Counseling for the Family: The Neglected Aspect of Addiction Treatment in Canada

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ABSTRACT. There has been a historic neglect of both research and practice in the area of counselling for the family members of alcohol or other drug abusers by the addiction field in Canada. As a result, treatment for individual family members affected by alcoholism and other drug addiction remains a neglected component of the majority of Canadian addiction programs. When family involvement is incorporated, the tendency has been to concentrate on orientation and education rather than on the provision of counseling for the family members. This dearth of programming exists despite the knowledge that an active alcohol or drug abuser's behaviour disrupts the entire family system, including the functioning and development of children. Each family member is uniquely affected with negative outcomes ranging from economic hardship to violence being perpetrated against them to an increased risk among children of becoming alcohol or drug abusers themselves. Thus, treating only the active alcohol or other drug abuser is limiting and an overly narrow orientation for the enhancement of both family and community health.

KEYWORDS. Family treatment, substance abuse, research, Canada

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INTRODUCTION

Counselling individuals with alcohol and other drug related problems is a relatively new phenomenon, with a contemporary history dating back only to 1935. The term alcoholic, itself, did not enter our vocabulary until introduced by Swedish public-health physician Magnus Huss in 1849 (Csiernik, 1999). Since that time alcohol and drug abuse intervention has placed the individual at the centre of treatment and has purposefully isolated the substance user from his or her family unit. Families, when considered at all, have at best been viewed as secondary systems (French 1987; Kaufman and Kaufmann, 1979; Nichols and Schwartz, 1995; Steinglass, 1992).

Alcoholism and other substance dependency have a powerful effect on family relations and have become recognized as a significant family stressor. By the time most substance abusers are referred to treatment, their drug use has touched not only themselves but also their entire social and family structure. Thus, one individual's behaviour and addiction can impact on his or her partner, the couple's children and even the user's parents and siblings (Campbell, Masters and Johnson, 1998; Cowley and Gordon, 1995; Fleming et al., 1998; Hall, Henggeler, Ferreira and East, 1992; O'Farrell, 1991; Usher, 1992). This should not be a surprise as the family is still the primary biological, economic, social, legal and historical unit of our society. The family provides us with four cornerstones of living; our initial self worth, how to communicate, the rules of living, and our links with society. Research indicates that each user seriously influences the lives of from four to six other people (Abbott, 2000). Grant's (2000) recent study indicated that one in four children in the United States lives in a family that has a history of alcohol abuse and is exposed to direct negative consequences ranging from economic hardship to violence to a greater propensity to abuse alcohol or other drugs themselves.

Not only are children of alcoholics at greater risk for alcoholism and other drug abuse than children of a non-alcohol abusing parent, but they also consistently score lower in tests of cognitive verbal abilities. This attribute is correlated with impeded school performance, poorer peer relationships, and the inability to develop and sustain intimate relationships including having lower levels of trust. Simply put, children raised in families where at least one parent is a substance abuser have substantially different life experiences than do their peers (Friedman and Utada, 1992; Jones and Carlson, 1992; NCADI, 1994; Nurco and Lerner, 1996). In August of 1994, the Canadian magazine Maclean's ran a special report

on adolescent murderers in Canada. Each one of the children profiled either came from a nuclear family where one of the parents had an addiction or they themselves had a chemical dependency (Kahila, Wood and DeMont, 1994). Difficulties within a marriage and a family may lead to an increase in alcohol or other psychoactive drug addiction. Abusive use of substances may in turn lead to separation and divorce and is strongly correlated with violence in the family (Corneal et al., 1995).

Once drug problems have developed and become incorporated into a family's functioning the nature of family homeostasis can actually work to maintain the dysfunctional behaviour. Thus, if the individual seeks treatment and is successful and the substance abuse ceases, everyone within the nuclear family and often members of the extended family may become vulnerable to the unbalanced family system. This disequilibrium, created by the positive act of treatment and rehabilitation, can make the family seem and feel dysfunctional because they no longer know how to act or behave with the newly sober or straight person as part of their system. One simple method, and often the easiest method to remove this family uneasiness, is for the family to attempt to return to the previous homeostatic state. This return to the status quo entails sabotaging treatment and the ongoing recovery process. Thus, in applying a family systems model one is forced to recognise and acknowledge that problems both influence and are influenced by the family.

