement. Perceived disadvantages include staff feelings that family members:

- disappoint the child when they are unpredictable;
- increase the stress and tension of the child;
- clash with the staff over rules and practices; and,
- interfere with the child's relationship with the staff.

Family members also report obstacles that can hinder high levels of family involvement. A recent set of focus groups[15] was conducted with the parents of adolescents receiving substance abuse treatment, which addressed some of the obstacles that parents encounter. For example, parents stated that much of the jargon (e.g., level 2, client "privileges", etc), often common in residential treatment programs, may alienate rather than engage parents that are unfamiliar with this jargon. At times it is difficult to acknowledge that we, as service providers, often take for granted that everyone understands and accepts the "culture" most prevalent in treatment programs. For example, there are rules regarding such confidentiality, confrontation, and visitation guidelines that may not necessarily make sense to the parents of an adolescent in treatment. Active engagement means that the rationale for these rules and ideas is discussed in detail with parents and that differing perspectives can be respectfully heard and discussed.

*Find out what family members really need.* Family members can often be successfully engaged by offering information and/or services that the family members feel they truly need and that have been difficult to obtain elsewhere. Parents and other family members will often say that they benefit greatly from psycho-educational activities, such as groups focused on topics listed in the adjacent box. The overall perceived value of the program increases, as does the family member participation, when the program can include components that the family members have a "readiness" for. Some parents may be attracted to support groups in which they can openly discuss personal issues, such as hopelessness, frustration, and burnout.

## Psycho-educational Group Topics for Parents

- Addiction and recovery process
- Detecting and managing co-occurring disorders
- Drugs of abuse and signs of drug use that a parent can detect
- Developmental issues during the adolescent stage
- The possible role of medications and concerns regarding the overuse of prescription medications.
- Risky sexual behavior and how to talk to adolescents.
- Parenting practices with challenging adolescents.
- Special issues in blended and single parent families.

*Look for family relationship patterns commonly associated with reluctance to engage.* There are often family dynamics and relationship patterns that directly contribute to a family member's reluctance to participate in treatment. Some research has suggested specific types of familial issues that keep family members from participating.[16] For example, at times there may be an unspoken but determined decision taken by one member of the family that another member should not enter a treatment session (even if the adolescent is the main focus of the treatment) because there are issues that he/she would like to keep private. These issues may be such things as marital infidelity, domestic violence, a parent's substance use, and talk of possible divorce. When the counselor notices that the engaged family member is very quick to justify the other family members lack of participation, he/she may begin to suspect one or more of these issues may be present. In this scenario, the engaged family member actively blocks the inclusion of the non-engaged family member(s). Typically, the best way for the counselor to proceed is to agree to very clear guidelines for what will be discussed in treatment and to assure the engaged family member that the counselor will not allow the focus of the treatment to go in unnecessary directions.

In other circumstances, there may be family members whose participation is not being actively blocked by the engaged member. The counselor can, in this case, both ally with the participating member to better understand what keeps the other out, and also reach out directly to the disengaged member(s) to express the importance of their participation. The longer the disengaged member is left out of the treatment, the stronger the message becomes that they are not really needed or valued in the treatment.

In a study of the efficacy of engagement strategies, Santisteban et al.[17] randomized 196 substance abusing adolescents and their families to one of two conditions (the specialized *structural strategic engagement* or the *engagement as usual*). The *engagement as usual* condition was based on a survey of the engagement practices of community agencies treating adolescents. The findings for families that received the *specialized intervention* showed that 81% of adolescents and their families were engaged into treatment as compared to 60% of those in the *engagement as usual* group (See Figure 1). These results revealed that counselors can significantly improve the rates of engagement of both reluctant adolescents and reluctant family members by using specialized engagement strategies (mostly consisting of telephone interventions with some limited visits to meet with reluctant adolescents) and by tailoring interventions to the specific family relationship patterns that may lead to poor engagement rates.

In comparing these patterns, it should be evident that the nature of the counselor's engagement work is more complex with some families. In some families, merely giving them information about why their participation would be beneficial (e.g., "You need to better understand your daughter's depression as it services as a trigger to drug use…") will be enough. In other families, there may be deeply entrenched family conflicts of different kinds that actively block their entry into treatment. In these latter instances, the counselor must actually diagnose and address these obstacles to achieve the engagement of entire families.

