An Examination of Family-Involved Approaches to Alcoholism Treatment

James G. Chan

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James G. Chan
University of British Columbia

This article introduces the development and theoretical underpinnings of family-involved treatment for alcoholism against a backdrop of major theories of addiction. It describes several interventions from the family therapy literature in relation to Prochaska, DiClemente, and Norcross's model of change, with an emphasis on behavioral techniques. It also outlines efficacy research and considers some problems with the family approach. Although the lack of agreement regarding theory and practice may be the most salient difficulty for the field, the discussion further reveals an inconsistency between the tenets of the family systems paradigm and behaviorally-based family interventions. It suggests that the family approach should expand its scope of analysis and challenges researchers to incorporate additional techniques from diverse perspectives.

Keywords: *family therapy; alcoholism; addiction; systems theory*

This article introduces treatments for alcoholism that involve all family members, as alcohol addiction is a problem that negatively impacts families and has many far-reaching effects in contemporary society. According to a report prepared by the Schneider Institute for Health Policy (2001), alcohol and other substance abuse is the cause of more deaths, illnesses, and disabilities than any other preventable health condition, and consequently undermines family life, the economy, and public safety.

What can helping professionals do to assist families in dealing with this very serious issue? To answer this question, it is useful to consider how some traditional theories have conceptualized alcoholism, given that several authors suggest that therapists choose treatment methods based on their views of the cause of this problem (Glaser, Greenberg, & Barrett, 1978; Harris, 1990; Lawson, Peterson, & Lawson, 1983). This discussion begins by briefly outlining five major theories that take the family into account but do not make the family the most central aspect of their discourse. Steinglass (1976) noted an interesting tendency: The application of family-involved approaches to the treatment of alcoholics and their families during the 1960s and 1970s was instituted to a greater extent by practitioners in the field of alcohol treatment than by marriage and family therapists. More recently, the use of marital and family therapy with alcoholic populations has flourished to become a mandatory component in many treatment programs (Thomas, 1989).

This article reviews some of the theoretical underpinnings of family-involved treatment before it presents various interventions. It also briefly examines efficacy studies in family-involved treatment research and concludes by contemplating some of the problems and limitations of these approaches to the treatment of alcoholism. Although there may be no agreed-upon definition of alcoholism, it is defined here as the repeated use or compelling involvement with alcohol that results in long-term negative consequences that are physiologically harmful or highly disadvantageous societally (Pomerleau & Pomerleau, 1987). The terms *alcoholic*, *alcoholism*, and *addiction* are used synonymously.

REVIEW OF MAJOR THEORIES OF ADDICTION

Although the purpose of this article is not to examine all theories of addiction, it is possible to begin by noting that the phenomenon of alcoholism has historically been perceived as a condition that affected individuals; accordingly, treatment was principally applied at the individual level (Lawson et al., 1983; Thomas, 1989). For instance, psychoanalytic theory views alcoholism as the result of a person's pursuit of sensuous satisfaction, fixation at an early stage of development (e.g., oral fixation), and conflict among components of the self (i.e., ego, id, superego) (Barry, 1988). Unsatisfied with

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the postulation of inferred or unobservable variables, learning theorists contend that alcoholism and its related behaviors can be understood as being the products of reinforcement (Lipps, 1999). One of the most popular theories of alcoholism (and addiction in general) has been termed the *disease model* (Alexander & Schweighofer, 1988; Glaser, Greenberg, & Barrett, 1978). From this perspective, alcoholism is conceived of as a progressive and predictable disease that is characterized by features such as a genetic predisposition and the loss of control over the consumption of alcohol.

Over time, a fundamental transformation took place whereby the focus on the individual (referred to as the "identified patient") continued, but the family began to be seen as either being the cause of alcoholism or being involved in its maintenance (Thomas, 1989). This view of the individual as influenced by his or her family and larger context is implicit in sociological theory, which stresses the importance of cultural attitudes, suggesting that alcohol is sometimes used in families as a rite of passage (Lawson et al., 1983). The proponents of adaptive theory (Alexander, 1990) view family dysfunction as a contributor to alcoholism as well, although other devastating forces such as unemployment, poverty, violence, and power inequalities in society are implicated. The stress produced by these forces is thought to engender existential pain, and alcoholism is considered an adaptive response that numbs, distracts, and masks this discomfort.

There are a variety of treatment methods that have been spawned from these theories. For example, where psychoanalytic therapists might attempt to help alcoholic clients resolve internal conflict (e.g., oral fixation) through insights achieved during extensive psychotherapy (Barry, 1988), learning theorists attempt to intervene using a structured system of behavior modification (Lawson et al., 1983). It was not until relatively recently that theories of alcoholism have been constructed and developed with the family as their central focus. Some authors have insinuated that the family-involved approach was applied to the treatment of alcoholism as an alternative to the predominant disease model whose principles form the basis of most traditional interventions such as Alcoholics Anonymous (AA) (De Maio, 1989; McCrady, 1990).

There are several underlying assumptions of the disease approach to treatment, the most salient of which is the way alcoholism is conceptualized. Viewing alcoholism as a disease implies a linear explanation for the etiology of alcoholism (as opposed to considering the complex interaction of many influences) and limits the scope of investigation to the level of the individual. Traditional (e.g., AA) treatment approaches encourage alcoholics to overcome defense mechanisms (e.g., denial), which are thought to sustain the disease. At the same time, individuals are absolved from being blamed for their own failure to overcome addiction by the assumption that victims of alcoholism are powerless over the disease. Ironically, the person is still held accountable for his or her recovery, although they are encouraged to appeal to a higher spiritual power for assistance.