THE FAMILY AND ADDICTION PROGRAMMING

On the micro level of addiction treatment there are three potential targets. The primary target remains, and needs to remain, the individual with the substance abuse problem. The second level of intervention is the substance abuser as located within his or her family unit. However, it is also feasible, valuable and necessary to work with individual non-abusing members of the family unit just as we intervene with individual substance abusers. The addiction field has become quite adept at working with substance abusers. This same approach and expertise has not, however, been used extensively in Canada with individual members of the family unit whose lives have been directly and indirectly altered by the abuse of psychoactive drugs and the accompanying behaviours.

Work with the family moves us away from a therapeutic model focused exclusively upon individual pathology and places emphasis on

the family as the unit of treatment. It also acknowledges the need for concurrent individual intervention with family members. Family work in addictions varies in intensity depending upon the mandate of the treatment program. The four primary approaches are:

1. Family Orientation–this entails informing family members about the rehabilitation program upon which the identified client is embarking. It is used to enlist family support in the client's treatment.
2. Family Education–this approach is used to inform family members about family relation issues, and how they may be relevant to substance abuse and the substance abuser.
3. Family Counselling–this is employed to bring about the resolution of problems identified by family members as related to the substance abuser.
4. Family Therapy–this method is employed to bring about significant and permanent changes to intractable areas of systemic family dysfunction as it relates to the abuse of substances by a family member (Boudreau, 1997).

Family treatment has a variety of interpretations, though in general it emphasizes the process of communication and interaction within the family rather than focusing exclusively upon the substance abuser. Family treatment typically evolves around the following interactional issues:

- all couples and families have problems, but substance abuse prevents resolution of these problems and creates new and more complex problems;
- no individual can force another to change;
- personal change comes through accepting responsibility for one's own behaviour;
- all members of the family are involved in the problem, and all have responsibility in finding some form of resolution; and,
- removal of substances from the family system represents a necessary beginning in the recovery process, yet is incomplete in itself.

Working with families, therefore, entails treating the context of the problem along with the actual problem. Family intervention is by no means a straight forward activity. There are a variety of competing methods all with valid theoretical foundations. The most significant approaches historically have been: structural, behaviourial, multigenerational and strategic (Bloom, 1991; Boudreau, 1997; Bowen, 1991; Goldenberg and

Goldenberg, 1980). The commonality, regardless of which approach is employed, is that the family is treated as a unit and the substance abuser is not viewed in isolation. However, if the substance abuser chooses not to enter treatment or is unable to complete a rehabilitation program, it remains appropriate and prudent to provide assistance to the other members of the family.

MUTUAL AID/SELF-HELP INITIATIVES

The most prominent mutual aid/self-help initiative in the addiction field derives from the twelve steps that were conceived by the early members of Alcoholics Anonymous sixty years ago (Alcoholics Anonymous, 1997). The importance of twelve step programs to addiction counselling has been recently documented in detail (Csiernik, 2000). Many of the principles adapted from twelve step programs align with the principles of a family systems approach including helping family members differentiate from each other and breaking out of dysfunctional patterns (Nichols and Schwartz, 1995). Family systems work also places importance on psycho-educational activity as does twelve-step programming (Steinglass, 1992).

