FAMILY THERAPY

for Substance Abuse in Hispanic Adolescents

Dialogue on Science and Addiction

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About the Author

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Dr. Daniel Santisteban received a BS in Psychology from Rutgers University, a PhD in Clinical Psychology from the University of Miami and completed his internship training in New York University's Bellevue Medical Center. He is currently a Research Professor at the Center for Family Studies, Department of Psychiatry and Behavioral Sciences, Miller School of Medicine, University of Miami.

He has been the recipient of several R01 grants from NIDA to develop enhancements to family treatments for special populations (Hispanics and drug abusing adolescents with co-occurring disorders), including a study developing and testing family interventions that address unique treatment needs of Hispanics. Santisteban has also served as PI and Co-PI on a number of treatment and prevention trials including the Florida component of the NIDA Clinical Trials Network.

Dr. Santisteban has published extensively on family therapy and cultural competence and regularly conducts national and international trainings on these topics, as well as on the bridging of research and practice. In 2002 Dr. Santisteban co-edited the book Family Psycology: Science-Based Interventions which highlights the field's best science-based practices and was senior author on the chapter on cultural considerations in family research. Dr. Santisteban received the 2004 American Family Therapy Academy award for Distinguished Contribution to Family Systems Research.

Dr. Santisteban's work at the national level has included serving as a standing member of a NIDA grant review committee (NIDA E), on the editorial board of the journal Science and Practice Perspectives, and serving as a consultant to federal agencies such as the Center for Substance Abuse Treatment. At the state level, he works closely with the Florida Alcohol and Drug Abuse Association, the Addiction Technology Transfer Center, and the Department of Children and Families State Director for Substance Abuse Programs to bridge research and practice in substance abuse treatment.

Introduction

Family Therapy for Substance Abuse among Hispanic Adolescents

Family therapy has been shown to be a very powerful tool for treating adolescent substance abuse. The impressive scientific literature that supports its use includes highly rigorous and well-controlled studies of different forms of family therapy. Family Therapy can be powerful because it can work at many levels. It can target individual family members, important subgroups such as couples or siblings, causes and/or consequences of drug use, family member responses to societal discrimination and oppression, and many other key processes. Family therapy models are not always, however, easy to learn and integrate into ongoing practice. Most family therapy models stretch the counselor to new ways of conceptualizing problems and to utilize interventions that differ significantly from those utilized within more traditional individually oriented models of addiction treatment. The treatment of Hispanic substance abusers also presents some unique challenges to counselors. It requires gaining an understanding of some pro unique stressors that can disrupt family life and contribute to substance abuse problems.

One purpose of this manual is to introduce counselors to basic systemic thinking about addiction and the family context of addiction. Where applicable, we present unique aspects of Hispanic families. In this manual we also seek to articulate major strengths of family models, the importance of cultural competence in working with Hispanics, and unique aspects of working with adolescents. We hope that this manual helps to teach family treatment concepts, techniques and strategies in a manner that practitioners find useful for their work with substance abusing Hispanic clients.

It is very important to understand that it is not the intent of this manual to present a specific model of family therapy. A number of different empirically supported family treatments are currently available and have their own treatment manuals and intensive training programs that can certify a therapist in that given model. It is also beyond the scope of this manual to present all the variants of family therapy and their associated details. The more limited goal that can be met by this manual is to expose counselors to family theory and practice, to identify some of the conceptual shifts that the practitioner must make, and to try to clarify some of the How's and Why's of family therapy.

Whenever possible we introduce topics that are often absent from training on specific model strategies and techniques such as what can go wrong in family therapy.

Will I be ready to competently implement family therapy sessions with difficult populations after reading this manual?

Family therapy can be a very powerful intervention, but it is also a complex set of processes that requires considerable training to do well. Many things can go wrong and the family therapy experience can be counter-productive for the client if a therapist mishandles the family session. An example of mishandling is not being in control of a session that contains high levels of negativity and verbal aggression. Only well-trained therapists and counselors should conduct family therapy sessions with explosive families (distinction between family therapy and family involvement is made below). It is the writer's hope that this manual will help simplify some of the mysteries of family therapy, point to aspects of family therapy that are more and less complex, and promote interest in counselors to seek intensive training on an empirically supported form of family therapy. It is said that prior to making major changes in practice – like adopting new evidence based treatments - there must be a level of readiness to change. It is hoped that this nature walk through the forest of family therapy, can help increase readiness among counselors previously unfamiliar with its varied terrain, and spark an interest in further training.

Basic definitions that form the foundation of culturally competent family therapy with Hispanic substance abusing adolescents are presented below:

What exactly is a Hispanic? There is great complexity and diversity within and between groups that are typically included under the Hispanic umbrella. Although groups such as Mexicans, Puerto Ricans, Cubans, Spaniards, and Nicaraguans, to name just a few, often share common linguistic, cultural, and family values, there are also substantial differences between them. Differences include reasons for and route of historical and current migration, length of residence in the U.S., level of acculturation, traditionalism, social class, education, and other life experiences (marginalization, immigration-related separations, etc.). The experience of a Mexican American whose family has been in New Mexico for three generations, or a Puerto Rican whose family has been living on the island for the same amount of time, may differ across many dimensions from a Venezuelan who has been in the U.S. for four months. It should be noted that many individuals under the umbrella of Hispanic would prefer to be called Latino and most can point out the errors and overgeneralizations that occur with the use of any such larger categorization. Most would prefer to be known by their country of origin (e.g., Mexican, or Puerto Rican). While it is common to use such general categories such as Hispanic or Latino for the sake of convenience and to attempt to point to commonalities shared by a larger group of people, it is important to always keep in mind the substantial limitations of such categorical labels.

What are the Basics of Cultural Competence?

Cultural competence can be defined as a set of behaviors, practices, and attitudes that enables a counselor to function effectively in the context of culture-related differences. Cultural competence can positively impact many aspects of the counseling relationship such as engagement and retention of culturally diverse clients, establishing a high level of client-counselor communication and trust, and the successful development of a therapeutic alliance. Each of these areas is believed to be critical to successful treatment outcomes.

Guidelines for cultural competency have focused on specific competencies in many areas. For example, the culturally competent counselor must:

1) Be aware of his/her own cultural heritage, values, and biases related to identified minority groups,
2) Have knowledge of the experiences of prejudice, oppression, and discrimination that impinge on the daily lives of minority groups,
3) Have knowledge of culture-related views about illness, help-seeking behaviors, and expectations for helper-patient relationships, and
4) Have the professional skills in treatment to competently address the clinical problem in the context of all of the culture-related complexity described in points 1-3 (APA, 1993).

