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Addiction, culture and family therapy strategies

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This update reviews the empirical evidence supporting the use of couple and family therapies in managing families affected by addiction, both adolescent and adult populations. A particular focus of the paper is the need for a "culturally competent" strategy in assessing and treating target families.

Key words: Addiction, culture, family therapy.

Introduction

Compelling evidence now supports the clinical insight that couple and family therapies have a significant role to play in the management of addiction. This update aims at reducing the large gap between research and practice in helping families, as well as highlighting the relevance of culture in these approaches.

Substance use disorders and family interventions

Substance use and aspects of family life and relationships have long been connected to the initiation, exacerbation and relapse of the spectrum of substance use disorders. Examples include that poor parent-adolescent relationships consistently predict adolescent drug use across cultures and time; negative communications and poor-coping strategies within a marriage may initiate and perpetuate drug use while close relationships with healthy families-of-origin may buffer the abuser from relapse.[1]

In contrast, a number of reviews of family-based interventions over the last thirty years concluded that while several strategies were identified as "promising", the relative dearth of empirical studies precluded the demonstration of efficacy or effectiveness of most modalities.[2] Within the last ten years, more rigorous investigation of the impact of these interventions have been published, spurred by the availability of several manualized couple/family-based approaches. Three preponderant theoretical perspectives for family strategies in addiction have emerged.[3] Table 1 compares the various tenets involved:

a. The family disease approaches whereby addiction is conceptualized as a family illness suffered not only by the addicted individual but by family members viewed as "co-dependent". Each member must address its respective disease process individually. This tenet while popular has limited empirical evidence.

b. The family system approaches whereby general systems theory is applied to the family interactions becoming organized around the addiction and maintaining a dynamic balance between the addiction and family functioning. Related strategies have included:

- Unilateral engagement techniques educating the family about intervening as a group to confront or motivate their affected relative to become aware of their problem and need for remedial help. In this early phase, the concerned family member is not involved.
- Inclusive systems techniques, preferred by many family therapists, aiming at modifying family dynamics and interactions that dominate the family's "need" for their relative's addiction.

c. The behavioral approaches whereby it is assumed that family interactions reinforce the addictive behavior and therapy aims at breaking this reinforcement and fostering behaviors conducive to abstinence.

Among adolescent populations, cost-effective family systems approaches are now shown to significantly reduce drug use, achieve better retention rates, reduce comorbid externalizing problems, improve school and performance as well as overall family function. A major comparison of the available strategies has been the National Institute of Drug Abuse (NIDA) Cannabis Youth Treatment Study (CYT), a multi-site randomized clinical trial of five state-of-the-art approaches. The family approaches included Multi-Dimensional Family Therapy (MDFT), a developmentally and ecologically oriented approach to reducing adolescent drug use and related problems by intervening in the multiple systems that maintain these symptoms. MDFT reduced adolescents' substance use by 27% from intake to discharge in the CYT study and 65% had no past month use at the 3 month follow-up.[4]

The second approach, the Family Support Network (FSN), combined individual cognitive behavior therapy (CBT) and motivational enhancement therapy sessions for the adolescent with parent psychoeducational groups, home visits and case management services. FSN reduced past month use by 44% between intake and the end of treatment and similar to MDFT had 64% no past month use at the 3 month follow-up.[5]

A third approach, Multi-Systemic Therapy (MST), a social ecological approach to altering the multiple

Table 1. Marriage and family therapy of alcoholism.

Model	Family disease (e.g., Twelve Step, Al-Anon)	Family systems (a) Unilateral (b) System engagement (e.g., CRAFT,* PTC,** Johnson Intervention)	Behavioral marital (BCT)	
Theory	Addiction is a family illness of co-dependence	Family can either reinforce or discourage drinking	Addiction has "functional benefit" for family system	Relationship conflict may trigger or perpetuate addiction
Target group	Concerned Significant Other (CSO)	Concerned Significant Other	Family seen with addict	Addict with spouse
Goals	Personal well-being of family members	Influencing addict to enter treatment	Relationships change underlying addiction	Abstinence and stable relations
Interventions	Detachment and focus on personal growth	Reinforce non-drinking communication and treatment invitation	Changes in roles. Communication and problem-solving	Abstinence contracts Increasing positives communication skills
Main evidence	Rychtarik et al 1998: manualized controlled study CSO>waiting list	Miller et al 1999: manualized CRAFT> Johnson Barber et al 1998: promising PTC	Steinglass et al 1987: review of strategies	Fals-Stewart et al 2004: more abstinence, less problems, more cost-effective

* CRAFT: Community Reinforcement & Family Training, ** PTC: Pressure to Change

risk factors that create and maintain adolescent substance abuse and delinquency was compared in a 4-year outcome trial with "community services as usual". The percentage of urines free of marihuana among adults receiving MST (55%) was higher than the comparison group (28%).[6]

The main tested behavioral approach in this age group is Functional Family Therapy which aims at altering family maladaptive patterns reinforcing the adolescent's problems and establishing more effective problem solving approaches.[7] This approach particularly combined with CBT demonstrated significant reductions in drug use between intake to treatment and a 7-month follow-up assessment.