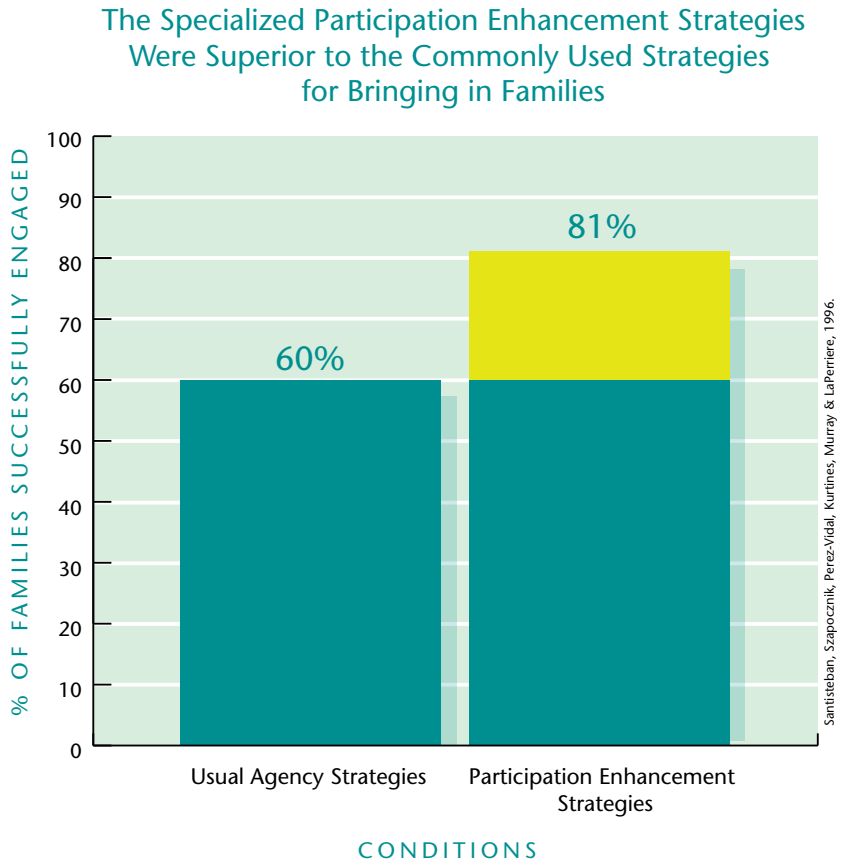


*Figure 1. Specialized Participation Engagement Strategies*

*Using interventions with concerned others to bring drug users into treatment.* In addition to the strategies for engaging the family members of an adolescent who is already in treatment, there are also models of engagement that focus primarily on working with family members first, with the intention of later engaging the drug abuser who refuses to enter treatment. These interventions use the natural influence of family, friends, coworkers, and other social network members to motivate the person with a substance use problem to attend treatment. Although the various intervention packages differ on some key components, they are similar in that they choreograph very specific and powerful messages that the "concerned others" deliver to the substance abusing individual.

One of the earliest and best known interventions of this type is the Johnson Intervention.[18] This intervention uses multiple meetings with family members and concerned others to craft and rehearse how best to present the pain and negative impact that the individual's addiction has brought them. It also incorporates a specific meeting in which the family members share the love and concern that has prompted them to move the individual toward substance abuse treatment, and define the consequences that will occur if the individual's drug or alcohol usage continues.

The ARISE intervention (A Relational Sequence for Engagement) is similar to the Johnson Intervention in some respects, however, ARISE has a number of distinctive features. This intervention seeks to be more non-blaming, nonjudgmental, and committed to family competence, resulting in a "gentler,"

more systemic approach to bring the substance abusing individual into treatment.[19] The intervention package includes three stages of work, with actions moving to the next highest level or stage only if the preceding stage has not succeeded in engaging the person into treatment.