In this manual we will attempt to shed light on the types of culture-related contextual factors that can influence family processes and the practice of family treatment with Hispanics.

What is a family and who defines its boundaries?

The family is considered to be one of the most basic units of society. The family is the primary context in which youngsters grow, develop an identity, are socialized, are hurt and healed, and in which individuals struggle with powerful developmental issues. Despite life cycle changes and the natural development of autonomy, the family can continue to be very influential, even to old age when heavy reliance on the family often comes full circle, appearing as it was during childhood. The family is a naturally occurring unit and the context in which most intense behavior-shaping experiences occur. The family can serve a protective and insulating role, or it can serve as the fertile ground in which severe problems can take root.

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. Elective families may include same-sex partners, godparents, fictive kin and other significant but non-biologically-related, others. The ability to define elective families cannot be overstated. Elective families are networks of support and resources that

are too often missed by family therapists despite the family's crucial role in the process of recovery. For all these reasons, the counselor is incapable of easily defining "the family" without the client. The counselor can, however, encourage the client to be flexible in terms of the definition of family and thereby, expand the network of resources that can support recovery. The individuals that the client has chosen to be their primary supportive group must be fully mobilized during the recovery process to achieve a successful outcome.

What does the Substance Abuse Profile of Hispanic Asolescents Look Like?

Socioeconomic differences between adolescents often contribute to different profiles of illicit drugs used. In general, however, the profile of Hispanic adolescents indicates a very high rate of use in 8th and 10th graders. These youth report the highest lifetime, annual, and 30 day prevalence rates of alcohol, cigarette, and licit or illicit drug use (all classes of illicit drugs with the exception of amphetamines) of any racial/ethnic groups (Johnston et al 2006). In 2005 some of the most commonly reported substance of abuse by adolescents in 12th grade was: Alcohol (67 % in the last year), Marijuana/Hashish (34%), Tranquilizers (7%), with Inhalants, Hallucinogens, and Cocaine ranging between 5% - 6%. Monitoring of new trends among adolescents is always important as is demonstrated by the rapid rise of prescription drug abuse in this population.

Chapter I

Benefits of Working with Families

REDUCING NEGATIVITY AND CONFLICT THAT ARISES FROM ADDICTIVE BEHAVIOR

Families cannot help but impact and be impacted by a substance-abusing member. Negativity is common in families with a substance-abusing member, and can come from both the substance abusers themselves and from the other family members that become frustrated and hopeless about behaviors associated with the addiction. Chronic negativity is often one of the most difficult family characteristics to address in family therapy because if not handled competently early in treatment, it is likely to lead to “out of control” family sessions and to premature drop-outs. In many families, negativity leads directly to physical aggression and violence, and consequently the involvement of police and protective services. Research has pointed to the likelihood that couples violence is much more common (up to 8 times more common in one study) on days when there is substance abuse. This violence is also likely to spill over toward children when they are present in a family. Family therapy can focus on the roots of negativity, the sequences that lead to violence and on creating protective strategies in the family to keep family members safe.

Mobilizing more people to support recovery

It is possible to mobilize many helpers to give support (emotional, practical and instrumental) to help in the recovery process. The mobilization of caring and involved family members, who can modify the daily context of the substance abuser, makes it much more likely that treatment can have a powerful impact. Through the mobilization of family members and others in the client network, one can reduce the frequency of conflict that can serve as emotional triggers to relapse, increase the amount of available support at critical times, or help in creating drug-free environments for daily activities. The family, which is the naturally occurring environment of the substance abusing individual, must be mobilized fully to assist in the long and difficult recovery process. In effect, this aspect of family treatment increases the therapeutic influence during the treatment phase.

Having a beneficial effect long after the treatment phase is over

Discreet treatment episodes are not consistent with the nature of a chronic problem. An important but often overlooked fact is that there is a poor fit between the paradigm that is used to treat substance abuse, and its often chronic nature. The manner in which we typically conceptualize treatment is as a discreet episode of relatively intensive intervention followed by discharge

(often called graduation). This paradigm is inconsistent with the knowledge that substance abuse is associated with frequent relapse and as is argued by McClelland, its course is more chronic health condition. A very real benefit of family therapy is that it assumes it targets not only the individual substance abuser but also the entire family context. By having a therapeutic impact on the family context in which the client will remain after the treatment episode, the therapeutic effect can last beyond that treatment episode. Whether that modification is achieved in the partner of an adult substance abuser or the parents of a substance-abusing adolescent, there should be more likelihood of sustained impact. This is not a perfect solution, of course, because even dysfunctional family relationships can also relapse after treatment-related change and may require booster sessions. But modification of the entire family context does offer more of an opportunity for sustained impact. Family interventions that work with parents to modify other key aspects of the youth's ecology (for example school and peers) can also be thought to have a more sustained impact.

Family therapy can improve retention of key family members

There are some indications of higher rates of engagement and retention in therapy when multiple family members are involved. Although the initial engagement of multiple family members is certainly a challenge, having multiple family members participating and fully engaged in treatment actually helps keep an adolescent in treatment even when the youth begins to disengage from, or feel ambivalent about, treatment. This is important because the therapy process is rarely characterized by a smooth and consistent trajectory of improvement. There are many ups and downs as clients come in and out of difficult treatment stages. By engaging parents, a partner or spouse, one can mobilize an ally that can keep the primary patient involved in treatment and motivated even through the more difficult phases of therapy.

Why is family therapy perceived as compatible with the expectations of many Hispanic families?

There are at least two reasons why it has been argued that family therapy can be particularly useful for working with Hispanic families. The first is that it can address the adverse effects on the family of such things as immigration and acculturation stress among immigrant Hispanics, and social stressors and discrimination faced by many Hispanics. The second reason is that it is consistent with the familial orientation that research has shown to be particularly prominent among many Hispanic families.

The ability to address intra-familial consequences of responses to stressors.

A primary reason why family-based interventions are thought be compatible with Hispanic families is that there are very powerful stressors faced by Hispanic families that can adversely affect family relationships and family well-being. Stressors such as immigration stress, disruption of support systems, discrimination, separation of family due to migration, and acculturation stress, can greatly disrupt families. These experiences can adversely impact family com-

munication, family cohesion, and parenting practices in Hispanic families. During the acculturation process, family members find themselves having to learn a new language, new societal norms, and new practical skills needed in the new host community. Whereas youth more quickly become fluent in the ways of the host context as a result of public education and peer interactions, parents do not tend to acquire the skills and preferences as readily.