Unfortunately, there has been minimal research conducted as to the value of ALANON, a twelve step mutual aid program created to assist those living with an alcohol abuser, or any of the programs related to it such as Alateen, Adult Children of Alcoholics (AcoA), and Naranon. However, the little that has been published has been supportive of this form of self-help activity. Friedemann (1996) compared the family functioning of 39 family members who participated in Al-Anon, while their partner received treatment, to the family functioning of a group of 21 controls. The control group all had their partner enrolled in an inpatient program, and thus receiving rehabilitation services, however, the family members received no formal or informal support. One month after treatment was completed family members attending Al-Anon had a higher rating of family effectiveness than did members of the control group. Three months after treatment was completed 39% of subjects who had a family member attending Al-Anon had relapsed compared with 61% of those in the control group. Involvement with Al-Anon has been shown to enhance social support (Harmon et al., 1990) and coping skills (Rychtarik et al., 1988).

In addition, addiction treatment has borrowed from family counselling in another significant manner. The typology of Adult Children of Alcoholics proposed by Wegscheider-Cruse in 1985 of hero, scapegoat,

lost child and mascot was adopted from the ideas of family roles earlier proposed by the social worker and family therapist, Virginia Satir (1972).

RESEARCH FINDINGS

While relatively new, the idea of working with families in addictions has some substantive empirical support. The scientific literature, however, focuses on how the family can support the substance abuser. A review of Psychinfo and Sociological Abstracts found less than a dozen pertinent research studies published over the past 15 years. Of these, many focused on how enhanced family functioning assisted alcoholics or drug addicts with their treatment programs and recovery rather than on the needs of the family itself, or of individual family members. Little formal research has been conducted on what are needs of non-alcohol or drug abusing family members either in conjunction with or independent of the treatment of the substance abusers (Lawson and Lawson, 1991). Stanton and Todd (1982) published a landmark article on the value of family counselling with heroin addicts nearly twenty years ago. They demonstrated, in a controlled experiment, how family counselling led to marked improvement over non-family treatments on several drug related outcome measures both at the termination of treatment and at subsequent follow-up intervals. The significance of this study is the fact that heroin abusers are among the most chronic relapsers and yet family involvement was able to make a significant impact on lapsing and relapsing events, as well as on overall family functioning.

Family counselling was also demonstrated to be an effective mechanism in dealing with adolescent drug users by Lewis, Piercy, Sprenkle and Trepper in 1990 and by Joanning, Quinn, Thomas and Mullen in 1992. Pidock and Fischer (1998) in a study of 928 university students found that students with parents in recovery from addiction had less problematic addictive behaviours than those students without parental recovery. This included less alcohol and drug use and dependency and fewer eating disorders.

In 1980, Finney, Mews and Mewborn postulated that not only do family members have a negative involvement in the maintenance of alcohol abusing behaviour they can also have a highly positive effect on the maintenance of sobriety. Twelve years later Horberg and Schlesinger (1992) presented their model that highlighted the importance of strengthening the family members before being able to actively con-

front the addiction. Unfortunately, much of the research in this area remains preliminary and exploratory in nature. Nichols and Schwartz (1995) hypothesized that the lack of extensive funding for research in this area may be a result of the entrenched nature of traditional addiction programming and its primary focus upon the individual rather than upon the family. This has led to the field ignoring the needs of individual family members for the sake of concentrating limited treatment resources on the substance abuser.

It was Edwards and Steinglass (1995), however, who best summarized the existing accumulated work in this area with their meta-analysis of 21 studies of family-involved treatment for alcoholism. Their review divided the studies into three distinct phases of treatment: initiation, primary treatment, and aftercare. Their analysis concluded that family counselling was effective in moving adults into treatment and that the family was an extremely effective mechanism for motivation. This finding brought empirical support to the long held belief by certain sectors of the addiction field that family treatment was an effective support intervention. Edwards and Steinglass further found that family treatment was actually marginally superior to individual treatment. Two prominent factors associated with successful outcomes for family treatment were investment in the relationship and perceived support from the partner for abstinence. Modest benefits beyond individual work were also discovered for family-involved relapse prevention programming in the aftercare phase of treatment. However, there were no specific studies discussed by Edwards and Steinglass that examined interventions when the family sought assistance without the substance abuser being involved in some aspect of addiction programming.

