

FAMILY THERAPY WITH DRUG ADDICTS: An Integrated Approach

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Major causes of drug abuse identified in the literature are outlined. Contributing factors are located on individual, interpersonal, and social levels, with the family of origin established as very important. An integrated approach to family therapy that takes all these levels into account is described employing concepts, hypotheses, and techniques from different kinds of therapy.

Drug addiction means long duration, high frequency, and intense levels of drug use leading to physiological and psychological dependence. As the addict cannot at will discontinue use of drugs and as substance abuse impairs the well-being and social functioning of the individual, drug addiction is considered to be an illness. Thus, its treatment is paid by all health insurance companies in West Germany.²³

During the late sixties and early seventies, it was found that individual psychotherapy of drug addicts, with its emphasis on psychodynamics, usually was not effective. Low rates of recovery were reported, and relapse often occurred among addicts who had improved. It was also observed that during the period of improvement, addicts' families of origin suffered crises of their own, members became depressed, parents spoke of divorce, siblings developed symptoms; these crises dissipated as soon as the patients relapsed into addiction. This "family detoxification cycle" was recognized as an interpersonal process in which

the failure of the addicts facilitated unity in their families.^{31, 32, 34} Moreover, it was observed that families often sabotaged the treatment of addicted members^{30, 31, 33} or that relapses occurred when drug abusers returned to their families of origin as rehabilitated patients.^{13, 31} It seemed that these families "needed" the drug abusing members, tried to keep them in their designated "sick" role, and put pressure on rehabilitated patients to return to their old modes of behavior.

These observations led to a closer look at the family relations of addicts. It was noticed that drug abusers tended to have close family ties up to the age of 30 and beyond; only in rare cases, mostly in late-state addiction, were these ties broken.^{22, 27, 32, 33} More than 60% of drug abusers lived with their families of origin.^{24, 34, 35} The relatives often overlooked their substance abuse and sometimes encouraged it, overtly or covertly, e.g., by giving them money.^{10, 30, 31, 33}

Thus drug abuse was recognized as a so-

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cial phenomenon. It was hypothesized that families helped to produce the addict and maintain the problem behavior. The locus of the problem was found in the family; drug abuse was seen as a symptom of family pathology.^{12, 19, 21, 26, 32} It followed that the treatment of substance abuse would have to deal with pathological characteristics of the addict's family. Thus, in the early seventies, a number of drug treatment facilities began to use family therapy techniques. According to a national survey by Coleman and Davis,⁴ 93% of 2,012 agencies in the United States, Puerto Rico, and the Virgin Islands that returned the questionnaires already provided some type of family therapy to drug abusers.

This article describes psychological, interpersonal, and social factors that are involved in the development and maintenance of drug abuse, with special emphasis on family variables. A theory of family therapy is outlined that considers interventions on the individual, interpersonal, and social level. This theory is based on what I call "Integrative Family Therapy."³⁷ It starts from the hypothesis that each family therapist develops an individual approach to family therapy that is formed in part by the therapist's own age, sex, life history, personality, values, attitudes, training, and working conditions. Further, family therapy, in practice, functions on a very limited and one-sided theoretical base. This can be seen when comparing different approaches or schools of family therapy that focus, for example, on system processes (Haley, Watzlawick), family structures (Minuchin), behavior (Lieberman, Patterson), experience (Satir, Whitaker), or psychodynamics (Ackerman, Boszormenyi-Nagy). More importantly, it is apparent in the clinical setting, where the therapist is confronted with verbal and nonverbal behavior, idiosyncratic codes, intrapsychic and interpersonal processes, interactional patterns, cultural values, etc. Since it is impossible to register and process this multitude of impres-

sions completely, attention is concentrated on a few categories of variables, *e.g.*, psychodynamics, behavior, experience, emotions, family structure, roles, or system processes. These preliminary decisions determine what is perceived in the treatment situation and described in publications. From the multitude of observable variables, it follows that a great number of treatment approaches with different foci are developed. In fact, there are probably as many approaches to psychotherapy as there are therapists—well beyond the 250 mentioned by Herink.⁹

It follows that, on the one hand, all approaches to family therapy are incomplete and reductionist. On the other hand, I believe that nearly all are "true;" starting from different standpoints and perspectives, they each focus on special elements and aspects, and each arrives at individual concepts and hypotheses that are equally valid and uniquely valuable. The field of family therapy can progress at the moment only by means of empirical research (on the validity of hypotheses, the effectiveness of techniques, etc.) or by integrating the concepts, hypotheses, and techniques from all these different approaches in order to arrive at an encompassing theory which reflects the whole reality and not only selected aspects of it.^{36, 37} Kendall¹⁷ wrote:

