Systemic-motivational therapy for substance abuse disorders: an integrative model

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Although recent reviews of the literature on families and substance misuse offer compelling evidence that inclusion of families significantly improves treatment engagement, retention and outcome, family therapy remains peripheral in most substance abuse treatment programmes. Furthermore, many of the treatment approaches that have been included under the term 'family therapy' continue to focus on the substance abuser as the sole target of treatment. Still conspicuously absent are treatment models based on family systems approaches, with outcomes targeted at non-abusing family members as well. This article presents an overview of one such family-focused substance abuse treatment model – systemic-motivational therapy – that combines a family systems approach with techniques derived from motivational interviewing, but this time is applied to work with the family as a unit. The background for the development of the model will be described, as well as the assessment/consultation, family-level action plan, and aftercare/relapse prevention phases of the treatment approach.

Introduction

After three decades of research and clinical experiences working with substance misusers and their families, a compelling case may now be made that viewing substance misuse behaviour within a family context adds a powerful perspective to our understanding of these at times baffling behavioural disorders. It has long been accepted that at least some forms of these disorders have a genetic predisposition; that is, that they are family-linked. Equally important has been the growing understanding that so many of the secondary consequences of chronic substance misuse impact negatively upon other family members at a level at least equal to that of the impact upon the addicted person. One need only mention the incidence rates of physical violence,
sexual abuse, financial crises, divorce, effects on children and so on to make this point (Baucom et al., 1998; Johnson and Leff, 1999; Rotunda and O’Farrell, 1997; Rotunda et al., 1995; Velleman, 2006). Thus families, as well as users, have a major stake in the success of substance misuse treatment, and it would therefore seem self-evident that families would welcome opportunities to participate actively in treatment programmes for these disorders.

Furthermore, support for the value of including families as components of substance misuse treatment problems is now coming from multiple directions. Recent literature reviews have consistently pointed to three main findings: (1) involvement of family members during the pre-treatment phase significantly improves engagement of substance abusers in treatment; (2) involvement of the family also improves retention in treatment; and (3) long-term outcomes are more positive when families and/or social networks are components of the treatment approach (Edwards and Steinglass, 1995; Miller et al., 1999; O’Farrell and Fals-Stewart, 2003; Rowe and Liddle, 2003; Stanton and Heath, 2005; Thomas and Corcoran, 2001).

Particularly impressive has been the by now indubitable evidence that the inclusion of family members in the initial stages of contact around engagement significantly increases the likelihood that the substance user will ultimately become engaged in active treatment. The recent Stanton (2004) review, as one example, identified eleven separate family-oriented programmes designed to increase engagement of a substance-abusing family member and reported a powerful impact of these programmes (upward of 65 per cent engagement rates) when compared to wait-list control groups (averaging 6 per cent engagement rates).

Although perhaps not as powerful as the engagement data, a compelling story has also been emerging about the effectiveness of marital and family treatment approaches in reducing the negative effect of substance misuse disorders, and of sustaining those positive outcomes. For example, Miller and Wilbourne (2002), in their review of the most impressive evidence-based treatment approaches to substance misuse disorders, point out that as many as nine of the eleven approaches they identified as effective emphasize a focus on family or social networks as a key ‘active ingredient’ of the treatment approach. Hence a conclusion that the family (as the patient’s most important social context) is a key ingredient in treatment success would seem to be amply supported by the treatment outcome literature.

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As these reviews also highlight, family treatment research has had yet another potentially important influence, that of expanding significantly the criteria sets being used to define treatment success in the addictions field. Instead of a focus on cessation of alcohol or drug use as the sole criterion of success, family researchers have moved to an expanded view that includes the substance user’s interpersonal relationships and social functioning, a reflection of a more multidimensional definition of substance abuse/misuse. Thus treatment evaluation studies such as those of Fals-Stewart and O’Farrell (Fals-Stewart et al., 1999; O’Farrell and Fals-Stewart, 2003), or of McCrady and colleagues (McCrady et al., 1991, 1999) have incorporated measures of dyadic adjustment, work functioning and harm reduction. Often these measures have included separate assessments of relationship functioning of spouses or partners (or parental functioning if the study is about adolescent drug users), which in combination have provided a far richer picture of the impact of treatment programmes on family life.