It is not always the case that stressors related to immigration or acculturation cause family problems and symptoms in its individual family members. Most individuals work through these stressors without major complications. However, it is important to acknowledge that these major stressors can exacerbate existing family vulnerabilities and conflicts and contribute to substantial family member symptomatology. Said in a different way, certain families that have pre-existing family conflicts and poor levels of parent-child attachments are more likely to have those vulnerabilities not only exposed but exacerbated by the stressors described above. For example, preexisting intergenerational differences in values and behavior can be made even more prominent by adoption of different values and behaviors from the new host culture. In practical terms, this manifests itself as youth who begin to accept messages about such things as curfew, dating, autonomy, dress, speech, music, that are very different from that of their parents. Most importantly, because relationships are already poor, the adolescent does not attempt to strike a balance between the two competing positions. When family problems are not preexisting, the adolescent might work harder at finding a mid-ground or an acceptable integration of the two competing views. With successful family work, the counselor can achieve integration of cultural norms that the entire family can be more comfortable with. Also, the differences that do remain, are perceived more as naturally occurring acculturation responses, rather than as purposeful attempts to alienate or contradict the parents.

The parents of youth who are changing rapidly are more challenged in their parenting. They are faced with both changes due to growing up and changes due to rapid acculturation. But the youth are not the only ones who are changing. Parents may also be hearing and seeing ways of parenting that are different from those that were most commonly practiced by their parents. Whether considering parenting views more consistent with things like corporal punishment or a more strict expectation of obedience by the youth, parents begin to hear messages that over time changes these pre-existing views and cause them to have to modify their parenting practices.
Research suggests that acculturating parents may vacillate regarding how to do their parenting and as a result, lower their level of involvement with the youth. Further research suggests that these changes are not beneficial to the youth.

Falicov describes the need to use a “Sociopolitical Lens” to fully appreciate the social injustices and the limited social and economic opportunities that are prominent in the lives of African Americans, Hispanics, and others. These limited opportunities relate directly to educational, substance abuse and mental health resources. Counselors working with families have a unique opportunity to appreciate the impact of these powerful contextual stressors on individuals and families, and to master interventions that can empower families in their interactions with the larger social systems opportunity to appreciate the impact of these powerful contextual stressors on individuals and families, and to master interventions that can empower families in their interactions with the larger social systems.

When immigration is a disruptive force to family relations

Another family pattern worth discussing pertains to immigration-related parent-child separations that can be a disruptive force to family relations and child development. When parents immigrate ahead of their children or must send their children ahead of them, there can be a breaking of ties among nuclear family members with resulting feelings of abandonment and loss on the part of the youth. Reunions that take place as the youth reaches adolescence can result in behavior problems because of a number of powerful family dynamics specific to the separations. These include:

1) Child's feelings of abandonment and resentment as well as guilt for having these feelings

2) Dual loyalties toward biological parent vs. the family member who was the primary caretaker during the separation

3) A Hispanic family belief that the open display of negativity is disrespectful

4) Parent's dual loyalty between a new romantic-partner and the separated children

5) Age-inappropriate parenting behavior, partly because the parent has not adjusted to the child's development that occurred during the separation; and

6) Parental reluctance to set limits because of the guilt associated with the separation.

Interestingly, these types of dynamics do not emerge only during the family's primary immigration experience. Hispanic families that have extended family members spread across borders (e.g., U.S. mainland, Puerto Rico, Mexico, Nicaragua, Dominican Republic) will often send children across the borders to take them away from deviant peers and other drug using contexts. These separations resulting from the utilization of extended families in other countries can also bring about powerful separation and abandonment issues that can be addressed in family therapy. These are only some of the types of family stressors faced by Hispanic families. Family interventions are well suited to address all of these types of family conflicts and parenting practices issues.

Familismo refers to a strong identification and attachment of individuals with both their nuclear and extended families. Familismo is also manifested by strong feelings of loyalty, reciprocity and solidarity among members of the same family. Having a strong sense of familismo does not of course guarantee anything. It does not mean that family members will always be willing to get involved in the problems of a family member that has been problematic (as is the case with delinquent or substance abusing adolescents) or that there are not family secrets that patients wish to keep concealed. It does mean, however, that among a large proportion of families, there is a general assumption and belief that family members should help each other, stay

involved during hard times, and that there is a more permeable (less rigid) boundary between private individual, and family matters. When this family orientation is strong, family therapy maybe more easily accepted while attempts at adolescent differentiation may become more of a challenge.

The first reason why family therapy is thought to be useful with Hispanics is the apparent compatibility between family therapy and the commonly reported value in Hispanic families of familismo or familism.

Chapter 2

Basic Concepts of Family Therapy

DISTINGUISHING FAMILY THERAPY FROM FAMILY-BASED INTERVENTIONS

Let's begin by discussing what is and is not family therapy. It is important when thinking about working with families, to understand the many levels of family involvement that one can have, the goals of each level of family involvement, and the skills needed to meet those goals. A model outlined by Doherty and Baird (1986) for family-centered medical care, is very helpful in thinking about the manner in which one approaches families. Their model describes the level of family involvement as follows:

• **Level One** - There is little emphasis on the possible role that families play in patient care.

• **Level Two** - Reflects involvement of the family not only for information gathering that can help in the tailoring of information, but also for mobilizing simple family behaviors that can help the patient with their problem (e.g., helping with treatment compliance).

• **Level Three** - Moves more deeply into the family by including an understanding of the family's stress and pain, and trying to provide support and empathy, caring for the affective side of the family. At level three one can begin to see more clearly an expansion of the target of intervention as the practitioner attempts to alleviate problems and pain in the larger system.

• **Level Four** - Involves a higher level of intensity of family intervention, beginning to conceptually link problematic family behaviors to the present problems (not necessarily as causes but perhaps as resulting from and helping to maintain the present problem). Limited and focused interventions can be used to impact family relationships that in turn, can impact the presenting problem.

• **Level Five** - More sophisticated and intensive family treatment is found at this level. Here highly trained family therapists seek to diagnose and treat more dysfunctional and entrenched family dynamics that require an intensive and sustained treatment focus.

Because of the high levels of negativity, potential for violence, and past traumas that may be found in some families, it is critically important that the therapist be well trained in family therapy to do the work at Level Five.

One of the great benefits of such a conceptual model is that one can plan the intensity and focus of interventions and be more mindful about the goals of the family intervention. It is all too common for the counselor entering into a family system to simply react to weekly issues presented by the family and fail to plan attainable goals. Touching on this or that family problem or stressor is unlikely to be helpful to the family or the primary patient. Therefore any family change that is sought and attempted, should be well thought-out, attainable, and linked to the presenting problem that one wishes to impact. Family education that teaches family members about substance abuse, related emotional and physical problems, and consequences of substance abuse should never be confused with the more intensive family treatment that specifically targets changes in family relationships and maladaptive family interactions. This framework is also very helpful to treatment agencies that wish to adopt family treatment within its services. At an agency level, one must match the anticipated level of family intervention with the family therapy training and coaching provided to counselors.