FAMILY-INVOLVED APPROACHES TO THE TREATMENT OF ALCOHOLISM

The philosophy that guides the family-involved approach to alcoholism stands in sharp contrast to the disease model. The most obvious difference between these two paradigms concerns the issue of etiology. Where the disease model points to a single causal factor in alcoholism (i.e., a disease process), family practitioners supplant the concept of circular causality and argue that interpersonal dynamics and communication processes within the family establish or maintain addictive behavior (Collins, 1990; Lipps, 1999). This process of interaction, known in the field of family therapy as reciprocal determinism, suggests that alcoholism both affects and is affected by all other members within the family system (Collins, 1990). The underlying assumption here is that alcoholism cannot be construed as a problem that resides within individuals but rather, as existing in the context of larger systems, particularly the family (De Maio, 1989). Irrespective of this theoretical foundation, researchers have not completely determined the role that the family plays in the cause of alcoholism (Davis, 1980), suggesting that the family therapy discourse has not yet fully addressed the issue of etiology.

A further assumption of the family-involved approach posits that members constantly attempt to establish and maintain a sense of equilibrium. In the case of the family where one member is alcoholic, that individual's drinking problem is conceptualized as a "central organizing principle" that stabilizes the system (Lipps, 1999). Alcoholism is therefore defined as a homeostatic maintaining force that enables the family to maintain stability and avoid change (Barnard, 1981; Collins, 1990; Davis, 1980; Lipps, 1999; Steinglass, 1992). Using the concept of homeostasis, De Maio (1989) suggests that the defense mechanism of denial can be reframed as an individual's attempt to maintain the stability of the family system.

Although this discussion has contrasted the family-involved approach to the disease model of alcoholism, similar differences exist between family systems theory and other individually oriented perspectives. In sum, the family-involved approach to alcoholism treatment is characterized by (a) a focus on the family as a unit that is presumed to interact in a reciprocally deterministic manner, (b) the belief that the member of the family who expresses alcoholic behaviors (i.e., the identified patient) expresses disturbance within the system on behalf of all members of the family, and (c) the view that families attempt to establish and maintain a sense of equilibrium through interaction and communication patterns, even though this process may result in maladaptive consequences (Collins, 1990).

In terms of treatment, there are subtle differences in the way that family practitioners proceed. It should be pointed out that there are interventions specifically designed to assist families with an adolescent alcoholic (Trepper, Piercy, Lewis, Volk, & Sprenkle, 1993); however, this article is concerned with interventions that target primarily alcoholic adults within the context of the family. A major concern for practitioners is whether to concentrate on helping the client to stop drinking or whether to attempt to improve family functioning with the goal of a corresponding improvement in addictive behavior (Davis, 1980; O' Farrell, 1995). Harris's (1990) three-level approach to family intervention addresses both individual and family functioning. At the first level of intervention, the therapist focuses primarily on the needs of the alcoholic. At the second level, the needs of the alcoholic and the needs of the family are considered equally, and at the third level, the needs of the family are paramount. Whereas various methods can be utilized to intervene at each level, this classification system does not provide clear guidelines with regard to whether these three levels are to be tackled independently, simultaneously, or in succession.

…family-involved treatment must expand its scope to address alcoholism from micro to macro levels.

To solve the problem of determining the most efficient treatment plan, it is useful to apply a popular model in the field of addictions known as the Transtheoretical Model of Change (Prochaska, DiClemente, & Norcross, 1992). According to the Transtheoretical Model of Change, the modification of alcoholic behavior is to be viewed as a developmental process that occurs in five distinct stages. These include the precontemplation, contemplation, preparation, action, and maintenance stages. Within each stage, different changes in attitudes, intentions, and behaviors are presumed to occur. Although individuals do not necessarily progress through these stages in a linear fashion, Prochaska et al. (1992) argued that there are separate goals and interventions appropriate for each separate stage. A major contribution of this model is that it allows several therapeutic interventions to be incorporated into a treatment plan (hence the term *transtheoretical*). For example, an individual's recovery from alcoholism may consist of the emotional arousal produced by experiential therapy, profound insights gained from psychodynamic intervention, meanings and decisions resulting from the existential approach, and the management of change using the techniques of behaviorism.

Several practitioners and theorists in the field of family therapy have blended the Transtheoretical Model of Change with family-involved interventions (e.g., Edwards & Steinglass, 1995; O'Farrell, 1995; Vetere & Henley, 2001). The problem encountered by Harris's (1990) model (i.e., the dilemma of whether therapists should focus primarily on the individual, the family, or both) is circumvented when the family is seen as an integral part of the recovery process. The developmental perspective that results from this combination of paradigms is highly advantageous because it allows practitioners to address the differential issues and family roles associated with each stage of change. For example, for the client in the precontemplative stage (in which the family perceives a problem but the client does not), intervention may focus on helping the family raise the client's awareness of problem(s) and motivate him or her to enter into treatment (McCrady, 1986). During the action stage (in which the client has initiated change), the entire family could be involved in therapy to alleviate problems that may have preceded alcoholism or the problems that are serving to sustain it. In the maintenance stage (in which the client has managed to change problematic behaviors for at least 6 months), family interventions might focus on reinforcing change efforts and supporting the individual. Thus, the Transtheoretical Model of Change proves a useful framework for planning treatment strategies both at the individual and at the family level.