Integration refers to a bringing together or incorporating of parts into a whole. Once something is integrated it can be said to be a combination or coordination of separate elements so as to provide a harmonious, interrelated whole. (p. 560)

An integrated theory is reached by constant switching of perspectives, by connecting complementary aspects, and by synthesizing divergent positions. It is essential that an encompassing theory like that of Integrative Family Therapy be developed because: 1) People are biological, emotional, intellectual, spiritual, and social beings. Only genuinely integrative approaches can arrive at a sufficiently holistic view of hu-

man beings in their uniqueness and individuality. 2) Individual, family, and therapy situations are characterized by a multitude of interdependent variables. Registering and conceptualizing as many biological, psychological, interactional, institutional, and sociocultural factors as possible can only be achieved by approaches such as that of Integrative Family Therapy. 3) Only flexibility of techniques and perspectives can produce a multidimensional picture of the individual in his or her context. 4) Different approaches to family therapy contain similar findings, concepts, and techniques. Integrative Family Therapy and comparable theories try to incorporate them all. 5) Varied concepts and hypotheses arising from different approaches can be complementary and compatible, and can be subsumed in a single theory. This belief is supported, for example, by a multitude of articles on the combination of different approaches of psychotherapy.³⁶

By integrating relevant concepts, hypotheses, and techniques from a variety of approaches, this paper will present a theory of family pathology and therapy with respect to drug abuse.

THE ADDICT

Stanton³¹ wrote about the addict:

Drug misuse appears initially to be an adolescent phenomenon. It is tied to the normal, albeit troublesome, process of growing up, experimenting with new behaviors, becoming self-assertive, developing close (usually heterosexual) relationships with people outside the family, and leaving home. (p. 84)

In this period of great vulnerability, adolescents also have to deal with issues of family loyalty, separation and individuation; achieve a secure identity; and find a new way of dealing with their parents.^{12, 14, 34, 40}

Future addicts usually fail at most of these tasks. Quite early in their life they were often identified as problem children and seen as weak, inadequate, immature and in need of help. Due to their handicapped develop-

ment, they have a limited selection of coping mechanisms, little control over their lives, and few ways to assert themselves.^{7, 13, 22, 27} Thus they often fail at school, quit before graduation, get work below their abilities, cannot support themselves, or refuse to accept social responsibilities.^{12, 26, 34, 40} Due to their maladjustment and the negative attitudes of others toward them, they usually develop an identity failure, a derogatory self-image, and feelings of inadequacy.^{7, 10, 25, 26, 41} Quite often, they use drugs as a way to give temporary meaning and significance to their lives, to deaden painful feelings like low self-esteem and depression, to deal with emotional burdens, and to relieve concern about lack of assertiveness.^{6, 10, 16, 18} Feeling emotionally sterile or trapped, they also use drugs as a way to excitement, to stimulate internal psychic processes, to break out, or to make contact with inner experiences.^{16, 18}

Future drug addicts are usually alienated from their peers and socially isolated. They lack real relationships, experience few romantic episodes, and expect rejection by others. Therefore, they often use drugs as a means of coping with the absence of intimacy and as a source of relief from loneliness, despair, and frustration.^{6, 7, 10, 16, 18, 27, 40} Moreover, such people are unsuccessful in heterosexual relationships, suffer from expectations of inadequate sexual performance, and fail to develop a secure sexual identity in adolescence. For example, Kirschenbaum, Leonoff, and Maliano¹⁸ wrote:

Lacking such an identity, drug use became a means of avoiding dealing with these newly developed sexual feelings and sexual role requirements. (p. 54)

Moreover, drug abuse reduces the sex drive and often serves as an excuse for not developing appropriate heterosexual relationships.^{16, 26, 34}

Due to low levels of self-differentiation and diffuse psychological boundaries, inac-

curate self-perception can be observed in many cases of substance abuse. As already noted, addicts usually remain intimately involved with their families and achieve no real independence—only a pseudo-adult stance.^{16, 34, 39} Feeling trapped, addicts may unconsciously attempt to break out of this enmeshment, to rebel against their parents, or to punish them for not allowing individuation and separation. However, they may also turn the rage originally felt toward the parents against themselves which leads to a suicidal and self-punitive life-style.²⁵ In other cases, administering drugs to themselves may be one of few situations in which addicts experience control over their own lives.³⁹