Variants of family therapy

There are many variants of family therapy, far too many to cover in this guide. For a thorough discussion of the many variants and core questions of family therapy in the treatment of substance abuse, the reader can begin with the Center of Substance Abuse Treatment's Family TIP 39 and other recommended sources in the back of this document. Some models such as Psychodynamic and Existential family therapy, may be more common in other symptom areas but less commonly used in the treatment of addiction. The types of family therapy most commonly used in the treatment of addiction can be generally categorized as: family disease models, family systems models, behavioral models, and mixed models:

a. The family disease model tends to emphasize codependency, and enabling behavior. In this model the disease is conceptualized as being shared by the entire family. Enabling behavior is thought of as those behaviors that can maintain the drug or alcohol use by making life easier for the addict or by helping them avoid negative consequences. With family therapy, family members are helped to make changes in themselves so that they do not continue to be overly connected/enmeshed with the addict and over-functioning to compensate for the addiction.

b. The family systems model tends to look at drug or alcohol use as serving a role in the family system. Within this theory family systems are thought to seek homeostasis. That is, families systems seek to avoid change and try to maintain stability. Drug or alcohol use becomes a critical piece within the repetitive family sequences. When there is a change in these addictive behaviors, the family system can become destabilized. For example, a father who stops drinking and now has more contact with his children, may become more control-

ling of their behavior and elicit rebellion. In this case, the system may seek homeostasis because there is great stress resulting from the instability brought about by abstinence. Family systems theory seeks to modify family characteristics such as boundaries, family rules, and seeks to make family member roles more flexible so that the system can better adjust to the more adaptive behaviors and not work against them.

c. The family behavioral model emphasizes the triggers and consequences of addictive behavior. Counselors seek to understand the interpersonal behaviors that trigger drinking or drug use and seek to help the addict find alternative responses to those triggers. In addition, there is a focus on the interpersonal consequences of addictive behavior and of abstinence. By increasing a spouse's positive reinforcement of abstinence, for example, the addictive behavior may be decreased and couples functioning improved. It should be noted that family treatment models rarely fall neatly into one of these categories. Most family treatments use a combination of many of the concepts and strategies outlined above. In addition, family research tends to focus on understanding how family processes are involved in the etiology of addiction, that is:

1) How family may contribute to the emergence of an addiction,
2) How family processes may serve to maintain the addictive behavior
3) How positive family forces can be mobilized to bring about change in the addictive behavior.

In all of these three realms, family research has a strong track record of success and has led to a number of treatments with proven effectiveness.

Is there always a simple fit between family therapy and addiction treatment?

Although it is highly desirable to integrate family therapy and addiction counseling, one must acknowledge that this is not always a simple task. Substance abuse counselors have often drawn on personal recovery experiences in developing their counseling approach and have integrated concepts and strategies from the addiction recovery field that are quite different from family therapy approaches. It is no simple task to integrate conceptual frameworks that are based on individual disease models or individual pathology with family theories and interventions. For example, a family systems perspective may appear to spread responsibility for a substance abuse event to the family, while the individual approach emphasizes the importance of individual responsibility. An understanding of the possible tensions between models is needed not only by counselors, but also by family therapy trainers. Having knowledge of family theory and interventions does not mean that the trainers know enough about more traditional disease models to empathize with the struggles the counselors must face integrating a new treatment approach. These issues cannot be taken lightly when the goal is to truly integrate family therapy

into the agency or counselor toolbox. Recent research has shown that it is important to monitor the degree to which substance abuse counselors feel the new treatment fits with the previous and ongoing treatment and their possible discomfort concerning that fit. Creation of a hodgepodge of different treatments is unlikely to work as well as an integrated conceptual and intervention framework. To gain the full impact of adding family treatment to an addiction program, it is important to work during training and supervision, on the integration of the models.

Chapter 3

Getting Started with Family Therapy

PRE-TREATMENT ENGAGEMENT

Counselors providing drug abuse treatment recognize the difficulties inherent in successfully engaging entire families into therapy. Because of these difficulties it is not surprising that even experienced practitioners may treat individuals only, or subsets of families, despite strong convictions that conjoint family therapy is the treatment of choice. In these cases, recognition of the importance of having all family members present in the therapy has little impact if practitioners do not have special skills or strategies for bringing this about.

Having special skills to engage more successfully starts with conceptualizing the problem differently. It is not helpful for a therapist to expect that merely giving the family an appointment will lead to all family members coming to treatment. Instead the therapist should expect that any prominent family relationship problem that exists, will negatively impact engagement. For example, any disengaged family member that is feeling helpless and has given the time and effort needed to come to treatment. This is especially true if he/she is angry with the family member who "really" needs to change and has stubbornly refused to do so. This may also be true if a traditional Hispanic father perceived treatment as an admission that he has lost control of his family. An out-of-control teenager who has in effect, overpowered his parents, is unlikely to come to treatment without a fight. This is logical because the therapist is perceived as the parentally in the battle to get the teen under control. When couples have powerful conflict and/or the potential for violence, at least one member may be reluctant to expose the conflict and violence. In summary, it is not very logical to expect families to put any problematic behaviors "on hold" until after they reach the office. These core problems must be addressed starting with the first phone call, using specialized strategies tailored to the family situation.

During pre-treatment engagement phone contacts, the counselor must identify hidden family dynamics that can easily block engagement into treatment. For example, in some families it will be clear that the acting out/drug using adolescent is very powerful and can refuse to enter treatment. Unless the counselor has some outside leverage (like juvenile court pressure) the most effective way to work with this type of family is to contact the powerful adolescent directly and immediately ally with his agenda. It must be made clear that the therapist will make sure that therapy works toward achieving her/his goals. In other families, the counselor may learn that there is a disengaged family member who refused to come in although the other members really want him or her to participate. In these families there may well be intense marital conflict that is being avoided by the disengaged member. In working with this type of family, the therapist must build upon the caller's

willingness to change from the outset. By empathizing with the caller's frustration over the spouse's disengagement, the therapist can direct the caller to interact with the disengaged parent in a new, more adaptive way. Assuming that there are powerful marital issues that are unresolved, the therapist must ensure that the caller approaches the disengaged spouse in a way that insulates the marital conflict. This is accomplished by presenting therapy as a much focused process in which, at least initially, only issues that are very clearly related to the adolescent's behavior, and not overarching marital issues, are targeted. This focus can expand later if the therapy is perceived as helpful.