At the same time, the treatment outcome reviews cited above also alert us that what are being lumped together under the term ‘family interventions’ are in fact a wide array of approaches, many of which continue to focus primarily on the substance-abusing family member. Thus although many models advocate involving family members in treatment and recovery, it is not necessarily the case that the welfare and psychosocial functioning of these family members are being given equal weight in assessing the effectiveness of the treatment approach. Nor is it the case that the majority of these treatment approaches rely on systemic views of the family as the basis for their intervention. Instead, the vast majority of treatment approaches in the substance abuse field continue to be built around the user as the target of therapy, with families often only included after individual treatment targeted at detoxification and restabilization of the abuser has been achieved. Even then, in many programmes families are seen as adjunctive to the abusers treatment, with rehabilitation taking primacy.

Yet if the addictions field is to take seriously the wealth of data about the impact of chronic substance misuse on family life, not only should researchers expand their criteria of post-treatment success to include the welfare of all family members, but clinicians should also expand the scope of their clinical interventions to take advantage of approaches and techniques developed by family therapists to successfully assist families with other chronic conditions comparable to Systemic-motivational therapy.
substance abuse disorders. Paramount here is the use of psychoeducational and narrative therapy approaches to help families coping with both chronic psychiatric and medical conditions (Dixon et al., 2000; Freedman and Combs, 1996; Goldstein and Miklowitz, 1995; McFarlane et al., 2003; Sheinberg and Fraenkel, 2001; Steinglass, 1998).

This divide between the family therapy and addiction treatment fields is an unfortunate one, not only owing to the dramatic impact of substance abuse disorders on family life, but also because many of the more exciting approaches to substance misuse treatment incorporate techniques that bear striking resemblances to techniques that have been used with equal success by family therapists. In particular, some of the ideas central to the treatment approach called motivational interviewing (MI) – for example, the adoption of a non-pathologizing therapeutic stance; the importance of therapist neutrality; the focus on therapist transparency; the development of interviewing techniques to get at underlying beliefs about the function of behaviours like substance misuse; and the critical importance of ambivalence in understanding resistance to change – are entirely analogous to core constructs in family therapy approaches like narrative therapy.

MI has gained immense popularity as a substance abuse treatment approach in both the USA and the UK. However, to date it has been primarily viewed as an approach applicable for work with individuals. But a compelling case can be made that it should be equally effective if applied to families. This contention has already been amply supported by the data comparing the effectiveness of programmes like CRAFT, which uses MI principles to teach non-confrontational techniques and positive reinforcement towards the goal of increasing the substance abuser’s motivation for treatment (Smith and Meyers, 2004).1

To summarize, if one was to combine the various findings and conclusions from the above trends in the literature on families and substance misuse, the following major assertions seem warranted:

- The negative impact of drug and/or alcohol abuse falls equally on all family members, although perhaps in different domains of life.

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1 A randomized trial of the CRAFT approach, which compared it to Al-Anon facilitation and Johnson Institute family interventions, clearly demonstrated its superiority in effectively engaging substance abusers in treatment (64 per cent for CRAFT; 13 per cent for Al-Anon; 30 per cent for Johnson Interventions) (Meyers et al., 1999).
• Active involvement of families in both the engagement and treatment phases of therapy improves outcomes.
• Although the well-being of non-abusing family members is increasingly being taken into account in the assessment of treatment outcomes, the vast majority of treatment approaches target the user’s behaviour and focus on substance use reduction or abstinence as the primary outcome variable.
• Family therapy remains at best an adjunctive component of most substance abuse treatment programmes.
• Even among family therapy approaches, treatment models based on family systems concepts are very much in the minority, with behavioural couple and family therapy being far more prominent (including as the treatment of primary interest in the vast preponderance of randomized clinical trials in this area).
• Motivational interviewing, an approach that has had great success when applied to substance-abusing individuals, has yet to be fully integrated with a family systems approach to substance abuse treatment.