FAMILY OF ORIGIN

Communication within families of drug abusers is characterized by unclear messages, vague information-giving, lack of direct talk, avoidance of eye contact, frequent interruptions, and speaking for others.^{1, 33} There is little, or only indirect, expression of positive or negative emotions as family members are very concerned with impulse control. Hostile feelings are usually defined as unacceptable and cause fear and guilt.^{6, 16, 18, 25} Thus, only by getting high can the addict experience and express strong feelings.¹²

Family members describe life at home as dull, lifeless, shallow, affectless, and without enjoyment, fun, and humor. Quite often, they experience feelings of love and hostility simultaneously. They feel encapsulated, separated, unaccepted, misunderstood, and confused.^{16, 18} Thus Reilly²⁵ reported:

Family members generally experience chronic feelings of mutual alienation, loneliness, meaninglessness, rejection, abandonment, loss, deprivation, guilt, anxiety, rage, depression, and worthlessness. (p. 154)

They often defend against these emotions by heavy alcohol consumption, self-medica-

tion, or overeating, all of which serve as anesthetics, tranquilizers, and antidepressants. Thus there is a higher than average frequency of multigenerational alcohol abuse, chemical dependency, and compulsive disorders in families of addicts,^{6, 13, 14, 16, 19, 25, 26, 32, 33, 40, 43} especially in one-parent families.⁴² It is evident that parental modeling plays a great role in the etiology of substance abuse: Children's first experience of drugs is at home; future addicts are exposed to the use of chemicals in their families of origin for long periods of time. Sometimes their siblings also misuse drugs.¹⁶

Parents of addicts not only rationalize their own misuse of legal drugs and medication, but quite often deny their children's substance abuse. In some cases, children's drug taking goes unrecognized by parents who get vicarious satisfaction from it; often, their attitudes condone or encourage the substance abuse.^{12, 13, 16, 19, 31, 32} In these cases, according to Reilly,²⁵ the addict

... is frequently unconsciously motivated to flaunt, even to "advertise" his drug use, in an attempt both to invoke parental attention and concern, and to provoke the imposition of external limits upon his impulses and behavior. (p. 153).

Sometimes parents are simply ignorant of chemical dependency, the effects of drugs, or the drug scene.^{13, 42} If parents have noticed the substance abuse, neither they nor the addicts accept any responsibility for it. The parents blame each other, protect themselves by counterattacking, or name external explanations for drug abuse. If they blame the addicts, it is usually with the implication that the fact of dependency absolves the addicts from accountability for their behavior.^{12, 25, 34}

Parents in such families usually suffer from disturbed marital relationships, emotional distance, lack of intimacy, and dissatisfaction with their sex lives. Few decisions are jointly made.^{6, 8, 12, 18, 19, 26, 32}

The opposite-sex parents often try to compensate for their poor marital relationship by involving the children who are the future addicts in symbiotic relationships or by treating them as spouse surrogates. Thus they are overprotective, controlling, indulgent, infantilizing, or even seductive and sexually aggressive. Usually their most intimate relationships are with the future drug abusers, who have to meet their strong emotional needs.^{5, 8, 14, 16, 19, 26, 28, 31-33, 39} The high incidence of incest—up to 50% of female addicts were sexually abused as children—is evidence of the intensity of the parent-child relationship.^{16, 31-33, 40, 43}

When future substance abusers try to separate from their parents, they suffer from strong feelings of guilt as their attempts at individuation create anxiety in their opposite-sex parents, who may become depressed and suicidal. Misusing drugs keeps the children dependent and absolves them from both adult responsibility and the failure to separate. Moreover, this also reinforces the parents' feeling that it is necessary to take care of the addicts, thus legitimizing the overinvolvement and enmeshment. Therefore, while opposite-sex parents may criticize the behavior of their children, they rarely attempt to change it. They may even encourage it by not destroying drugs or by leaving money around for them to steal.^{16, 26}

Same-sex parents are usually distant and punitive as a result of such feelings as anger, rage, and rejection.^{18, 32} Mothers of female addicts are often in open competition with their daughters. Sometimes they are described as authoritarian, hostile, overprotective, or chaotic.^{16, 33} Fathers of male drug abusers often are detached, disengaged, uninvolved, and peripheral. They provide for the material needs of their families but spend little time in them; for instance, they may be workaholics or involved in activities with other men. To the outside world they seem to be authoritarian males, yet in their families they are "straw men" and clearly second-

dary to their wives. The mothers, although very much in charge, contribute to the myth that their husbands control the family.^{5, 8, 16, 18, 19, 26, 27, 33, 39}