Family Systems Interventions

In the literature pertaining to family treatment of alcoholism, it appears that behaviorally based family therapies are contrasted with interventions more generally described as family systems approaches (Edwards & Steinglass, 1995; Lipps, 1999; McCrady, 1990). Before beginning with a description of the so-called family systems approach, a definition is in order. The family systems perspective is typified by interventions that focus on interpersonal relationships and communicative transactions, having improved family functioning as their primary goal (Lawson et al., 1983). By changing the way that the family operates, it is assumed that alcohol will no longer function as a homeostatic maintaining force, which, in turn, will result in a change in drinking behavior (Lipps, 1999).

In a meta-analysis that investigated the efficacy of family treatment for alcoholism, Edwards and Steinglass (1995) described four studies of family systems treatment. The first intervention, couples treatment, involved discussions of transactional analysis game playing, AA or Al-Anon meetings, and joint recreational activities. A second intervention focused on the expression of feelings and the improvement of communication and problem solving. In the third intervention, called multiple couple therapy, "couples discussed how alcohol had affected their marriage, how each of the partners felt about it, how each of them had acted to bring about the situations leading to alcoholism, and how they could alleviate these situations" (p. 487). Problem-solving issues regarding sex, finances, children, occupation, and leisure time were also

included in this approach. Similarly, in the last family systems method outlined, couples examined the possibility that alcohol served an adaptive role in family functioning and were helped to assess and alter the association between poor interaction patterns and drinking behavior.

Murray Bowen (1974), a major proponent of the family systems paradigm, used the concepts of emotional cutoff, differentiation of self, and the family projection process to describe two clinical patterns of alcoholism. Bowen hypothesized that individuals emotionally cut off from parents tend to overfunction and may turn to alcohol for relief from isolation and feeling overburdened. On the other hand, individuals who are emotionally fused with a parent and lack a sense of self may also collapse into a life of alcoholism. Bowen used the concept of "stucktogetherness" to describe how alcoholism pulls the family together during times of crisis or tension, and thus serves to maintain homeostasis (Lawson et al., 1983). Alcoholism treatment from this perspective involves educating the family about how family systems work, reducing the level of anxiety in the family, and promoting differentiation in all family members (Bowen, 1974; Davis, 1980; Lawson et al., 1983).

Behavioral Family Interventions

A survey of family-involved approaches to alcoholism conducted for this article revealed that the majority of formally designed interventions are based on behavioral principles and techniques (Edwards & Steinglass, 1995; Lipps, 1999). There are wide variations in the application and use of the behavioral approach, including: behavioral family counseling, alcohol behavioral marital therapy, relationship enhanced cognitive behavior therapy, and behavioral marital family therapy plus relapse prevention, to name only a few (Edwards & Steinglass, 1995)! An exhaustive review of behavioral interventions is beyond the scope of this article.

The behavioral family approach to the treatment of alcoholism differs from the family systems approach in several ways. For example, the theoretical foundation of behavioral family therapy is based on the role of operant and classical conditioning in the development of alcoholism, though cognitive processes and other family systems concepts (such as reciprocal determinism and homeostasis) also receive attention. Drinking behavior is thought to be reinforced by the pleasant, relaxing physiological effect that is produced by ethyl alcohol (Lipps, 1999). The increased opportunity for social interaction might also be considered a reinforcer of this type of behavior. Families are believed to reinforce alcoholic behaviors, for instance, by providing attention (through nagging about current or previous drinking) or caretaking (i.e., protecting the alcoholic from the negative consequences of his or her actions) (Collins, 1990). The process of behavioral family intervention involves assessment (functional analysis of problem areas), identifying target behaviors that require modification, tailoring interventions to alter target behaviors (often using homework assignments), and evaluating these interventions (Lawson et al., 1983). The general therapeutic goal, then, is to reinforce positive interactions among family members and decrease negative behaviors or interactions associated with drinking (Collins, 1990).

Despite the fact that researchers in the area of family-involved treatment for alcoholism present behavioral therapies with families and family systems models as almost mutually exclusive approaches, it should be noted that there is much overlap in the underlying principles and applications of these two broad categories (Edwards & Steinglass, 1995; Lipps, 1999). For example, Edwards and Steinglass (1995) compared interactional couples therapy—which they described as a systemic marital therapy—with behavioral marital therapy (BMT) in their meta-analysis. Whereas BMT involved increasing positive behaviors through rehearsal, interactional couples therapy emphasized the couples' exchanging of feelings, their mutual support, and facilitating insight into the relationship. Both therapies, nonetheless, were focused on reducing drinking and conflict, improving communication and positive interactions, and helping couples develop better problem-solving strategies. Lipps (1999) pointed out that both BMT and family systems approaches recognize the importance of the interplay between behavior and environment (i.e., reciprocal determinism). Let us now consider two methods of behavioral family intervention designed to initiate change, two methods used to promote action, and two methods used to maintain change.