- *Telephone Coaching (Stage I)* consists of supporting the person who has made a telephone call for help, and guiding the caller to create a larger system of concerned others that attempt to steer the substance abuser toward treatment.
- *Mobilizing the Network (Stage II)* involves meetings with the network of concerned others to develop more precise strategies and communications directed toward the substance abuser.
- *The ARISE Intervention (Stage III)* is reached when, in spite of the network's confrontation, encouragement, support and understanding, the substance abusing individual has refused to stop using and enter treatment. In this Stage, an intervention resembling the Johnson Intervention takes place.

One of the best researched methods for working with concerned others is the Community Reinforcement and Family Therapy.[20] This approach is designed to increase rates of engagement of the substance abusing person through the work with concerned others, and to improve the functioning of the concerned others. This combination is expected to lead to better long term outcomes in treatment engagement, retention, and rates of recovery. In a small randomized trial,[21] Community Reinforcement Training (CRT) led to significantly more family member sessions (8.6 weeks vs. 5.2 weeks), a higher percentage of treatment completers (86% vs. 39%), and a high percentage of target users brought into treatment (64% vs. 17%) when compared to a 12-step self-help group (see Figure 2).

Although the data presented involves the use of CRT with adult substance abusing individuals, its variants have also been adapted to be used the adolescents with parents and other family members as the targets of the intervention. This is relevant to work with adolescents and has promising findings from the point of view of both engagement and presenting symptom outcomes.

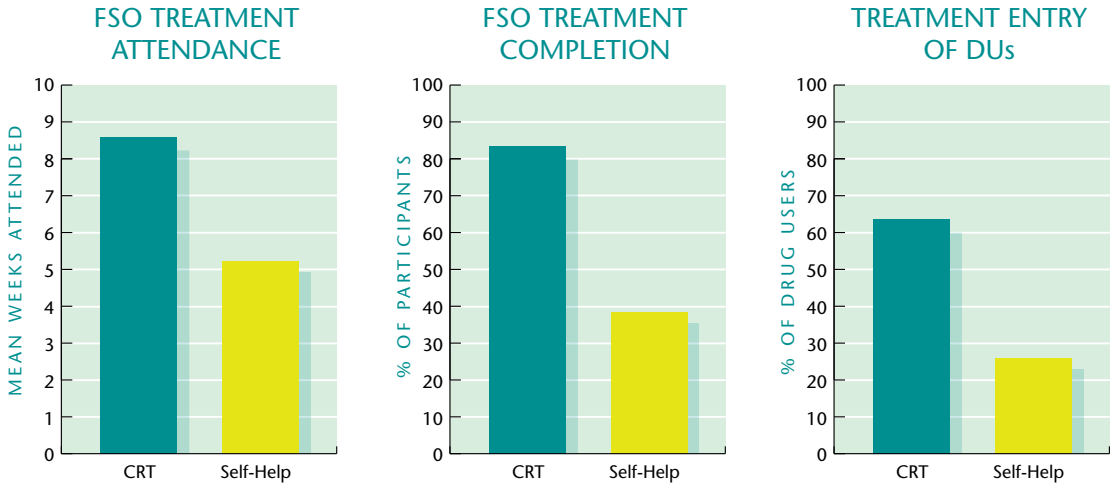


*Figure 2.*
*CRT and Self-Help in the FSO Treatment Process*

INTERVENTION

## Cultural Factors and the Engagement Process

When considering any complex process such as engagement or treatment-seeking behavior, it is very important to have a framework for considering the role of cultural factors. Cultural factors are crucial to a counselor's ability to "read" the family and to truly "connect" with them during the initiation of the therapeutic process. In working with families from diverse cultures, the counselor must consider: 1) his/her counselor's knowledge of the family's culture, world view, beliefs, and/or value system; and, 2) the compatibility between the underlying assumptions and techniques of a given therapeutic approach and the expectations/value system of the client and family. While a full analysis of the impact of cultural factors is beyond the scope of this article, some of the more salient cultural characteristics and their specific relationship to the process of engagement are briefly considered.

