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TRIMS therapy notes

Family Therapy for Drug Addicts

The TRIMS drug abuse program offers outpatient methadone maintenance, a chemical-free outpatient clinic, counseling in the style of Narcotics Anonymous, and an inpatient detoxification unit. Although their methods are different, the common goal of these services is to help drug-abusing clients achieve a lifestyle free of chemical dependence. Our primary mode is individual therapy, but we are exploring family therapy for drug addicts because dependence on drugs and dependence on the family are often related (Harbin and Maziar, 1975; Klagsbrun and Davis, 1977; Seldin, 1972; Stanton, 1978).

The family systems model of therapy applies well to treatment of drug addiction because excessive dependence on the family prevents the addict from achieving psychosocial maturity. Emphasis on direct treatment of the addict's family is a significant departure from conventional drug substitution (methadone) and behavioral models of treatment.

The model suggested here is largely derived from research by the Philadelphia Child Guidance Clinic's Addicts and Families Project (Stanton et al., 1978). The Philadelphia group notes that the heroin addict's usual pattern of moving in and out of the drug culture corresponds to his or her engagement in and disengagement from the family. Often the addiction syndrome begins in adolescence, and it serves the teenager as leverage for separating from the family. The adolescent's need for such a radical route to independence reflects the high degree of anxiety the addict and family feel about separation. Heroin gives the adolescent a dramatic symbol of identification away from the family, while it functions pharmacologically to suppress the anxiety of separating.

Given the legal, financial, and other barriers to procuring drugs that are inherent in the American illicit narcotics supply system, the addict is destined to "fail" even as an addict. After the addict experiences a crisis, like arrest, overdose, or involuntary withdrawal, the family will often rescue him or her. The negative connotations of failure and the consequently intensified dependence on the family necessitate the addict's renewed reliance on drugs as a means of reestablishing his or her independence. Even if the addict is relatively "successful" in maintaining the drug habit, the demands of the addict lifestyle retard or circumvent achievement of basic developmental tasks—civic and vocational identity, financial independence, and affiliation with reliable support networks outside the family.

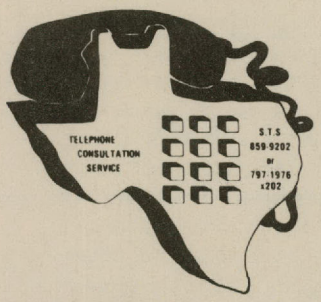
The net effect is that the addict remains at a plateau of immature psychosocial development, which confirms the family's apprehensions about separation. In a paradoxical manner, the addiction allows the addict to be simultaneously "in" and "out," competent and incompetent, dependent and independent. Such "pseudo-individuation" may profoundly delay the addict's maturation and maintain the addict and family in a seemingly endless cycle of mutual dependence.

For these reasons, the therapeutic focus should be on the addict's family system. For adolescent and especially adult addicts, this includes at least the addict's parents. Even "old-time junkies"—middle-aged persons who have been addicted for at least ten years—usually live with or in close proximity to their parents or to relatives who have taken on a parental role.

The first step in therapy is active recruitment of family members. Since the pathology of addiction has served to mask the family's fears about separation, the mere suggestion of including both parents and addict in treatment may be construed as a threat to family cohesion and survival.

The clinician who attempts such family recruitment should be prepared for either overt resistance or covert sabotage (such as clients not showing up for contracted therapy sessions). The experiences of the Philadelphia group and ours suggest that persistence is the key to successful recruiting of the family. This includes telephone calls and visits to the addict's home.

In treatment, the therapist begins to address specific reciprocal behaviors between the parents and the addict that have allowed or even encouraged drug dependence. These behaviors include the previously mentioned rescue efforts; inappropriate financial support from the parents; the addict's failure to leave home or his/her episodic return; excessive contact between addict and family, like daily visits or phone conversations. Because a direct assault on these behaviors may meet overwhelming resistance, the therapist may choose techniques of paradoxical and strategic intervention described in the family therapy literature (Haley, 1976; Watzlawick et al., 1974).



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Call the TRIMS consultation service for diagnostic or treatment advice, or for a literature search on a specific topic.

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Therapy will progress gradually as the addict's independence from the family grows. Long-term therapy is often necessary to repair long delays in family separation and the addict's maturation. The therapist should be prepared for setbacks as the family takes two steps forward and one step back.

The results can be gratifying, because the addict is often able to give up dependence on drugs in conjunction with dependence from the family. The family, in turn, is liberated from material and emotional bondage to the addict livestyle and, even more important, both the former addict and the family may rediscover each other outside the context of extreme chemical and familial dependence.

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