Fathers typically are only minimally involved with their drug-abusing sons. The fathers' psychological absence prevents a healthy and constructive rebellion against them, thus making self-differentiation more difficult. Moreover, they are not figures with whom their sons can identify positively. Being weak, they often unconsciously encourage their sons' failure at school, work, or in life because they do not want competition. By the same token, they also perceive the developing sexuality of adolescents as a threat to their maleness. Generally, they have low expectations of their sons.^{8, 18, 19, 26}

As the enmeshment between the drug-abusing son and his mother separates the latter from her husband, the father is often jealous of his son and retaliates with rage, violence, and hate. This frequently leads to tensions and conflicts between them. The father tries to discipline his son, control his behavior, and scapegoat him. However, his attempts are usually undercut and blocked by his wife. Schwartzman²⁶ wrote:

The mother's role as the protector of the addict was reinforced by the father's demand that the addict stop using drugs and get a job or leave home. The mother blamed her overprotectiveness on her husband's hostility toward their son or her husband's inadequacies as a father. . . . The father, in turn, blamed the mother for preventing their son from growing up by overprotecting him. (p. 155)

Thus this recurring situation leads to marital conflict in which mother and son form a coalition against father, thereby reinforcing their own symbiotic relationship. The resulting anger and mutual blaming increase the emotional distance between the spouses and often lead them to discontinue sexual relations. Moreover, the father is robbed of his power as spouse and parent. Similar patterns can be observed in

families in which a daughter is abusing drugs.^{1, 5, 8, 13, 14, 16, 26, 33}

Parents often differ in child-rearing concepts. As a result, they fail to set clear and firm limits for their children—they fail to punish problem behavior, are inconsistent, or disagree over whether and how to discipline. There is little shared authority or emphasis on the children's responsibility for their own behavior.^{7, 12, 13, 16, 20, 25, 33} Sometimes parents are so moralistic and critical that their children reject their standards and values and select radically different activities and friends, *e.g.*, on the drug scene.¹⁸ In other cases, according to Harbin and Maziar,⁸

... parents might constantly encourage the child to satisfy frustrations through relatedness to inanimate objects, *i.e.*, pacifiers, toys, medication, in place of interpersonal investments. The child would thus learn that the most consistent and safe way to satisfy internal needs and conflicts is to rely on non-human objects. (p. 428)

The non-human objects can take the form of drugs.

In families of future addicts children are rarely praised, positively reinforced, nurtured, or validated. There is little expression of love and affection. Instead, there are high rates of negative and judgmental messages in the form of criticism, complaints, and nagging. As the only available reinforcers are negative affective displays, children learn that the way to get attention is to cause trouble; this they can do by becoming addicted.^{16, 18, 20, 25, 31} Future drug addicts are either faced by their parents' low expectations (self-fulfilling prophecy) or by their high performance standards and achievement orientations. The latter often lead to fear of failure, task-avoidance, insecurity, and feelings of inferiority. By abusing drugs the addicts avoid facing these high expectations, being absolved of responsibility for their behavior.^{10, 25, 26, 33} This situation is often aggravated by siblings who are highly successful in school or life;¹⁶ the future addicts nearly always lose when try-

ing to compete with them. The behavioral consequence has been outlined by Huberty and Huberty:¹³

Hence, it is more satisfying to get recognition for being bad than it is to be mediocre and receive no unique recognition. (p. 581)

The independence, self-differentiation, identity-formation, and self-assertion of their children is rarely furthered by parents of future addicts. They have little tolerance for their children's individuality, do not provide them with personal space, react negatively to their attempts at establishing their own identity, and fail to validate them as unique persons.^{1, 18, 33} Thus, these children are unprepared for the tasks of adolescence and some try to avoid maturation, individuation, and separation by misusing drugs. In other cases, they try to reconcile the urge to leave home with pressure from enmeshed family members to stay. Their parents experience stress and intolerable anxiety when these children attempt to separate (especially in one-parent families). They fear the children's emancipation for its possible effects on their family; they see it as a threat to the family's homeostasis, are afraid of losing psychological resources, and are unwilling to enter a new stage of the family life cycle.³⁸ Sometimes a strong move toward individuation also stimulates conflict between the parents, reactivating old dependence-independence issues from early marriage or from the families of origin. Therefore, these parents covertly encourage their children to stay at home, invoke feelings of guilt in order to curb strivings for autonomy, or appeal to loyalty by sending the message: "We can't survive without you." Addicts then offer their problem as a way of avoiding separation. Stanton and his colleagues³⁴ generalized about a male addict:

Consequently, the pressure on him not to leave is so powerful that the family will endure (and even encourage) terrible indignities such as his lying, stealing, and the public shame he generates rather than take a firm position in relation to him. (p. 131)

These strong forces explain why addicts stay with their families of origin even to the age of 30 or 35.