There are a number of studies that suggest that programs that take a client's culture and life experiences into account can be more successful at engagement and retention. One study of the retention rates of Mexican Americans, who were treated in an ethnicity-specific program, compared this group to a mainstream treatment program. Researchers found that the Mexican Americans in this ethnically-specific program were 11 times more likely to return after the first session as compared to mainstream programs.[22] In making sense of these types of findings, it has been argued that the critical issue is not simply matching patient and therapist/assessor on ethnicity, but instead, ensuring that therapists/assessors demonstrate: 1) an understanding of stressors related to such things as immigration, acculturation, and discrimination; and, 2) positive attitudes toward a client's cultural uniqueness.[23]

A more recent finding suggests that the introduction of ethnicity/race related content to the conversation can enhance adolescent engagement into therapy.[24] Clinical researchers working with African American youth and families found that by adding salient cultural theme content such as (anger, alienation, and journey from boyhood to manhood), engagement could be significantly increased.

It should be noted that in some ethnic and racial groups, there is a higher proportion of families that have a very traditional or "hierarchical" family organization. When this type of family organization is prominent, parents of an out-of-control and highly rebellious adolescent may feel particularly weak, defeated, and ashamed because they are unable to carry out their expected roles as powerful leaders. In some ways, the introduction of the counselor to the problem punctuates the humiliating fact that the parents are unable to be effective leaders in the family. The counselor can be particularly sensitive to the potentially threatening nature of her/his perceived role by attending to the family's hierarchical nature. The counselor can, from the very first contact, send the message that the parents are the leaders of the family and that the counselor cannot do the job of helping the youngster without their expertise and leadership.

The culturally competent counselor must be sensitive to people who have been the targets of chronic discrimination, such as people of color, as there may be a stronger sense of distrust. During any first encounters with people who

have faced discrimination, counselors need to be aware that the family may have an overriding concern that large institutions may practice subtle forms of discrimination which results in a level of healthy skepticism.

In many instances in which the families are immigrants, parents and youngsters are caught in a clash of cultures (new host vs. original culture) and their differing values. The hopelessness that can block engagement can often be diminished by reframing the major clash as being between cultures and not individuals. That is, the adolescent can be seen as not primarily rebelling against father but reflecting a more individualistic set of values than those espoused by the original culture. By normalizing this process of clashing values and norms, the counselor can assist the family in reducing the level of defensiveness and hopelessness.

Finally, with minority patients it is most important to establish the credibility of the counselor. Credibility comes in part, when the counselor understands the client's expectations and works to create a fit between treatment and client expectations. Sensitivity and respect for the beliefs and world-view of the client/family is crucial. In families that expect a no-nonsense, problem solving approach, the counseling can be presented as having concrete and attainable short-term goals that fit in to the parent's problem orientation. Indicators of progress early in the treatment may be particularly important in terms of retention in treatment.

## Conclusions

Many forces can influence the engagement process. Forces exist at the level of the family system (e.g., marital conflicts a family member may wish to avoid), and at the level of the counselor system (e.g., views regarding resistance and the pros and cons of family involvement, cultural competence). Counselors can now be guided by research that has focused on the engagement process. Thoughtfully-developed and carefully executed strategies can make a big difference in the rates of engagement of family members into the ongoing treatment of a substance abusing member, and in motivating a reluctant substance abusing individual into treatment. The talent and clinical creativity of the counselor is tested during the engagement process, as much if not more than, during the treatment process because many of the influencing factors are behind the scenes and yet to be known. By thinking of the complex clinical process as beginning from the very first phone contact rather than at the first session, the counselor can use her/his expertise to engage as much of the family network and its resources as possible. This system and all of its resources will be needed to keep the recovery process on track throughout the client's life.

### Tips for Successful Engagement of Family Members

1. Have a flexible understanding of "resistance" as a natural response to requests for change.
2. Be willing to challenge your habitual ways of engaging family members into the process of treatment.
3. Have a clear perspective of the possible benefits of family involvement and help families understand these benefits.
4. Have a clear vision of the type and level of family involvement that is optimal given the resources and family situation.
5. Develop a set of strategies for tailoring the engagement interventions to the specific conditions of the family.