During the exploratory phone call the therapist may learn, however, that the callers initiating treatment really do not want that disengaged family member to come to treatment. He or she may reveal secrets that the caller does not want revealed. In these cases, the therapist's job is more focused on the initiator of therapy and involves showing him or her why leaving out this family member is hurtful in the long run. Special permission must be sought such that the initiator of treatment allows the counselor to call and schedule the disengaged member directly. These are just some examples of ways of engaging a reluctant family member into treatment and how the treatment agenda must be shaped to match the needs of individual family members and situations.

In-Session Joining

The first step in working with a family once they are in front of the therapist is to establish a therapeutic relationship. The complexity of becoming the leader of a system increases with the number of different agendas the family comes to treatment with. When there are multiple agendas (one spouse may want a divorce, while the other wants reconciliation; or an adolescents wants to avoid a court hearing while a parent wants her son to stop abusing drugs and her spouse to get more involved), the therapist must be even more masterful at engaging and joining all members. It is indeed an art to juggle multiple alliances with family members with different agendas for treatment. The therapist must join all members and empathize with their positions, but also craft treatment goals that can satisfy all members.

To become the leader of the therapeutic system, the counselor must earn the trust and respect of the family. The counselor achieves the leadership position by displaying caring, respect, and understanding of all members, by showing cultural 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 reducing the presenting symptom of substance abuse, reducing negativity and increasing family support. It is important to give thought to the defining of goals so that the counselor can give each family member what he or she needs. For example, by making the youth more responsible on key behaviors (meeting parent goal) the parent "gets off the kids back" (adolescent goal). Further, there is an emphasis on mobilizing the emotional component of the parent-adolescent relationship. That is, helping the family members to re-experience the intensity of their positive feelings for each other. This is the fuel that keeps family members working through difficult therapy stages.

Although some family models continue to emphasize only conjoint family sessions, (sessions were the entire family is present) other adolescent treatments allow for separate sessions for adolescents and parents so that there are distinct joining strategies and maneuvers that are tailored to the participant's distinct needs. Adolescent have specific developmental needs, challenges, and opportunities and the inclusion of additional individual work can help provide something unique to their situation.

A very important part of joining is to make all family members feel that their participation in the session matters. If a person is not involved in the family session, they are less likely to return to future sessions. Every family member has a role to play in the long and difficult recovery process. It is worthwhile for the counselor and his/her supervisor to think through what these roles are for each family member and to make sure it is not neglected in treatment. It is easy to have sessions overly focused on new crises and fail to follow a well-developed plan for increasing family support from many different members. It is also useful to help the family see the problem and the solution as interactional. That is, help the family to understand how family interactions and relationships can exacerbate the problem, or conversely, how they can help solve the problem. After all, we are providing family therapy for a problem many see as an individual problem. Early in the treatment process we must help families understand why we consider it important to treat the entire family. All of these strategies share common process; that of having families redefine the problem behavior and having a more complex and hopeful vision of the problem and of the family context in which the problem exists.

For immigrant families, there is a full immigration/acculturation history to understand. Where were parents/child born, why did they leave their country (i.e., reasons, expectations), what was life like back home (stress, politics), how did they arrive (route and dangers), who did they come with, why and how was that decision made, what type of support was available on arrival, problems encountered, how has the parent and family changed over time (values and behaviors), have there been different rates of adjustment/acculturation, has that different profile of adjustment resulted in stress?. What changes in social and economic status have occurred and what stress has arisen due to that loss? Immigration/documentation problems, change in social networks, perceived alienation, isolation, discrimination are all critical factors to consider. Are the participants connected with agencies that can be helpful with their documentation process? Being informed about these powerful experiences and open to integrating these into the therapy can be an effective joining tool.

Instilling hope

A major family strategy is to punctuate the deeper connections and feelings between family members, and to rekindle hope that the family can move toward its desired state, despite the many problems that have emerged. This sense of a special relationship helps family members go beyond their habitual behaviors and take more risks in their relationship. By punctuating pain, or despair, or hurt, rather than the usual anger, family members become more willing to

fight for the survival of the relationship.

Hopelessness makes behavioral change unlikely because family members give up quickly on any behavioral change that is implemented in the family. Hopelessness leads to more negativity, less tolerance, discontinuation of recommended parenting strategies such as monitoring or guidance, and often to parents who want their youngsters removed from the house. Hope can be instilled by many interventions. Demonstrating that others go through similar problems and resolve them with continued effort, explaining that many adolescent problems dissipate with time if parents continue appropriate parenting, normalizing the problem by showing it is the result of immigration/acculturation, or other stressors.

Keeping control of the session

A very important process highlighted within many family treatments is the interruption of highly negative and hostile family exchanges. While some level of negativity is inevitable in family sessions, ongoing hostile exchanges particularly during early sessions can be especially hurtful to creating an alliance with the therapist. In a dysfunctional scenario, when these exchanges are allowed to continue, family members may refuse to return for future sessions. In the worst-case scenario, violent behavior can erupt in sessions because the sequence of negativity may go beyond the point in which the more violent family members typically leave the scene of the interaction. One of the most effective family interventions for disrupting highly negative interactions is reframing. Simply stated, reframing offers a new and more positive interpretation of problematic family interactions. Benevolent and loving intentions behind the problematic behaviors are highlighted, even as the problematic aspects are acknowledged.

“I hear what you are saying, that it feels like your mother is trying to run your life (validates son’s feeling), when parents care about their children and try to keep them safe (mom’s loving intent is highlighted), it may often feel like that. How can we help mom do her job as a caring, loving parent, in a way that doesn’t feel so controlling?”

Reframing, attempts to change the attributions or meaning that a behavior has, replacing a more negative interpretation with a more positive one. For example, a parent’s close monitoring can be explained as love, concern, and protection, rather than as any special need to be controlling. Likewise an adolescent’s high level of emotion and intensity can be labeled as passion, which can be used positively and creatively.

“Dad, you experience your daughter as disrespectful, and she is definitely a very passionate person. That passion will serve her well when she takes on a good cause, how can we make sure in your conversations that she can be passionate without being disrespectful? Another common technique is simply blocking the negative interaction early in the sequence to interrupt the usual family dance. Counselors must feel very comfortable taking an active role in family sessions and frequently interrupting emotion-laden dialogue.”

Dad, let me stop you a second, so that your daughter can fully explain what she means. I think she has thought through the problem in her own way, and you may want to hear the thinking that is behind her statement.