Family Interventions Aimed at Initiating Change

One form of family intervention used at the precontemplative and preparation stages of the Transtheoretical Model of Change (Prochaska et al., 1992) is unilateral family therapy (Thomas & Ager, 1993). The aim of this intervention is to assist the cooperative, nonaddicted spouse in influencing the uncooperative partner to stop the addictive behavior. In other words, therapists see the spouse or partner of an addicted individual as a means of entering the family system so that it can be changed. With the goal of motivating the alcoholic person to engage in some sort of treatment, the therapist attempts to facilitate change in family functioning using a variety of techniques. The cooperative spouse is initially helped to reduce anxiety levels that result from being in a relationship with an alcoholic without being blamed for his or her partner's behavior. The therapist also attempts to reduce marital discord and other interactions that are thought to promote alcoholism through the use of education and couples therapy (Edwards & Steinglass, 1995). Additional techniques include behavioral contracting, neutralizing old alcohol control behaviors, relapse prevention training, and supporting the maintenance of treatment gains.

Community reinforcement training (CRT) (Sisson & Azrin, 1993) also attempts to assist the nonalcoholic spouse

to encourage the alcoholic to obtain treatment. However, in CRT, interventions are not deployed until the individual states a desire to cease alcoholic behavior (Edwards & Steinglass, 1995). The program of CRT assists the partner of the alcoholic to avoid physical abuse, to encourage sobriety, and to assist with treatment once it is obtained. Spouses are taught how to assess the severity of alcoholism and how to encourage treatment at opportune times. The behavioral underpinnings of CRT are evinced in the education component of this therapeutic program, in which spouses are trained to positively reinforce various behaviors (e.g., compliance with Antabuse, a drug that causes illness when alcohol is ingested) to prolong periods of sobriety. Punishment is also used to alter behavior, as when negative consequences for alcoholic behavior are established.

Family Interventions at the Action Stage

Counseling for alcoholics' marriages is a method of couples group therapy that is based on BMT and is designed to stabilize and maintain the process of change once it has been initiated (O'Farrell, 1993). The pregroup sessions are particularly important to this method, when initial interviews, Antabuse contracts, and formal assessments are arranged. This phase of treatment is followed by a series of ten weekly group meetings, where techniques such as behavior change agreements and the sharing of rewarding experiences are used to increase positive couple and family interactions. Weekly homework assignments help couples increase positive activities, increase caring behaviors, improve communication and problem solving skills, and sustain the Antabuse contract.

Alcohol behavioral marital therapy is an outpatient intervention that regards the alcoholic client and the nonalcoholic spouse as equal partners in the treatment process. The first step of this method is to conduct a functional analysis of the antecedents, accompanying events, and consequences of drinking behavior (Noel & McCrady, 1993). The therapist proceeds by setting goals and emphasizing the importance of self-monitoring urges as well as actual drinking behaviors. Various interventions directed at modifying behavior are employed, including drink refusal training, assertiveness training, relaxation training, cognitive restructuring, and educating clients about the effects of alcohol (Edwards and Steinglass, 1995). Spouses are also trained to reinforce abstinence, to decrease behaviors that cue drinking, and to avoid protecting the alcoholic from the consequences of drinking. Techniques that focus on the marital relationship, such as communication training, planning and implementing shared activities, and problem-solving training, are also utilized.

Family Interventions for the Maintenance Stage

The terms *relapse prevention*, *maintenance*, and *aftercare* are used to describe interventions that are employed to sustain treatment gains once the goal of abstinence or controlled drinking has been achieved. Ossip-Klein and Rychtarik (1993) described an intervention that begins with biweekly sessions for the first 2 months, followed by once per month for a 6-month period, and then every 3 months until a termination date is mutually determined. A behavioral contract between the recovering client and his or her spouse is emphasized, whereby jointly devised incentives are used to reward the alcoholic for attending aftercare sessions and maintaining treatment gains. Other aspects of this program of intervention include problem solving in situations when the alcoholic is tempted to drink, developing coping skills, and discussing marital issues.

Finally, in a relapse prevention program that follows BMT, O'Farrell (1993) outlined the three main goals of assisting the couple to (a) maintain marital and treatment gains, (b) identify and resolve problems in their marriage or problems related to drinking that were previously unaddressed, and (c) develop a relapse prevention plan. To address previously unresolved issues, the therapist may help the couple deal with problems associated with developmental changes (i.e., role adjustment), difficulties external to the family (e.g., unemployment), and/or sexual problems. The relapse prevention component provides a context for discussing relapse. It helps clients to identify high-risk situations and to determine ways to recover from relapse as quickly as possible in the event that it occurs. Like the behavioral contracting method presented above, this approach begins with biweekly sessions and is gradually tapered off. However, the intervention is ideally limited to 1 year following marital therapy.

Other Family-Involved Approaches to Alcoholism Treatment

Two additional approaches that elude classification in behavioral or family systems frameworks are the Johnson Institute intervention and Al-Anon. The Johnson Institute approach operates by enlisting family members and significant others who are concerned about a loved one's excessive drinking (Liepman, 1993). Under the leadership of the interventionist-director, the team of concerned individuals is trained to deliver a rehearsed confrontation, with the goal of having the alcoholic individual enter treatment. Al-Anon is an Alcoholics Anonymous–affiliated support group for those who are distraught by another family member's alcoholism. The aim of Al-Anon is to encourage family members to detach themselves from the alcoholic's drinking behavior and to focus on fulfilling their own areas of interest and satisfaction (Collins, 1990). Although these two methods are popular and frequently used, they are not covered in this discussion because they lack empirical research support (Collins, 1990; Edwards & Steinglass, 1995; O'Farrell, 1995). We now turn to a brief review of research in the area of family-involved treatment of alcoholism.