## Resources for Practitioners

The following Evidence Based Practices (EBPs) are a few selected resources for counselors to consider for use in their work with families. These programs are designed to engage families in the adolescent treatment process.

### *Multidimensional Family Therapy (MDFT)*

This family therapy protocol treats polydrug-abusing adolescents by targeting the individual adolescent, the parent(s), the relationship between children and parents, and other systems (school, peers, juvenile justice, etc.). Interventions work within the multiple dimensions of adolescent development, and they target the processes known to produce and/or maintain drug taking and related problem behaviors. MDFT typically involves 14-16 weekly sessions, ranging from 60-90 minutes each, and incorporating both individual and family formats.

Citation: Liddle, H.A. (2002). *Multidimensional Family Therapy for Adolescent Cannabis Users, Cannabis Youth Treatment Series, Volume 5*. DHHS Pub. No. 02–3660 Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Order free print copy from National Clearinghouse for Alcohol & Drug Information (Inventory #BKD388); or purchase print copy ($30) or download for free from SAMHSA's Knowledge Application website:
http://kap.samhsa.gov/products/manuals/cyt/index.htm

### *Multisystemic Therapy (MST): Primary Manual for Treating Serious Antisocial Behavior in Adolescents*

MST is a family and community-based treatment for adolescents presenting serious antisocial behavior (e.g., violence, substance abuse) and who are at imminent risk of out-of-home placement such as incarceration. It is a manualized treatment that encompasses a comprehensive set of identified risk factors targeted through individualized interventions and delineates interventions that integrate empirically-based clinical techniques into a broad-based ecological framework.

Citation: Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowand, M.D., & Cunningham, P.B. (1998). *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*. New York: Guilford Press.

Purchase the book from Guilford Press (Catalogue number 0106) or visit the MST comprehensive website:
www.mstservices.com/index.php

### *Brief Strategic Family Therapy (BSFT)*

This is a brief intervention used to treat adolescent drug use that occurs in conjunction with other problem behaviors. These behaviors include things such as conduct problems at home and at school, oppositional behavior, and delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. Family interactions are thought to maintain or exacerbate adolescent drug abuse and other behavioral problems are targeted. Treatment typically involves 12-24 sessions, each 90 minutes in length, for 4 months. Additionally, there ay be up to 8 "booster" sessions. The number of sessions needed depends on the severity of the problem.

Citation: Szapocznik, J., Hervis, O., & Schwartz, S. (2003). *Brief Strategic Family Therapy for Adolescent Drug Use,* NIH Publication Number 03-4751. Washington, DC: National Institute on Drug Abuse.

Available from NIDA online:
www.drugabuse.gov/TXManuals/bsft/BSFTIndex.html

### *Family Support Network (FSN) for Adolescent Cannabis Users*

This intervention seeks to extend the focus of treatment beyond the world of the adolescent by engaging the family, a major system in his or her life. FSN consists of several components, each designed to achieve specific objectives:

- Case management
- Six parent education (PE) groups
- Three or four in-home family therapy sessions.

The FSN process is a family intervention designed to be used in conjunction with any standard adolescent treatment approach.

Citation: Hamilton, N.L., Brantley, L.B., Tims, F.M., Angelovich, N., & McDougall, B. (2001). *Family Support Network for Adolescent Cannabis Users, Cannabis Youth Treatment (CYT) Series, Volume 3*. DHHS Pub. No. (SMA) 01–3488. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Order from the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686 or 1-800-487-4889 (TDD). Or download for free from SAMHSA's Knowledge Application website:
http://kap.samhsa.gov/products/manuals/cyt/index.htm

### *Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)*

This guidebook presents the SAFERR model for helping staff of public and private agencies (child welfare, substance abuse treatment, and the courts) respond to families affected by substance use disorders. The SAFERR model and this guidebook were developed by the National Center on Substance Abuse and Child Welfare (NCSACW). The model includes screening and assessment tools and efficient communication strategies that support sound and timely decisions about the safety of children and about the treatment and recovery of parents. It includes guidance for developing collaborative relationships between the systems to help improve outcomes for these families.

For a free download of the manual, go to:
www.ncsacw.samhsa.gov/files/SAFERR.pdf

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