“Hold on Mom; let’s let Dad and your son get to some resolution of this disagreement. You usually step in to help them but let’s let them do it alone today.
It should be noted that while joining is an activity that is very salient with the initiation of treatment, it is not restricted to that period. Indeed, family therapy has many ebbs and flows of therapeutic alliance and it is likely that joining will take place at many points with different family members at difficult stages of treatment.”

Chapter 4

Conceptualizing the Problem

PROCESS VS. CONTENT: DIAGNOSING PROBLEMS AND PLANNING CHANGE

There is an important distinction made in family therapy between the use of process and content in formulations of problems and in targets of change. Content refers to what is being said, the facts about a story, the specific arguments being used by different family members, the different points of view, or the discrepancies in the stories as told by different members. Traditionally, individual oriented treatments such as psychodynamic and cognitive behavioral therapies focus heavily on the content of what is said because there are facts, past experiences, or ways of perceiving events that shed light on the problem, and if corrected, can lead to symptom improvement. Conversely, many types of family therapy have emphasized a focus on process. A process focus in family work emphasizes the way in which family members interact, the visible interpersonal (often non-verbal) behaviors involved in an interaction. The work might focus, for example, on who argues with whom, with what intensity and who jumps in to support whom, rather than what they are arguing about. Process looks at the fact that family members are supporting one member and alienating another, rather than what the specific issue is. It focuses on repetitive alliances or coalitions that form between certain family member (and often against specific other members) rather than on the content that leads them to agree on a specific topic at a given time.

Family interventions often target family patterns of interaction such as increasing support from one family member to another, reducing over-involvement within a dyad, ensuring some relational needs are met for a dyad, and/or modifying a repetitive sequence of behavior that may lead to interpersonal aggression or violence. Here the focus is less on correcting the perception of an event or on the rationales for differences of opinions but on blocking certain repetitive interpersonal sequences that are hypothesized to contribute to symptoms.

While some models tend to heavily emphasize either content or process work, both foci are important in family work. Recent efforts at integrating work at the content and process level articulate key content areas that are critically important to many Hispanic families and create psycho educational modules that can focus on key content areas. These include, for example, focusing on immigration history and stressors, parent-child separations during immigration that can disrupt the relationship, parenting skills, and drug education with an emphasis on views that are sometimes culturally- linked. Likewise a couple's treatment for adult substance abusers provides couples with written information on the basics of drugs and alcohol use, on couples functioning and relationship

improvement, and guidelines for continuing recovery. In these models of treatment, there is an assumption that in addition to process work, there is also a benefit to systematically teaching some basic information.

Work at the process level complements these strategies for sharing important information. Direct in-vivo modification of the relational characteristics of the couple or family continues to be most powerful as a change agent. The important thing is that counselors know when they are moving from content to a process focus and do it in a thoughtful, planned, and informed way. A focus on content may inappropriately occur simply because it is perceived as easier, because the story seems interesting, or because the counselor is struggling to see the key process of the family. These comprise the wrong reasons. On the other hand, selective focus on an important content or theme should be planned because it will facilitate a key relational change. Information regarding parenting skills for example can be given in the service of modifying parenting interactions. A focus on the details of stories regarding physical or sexual abuse may be needed prior to attempting to repair a relationship of distrust. A discussion of the ways values can change as part of immigration and acculturation may facilitate reparation of conflicts between younger and older family members who are acculturating at different rates.

Diagnosing the family system in structural and systemic terms

Families that are functioning in a healthy manner are supporting and nurturing the well-being of each of the family members. When working with a family system, the counselor wants to diagnose how the different components of the family work together – what Minuchin called the family dance. Given that families tend to have repetitive patterns of behaviors and habitual ways of handling key challenges, it is essential that the counselor is able to identify those family patterns that are helpful to the family members, and those that are hurtful or keeping them stuck in a problem. The original tenets of Structural and Strategic family therapy, for example, focus on the manner in which family members organize themselves in response to functional demands, tasks, and family events. The particular roles and positions of family members tend to remain relatively constant, forming a predictable pattern of relating to one another. What does it mean that there are habitual behavior patterns? It means that when a husband and wife get frustrated over a conflict around finances, there is likely to be a repetitive pattern. It is predictable who will bring up the problem, who will try to avoid it, who will blame who, who will become most frustrated first, who will walk away or raise their voice first, and what behaviors will follow (for example going to bed angry, not speaking for the rest of the night, etc.) The more maladaptive the family pattern, the more predictability and rigidity there is. When families are working in more adaptive ways, they tend to have more flexibility in their patterns of behaviors and can therefore adjust better to new circumstances. Families that have taken on more maladaptive patterns are more rigid in their patterns of behavior and are more likely to intensify habitual patterns that don't work to address new challenges. Many challenges families face are unpredictable, but others can be predicted based on the life-cycle of the family and the specific challenges expected during specific life-cycles. For example, a family system must change when they move from being a family with a child to a family with

an adolescent. Flexibility is needed to ensure that family interaction patterns are age appropriate and capable of addressing new, more adult behaviors. More unpredictable challenges emerge when youth are more volatile, vulnerable to emotional disregulation, or are pulled into powerful deviant peer contexts.

The goal of family therapy is to restructure maladaptive family behavior patterns with the aim of improving the family's ability to work together in a competent and cooperative manner with those life tasks that are most salient at that particular time. Family interventions are designed to disrupt habitual systemic responses that are not helping families help their troubled family members. There is a strong assumption that small but key behavioral changes, enacted in sessions and promoted between sessions by task assignment, are the best vehicle for promoting more adaptive family functioning. The target of change is likely to be the family interactions that are most proximal to the presenting complaint. Remember parental figures need not be mother and father. They could be for example mother and grandmother or father and aunt.

Important Patterns

When working with a family system with a symptomatic adolescent, one of the first questions is: How are the parental figures working together? Are the adults in agreement about the nature of the problem? Are they in agreement about how to handle the problem? Do they support one another's positions or do they undermine each other's position? Do conflicts between them spill out and affect their parenting behaviors? Repetitive patterns of this type would suggest the need for treatment interventions targeting the parental subsystem. The more agreement and support is evident in this partnership, for the more the family can support healthy child and adolescent development.

How much negativity is there between specific dyads versus the amount of support?

Is it always the same (rigid) or does it fluctuate depending on the particular issue? How do family members address conflict? Do they make believe there are no conflicts, do the identify them but then avoid them, do they argue incessantly, or are they able to find some reasonable resolution and move out of the conflict to a stage of support? Patterns such as these suggest repetitive patterns that may or may not allow successful conflict resolution.

Are there any consequences of symptomatic behavior that can be seen as positively rewarding?