In the adult groups, the preponderance of evidence has been provided by a series of studies involving Behavioral Couples Therapy (BCT). Suited to a predominantly nuclear family structure in North America, BCT has gained prominence for enlisting the family's help after the alcohol or drug-dependent person has sought treatment. In recognition of the "destructive cycle" between substance abuse and relationship dissatisfaction, instability and irritability, the main objectives of BCT are to eliminate abusive drinking and drug abuse and to engaging the couple/family support for the patient's effort to change as well as restructuring to that effect the couple/family interactions patterns. The number of sessions administered have ranged between 15 to 20 sessions for individual couples over 5–6 months or brief group sessions for 3 to 4 couples together over 9–12 weeks. BCT has been fully manualized.[3]

BCT is only suitable for couples who are committed to their relationships (partners for at least 1 year, and if briefly separated, attempting to reconcile). They must be able to acquire new information and skills and must both share a primary goal of abstinence. Aggression is an exclusion criterion and so are addicted couples which are more enabling of each other. This in reality has had the unfortunate result of eliminating more female patients in a relation with a using male.

Most of the published outcome studies have focused on individual marital therapy. A pilot group BCT therapy program, based on the experience with 38 couples so far seen, 3 or 4 couples at a time, compared to 33 couples who refused the approach demonstrated sizable improvement at the 6 month follow-up.[8]

Culture and family therapy

The current empirical evidence is however overwhelmingly rooted in a Western and particularly North American nuclear family perspective. Family interventions within other cultural contexts must account among others for significantly different structures, power division, religions, attitude towards drugs and the role of self-help. Families in multicultural societies for more than one generation will also develop their unique blended perspectives. Within the constraint of this update, a few examples of the impact of culture are presented.

Families are the conveyors of traditional cultural norms, rules and values and will accordingly shape attitudes towards substance use. For instance, smoking among Pakistani and Bangladeshi men is an accepted tradition, contributing to group cohesion and identity. Consequently, young boys grow to become smokers. Contrastingly, smoking among women is not acceptable and carries a cultural taboo and stigma. When transplanted into multicultural societies like in the United Kingdom, offspring of these families criticize their fathers for smoking.[9]

Each family has its own culture and its own dynamic and, when substance abuse occurs, the response of different family members is not necessarily uniform. For example, the family may split into rejecting and rescuing factions, this leading to family conflict. Wider cultural factors undoubtedly also affect the family's response to substance abuse. In traditional societies, accustomed to folk methods of confronting difficulties and problem-solving, a professional therapist may meet considerable resistance, which can be alleviated if the position of an older person in supervising treatment is recognized and acknowledged. To understand the experience of a family from a very different culture requires a mind that can be open to new constructions of the pattern of family life, both internally and externally and in terms of custom and expectation. For example, respected kinship and authority structures in Asian and African extended families are strikingly different to those in western families and, in countries where the family is the nucleus of society, it often plays a significant role in bringing the abuser to treatment. Certainly, substance abusers themselves perceive family support as most important for remaining in treatment.[10] A review of research studies testing the effectiveness of culturally adapted family-based interventions reported an increase in treatment retention by 40% compared to generic family interventions.[11] This is of particular importance as the use of services by ethnic minorities tends to be low.

Family attitudes toward drinking and the drinker may also be harnessed towards prevention and recovery. It has been recognized that in some family-centered European cultures (like the Italian, Greek, Portuguese and Spanish), exerting familial informal social control with regard to drinking is successful in preventing alcohol abuse. Families act as the primary groups for alcohol-related problem intervention. The Italian experience in extended family recovery started 25 years ago. The number of Clubs of Treated Alcoholics (CAT) is four times greater than groups of Alcoholics Anonymous. The CAT considers addiction as a family and community style, thus involving family and community members early into treatment. Changes in alcoholics' social functioning should be visible within the community in order for it to change.[12] Modalities of treatment mainly involve extended family and community reinforcement training but other components like BCT are also present.

Expressed emotions as attitudinal indicator

Recently, emotional attitudes towards the patient of key relatives have been associated with maladaptive coping mechanisms. These attitudes are also shaped by culture. People with schizophrenia from families that express high levels of criticism, hostility and emotional over-involvement, according to the Expressed Emotion (EE) Index, have more frequent relapses than people with similar problems from families that tend to be less expressive. Little is known about EE as predictor of relapse for substance related disorders. Alcoholic patients with high EE spouses, when compared with their counterparts with low EE spouses, were more likely to relapse, had a shorter time to relapse, and drank on a greater percentage of days in the 12 months after starting behavioral marital therapy.[13]

In a pilot trial in Milan,[14] frequencies of high EE were investigated by the Camberwell Family Interview

in relatives of people with heroin dependence in outpatient and residential treatment and compared with those of relatives of schizophrenic patients in standard outpatient care. Thirty patients affected by DSM-IV Opioid Dependence were recruited before entering an outpatient program and 47 key relatives were identified; 12 other patients were recruited before entering a residential program and 24 of their key relatives. A random comparison sample of 30 patients with schizophrenia were recruited along with 45 of their key relatives. Relatives higher EE appeared to be positively co-related to the severity of the opiate condition. Indeed the relatives scores of the residential group were similar to those of schizophrenia. The EE score did not however predict the potential for relapses in a 24 month follow-up.