PROGRAMMING INITIATIVES

In 1995 the Canadian Department of National Defence (DND) conducted an extensive review and evaluation of their existing addiction treatment services. In their period of personnel downsizing support services also had to be transformed. DND had several dedicated addiction treatment services across Canada and had to somehow integrate them into one program. The opening paragraph of the recommendations section read:

> . . . the most judicious use of funds would be to establish a comprehensive multi-modal addiction system either through three distinct

> residential programs or the integration of services into one facility that can also continue to accommodate family members and enhance their participation in the treatment process. (Coshan and Csiernik, 1995, p. 7)

But what of counselling for individual family members? As has been illustrated, there has been little empirical work done in this area. Most of what has been done is anecdotal and falls under the heading of co-dependency studies (Mannion, 1991; Miller and Gorski, 1982; Miller, 1987; Rosellini, 1989; Whitfield, 1989). While this term has both positive and negative connotations it is a limiting construct in that it does not view the family or family members independent of the drug use or the drug user. This is particularly relevant in that the majority of family members who do seek help do so voluntarily and not under any type of pressure or coercion that often accompanies the alcohol or other drug abuser's treatment. What is fortunate, though, is that treatment for this group does not need to be elaborate or complex, it merely needs an opportunity to be delivered. Education and reframing of experiences have both been shown to work extremely well with this population (Kannel, 1999).

Despite being a neglected area in Canada, family counselling has not been as minimized in the United States where some notable programming initiatives have existed for some time. Hazelden, among the pioneers in addiction counselling in North America, provides family orientation, family education, and family counselling with an emphasis on skills building along with introduction to self-help for family members. Hazelden offers a family residential program that is typically five days in length though it can be tailored to individual family needs. The Caron Foundation, located in Pennsylvania, is another nationally recognized American facility with specific family programming. The Caron Foundation runs three day family education programs that are open not only to family members and friends of those in a Caron treatment program, but also to Adult Children of Alcoholics and those who have had a previous relationship with an alcoholic or drug addict. Since the Caron Foundation takes a disease model approach, its treatment orientation for family members is that of co-dependency and it was the first facility in the United States to offer a residential co-dependency treatment programming. As such, it assumes its clients view themselves primarily as victims of circumstances, have a difficulty with identifying and expressing emotions, fear abandonment and have difficulty asking for help. The disease conception of addiction remains a strong theme in

American treatment where, unlike Canada, many treatment facilities remain associated with or housed within medical facilities.

Canadian family programs have been slower to develop and are proportionately fewer in number than those in the United States though they tend not to be dominated by any one singular treatment orientation. One example is the St. Norbert Foundation in Manitoba, which provides residential care but does not incorporate any form of 12 step programming. The organization states that focusing extensively on the process advocated by Alcoholics Anonymous and its associated programs contradicts its treatment philosophy that addiction is caused by many factors and is not exclusively an illness or a disease. In contrast to this is the family program run by the Alberta Alcohol and Drug Abuse Commission (AADAC) as part of its Business and Industry Clinic. The four day family program is open to anyone who has a family member in an AADAC treatment program as well as being open to those who wish to receive counselling because of a family-related alcohol or other drug problem. The AADAC program is open to those 14 years of age and older and does take a medical approach to its treatment. The program consists of five distinct components:

- information sessions
- learning new skills
- involvement with Al-Anon
- group counselling, and
- provision of support.

Themes discussed in the program include family roles, dysfunctional families, enabling, rebuilding relationships, communication styles, anger and self-esteem and applying the 12 steps of Alcoholics Anonymous to one's own healing. AADAC (2000) describes the program as:

> . . . a critical element in the treatment and recovery of alcoholics and their families because alcohol and/or drug use causes problems for families as well as for the addicted individual. By participating in the Family Program, family members gain a greater understanding of addiction and how it has affected them. (page 3)

However, the limited importance of addiction treatment for family members in Canada can perhaps be best observed through examining the directory of treatment resources for the province of Ontario. As recently as 1991-1992 the Ontario Alcohol and Drug Treatment resource

directory did not offer a separate directory for family programs. Special populations that did warrant a listing were: employed problem drinkers, impaired drivers, native people, seniors, skid row, women and youth; but not families (Addiction Research Foundation, 1991). However, by 2000 there was a distinct listing for family intervention and 76 of Ontario's 230 registered addiction treatment resources reported that they provided some type of programming specifically targeted for family members. While this appears as a significant number, Table 1 illustrates the exact types of family interventions presently offered.