For example, does a person who loses control of their emotions and behaviors get their way at the end of that interaction? Does an adolescent who cuts him/herself get special attention they couldn't get before? Is there peace in the household only when a parent is drunk or high? Patterns like this suggest that there is highly problematic reward system in place that is likely to maintain symptomatology.

Are the people that should be in charge and providing leadership in the family actually doing so or are family members who do not have the adequate resources (such as young parental children) running the show? What are the subtle but repetitive examples of important lack of parental and adult leadership that puts young children at risk?

Are certain family members always allying with each other in a coalition against another? What are the prices that even the allies pay by being so close and excluding themselves from a relationship with other family members?
These are all examples of some of the core repetitive patterns that can be uncovered or diagnosed in family systems and that lead directly to family-focused interventions.

Chapter 5
Bringing About Change in Families

Consistent with the types of questions asked above in the section on identifying problematic family relationship patterns, the types of changes sought tend to increase family member support, reduce blaming and negativity, improve family communication and conflict resolution, help members of family subsystems (e.g., sibling subsystems, parental subsystems, marital subsystems) work effectively together, help adult family members work effectively with the youth's ecology (e.g., school, mental health system, juvenile justice) to the benefit of the child, and reduce other familial risk factors while increasing resiliency and protective factors.

The family therapist helps family members master new skills and add more effective behaviors to their repertoire. "In-vivo" modification of behavior patterns reshape the previously maladaptive behavior patterns into more adaptive and flexible behaviors patterns. Where previously there was a repetitive interaction that included only negativity a REFRAME helps to highlight the benevolent intention behind the interaction.

In the interaction when a parent tends to dominate the conversation, never allowing the other parent and child to reach a resolution, the therapists BLOCKS, the over functioning or intrusive parent and supports the extension of the other dialogue to a point rarely reached. The therapist sometimes does not look very polite but he/she must let the family know why there is a need for a traffic cop to direct traffic at important intersections. Also, being directive does not mean being disrespectful to families.

By working in the present interactions of the session (rather than talking about what happened last week) the therapist can make it happen. That means that the therapist shapes the behavior on the spot so that family members learn that they can do it, and what it feels like to do it. A new behavior by one family member elicits new behaviors from another family member. The therapist must be comfortable with being directive in most forms of family therapy.

When family members go through an important message without giving it the significance it deserves, the therapist HIGHLIGHTS or PUNCTUATES the message, thus taking its meaning to a new place. A therapist may say, "your father just said he is fearful of losing you to the streets and never seeing you have your own family has he ever said that to you before? Do you fully understand the pain and dreams that are behind that new statement? Let's discuss it more because there are few things deeper than these types of dreams parents have for their children."

Tasks are used to bring about new behavior. They can be assigned to occur inside of a session in the present interaction, or they can be assigned as homework to be done after the session. Tasks are designed to add new behaviors into the family member patterns. Family members that typically do not spend time together may be asked to do so as collective homework. It is generally wise to assign and have family members complete tasks in the office under therapist supervision, before assigning them to do so outside the session. That way, they know that it can be done, they get over the initial awkwardness, and they get to ask anything they don't understand about the task. It is a mistake to ask family member to do things totally different from what has been accomplished in session because they will be likely to fail or totally avoid it.

What Can Go Wrong in Family Therapy

Too much negativity, too much hopelessness

Family members will wonder why they come to therapy if loved ones are going to pull out all their weapons and ammunition to attack or to say they have lost all hope. Premature dropping out becomes likely. It is best to block attacking at the onset of therapy and reframe the interactions. The therapist must also create with the family a vision of a better place this family can reach.

Too much focus on content and failure to understand the underlying family process

Discussions focused on new facts, opinions, and happenings can go on for ever and fail to address the underlying quality of the relationship. Think about who is supporting, attacking, undermining, helping, guiding who in the family. Is that different or the usual? Let's add something new to that dance!

Allying with the same family members all the time

One of the important tasks of the therapist is to balance alliances and to make sure the needs of everyone are met. If you always find yourself agreeing with the wise family member and disagreeing with the seemingly less competent family member, you are probably trapped in an unproductive maze. Reassess your assumptions or seek consultation from a peer.

Failure to amplify/punctuate key communications and relationship aspects

If everything is done at the same volume and with the same affect, and topics come and go, it is likely the family will not remember the most important messages of the session. Punctuate really important new behaviors and messages so that family members can appreciate that something new and important has happened. This will also help to raise hope that not all is lost.

Example
“It is very painful to hear your daughter talk about her cravings but notice this is the first time she trusts you enough to be honest about her struggle. This is a HUGE accomplishment.”

Having the wrong people in the session

If therapists just accept those who come in easily and do not attempt to reach reluctant family members or elective family members, therapists are working with one hand tied behind their back. Reluctant family members are often the key to change and the therapist needs all of the resources a family network has available to make significant and lasting changes. Use engagement strategies and also map the family network to locate supportive figures that haven’t been thought of. Having a single parent nuclear family does not mean you fail to consider extended family and kin.

Chapter 6
Special Issues in Treating Substance Abuse in Adolescents

The adolescent developmental stage

The adolescent developmental stage is characterized by many major changes, including biological, cognitive, and interpersonal changes. Biological changes during adolescence children experience growth spurts, changes in body shape and facial features and hormonal changes related to the emergence of sexuality. In addition to the actual changes that occur, it is also important to consider how early or late they occur during the developmental stage. For example, both boys and girls who mature early may be at a greater risk for substance abuse and risky sexual behaviors. The way parents react to their child's physical maturation may also play a role in how the child reacts to the changes that occur in them. During adolescence the physical changes that the adolescent experiences are coupled with the sudden awareness of their sexuality. Parents can guide their adolescents toward a healthy lifestyle by talking to them about sex and the dangers of risky sexual behaviors. Parents, however, often shy away from the topic. This is particularly true for Hispanic parents namely because sex is a topic that is considered taboo. Research has shown that Hispanic adolescents report less communication with their parents about sex than non-Hispanic adolescents.

Cognitive Changes

Adolescents also experience changes at the cognitive level. The adolescent stage is characterized by the development of abstract thinking, hypothetical reasoning, and consequential thinking. For example, consequential thinking allows them to consider different solutions to a problem and what consequences there may be for each solution. As the youngster reach and pass through adolescence, the development of new skills for adaptively handling personal and environmental challenges is expected and developmentally appropriate. Interestingly, recent research that suggests there are major areas of the brain that do not fully develop until the mid-twenties, raise important issues about the extent to which adolescents may still be limited in terms of having all the tools needed to make good decisions.