EFFICACY STUDIES

Many authors have regarded the active involvement of family members, especially spouses, as an important component of a comprehensive alcoholism treatment program (Edwards & Steinglass, 1995; Lipps, 1999; O'Farrell, 1993; Thomas, 1989). As a result, there have been several outcome studies conducted that compare individual treatment modalities to family interventions. Overall, these studies have yielded encouraging results. For example, in the meta-analysis by Edwards and Steinglass (1995) mentioned above, family systems approaches produced higher rates of abstinence as compared to individual treatment approaches in three separate studies and in one study that compared family systems intervention to a no-treatment control group.

Behaviorally-based family interventions have received more research attention primarily because they are regarded as having greater measurement precision, better research methodologies, and a strong relationship between research and practice (Collins, 1990). In evaluating interventions designed to encourage treatment, Thomas, Yoshioka, Ager, and Adams (1993) randomly assigned spouses to a group that offered immediate unilateral family therapy (UFT) ($n = 27$) or delayed UFT ($n = 28$). Compared to a nonrandom comparison group of 14 spouses who did not receive treatment, both UFT treatment groups were shown to be effective in reducing spouses' life distress, psychopathology, enabling behaviors, and attempts to control their partners' drinking. Perhaps most important, this intervention resulted in observable changes in the alcoholics' behavior, as 57% of abusers whose spouses received UFT entered treatment compared to only 31% of abusers whose spouses did not receive UFT. Spouses who underwent UFT also enjoyed improved marital adjustment and satisfaction. In another study that compared CRT to traditional (e.g., Al-Anon) types of counseling, Sisson and Azrin (1993) found that 6 out of 7 alcoholics whose partners participated in CRT entered treatment, whereas not 1 of the alcoholics whose partners received traditional counseling did so.

Studies of BMT and alcohol behavioral marital therapy serve as indices of the effectiveness of family interventions at Prochaska et al.'s (1992) action stage. For example, O' Farrell (1993) reported that alcoholics involved in BMT spent fewer alcohol-involved days during treatment and did better on an index of overall drinking outcomes as compared to interactionally treated couples and a no-treatment control group. In a comparison of minimal spouse involvement, alcohol-focused spouse involvement, and alcohol behavioral marital therapy, all three interventions resulted in increased marital satisfaction, increased sexual activity, improved occupational stability, and remarkable decreases in drinking (Noel & McCrady, 1993). Moreover, alcohol behavioral marital therapy produced faster declines in drinking behavior and higher levels of marital satisfaction than the other two methods.

In terms of intervention at Prochaska et al.'s (1992) maintenance stage, the effect of relapse prevention sessions has been examined using couples who have participated in BMT. Alcoholics who received relapse prevention following BMT had more days abstinent, had fewer drinking days, maintained improvements in their marriages, and applied the skills learned during BMT more than a comparison group who did not receive the intervention (O'Farrell, 1993).

Despite considerable empirical support for behavioral family treatment of alcoholism, it is important to acknowledge that these methods have not been proven to be superior to what has been termed the family systems approach in this article (Lipps, 1999; Thomas, 1989). For example, by citing longitudinal studies of family treatment in which follow-up periods are more than 1 year, Edwards and Steinglass (1995) pointed out that gains achieved in family therapy diminish substantially over time. Notwithstanding, these researchers posited three factors that may mediate the effectiveness of family treatment: (a) whether the identified patient is male, (b) the level of family members' investment in their relationships, and (c) the level of perceived support from the nondrinking partner toward the goal of abstinence. In a more general sense, they also caution that family-involved treatment can only be considered marginally more effective than interventions that focus on the individual.

To strengthen beliefs about the efficacy of the family approach to alcoholism treatment, it has been suggested that methodological weaknesses of research in this area be addressed (Collins, 1990). For example, family-involved researchers are invited to investigate and specify the process of change as well as identify the factors that help to maintain gains in alcoholism treatment. Additional suggestions for methodological improvement include clarifying the goals of treatment, clarifying theoretical constructs (including expanding the definition of the family), including control groups and long-term follow-ups, and broadening outcome measures (Collins, 1990).

PROBLEMS WITH FAMILY APPROACHES TO TREATMENT

A fundamental question must first be raised before addressing research methodology in this area. That is, "what are the techniques that constitute family treatment for alcoholism?" This article has concentrated on behavioral interventions because they are more clearly described than other family approaches, which have been accused of neglecting to specify the exact nature of treatment (Thomas, 1989). Indeed, even leaders in the field of behavioral interventions complain of a lack of administration guidelines and procedures (O'Farrell, cited in O'Conner, 2001). Notwithstanding, the fact that there is no agreed-on theory of alcoholism in the field of family therapy represents a critical limitation of this approach, and correspondingly, there is no consensus as to

what constitutes family treatment (De Maio, 1989; Lawson et al., 1983; Leonard, 1990; Thomas, 1989; Trachtenburg, 1989).

Yet, the field abounds with family treatment approaches regardless of the dearth of unanimous theory and definitions. Some treatment approaches based on the disease model (e.g., AA)—along with popular literature in the area—produce another potential difficulty when members of alcoholic families are labeled with roles such as *hero*, *mascot*, *scapegoat*, and *lost child* (Black, 1982; Perkins, 1989). Although the aim of such labeling may be to identify roles (or behavioral patterns) for the purpose of analyzing the maintenance of family homeostasis, labeling may complicate the treatment process when it leads to negative internalized self-constructs or the development of convoluted theories of pathology by therapists (De Maio, 1989). This caveat is not meant to disqualify the disease model or treatments that categorize members in the family of the alcoholic. On the contrary, efforts have been made to integrate these approaches with the family systems framework. For instance, at the theoretical level, De Maio (1989) outlined philosophical similarities between the disease model and family systems theory, whereas Dephoure and Cammarota (1982) addressed the clinical utility of using the disease model to initially promote abstinence before attending to family dynamics that support alcoholic behavior.