A trial is currently being conducted about the effectiveness of manualized psychoeducation treatment in improving knowledge about addiction and lowering the EE profile as well. Following 9 ninety-minute weekly sessions, the EE profile was lowered in 18 among 35 re-tested relatives (34.6%, P=0.002) at 6 month follow-up. The family's knowledge about addiction increased as well. The Italian cultural approach to psychoeducation seems to favor an open discussion about presented topics and belief system. On the other hand, confrontational approach is not often accepted, and may result in further emotional suffering.

Conclusions

This update summarizes the growing empirical evidence supporting the effectiveness of couple and family based therapies in the management of substance related disorders. It also highlights the importance of cultural sensitivity and adaptation to enhance accessibility and retention of families, and improve the outcome of these interventions.

Research and guidelines in cultural adaptation are sparse due to the complexities presented by the diversities of culture yet "cultural competence" is an important therapeutic ingredient. A pilot study using an Expressed Emotion Index is presented for its promising comparative cultural potential. More related studies are encouraged.

Εξάρτηση από ουσίες, πολιτισμικοί παράγοντες και στρατηγικές οικογενειακής θεραπείας

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Στην ανασκόπηση αυτή περιλαμβάνονται οι εμπειρικές ενδείξεις που υποστηρίζουν τη χρήση θεραπείας ζεύγους και θεραπείας οικογένειας στην αντιμετώπιση οικογενειών με μέλη εξαρτημένα από ουσίες, τόσο εφήβους όσο και ενηλίκους. Η εργασία επικεντρώνεται ιδιαίτερα στην ανάγκη για μία «πολιτισμικά εναρμονισμένη» στρατηγική στην αξιολόγηση και τη θεραπεία των οικογενειών αυτών.

Λέξεις ευρετηρίου: Ουσιοεξάρτηση, πολιτισμικοί παράγοντες, θεραπεία οικογένειας.

References

1. Rowe CL, Liddle HA. Substance abuse. *J Marital Family Ther* 2003, 29:97–120
2. O'Farrell TJ, Fals-Stewart W. Alcohol abuse. *J Marital Family Ther* 2003, 29:121–146
3. Fals-Stewart W, O'Farrell TJ, Birchler GR. *Behavioral couple therapy for substance abuse: Rationale, methods and findings*. National Institute on Drug Abuse, Science and Practice Perspectives 2004, 2:30–41
4. Liddle HA. Multidimensional family therapy for adolescent cannabis users. *Cannabis Youth Treatment (CYT)* series (Vol. 5). Rockville, MD, Center for Substance Abuse Treatment, 2002
5. Dennis ML, Titus JC, Diamond G et al. The Cannabis Youth Treatment (CYT) experiment: Rationale, study design and analysis plans. *Addiction* 2002, 97(Suppl 1):16–34
6. Henggeler SW, Clingempeel WG, Brondino MJ et al. Four-year follow-up of multi-systemic therapy with substance abusing and substance dependent juvenile offenders. *J Am Acad Child Adolesc Psychiatry* 2002, 41:868–874
7. Waldron HB, Slesnick N, Brody JL et al. Treatment outcomes for adolescent substance abuse at 4 and 7 months assessments. *J Consult Clin Psychol* 2001, 69:802–813
8. el-Guebaly N, Richard R, Currie S et al. Behavioral couple therapy: individual and group interventions. *World Psychiatry* 2004, 3(Suppl 1):100–101
9. Bush J, White M, Kai J et al. Understanding influences on smoking in Bangladeshi and Pakistani adults: Community-based, qualitative study. *Br Med J* 2003, 326:962–967
10. Oyefeso A, Jones M, Ghodse H. Ethnic monitoring in Specialist Drug Services: a population-based analysis. *J Substance Misuse* 1996, 1:91–96
11. Kumpfer KL, Alvarado R, Smith P et al. Cultural sensitivity and adaptation in family-based prevention interventions. *Prev Sci* 2002, 3:241–246
12. Patussi V, Tumino E, Poldrugo F. The development of the Alcoholic Treatment Club System in Italy: fifteen years of experience. *Contemporary Drug Problems* 1996, 23:29–42
13. O'Farrell TJ, Hooley J, Fals-Stewart W et al. Expressed emotion and relapse in alcoholic patients. *J Consult Clin Psychol* 1998, 66:744–752
14. Carra G, Clerici M. Expressed emotion and substance-related disorders in outpatient and residential treatment: a case control study. *World Psychiatry* 2004, 3(Suppl 1):100–101

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