Interpersonal Changes

Changes in personal relationships are also characteristic of adolescence. More specifically, peers become increasingly important directly influential on adolescent choices. Most conflicts between parents and adolescents during this period are minor and revolve around differences in opinions about curfew, school grades, and peers. When adolescents learn to negotiate with parents around those issues and are able to compromise, they are developing their sense of self and autonomy, improving their self-competence and reasoning skills, and allowing for healthy interpersonal relationships. When conflict between parents and adolescents becomes severe due to failures in negotiation, the attachment between parent and child can be damaged. The literature on adolescent development shows that when adolescents do not have an emotional connection with their parents they are at greater risk for developing symptoms. Family therapists should consider the normative developmental processes that occur during adolescence and their impact on family relations while designing developmentally informed interventions.

Dealing With Co-Occurring Psychiatric Disorders

An important part of the family therapy involves helping the parents develop a better understanding of the adolescent's vulnerability to other psychiatric disorders. This new frame will help parents understand the long-term nature of the struggle that both the adolescent and the parent will have to sustain. Because of the severe drug use and behavior problems often displayed by the adolescents, it is often difficult for parents to look beyond the behaviors to see the pain and struggles that the adolescent is experiencing. It is the rule rather than the exception that for substance-abusing adolescents with severe behavior problems also suffer from other disorders, such as depression, ADHD and anxiety disorders. Therapists must detect co-occurring disorders early and help parents understand their contributions to behavior problems and to complications in treatment. Parents can be helped through their resistance in accepting that the adolescent has another disorder and through their feelings that it is manipulation by the adolescent to avoid taking responsibility for their actions.

Relapse

It is also critical for the therapist to help the parents understand that the "road to recovery" for the adolescent will not be easy and will take time, that there will be periods of great success as well as setbacks (relapse). The parents and adolescents would benefit greatly from understanding the need to take a long-term view and to commit themselves entirely in order to achieve the behavior changes they want for the adolescent and the family. The therapist will also have to work to instill hope in the family so that they do not become disengaged the first time that the adolescent uses drugs or participates in a delinquent behavior after treatment has begun.

HIV risk

Adolescents comprise an important at-risk population for contracting HIV. This is especially true for adolescents who are substance abusing and may be at particular risk during drug use episodes. Furthermore, many of the same poor interpersonal skills that contribute to the adolescent going along with drug use may also work to have them be easily pressured to have risky sex. From a clinical perspective another worrisome aspect is that it is less likely that Hispanic parents will talk to their children about HIV risk and sexually risky behavior. The inhibition toward serious discussion of sexuality is particularly problematic given evidence that the lack of open and comfortable discussion about sexuality, even in the most relevant relationships is a major concern for adolescent HIV prevention (IOM, 1997). There is evidence that parent-adolescent communication about sex decreases HIV risk behaviors and that youth reporting parent-adolescent discussions about sex are more likely to delay sexual activity. Interventions designed to reduce risky sexually behavior should be incorporated into any family interventions for substance abusing youth.

Working with adolescents during suicidal urges and ideation

Some adolescents demonstrate behavior that is indicative of suicidal urges and/or attempts. These behaviors must be taken very seriously. It is important to assess early on when an adolescent has a history or has the potential for suicide behavior. One of the advantages of working intensively with the family is that a plan can be devised for the accurate assessment of risk and the implementation of a plan to keep the adolescent safe. Both the family and the therapist must give the adolescent the important message that they will be taken seriously and given attention during the early stages of distress and pain that might lead to an attempt. It is all too common that the early indicators are not taken seriously and intensive attention is only given after an attempt. Unfortunately, this pattern of response is a powerful reinforcer of the suicidal behavior.

Working with hospitals and/or drug residential programs when client has been detained for suicidal/homicidal behavior or because of deteriorating drug use

When an adolescent is detained in a hospital or residential setting, it is critical that therapy continue with the family members and if at all possible, with the adolescent in the hospital. Whenever possible it is also preferable to have a family session at the hospital prior to the discharge of the patient. It is important for the therapist to work on several areas at this critical stage. The first involves the transition to the home. It may often be the case that the hospital setting provides a level of structure, attention, security and protection that are precisely those things often lacking in the home. The promotion of protective and monitoring functions at home may be a core piece of work that can begin during the hospitalization. This is also a time to help parents validate the adolescent's desire for more structure, predictability, etc., in the home.

Finally, it is helpful from a treatment perspective to work with the family in framing the current hospitalization as a crisis that is also an opportunity for change and which increases the ability of family members to re-evaluate their level of functioning and to modify habitual behaviors. This frame is a much more helpful one than one of hopelessness which can easily develop. When hopelessness sets in, it may lead many family members to disengage from the adolescent and from therapy. Once this happens, it becomes an added task for the therapist to re-engage members and show them how to use the energy to produce changes in the family system. When a therapist can continue to work with the family during a brief hospitalization or stay at a residential facility, it is easier to present the crisis as part of the treatment process and to show how the therapist conceptualizes the crisis as part of a trajectory toward more adaptive functioning.

Additional limits to confidentiality

Although adolescents may seek assurances that information will be kept confidential, especially from their parents, it is critical that the therapist be very clear about the limits in this area. Beyond the usual legal limits (danger to self or other, child or elderly abuse) in this population the therapist must discuss confidentiality regarding drug use. The therapist cannot ensure confidentiality regarding drug use because any sustained deterioration that puts the adolescent in danger, or any sustained level of high use that suggests that the therapy is not helping, may have to be discussed with the parent. Within this model it would be considered irresponsible on the part of the therapist to keep this type of information from a parent because it would undermine the protective functions that are so critical in families. The most the therapist can ensure is that the privacy of the adolescent will be a top priority and that in the event that sensitive material must be discussed; the therapist will work hard to prepare the parent to react in an adaptive manner. Counselors and their supervisors must discuss the limits of confidentiality so that these can be clearly conveyed to the adolescents and families ahead of time.

Conclusions

Family Therapy can be a powerful tool for treating adolescent substance abuse. Several models of family therapy have been empirically tested and shown to be efficacious and effective in modifying substance abuse in adolescents. In this family therapy manual we have attempted to present the range of issues that can be effectively addressed by family therapy, some of key aspects of family therapy, what can go right and what can go wrong. Exposure to the issues presented in this manual is meant to increase counselor readiness to seek training but is not sufficient to conduct family therapy sessions with difficult clients.

Family therapist must be well trained when working with the families of substance abusing youth because the work is difficult and when treatment takes a wrong turn, families can drop out prematurely. Training to certification is typically an intensive process that is well worth the effort. Agencies that wish to make sure that family therapy remains a major component of treatment would also do well to consider having supervisory-level staff also trained and able to provide leadership in this area.

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