This latter point, the potential value of a treatment approach that emphasizes the overlaps and similarities between concepts and techniques used by family systems therapists and those drawn from motivational interviewing, has been one of the major interests of mine and my colleagues at the Ackerman Institute’s Center for Substance Abuse and the Family. The resulting treatment approach, which we are calling systemic-motivational therapy (SMT), has been explicitly designed for work with families who have become organized around the substance misuse of one of their members, but, with modifications, may be thought of as a helpful approach for any family coping with a chronic psychiatric or medical condition. The primary focus of this article will be an overview of the background and core tenets of this model.

Background for the SMT model: a relational approach to treatment

Historically, the systemic-motivational therapy model may be thought of as having developed in four distinct phases: (1) the design and implementation of a series of empirical studies of families self-identified as struggling with chronic alcoholism; (2) the construction
of a family systems model of substance abuse based on findings from these studies; (3) the explication and pilot testing of a treatment approach based on the family systems model; and (4) the incorporation of key components of motivational interviewing into a revised treatment protocol.

The single most important element that has been at the core of each of these four phases has been a focus on family relationships, a focus that has provided the underpinning both for the proposed conceptual model of substance abuse and the family, and for the evolving approach to treatment. This ‘relational view’ includes not only an appreciation of the interrelationships of family members one with another, but also their complicated and often ambivalent relationships with substance use.

Similarly, this focus on a relational view has also been central to the therapy approaches evolving from the family systems model of substance abuse. Most important here is the stance the therapist takes in interacting with the family – a stance that is best described as that of a clinician-researcher who (1) collects data from the family about how substance misuse intersects with family life, (2) explores with the family its beliefs about why substance use has become so central in its life, and (3) identifies potential resources within the family that might be constructively applied to a better resolution of the substance abuse problem.

Conceptualizing the therapist as a clinician-researcher has been a natural outgrowth of the importance our initial observational research studies had in shaping our approach to treatment. These studies, carried out in the 1970s, collected data from families with alcoholic members during periods of time when alcohol was being consumed as well during periods of sobriety (Steinglass et al., 1977; Steinglass, 1981). As a result, we were able to directly observe and record differences in interactional behaviour dependent on the presence or absence of alcohol. In combination, the observational data brought home how profoundly different the behaviour of all family members was tied to the presence/absence of alcohol, and led to hypotheses about the potential role alcohol-related interactional behaviour might be playing in family problem-solving strategies (Steinglass, 1980).

The therapeutic implications of these studies were twofold: first, it made clear that therapists needed to understand the role that drug-related interactional behaviour plays in family life as a preliminary to instituting a treatment programme to detoxify the drug-abusing family member; and second, that the same observational methods
that had been designed for our research studies might, with mod-
ifications, become effective tools for assessment of family behaviour in
a treatment setting. Further, having the therapist use a questioning
stance similar to the neutral stance a researcher might take in
collecting observational data would facilitate getting at an under-
standing of the intricacies of the interrelationships between drug use/
abuse and family life that might otherwise remain hidden.

Also critical to the evolving treatment approach was that it was the
family as a whole that was being targeted as the primary focus of interest
and intervention. Thus it is the uncovering of family-level beliefs about
substance use and its concomitants that becomes the main focus for
therapeutic inquiry. Concomitantly, it is the family as a group that will
be mobilized to develop ideas about how to actively address the
substance abuse issue. This is not to say that the substance abuser is
being ignored, but rather that he or she is first and foremost being
evaluated within the context of the family.