The use of drugs can be seen, then, as a paradoxical solution to the dilemma of leaving or staying at home. On the one hand, the addicts experience some independence, autonomy, and distance by rebelling, by entering the drug scene against the wishes of their parents, and by escaping from home. They exercise control by refusing to change their behavior and continuing to use drugs. Moreover, they feel separate, powerful, and omnipotent when under the influence of drugs. On the other hand, addicts satisfy their parents' wish for a dependent child by their inability to succeed at school, at work, or in life. It is also true that many drugs induce a regressed, infantile euphoria. The incompetence, irresponsibility, and dependence of the addicts allow parents to define them as helpless, reinforce their need to act as parents and serve to rationalize their continuing overprotective and indulgent relationship. The most important consequence, according to Stanton,²⁹ is that "it allows the family to continue as it had before, without major disruptions, defections or role desertions" (p. 204). Therefore, addicts and their parents unconsciously do not want the drug abuse to stop, are highly ambivalent with respect to changes, and are resistant to therapeutic intervention. Substance misuse also sustains family cohesion, increases enmeshment, and strengthens bonds of loyalty which are only intensified when the addicts are hospitalized or jailed. Siblings and members of the extended families often get involved in the problem. These loyalty issues explain why drug abusers are highly protective of their parents and frequently absolve them of any responsibility for their addiction. All of them unconsciously regard abstinence and the resulting changes in behavior as disloyalty.^{1, 10, 12, 14, 16, 22, 24, 26, 28, 29, 31, 33, 39, 40}

Quite often, individuation and separation have become problems because the drug

abusers suffered a great emotional loss such as a parent dying, separating, or getting divorced. It is well documented that there is an above average absence of one parent in the future addict's childhood or early adolescence.^{7, 8, 14, 16, 19, 27, 32, 33, 42} Abusing drugs would then be a way of combating the pain caused by this traumatic and sometimes unexpected loss, of showing one's loyalty to the remaining parent, or of guarding against the pain of a new loss.

In other cases, one or both parents have never worked through the powerful feelings caused by the death of their own parents. Thus they suffer from a deep sense of emotional deprivation, separation anxiety, suppressed grief, and delayed mourning. These feelings cause them to discourage the individuation and independence of the future addicts, according to Reilly.²⁵

Parents who have never adequately mourned or accepted the loss of their own parents are usually unable to tolerate the "loss" of separation from their own children. (p. 159).

Overt or covert encouragement of addiction is a method of keeping their children indefinitely dependent and assuaging their own separation anxiety. For them, a dead child is more acceptable than one lost to the outside world. Sometimes these parents also identify their children with lost objects, as this conserves them, allows the expression of ambivalent emotions toward them, and prevents facing the loss. In many cases, the slow suicide of their drug-abusing children also allows them to reenact vicariously the unresolved deaths of their own parents. Such projections and processes of unresolved mourning may lead the addicts to sacrifice themselves in order to save their parents the pain of separation. This would explain why drug abusers often express a wish for death. In this light, addiction can be seen as a kind of chronic self-destruction which is sanctioned, or at least not resisted, by parents.^{14, 25, 28, 32, 34}

Less frequently, addiction serves to keep

the families of origin together. Many of these families are characterized by disengagement, isolation of subsystems, and lack of intimacy and affection. Communication is minimal except around the substance abuse. Especially when the addicts take drugs, their parents and other family members interact and argue with each other. As Kaufman and Kaufmann¹⁶ observed,

Frequently the crisis created by the drug-dependent member is the only way the family gets together and attempts some problem solving, or is the only opportunity for a "dead" family to experience emotions. (p. 45)

The addicts not only provide the spark of life and excitement in these emotionally starved families but also allow them to unite over their incapacitation. Scapegoating their drug-abusing children, blaming each other for their behavior and discussing their treatment are the only causes that make these parents relate to each other. Thus family life becomes organized entirely around the substance abuse. Because it intensifies family bonds and unites the family, there is a strong investment in keeping the children addicted. This would explain the double messages, the inconsistent limit-setting, the covert encouragement of substance misuse by these parents. 6, 7, 12, 14, 16, 18, 20, 25, 26, 28, 32, 33, 40