Family-involved therapies have also been condemned for minimizing the importance of factors that are related to alcoholism at the individual level. Critics have claimed that family approaches only partially address the complex problem of alcoholism because they ignore the defense mechanism of denial, which resides at the intrapersonal level (Howland, 1985). This lack of attention at the micro level has led many to suggest focusing on the client first by making the cessation of drinking the highest priority in treatment (Davis, 1980; Harris, 1990; Lawson et al., 1983; Littrell, 1991; Pearlman, 1988).

Further problems with family-involved alcoholism treatment appear when we consider that the preponderance of family interventions are based on behavioral techniques. The intimate association between traditional behavioral techniques and approaches to alcoholism treatment that involve the family may not present as an immediate problem because it has been argued that these two paradigms have much in common (Pearlman, 1988). For example, both perspectives focus on the present; emphasize the behavior of drinking rather than assume latent causal factors; and share several direct, problem-oriented techniques for treatment such as communication training, problem-solving training, and behavioral rehearsal. Perhaps most important, both perspectives are concerned with the antecedents and consequences of drinking behavior, although family systems theory accentuates the influence of interpersonal (i.e., familial) environmental factors.

Although some practitioners have utilized behavioral techniques in the context of family therapy (O'Farrell, 1993), a theoretical alliance between behaviorism and family systems theory seems intuitively problematic given that the underlying tenets of these two paradigms are opposed. To illustrate this inconsistency, recall that family practitioners embrace the notion of circular causality, which suggests that events should be considered from many, possibly mutually influential perspectives. Moreover, the family systems method advocates second-order cybernetics, maintaining that systems cannot be independently observed from an objective standpoint, and that the interpretation of each family member's experience is considered critically important (Goldenberg & Goldenberg, 2000). It can be argued, then, that the family systems approach assumes that different behaviors, family interactions, and communications have meaning on various levels, from the individual (or subjective) to the extraspective (or seemingly objective perspective) (De Maio, 1989). The importance placed on subjective experience implies the concepts of hermeneutics and human free will. That is, the family systems approach seems to support the notion that people actively interpret their environment and freely choose to behave based on those interpretations. Explaining behavior as a result of interpretive processes, however, is inappropriate from a strict behavioral viewpoint because mental operations cannot be empirically observed and are not fully understood. In contrast to the philosophical position implied by the family systems paradigm, behavioral interventions are historically rooted in the tradition of determinism, where the concept of human agency is denied (Alexander, 1990).

Behavioral family practitioners also appear to adopt more of an analytic perspective (where the focus is on parts) rather than a synoptic (holistic) approach that is espoused by systems thinkers. Recall that typical behavioral interventions involve a functional analysis of the antecedents and consequences of drinking behaviors and attempt to modify these behaviors through positive and negative reinforcement (Edwards & Steinglass, 1995). In other words, the behavioral approach is reductionist insofar as it is concerned with the quantification of discrete, empirical variables (behavioral units) and the manipulation of environmental stimuli to effect change. This reductionism is apparent when we consider that some family approaches to alcoholism treatment can be charged with overattending to surface-level behaviors (e.g., daily interactions and routines, family problem-solving behaviors, and family rituals) during the investigation into the mechanisms of family functioning (Steinglass, 1992).

A corollary that follows from the reductionism of the behavioral approach is that these interventions seem to explain alcoholism in terms of linear cause-effect relationships between environmental reinforcers and drinking behaviors. The focus is not on the interaction of various elements in the system (intrapersonal as well as interpersonal and/or global) as much as it is on establishing causal relationships between a few discrete variables.

With regard to the issue of perspective, Pearlman (1988) made an important distinction between family therapy and systems theory. He argued that it is an error to use the terms *family therapy* (a methodology that employs a wide variety of interventions focused on the family) and *systems theory* (an epistemology that is more holistic in outlook) as if they were synonymous, stressing that not all family therapies represent the application of systems theory. In the field of alcoholism, family practitioners' use of the concept of homeostasis to explain problem drinking exemplifies their within-family perspective. Rather than paying equal attention to macrosystems (e.g., employers, schools, societal attitudes/constraints), the family approach seems restricted to variables associated with the family, and thus can be criticized as an oversimplified paradigm for treating the complex phenomenon of alcoholism (Trachtenburg, 1989).

As a solution to the logical inconsistency between systems theory and behavioral interventions, perhaps the family-involved approach could incorporate additional philosophically congruent methods to counteract the reductionism and determinism inherent in most behavioral techniques. Phenomenological therapies (which emphasize meaning making), existential approaches (which embrace the concept of free will), and postmodern outlooks (which underscore the social construction of reality), seem to be appropriate candidates for synthesis with systems theory. The psychodynamic perspective may also serve to broaden the scope of inquiry and intervention for family therapists by contemplating underlying issues from a client's past. The fact that such material (e.g., meaning, human agency) may be instrumental in the development and maintenance of alcoholism may partly explain why the effects of behavioral treatment (which focuses mainly on immediate behaviors) diminish over time.