Toward the above therapeutic goals, the therapist enters into a
partnership with the family to explore the pros and cons not only of
different approaches to challenging substance misuse within the
family, but also the pros and cons of moving beyond substance misuse
as a major theme around which family life is being organized. This
partnership is characterized by a non-pathologizing, non-judgemen-
tal therapeutic stance in which the family (rather than the therapist) is
seen as the true expert regarding its own life experiences, successes
and challenges. Furthermore, the assumption on the part of the
therapist is that families have been behaving in ways that make sense
to them, even if at times their behaviour may seem baffling to
outsiders. Thus the therapist’s role is one of facilitating the family’s
accessing this inherent ‘expertise’ and applying it to new approaches
to disentangling itself from long-standing dilemmas (like chronic
substance abuse problems).

The questioning style is therefore one of genuine curiosity about the
ideas family members have about why alcohol and/or drugs have
become so central in the life of the family. These ideas (essentially
‘hypotheses’ about the causes of both the onset and seeming intract-
ability of substance misuse in their particular family) can then be
tested (challenged) via developing with the family quasi-experiments
to see if their ideas hold up to empirical testing. In addition, as part of
the ‘design’ of these mini-experiments, the family would also be urged
to specify what outcome criteria they would use to see if the ‘change
experiment’ is actually producing the hypothesized effects.

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The emphasis being placed on therapist stance in the SMT model is consonant with replicated findings about the key role therapist characteristics play as a determinant of treatment success (e.g., Luborsky et al., 1997). In the substance abuse treatment literature, investigators have pointed to such therapist characteristics as warmth, support, active listening, patient empowerment and so on as important factors associated with positive treatment outcome (Miller and Hester, 1980), characteristics that have been encompassed in the term ‘empathy’. In our model, therapist empathy takes the form of a collaborative relationship with the family, with the therapist taking on the role of clinician-researcher guiding the family in an exploration of its beliefs about the factors contributing to its substance abuse problem, its efforts to cope with this problem, and its ability to generate new ideas about how to resolve the negative impacts of substance misuse on abusing and non-abusing family members alike.

**Version 1 of the treatment model: a family systems approach**

The initial version of our family systems treatment model for substance abuse (Steinglass et al., 1987) was built around the four familiar components of: (1) assessment; (2) detoxification; (3) relapse prevention; and (4) rehabilitation (see Table 1). The difference here, however, was that each component was addressed at the whole family rather than the alcoholic individual alone. For example, the assessment phase was built around a series of conjoint family interviews directed at obtaining the perspectives of all family members about the history of substance use/misuse and its impact on individuals and relationships within the family. The underlying premise was that attempts to detoxify the substance-abusing family member(s) without first understanding the complex ways in which drug-related behaviour had become incorporated into family life might paradoxically lead to destabilization rather than improvement of family life.

The greatest departure from traditional treatment models for substance abuse was the model’s approach to detoxification. Consonant with the family system paradigm underlying our treatment model, the proposal was that when it came to detoxification, it was the entire family (as a behavioural system organized around substance use abuse) which needed to be detoxified. That is, the primary goal was not only cessation of drinking on the part of the substance-abusing patient, but the establishment of a drug-free family environment as well. This drug-free environment was to be accomplished through the

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negotiation of a *family-level* detoxification contract, a negotiation that asked for contributions and endorsement from all family members.

The details of the components of the family-level detoxification contract have been described elsewhere (Steinglass, 1999). Suffice it to say that it entailed the integration of six different components: (1) the development of a written contract conjointly constructed by the family and the therapist; (2) the use of a core set of metaphors around which the detoxification contract is framed; (3) a multi-stage strategy for implementing the scope of detoxification; (4) the use of public disclosure to reinforce the meaning and importance of the detoxification contract; (5) the use of a prospective, anticipatory stance to identify potential challenges to abstinence; and (6) ample rehearsal of strategies to effectively meet these potential challenges to abstinence.