Similar functions are served by drug abuse in families characterized by frequent marital conflicts. If these arguments threaten the continuance of the family, children might become addicted in order to distract their parents from fighting. Later on, taking drugs may keep marital conflicts from crystallizing or becoming disruptive. The parents avoid the roots of their own dissension by shifting the focus to the substance misuse; they can also act out their problems through disagreements about the addicts without the danger of divorce. Once the danger of separation has passed, the latter often stop using drugs. Then the refocusing of parental conflict on marital issues may cause a rep-

etition of their children's attention-getting and self-destructive behavior. It is evident that these vicious processes also explain the detoxification cycle.

In all these cases, the addict's behavior stabilizes the family. As Stanton²⁸ wrote, "In this sense, he is a loyal son who denies himself and rescues his family. He is a savior" (p. 192) who shifts the conflicts and pain between his parents onto himself. Moreover, in their role of scapegoats, addicts often have to represent bad parental introjects. In compensation, they assume a central position within their families, are sometimes envied by their siblings for all the attention they get, and may enjoy the secondary gains and rewards of the "sick" role. 1, 13, 18, 22, 25-27, 29, 31-33, 39

If addiction is a family disease and a family problem, the drug abuser can be regarded as the identified patient, the symptom of a disturbed family. Substance abuse has an adaptive function for the family because it satisfies its desire for stability. The family adjusts to the addiction, it becomes part of the family's equilibrium and the center of family life. The family, according to Huberty,¹² "then has a major psychological investment in maintaining that member as a drug abuser so as not to upset the family pattern" (p. 183). Therefore, it tries to maintain the addict's role and, as we have seen, is resistant to change.^{10, 13, 16, 18, 19, 22, 34, 40}

Nonfamilial factors, however, are also involved in the etiology of substance misuse. Few adolescents, for instance, enter the drug scene by chance; most are introduced to drugs by peers. Later on, the addiction is reinforced by other drug abusers, dealers, and the drug subculture with its own norms and way of life. Most addicts experience a feeling of belonging and independence in the drug scene despite the fact that its relationships tend to be transient and nonintimate. Sexuality is detached and mechanical or takes the form of prostitution. Most addicts move back and

forth between their drug-abusing peers and their families of origin, usually leaving the latter after conflicts or arguments.^{6, 14, 18, 27, 34}

Often the addiction is also triggered by extrafamilial events. The father may retire, lose his job, or suffer from occupational pressures due to increased demands or problems in his relationship with his employer, colleagues or subordinates. Sometimes he is rarely at home because he has to work overtime or holds multiple jobs. All of this might lead to a strained family climate. In other cases, a future drug addict might fail to get a job because of unfinished schooling or lack of a necessary skill. Those from poor or minority families might have gone to bad schools or be more likely to have grown up in one-parent families where they had to take over marital or parental roles. They frequently have an overwhelming sense of insignificance, feel worthless, needy, helpless, and depressed. They are likely to have easy access to drug dealers, and they learn at an early age to use drugs to fight these emotions.^{1, 6}

THE ADDICT'S MARRIAGE

When substance abusers marry, their newly formed families are clearly secondary to their families of origin. Roles and patterns of interaction established in the latter are carried over into the marriage, where relationships are quite often defined in the same way. Addicts frequently require their spouses to take care of them the way their mothers did before. When both spouses take drugs, the grandparents are often actively involved in their families, providing money or caring for the children.

Frequently, addicts attempt a flight from their parents by marrying. Addicts' parents, on their part, rarely give their permission for the marriage or they try to undercut it. The parents resent and criticize the spouses, fight with them frequently, and encourage their children to come back home. In nearly all cases, the married addicts have not really

differentiated themselves from their parents. In order to show devotion to their families of origin and fulfill their functions, they often fight with their spouses. They can thus return with some regularity to their parents to talk about marital conflicts. Quite often quarrels, sexual problems, and resulting demoralization lead to divorce and the return of the addicts to their families of origin. In other cases, the parents might invoke a family crisis if they fear that they are losing their children. The addicts are likely to respond by starting a fight with their spouses, indicating to their parents that they have not lost them. Quite often, the quarrels are used as an excuse to return home and help the parents.^{1, 12, 16, 31, 33, 40, 42} According to Stanton and his colleagues:²⁹