Nineteen (25.0%) organizations report offering individual counselling for family members as part of their mandate while another five (6.6%) do so if it is formally requested of them. Nine (11.8%) programs offer less intensive supportive counselling to individual family members. Seventeen organizations in Ontario offer education groups for family members while 16 provide actual support groups. Thus, less than 15% of the addiction treatment facilities in the province of Ontario provide professionally led group work for family members of persons with a substance abuse problem according to the registry.

Nine (11.8%) of the 76 agencies reporting family involvement merely refer family members to outside resources for family counselling while six (7.9%) identify their family intervention as linking family members with Al-Anon or other self-help groups. Among the 76 programs a few specialized initiatives do exist, though they make up a very small percentage of the total addictions programming in Ontario. There are only three residential programs for family members in the province, with a total of less than 50 available beds. The programs run for either five or six days, with all three having a co-dependency orientation. Thus, not a single non-disease model residential option for family members is available in a province with a population of 11 million persons, represents over one-third of the Canadian population. Four agencies do provide psycho-educational seminars and skills training for family members. Two other agencies take a behaviourial/systemic approach, while one runs co-joint family counselling groups with both the user and the family members meeting together on a weekly basis for group counselling.

Thus, the programming that does exist provides a mix between the historic disease concept and more contemporary, family systems initiatives. This would provide individual family members some choice and allow for some matching of client to counselling philosophy if the programs were not so geographically dispersed. While more agencies have acknowledged that some type of service should be provided to family

TABLE 1. Family Interventions Offered by Ontario Treatment Facilities

Type of Intervention	Number %	% of All Ontario Facilities
Individual Counselling to Family Members	19 (25.0%)	8.3%
Education Group	17 (22.4%)	7.4%
Support Group	16 (21.1%)	7.0%
Supportive Counselling	9 (11.8%)	3.9%
Referral to Family Counselling	9 (11.8%)	3.9%
Self-Help Group	6 (7.9%)	2.6%
Counselling Provided if Requested by Family	5 (6.6%)	2.2%
Psycho-Education and Skills Training	4 (5.3%)	1.7%
Residential Co-Dependent Programming	3 (3.9%)	1.3%
Family Therapy (Non-Specific)	3 (3.9%)	1.3%
Behaviourial/Systemic Family Counselling	2 (2.6%)	0.9%
Co-Joint Family Group Counselling	1 (1.3%)	0.4%
Training to Teach Family to Act as Client's Support Group	1 (1.3%)	0.4%

members the emphasis on this form of treatment remains marginalized with residential programming virtually non-existent.

CONCLUSION

The common definition of neglect is a lack of attention. "While many alcoholics have extensive marital and family problems and family adjustment is associated with better alcoholism treatment and outcomes at follow-up" (O'Farrell, 1995, p.195).There certainly has been a lack of attention paid to both the theory and practice of family treatment in addictions in Canada. Family treatment is not a focus of the majority of addiction treatment resources in Canada at the present time, despite an increased attention to the area. A family system orientation provides a comprehensive and meaningful approach to addressing underlying issues related to drug use. It is an integrated approach that views drug abuse and family functioning as interrelated. Family treatment, when incorporated with other counselling approaches, significantly increases the level of improvement observed at both short-term and long term follow-up intervals (Kolezon and Green, 1985; Lebell, 1986; and Thomas,

1989). The absence of family treatment in addiction treatment programs is an issue that urgently needs to be addressed. Even if an individual is not successful, or is not interested in receiving treatment, active involvement with the remaining members of the family remains possible, and in those circumstances is probably even more vital.

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