By asking the whole family to work together on framing the contract and by establishing as the treatment goal the metaphor of a drug-free family environment, the therapist is automatically reframing the entire substance abuse issue in family rather than individual terms. It is in this way that family-level detoxification differs from other contracting approaches that have been used successfully by behaviourally oriented family therapists in treating substance abuse (Keane *et al*., 1984; O’Farrell and Bayoq, 1986; O’Farrell *et al*., 1995).

In its original conceptualization, family-level detoxification had as its goal the *actual* removal of substances from the family system. Thus the contract that was negotiated with the family typically included: (1)
abstinence on the part of the identified abuser(s); (2) making the family’s home drug-free; and (3) negotiating with all family members that they would not use alcohol and/or drugs at family events (whether inside or outside the home). However, in practice as many families struggled with directly implementing a detoxification contract as embraced it. The clinical experience was that for many families, their ‘public’ endorsement of the contract was not matched by subsequent follow-through (that is, behavioural endorsement).

Put another way, internal motivation for change seemingly lagged behind verbal endorsement of change. Thus it seemed critical to the success of our treatment model that we both reconceptualize how we approached detoxification contracting and at the same time consider additional ways of addressing motivation for change at a family level. One promising avenue for addressing this second issue – that of increasing family-level motivation for change – was to incorporate aspects of a highly successful individual-level treatment approach to substance abuse – motivational interviewing – into our family-focused treatment model.

**Version 2 of the treatment model: combining family systems and motivational interviewing approaches**

Most addiction professionals are by now familiar with motivational interviewing (MI), an approach developed in the 1980s as a response to a set of empirical findings about the relative ineffectiveness of existing confrontational techniques then in widespread use in the addictions field in the USA (Miller and Rollnick, 2002). Based on the core tenets of Rogerian psychology and the transtheoretical model of change (TTM) of Prochaska and DiClemente (1984), and heavily focused on therapist behaviour as critical to its success, MI has also been closely associated with the newer ideas of addictions treatment encompassed in harm reduction and relapse prevention approaches to therapy (Marlatt, 1998; Marlatt and Gordon, 1985; Marlatt and Tapert, 1993).

Although the transtheoretical model has come under serious challenge recently (West, 2005), the manualized treatment model based on the core techniques of MI – motivational-enhancement therapy (MET) (Miller et al., 1992) – has been widely tested in randomized clinical trials with largely positive results. However, thus far virtually all of these trials have targeted individual substance abusers. Thus the treatment effectiveness of MI techniques when applied to couples or families remains largely untested (except, as
mentioned earlier, as an approach for helping spouses and children increase an abuser’s motivation for treatment (Landau et al., 2000; Meyers et al., 1999)). Hence combining family systems and MI concepts as the framework for an integrated treatment approach to substance abuse problems remains largely virgin territory.

How might such an integration look? Core to the MI approach are five basic principles critical in shaping therapist behaviour: (1) expressing empathy about the patient’s condition; (2) developing discrepancies regarding the patient’s beliefs about his or her behaviour; (3) avoiding arguments about continued substance use; (4) rolling with resistance to change; and (5) supporting patient self-efficacy regarding decisions about behaviour change, all of which are entirely compatible with techniques used by most family therapists.

But also critical to the MI substance abuse treatment approach is the need for the therapist to recognize and acknowledge the underlying ambivalence most abusers have about changing their behaviour, an ambivalence that is thought to stem from two different sources: the abuser’s reluctance to give up what are presumed to be positive aspects of substance use, and his or her doubts about whether change is in fact possible. A family systems perspective adds another important element to this formula: that ambivalence about change is felt not only by the abuser, but also by the family as a whole. Furthermore, this family-level ambivalence, it is postulated, is characteristically reinforced by underlying beliefs that behaviours tied to alcohol or drugs are necessary components of the family’s management of key problems in its life.