Vetere and Henley (2001) have, in fact, recently merged family-involved therapy with other techniques in the treatment of alcoholism. Their approach incorporates group-analytic psychotherapy methods that examine the content of spontaneous communication between family members, while paying special attention to the manifest and latent meaning embedded in family interactions. They also utilize the postmodern methods of externalizing the problem (a technique that encourages clients to objectify or personify problems) and the reflecting team (where members listen to candid comments made by therapists about the family) during consultations with families (Hoyt, 1998). The challenge that awaits others who attempt to further integrate various schools of thought will be to delineate sound theory, to document intervention methods, and to evaluate treatment outcomes in a way that is comparable to the scientific rigor of the behavioral tradition.

CONCLUSION

For the practitioner who is unfamiliar with the family-involved approach to the treatment of alcoholism, this article provides an overview of the field. The discussion presents various theories of alcoholism and a brief history of the family approach to treatment, and it outlines some specific interventions. The criticism that family approaches lack a uniform theory and a consistent set of intervention methods is supported. Although empirical research in this area does not provide unequivocal evidence of the effectiveness of family-involved interventions for alcoholism, the findings of several studies indicate that family therapy is helpful in rehabilitating alcoholics.

The focus of intervention at the familial level represents another critique of the field. It seems that family therapists tend not to pay sufficient attention to contextual factors that may influence alcoholism, even though they are associated with the systems perspective that is supposed to consider multiple causal factors. Conversely, family approaches are criticized for overlooking issues at the individual level as well. Thus, family-involved treatment must expand its scope to address alcoholism from micro to macro levels.

This article also reveals that a large number of family therapies for alcoholism employ techniques that are based on the philosophical tradition of behaviorism, which is fundamentally incongruent with the tenets of systems theory. Because behavioral family therapies are extraspective, deterministic, and reductionist, they appear limited in their ability to deal with the complexity of alcoholism (despite the methodological precision of the behavioral tradition and its contributions to the field).

To maximize the effectiveness of family-involved alcoholism treatment, this article calls for more researchers to blend various forms of psychotherapy with approaches that include the family—a request that reiterates the need for family clinicians and theorists to work toward a uniform set of theoretical principles. Only then can the theoretical fit between family-involved approaches and other forms of psychotherapy be explicated. Research methodology must also be improved so that blends of interventions can be empirically evaluated for effectiveness. Well-documented family interventions based on solid theoretical grounds may lead to a comprehensive model that practitioners could use to improve treatment of the recovering alcoholic.

REFERENCES

Alexander, B. K. (1990). The empirical and theoretical bases for an adaptive model of addiction. *The Journal of Drug Issues*, *20*(1), 37-65.

Alexander, B. K., & Schweighofer, A. R. F. (1988). Defining addiction. *Canadian Psychology*, *29*(2), 151-162.

Barnard, C. P. (1981). *Families, alcoholism and therapy.* Springfield, IL: Charles C Thomas.

Barry, H. (1988). Psychoanalytic theory of alcoholism. In C. D. Chaudron & D. A. Wilkinson (Eds.), *Theories on alcoholism* (pp. 103-141). Toronto, Ontario, Canada: Addiction Research Foundation.

Black, C. (1982). *It will never happen to me*. Denver, CO: M.A.C.

Bowen, M. (1974). Alcoholism as viewed through family systems theory and family psychotherapy. *Annals of the New York Academy of Science*, *233*, 115-122.

Collins, R. L. (1990). Family treatment of alcohol abuse: Behavioral and systems perspectives. In R. L. Collins, K. E. Leonard, & J. S. Searles (Eds.), *Alcohol and the family: Research and clinical perspectives* (pp. 338-355). New York: Guilford.

Davis, D. I. (1980). The family in alcoholism. In W. E. Fann, I. Karacan, A. D. Pokorny, & R. L. Williams (Eds.), *Phenomenology and treatment of alcoholism* (pp. 111-125). New York: Spectrum.

De Maio, R. (1989). Integrating traditional alcoholic treatment programs and family-systems therapy. *Family Systems Medicine*, *7*(3), 274-291.

Dephoure, M., & Cammarota, C. C. (1982). Treatment priorities in a family-involved alcoholism program. *Journal of Marital and Family Therapy*, *8*(1), 143-150.

Edwards, M. E., & Steinglass, P. (1995). Family therapy treatment outcomes for alcoholism. *Journal of Marital and Family Therapy*, *21*(4), 475-509.

Glaser, F. B., Greenberg, M. A., & Barrett, M. P. H. (1978). *A systems approach to alcohol treatment*. Toronto, Ontario, Canada: Addiction Research Foundation.

Goldenberg, I., & Goldenberg, H. (2000). *Family therapy: An overview* (5th ed.). Belmont, CA: Wadsworth/Thompson Learning.

Harris, V. A. (1990). Family therapy approaches to substance abuse with a special focus on alcohol issues. In H. B. Milkman & L. I. Sederer (Eds.), *Treatment choices for alcoholism and substance abuse* (pp. 309-321). Lexington, MA: Lexington Books.

Howland, V. J. (1985). The invisible problem: Treating alcoholism requires special awareness. *Family Therapy Networker*, *9*(6), 15-16.

Hoyt, M. F. (1998). *The handbook of constructive therapies: Innovative approaches from leading practitioners*. San Francisco: Jossey-Bass.

Lawson, G., Peterson, J. S., & Lawson, A. L. (1983). *Alcoholism and the family: A guide to treatment and prevention*. Rockville, MD: Aspen Systems Corporation.