Marital battles thus become a functional part of the intergenerational homeostatic system, possessing both adaptive and sacrificial qualities. (p. 141)

INTEGRATIVE FAMILY THERAPY

Earlier in this article, the integration of similar or complementary concepts and hypotheses of clinicians from different schools of family therapy was discussed, as was the resulting all-encompassing view of factors involved in the etiology and maintenance of substance misuse. The importance of many different biological, psychological, interpersonal, and sociocultural processes is recognized in Integrative Family Therapy, which intervenes on the individual, familial, and social level. It incorporates different strategies and techniques aimed at different kinds of pathogenic structures and processes. Properly integrated, they complement each other and facilitate changes in all the previously described factors involved in the etiology and maintenance of drug addiction. By starting from such an all-encompassing view of substance abuse, one arrives at a correspondingly broad approach to family therapy.^{36, 37}

On the individual level, the first step is to persuade the addicts to initiate detoxification. Whether this is done in a hospital or

clinic, or, more desirably, at home, the addicts must be led to take responsibility for their substance misuse and for remaining abstinent. To do so, they also need help in resisting pressure from drug-abusing peers, dealers, and others on the drug scene.^{1, 15, 21, 31, 34, 42} All addicts, no matter what their age, have to be aided in completing the tasks of adolescence. They need to become aware that they lack control over their lives and their behavior. Then they must be taught coping mechanisms, skills, and effective role behavior by such means as assertiveness training, modeling, role-playing, or behavior rehearsal; they must be helped to acquire decision-making and problem-solving abilities. Having dealt with their task-avoidance and fear of failure, they must then be motivated to strive for success at school, at work, and in life; problems of finding employment and dealing with superiors, teachers, and school counselors must be discussed. Carefully guided through these steps, addicts may gain a positive identity and self-esteem, become mature and independent, and accept social responsibilities.^{2, 25, 34, 37}

It is most important, however, to further the self-differentiation, individuation, and self-actualization of drug abusers. For example, therapy must help them make contact with inner experience and learn accurate self-perception. It enables them to develop close friendships and intimate relationships outside the family, thereby dealing with lack of social skills, sexual identity problems, and fears of inadequate sexual performance. It prepares them for life on their own, enables them to leave home, and facilitates separation.^{2, 14, 34, 35, 41, 43}

Therapy must seek to make all members of the family of origin responsible for the drug problem and its solution, putting a stop to mutual shifting of blame and ensuring that everyone accepts a part in the detoxification process by, for instance, keeping the addicts under observation to prevent them from taking drugs, intercepting calls from

dealers, or shielding them from substance-abusing friends.^{20, 21, 30, 31, 35} Therapy also brings parents face to face with their own abuse of alcohol and medication; according to Huberty and Huberty:¹⁴

Because of the high incidence of parental and sibling substance abuse, we ask all family members in therapy to abstain from all mood-altering substances. In addition to detecting otherwise hidden parental and sibling drug or alcohol abuse, such an agreement also removes the double standard attached to the drug abuser in therapy. Parents are thereby allowed to experience the adult peer pressures, which often produces greater empathy. (p. 98)

In general, therapists see the whole family as the patient and avoid the notion that the addict is the only sick or incompetent member. By exploring and discussing problems of other family members, therapists take the focus off the addict and show that drug abuse is actually a symptom of disturbed family functioning, that therapy is for the sake of all family members, and that everyone will have to change.^{10, 11, 20, 25, 31, 35}

During therapy sessions, the therapists further open and honest communication. In Reilly's²⁵ words:

From the beginning, family members are encouraged to talk primarily to each other rather than to the therapist; to argue with each other rather than complain about each other to the therapist; and to reargue disputes they had at home *in the session* rather than simply tell the therapist about them. (pp. 162-163)

Therapists must demand clear and explicit communication; therefore, they clarify mixed and ambiguous messages, remark upon private and nonverbal ones, and point out discrepancies between verbal and nonverbal behavior. In this way they serve as models for all family members. By encouraging family members to share their inner experiences and express positive, negative, and ambivalent feelings, therapists fight alienation and show that openness is not dangerous, that family members still feel positively toward each other, and that neg-

ative emotions are normal. Therapists also help members to express anger constructively and deal with the resulting guilt. Moreover, they give permission to be serious, humorous, funny, sad, etc., increasing the range of permitted behavior, making companionship more enjoyable, and increasing satisfaction with family life.^{3, 13, 14, 15, 20, 25, 37, 40}