Thus for the family the issue may not be so much ‘can I [the abuser] stop using’ – the MET concept – but rather, ‘if we change, will we no longer have access to behaviours that have helped us manage/solve/neutralize important problems in our lives?’ In other words, a family belief system about possible adaptive consequences of substance use in turn contributes to ambivalence about challenging and changing the role of substance use/abuse in family life. For the outsider (therapist), however, this family-level belief is very much open to challenge. That is, an underlying belief that altering patterns of substance use would inevitably also compromise family functioning is exactly the type of belief that a therapist might want to explore further with a family. When done in a respectful and neutral way, it becomes the family therapist’s equivalent of similar techniques employed in MI to raise doubts in a person’s mind about a belief that he or she is incapable of stopping or reducing alcohol use.
The above example is but one of many that would seem to support a contention that a merging of family systems and motivational interviewing techniques would have exciting possibilities for the substance abuse treatment field. Our current version of exactly such a systemic-motivational approach envisions treatment proceeding through three distinct phases:

1. An assessment/consultation phase which focuses on helping family members examine their current views about alcohol/drug use and abuse, and preparing the family for possible changes vis-à-vis substance use.
2. A family-level treatment phase in which the family develops and implements an action plan centred around altering the ways in which alcohol and drugs are used and abused.
3. An aftercare and relapse prevention phase in which the family institutes substance-free routines and rituals and makes decisions about the extent to which the family will involve itself in recovery/rehabilitation programmes.

A brief summary of the three phases of the SMT model follows (see Table 2 for an overview contrasting SMT to a traditional treatment approach for substance abuse disorders). Note that although each of the phases is still framed by concepts derived from our earlier family systems treatment model (Steinglass et al., 1987), it also places considerable weight on two important principles central to the motivational enhancement treatment approach – a thorough exploration of the pros and cons of continuing alcohol/drug use (ambivalence about change), and the neutrality taken by the therapist about continued substance use (the incorporation of harm reduction as a viable treatment goal). (Table 3 summarizes the key components of therapist behaviour/stance in the SMT approach.)

The assessment/consultation phase

The assessment phase is carried out via a series of conjoint family interviews (including the substance-abusing family member) in which the therapist positions him or herself as a consultant to the family, and early on focuses attention not only on family concerns, but also on family resources and examples of successful family management of prior problems. During these interviews, the therapist starts with the usual review of issues that brought the family to treatment – issues that may or may not initially include alcohol and/or drug abuse.
Assuming, however, that the focus will eventually move to concerns about substance use, the interviewing process is designed to reframe the ‘problem’ as a family-level issue by questioning the family about its prior history vis-à-vis drug use-misuse and exploration of the role of drug use in family life. Emphasis is placed on family-level belief systems about alcohol and drug use, and on encouraging the family to explore the pros and cons both of continuing this use and of eliminating it from family life. Further, because questions are being

TABLE 2 A comparison of the phases of treatment for SMT vs. traditional treatment

<table>
<thead>
<tr>
<th>Phases of addiction treatment</th>
<th>TRADITIONAL</th>
<th>SYSTEMIC-MOTIVATIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Assessment</td>
<td>• Bio/psycho/social assessment and history</td>
<td>• Consultation – getting ready for change</td>
</tr>
<tr>
<td></td>
<td>• Treatment planning</td>
<td>• Problem definition and acceptance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Resolution of at least 51 per cent of ambivalence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Confident enough to believe that change will be possible</td>
</tr>
<tr>
<td>II Primary treatment</td>
<td>• Detoxification</td>
<td>II Treatment-taking action</td>
</tr>
<tr>
<td></td>
<td>• Rehabilitation</td>
<td>• Develop plan</td>
</tr>
<tr>
<td></td>
<td>• Psychoeducation</td>
<td>• Build external structure</td>
</tr>
<tr>
<td></td>
<td>• Behaviour change</td>
<td>• Implement plan</td>
</tr>
<tr>
<td>III Aftercare</td>
<td>• Relapse prevention</td>
<td>III Aftercare – maintain change</td>
</tr>
<tr>
<td></td>
<td>• Self-help groups</td>
<td>• Build new infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop new strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Learn how to re-enter cycle</td>
</tr>
</tbody>
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TABLE 3 Components of the stance employed by a therapist when using systemic-motivational therapy