Leonard, K. E. (1990). Summary: Family processes and alcoholism. In R. L. Collins, K. E. Leonard, & J. S. Searles (Eds.), *Alcohol and the family: Research and clinical perspectives* (pp. 272-281). New York: Guilford.

Liepman, M. R. (1993). Using family influence to motivate alcoholics to enter treatment: The Johnson institute intervention approach. In T. J. O'Farrell (Ed.), *Treating alcohol problems: Marital and family interventions* (pp. 54-77). New York: Guilford.

Lipps, A. J. (1999). Family therapy in the treatment of alcohol related problems: A review of behavioral family therapy, family systems therapy, and treatment matching research. *Alcoholism Treatment Quarterly*, *17*(3), 13-23.

Littrell, J. (1991). *Understanding and treating alcoholism*. Hillsdale, NJ: Lawrence Erlbaum.

McCrady, B. S. (1986). The family in the change process. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 305-318). New York: Plenum Press.

McCrady, B. S. (1990). The marital relationship and alcoholism treatment. In R. L. Collins, K. E. Leonard, & J. S. Searles (Eds.), *Alcohol and the family: Research and clinical perspectives* (pp. 338-355). New York: Guilford.

Noel, N. E., & McCrady, B. S. (1993). Alcohol-focused spouse involvement with behavioral marital therapy. In T. J. O'Farrell (Ed.), *Treating alcohol problems: Marital and family interventions* (pp. 210-235). New York: Guilford.

O'Conner, E. (2001). Lean on me: Behavioral couples therapy offers addicts a path to recovery alongside a loved one. *Monitor on Psychology*, *32*(6), 44-45.

O'Farrell, T. J. (1993). A behavioral marital therapy couples group program for alcoholics and their spouses. In T. J. O'Farrell (Ed.), *Treating alcohol problems: Marital and family interventions* (pp. 170-209). New York: Guilford.

O'Farrell, T. J. (1995). Marital and family therapy. In R. K. Hester & W. R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (pp. 195-220). Boston: Allyn and Bacon.

Ossip-Klein, D. J., & Rychtarik, R. G. (1993). Behavioral contracts between alcoholics and family members: Improving aftercare participation and maintaining sobriety after inpatient alcoholism treatment. In T. J. O'Farrell (Ed.), *Treating alcohol problems: Marital and family interventions* (pp. 281-304). New York: Guilford.

Pearlman, S. (1988). Systems theory and alcoholism. In C. D. Chaudron & D. A. Wilkinson (Eds.), *Theories on alcoholism* (pp. 289-324). Toronto, Ontario, Canada: Addiction Research Foundation.

Perkins, S. E. (1989). Altering rigid family role behaviors in families with adolescents. *Alcoholism Treatment Quarterly*, *6*(1), 111-120.

Pomerleau, O. F., & Pomerleau, C. S. (1987). A behavioral view of substance abuse and addiction. *Journal of Drug Issues*, *22*(2), 111-131.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, *47*(9), 1102-1114.

Schneider Institute for Health Policy (2001). Substance abuse—The nation's number one health problem: Key indicators for policy. Retrieved February 10, 2002, from the Robert Wood Johnson Foundation Website: http://www.rwjf.org/app/rw_publications_and_links/advances/2001_Issue_2/rw_pub_advance_feature1.html

Sisson, R. W., & Azrin, N. H. (1993). Community reinforcement training for families: A method to get alcoholics into treatment. In T. J. O'Farrell (Ed.), *Treating alcohol problems: Marital and family interventions* (pp. 34-53). New York: Guilford.

Steinglass, P. (1976). Experimenting with family treatment approaches to alcoholism, 1950-1975: A review. *Family Process*, *15*, 97-123.

Steinglass, P. (1992). Family systems approaches to the alcoholic family: Research findings and their clinical applications. In S. Saitoh, P. Steinglass, & M. A. Schuckit (Eds.), *Alcoholism and the family* (pp. 155-171). New York: Brunner/Mazel.

Thomas, J. C. (1989). An overview of marital and family treatments with substance abusing populations. *Alcoholism Treatment Quarterly*, *6*(3/4), 91-102.

Thomas, E. J., & Ager, R. D. (1993). Unilateral family therapy with spouses of uncooperative alcohol abusers. In T. J. O'Farrell (Ed.), *Treating alcohol problems: Marital and family interventions* (pp. 3-33). New York: Guilford.

Thomas, E. J., Yoshioka, M., Ager, R. D., & Adams, K. B. (1993). *Experimental outcomes of spouse intervention to reach the uncooperative alcohol abuser: Preliminary report*. Unpublished manuscript.

Trachtenburg, M. (1989). Treating the addicted person: Beyond methodology. *Alcoholism Treatment Quarterly*, *6*(3/4), 175-188.

Trepper, T. S., Piercy, F. P., Lewis, R. A., Volk, R. J., & Sprenkle, D. H. (1993). Family therapy for adolescent alcohol abuse. In T. J. O'Farrell (Ed.), *Treating alcohol problems: Marital and family interventions* (pp. 261-278). New York: Guilford.

Vetere, A., & Henley, M. (2001). Integrating couples and family therapy into a community alcohol service: A pantheoretical approach. *Journal of Family Therapy*, *23*, 85-101.

***James G. Chan**, M. A., is with the Department of Educational and Counseling Psychology and Special Education at the University of British Columbia, Canada. Currently, James is a therapist at a residential treatment center for addiction working with individuals, groups, couples, and families.*