In most cases, the marriages of the addicts' parents need to be strengthened. Therapy then plays a role in resolving marital conflicts, improving communication between spouses, building mutual support, and dealing with sexual problems. In order to make the parents relate again as partners, therapists often give homework assignments, e.g., have the parents set specific times for a mutual activity or discussion. Therapy must also deal with the marital crises that can be expected when the addicts improve. It is of great importance that the drug abusers be freed from the responsibility for their parents' marriage and from roles as spouse surrogates. By detriangulation, by breaking alliances, and by establishing clear boundaries, therapy serves to keep them out of their parents' marital relationship and conflicts. It helps break the symbiosis between the addicts and their opposite-sex parents and establishes generational lines; this changes incestuous relationships and their effects on the children. At the same time, the same-sex parents must be brought into a more central position in their families: through therapy, they are encouraged to become involved with their addict children. Thus attitudes are improved, feelings clarified, and common interests discussed.^{6, 13, 14, 15, 25, 32, 35, 37, 40, 42}

Therapy must counter the opposite-sex parents' overprotection, indulgence, and infantilization of their drug-abusing children while trying at the same time to stop the scapegoating and blaming by the same-sex parents. It must enable them to accept their parental responsibility, take control, and improve their parental competence. They must

be helped to set consistent limits and enforce them jointly, and thus to work as a team. The parents must be made to realize that they often have unrealistic expectations and give attention only to the problematic behavior of their drug-abusing children. Encouraged to notice admirable traits and to reward desired behavior, they can learn techniques of positive reinforcement. In many cases, parents must be taught to relate to their drug-abusing children as real persons. To do this, therapists interpret projections, identifications, and attempts at object-conservation; deal with death themes, grief, and family secrets; discuss emotional losses, and let family members complete their mourning. They must also affirm family loyalties, showing that these will survive when children individuate, and resolve separation anxiety. Such interventions should lead to these parents accepting the individuality and difference of their children, seeing them as unique and separate persons, and allowing them to establish their own identity. In this way the parents get ready to let their drug-abusing children leave home.^{3, 6, 13-15, 24, 25, 30, 37, 41, 43}

While the therapeutic focus remains on the family of origin, problems affecting the newly created families of procreation of married addicts must also be addressed. Parents must be persuaded to develop more positive and accepting attitudes toward spouses of their addicted children. It is more important, however, to establish clear boundaries between the two families. Only then is it possible to focus on the marital relationship of the addict, solve conflicts, improve the sex life, and help an addicted spouse. The marital roles, patterns, and relationship definitions, unconsciously carried over from the families of origin, must also be identified.

On the social level, therapists must deal with the peer relationships of addicts. The latter must be separated from drug-abusing friends and freed from the drug scene. On the other hand, peers might be included in

some sessions in order to integrate the addicts in a supportive group, facilitate the separation from their parents, and discuss value conflicts.^{2, 3, 42} In a few cases, relatives, friends, teachers, parole officers, case-workers, and other individuals may be invited to some sessions. In this way therapists can gather new information and clarify previous observations. In addition, addicts' families can be integrated in a social network whose members might serve as resource people and service providers, help with problem solving and decision making, reduce alienation, and maintain positive changes.^{1, 2, 11, 19, 20, 37, 43} Similar goals can be reached by integrating the clients into such support groups as Families Anonymous which are longer lasting. However, multiple family and parents' groups are more therapeutic because their members have similar problems and therefore feel understood. Moreover, they share feelings, support each other, offer help in crisis situations, learn by identification or analogy, and use the strengths of other families as models.^{1, 13, 14, 20, 21, 31, 37, 41-43}

Therapists may also intervene in occupational, school and other systems. They may deal with the father's occupational pressures, job loss, and retirement. They may recommend that addicts change jobs or attend other schools. They may seek to improve the addict's relationship to teachers and schoolmates. If other agencies are involved, their cooperation must be elicited and their efforts coordinated.^{2, 30} In general, therapists try to strengthen the resistances of their clients to negative environmental factors. As Friedman⁶ noted, "Ideally, intervention would require that the total ecological environment of the family be examined and realigned" (p. 75).

Addressing issues on the individual, familial, and social levels, Integrative Family Therapy attempts to alter all the factors involved in the etiology and maintenance of substance abuse, using those strategies and techniques from different schools of

psychotherapy that are most likely to affect the particular pathogenic structures and processes presented. The treatment goals are realized when the addict has become abstinent and left home with a differentiated self—and when the pathogenic factors in the addict's family of origin and in the addict's marital relationship have been alleviated.

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