- Ambivalence about alcohol/drug use (and change) is normal
- Ambivalence can be resolved by working with the family’s intrinsic motivations and values
- The alliance between the clinician and the family is a collaborative partnership to which each brings important expertise
- An empathic, supportive, counselling style expressed through reflective listening provides conditions under which change can occur
- Curiosity about the unique benefits/risks of alcohol/drug use on the user and the family is essential, and leads to exploration of the user and family’s experience with addiction

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asked of all family members, it is far more likely that the therapist will be able to uncover and highlight discrepancies between beliefs and behaviour, a critical step in setting the stage for behaviour change.

Here are three examples of the types of responses typically voiced during initial assessment interviews in response to therapist queries about substance use, responses we would view as reflecting underlying beliefs either about why drugs are being used/abused (essentially a belief about etiology) or of the potential positive consequences of drug use (a belief about the pros of continuing substance use for family life):

- ‘When I drink, it helps me to chill out and I don’t feel so burdened by my problems.’
- ‘When he uses cocaine, he’s much more accessible so I don’t mind his using it.’
- ‘My neurons made me do it!’

Because the assessment process is from the start carried out via conjoint family interviews in which all family members contribute data and ideas, it is possible not only to generate a rich tableau of the role of alcohol/drug use in family life, but also to help the family see in what ways this use has inserted itself into its life. The goal here is to develop a picture of the extent to which family life has become altered and reorganized to accommodate substance use, and by extension to better understand the potential implications for the family of altering substance use behaviours. And because all family members are included in the discussion, inevitably the focus tends to move away from the substance-abusing family member as the sole source of family problems.

The family-level treatment phase

This phase parallels comparable phases in traditional treatment models in that its primary task is to generate and implement an action plan for change. Where it differs is that the action plan is both devised and implemented by the family as a group, working in consort. Consonant with the therapist acting as clinician-researcher, she or he describes this phase as one in which the family and therapist will collaboratively devise an ‘experiment’ designed to test the ‘hypotheses’ (beliefs) about the relationship between substance use and family life articulated by family members during the assessment phase.
The ‘default’ action plan (experiment) remains the family-level detoxification contract previously described as a core element of our earlier treatment model. However, because families are often reluctant to embrace detoxification as their initial action step, in such instances families are encouraged to generate a broader list of change options. The pros and cons of each of these options would then be thoroughly discussed. Consonant with a harm reduction approach, anticipating possible problems in implementing which ever action plan is selected would also be part of these discussions, as would ways of enlisting support from extended family and friendship networks in implementing the plan (Galanter, 1999).

Because the potential list of options generated by family members is often substantial, the therapist also helps the family identify a set of ‘outcome measures’ that could be used to evaluate whether a particular action plan is in fact working. In that the action plan is being envisioned as a ‘change experiment’, evaluating its potential effectiveness requires clearly articulated outcome criteria, a process that further reinforces the message that change is being targeted at the whole family, not simply at the abuser’s alcohol and/or drug use. Thus from start to finish, the treatment (change) phase of therapy evolves within the central metaphor of treatment as collaborative therapist/abuser/family research.

In our experience, this second phase of treatment is highly variable in course. Sometimes the very first action plan the family implements brings about significant change in substance use behaviour (this is especially true when the family buys into implementing a family-level detoxification contract as its initial ‘action plan’). At other times the route is more circuitous, with the family undergoing a series of trial-and-error efforts before they develop a strategy that brings about the desired outcomes. However, which ever pattern the family takes, it remains critically important that the therapist should not break technique in the face of seeming resistance to change, but rely instead on MI techniques like ‘rolling with the resistance’, this time applied to the family as a whole.

The aftercare and relapse prevention phase

As with all relapse prevention approaches, the main goal of this phase of the systemic-motivational treatment model is to maintain the changes that have occurred as a result of a successful action plan. Many treatment models have components designed to engage
families as part of aftercare and relapse prevention (McCrady et al., 1991, 2004; O’Farrell et al., 1998). At the same time, it is also the case that integrating traditional recovery approaches (especially twelve-step programmes) with family systems approaches has proven challenging. In part this is because traditional recovery programmes typically establish separate tracks for alcoholic and non-alcoholic family members (e.g. AA and Al-Anon). In part it may be attributable to the hostility to the harm-reduction approach expressed by many in the recovery community. Nevertheless, it is clearly important that better bridges be built between family systems and traditional recovery approaches.

The SMT model therefore approaches the aftercare phase as one in which families not only have to evaluate the role of traditional recovery programmes in their lives, but also to carry on conversations about the extent to which they want to emphasize containment of the threat of substance abuse relapse versus emphasizing non-alcohol-related issues in their lives. In the better of all possible worlds, both would be possible. But more often decisions have to be made about how to allocate limited family resources (time and money being the most important ones here). How to handle family conflicts and the normal hassles of daily living without potentially disrupting the recovery process is another issue often brought up by families for discussion during this phase of treatment.

It is our working assumption that if a family has successfully implemented an action plan (Phase II) entailing either actual family-level detoxification or an alteration in family belief systems about substance use/abuse, then the family now finds itself in unfamiliar territory. But new behaviour patterns are not necessarily yet in place. Nor are altered family priorities and future values firmly established. Thus the role of the therapist during this time is usually one of establishing a holding environment for the family members, giving them time to experiment together and evaluate which paths they want to follow in support of aftercare and relapse prevention.

Conclusion

The treatment model described above is built on the premise that when substance misuse behaviour is ongoing within a family, all members of the family are powerfully affected by this behaviour, and that it is therefore the whole family, rather than the abuser alone, that is the appropriate target for treatment. Further, the model
postulates at least the following three components as critical to the treatment approach:

- A therapeutic stance that emphasizes *therapist neutrality*, the use of *non-pathologizing language* with patients and families, and *family–therapist collaboration* (rather than a hierarchical approach in which the therapist takes the position of ‘expert’ and unilaterally defines the treatment goals for the family).
- A conviction that central to the success of treatment is the ability to ascertain both *individual and family-level beliefs* about the role of alcohol use in family life.
- A conviction that therapy, to be effective, must include a credible *action plan* for addressing the drinking behaviour itself that is *embraced by the entire family*.

I have argued that each of the above components parallels similar concepts that are central to ideas put forward in motivational interviewing. It is for this reason that an approach to substance abuse treatment that combines family systems and MI concepts has been so appealing. In addition, by drawing on these parallels, one can develop a treatment model that also potentially bridges the divide currently separating the worlds of family therapy and substance abuse treatment. That is, the potential synergy encompassed in family systems ideas and MI also means that both family therapists and addiction specialists can see their core ideas represented in the type of systemic-motivational approach to substance abuse treatment outlined in this article.

The efficacy of the SMT model has yet to be systematically tested. However, because it is firmly grounded both in empirical research findings about the relationship between substance abuse and family life, adopts a set of assessment techniques based on methods used in these prior studies, and draws heavily on therapeutic techniques (MI) of proven value in working with substance-abusing individuals, I would contend that the face validity of the SMT model is extremely strong.

Further, because the treatment model has been designed as if it is analogous to an empirical research inquiry, with the therapist viewed as a clinician-researcher, with treatment interventions conceptualized as mini-experiments, and with both behavioural alterations and outcome measures clearly identified, SMT is an approach that should be
readily manualizable and hence subject to objective evaluation in randomized outcome trials.

References


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