

RELAPSE PREVENTION
WITH ADOLESCENT SUBSTANCE ABUSERS
AND THEIR FAMILIES

by

Myra Binns Bridgforth

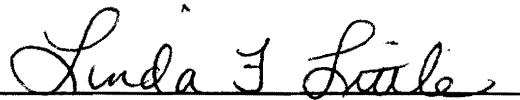
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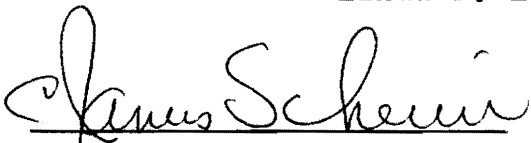
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And Their Families**

by

Myra Binns Bridgforth

**Committee Chairperson: Linda F. Little
Family and Child Development**

(ABSTRACT)

When adolescents enter residential treatment for difficulties experienced at school, with the juvenile justice system and/or their parent(s); substance abuse is often not identified as a significant contributor to the presenting problem. However, the dynamics of adolescent substance abuse are described in the literature as interactive processes affected by family dysfunctions, inadequately learned coping skills and significant stressors. In this study, a treatment strategy was developed for families of adolescents in a residential treatment center setting, where adolescents, along with other identified problems were also determined to be actively abusing drugs and or alcohol. The treatment strategies focused on alcohol/drug abuse

as a primary problem, and on relapse prevention through psychoeducation, family therapy and contingency contracting. Twelve adolescents and their families participated in the treatment program. A one year follow up was conducted. This thesis reports on four of these families indepth through the use of case studies. Comparisons and conclusions were drawn from the case studies which demonstrate that the treatment model is an effective auxiliary modality for use with substance abusing adolescents and their families.

ACKNOWLEDGEMENTS

I am fortunate to live, work and play within a system that supports, challenges and inspires me. The process of completing the requirements of a Masters degree in Marriage and Family therapy has graphically demonstrated how much I am indebted to "my system".

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During the last few years of training, I have been enriched by mentors who have taught me through their example, through supervision of cases and through their friendship. To Linda Little, thank you for being with me from the beginning and now into the future. You are my teacher, clinical supervisor, committee chairperson, Gestalt trainer and, most of all, my dear friend. Thank you to Ellen Luce for demonstrating patience and persistence and to Phyllis Jacobson-Kram for showing me the art and fun of working with families. Charlie Hoar

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TABLE OF CONTENTS

	Page
ABSTRACT	i
ACKNOWLEDGEMENTS	iii
TABLE OF CONTENTS	v
LIST OF FIGURES	vii
ARTICLE: Relapse Prevention With Adolescent Substance Abusers and Their Families	
Introduction	1
Efforts to Understand and Explain Relapse	1
Need for Consideration by Developmental Stages and Tasks	4
Need for Consideration of Adolescent's Larger Context	5
Purposes of Study	8
Methodology	12
Participants	12
Procedures	13
Treatment Strategy	15
Findings	24
Case Studies	24
Case Number One	25
Case Number Two	43
Case Number Three	64
Case Number Four	83

Discussion	101
Developmental Issues	101
Family Systems Issues	103
Treatment Affect Commonalities	106
What Was Learned in the Process	107
Limitations	108
Implications for the Future Research	109
References	110
Appendix A: Copies of the Four Case Study Contracts	122
Appendix B: Review of Related Literature	131
Overview	132
Adolescent Substance Abuse in a Family Context	135
Family Therapy	141
Family Therapy With Other Treatment Modalities	150
Contingency Contracting	151
Appendix C: Outline of Programs Developed for Purposes of This Study	159
Educational Sessions	160
Family Therapy Sessions	162
One Month Follow-up Session	163
Informed Consent Form	165
References	168
Vita	181

LIST OF FIGURES

Figure	Page
1 Systemic Model of Adolescent Relapse	9

Introduction

Efforts to Understand and Explain Relapse

Clinicians in the field of chemical dependency treatment and family therapy are beginning to recognize that relapse is a significant problem in working with chemically dependent clients. Recent research indicates that 40% of all persons attempting to recover from alcoholism fail repeatedly. (Gorski, 1985, 1986). Between 50% and 60% of treated alcoholics experience relapse within the first three months after treatment (Hunt, 1971). The entire focus of research on addictions is shifting from treatment success to examining the precipitants of relapse. "In the vernacular of Mark Twain on smoking and W. C. Fields on alcohol, 'giving it up is easy. I've done it a thousand times'" (Litman, Eiser, & Rawson, 1977, p. 157).

Current studies on relapse prevention differ in their definitions of relapse. Brownell, Marlatt, Lichtenstein and Wilson (1986) present a stage model of relapse as a way to explain the process. The stage model is considered within the context of the stages that precede relapse thereby drawing attention to what determines it. Another study defined relapse as a "violation of rules governing the rate or pattern of consummatory behavior" (Milkman, Weiner, &

Sunderwirth, 1984, p. 120). These authors also add "breakdown of treatment effectiveness" to their definition of relapse (p. 120). Still another definition explains relapse as the "decay of extinction" in which the previous behavior reemerged (Litman, Eiser, & Taylor, 1979, p. 192).

Gorski and Miller's (1982) psychosocial dysfunction model defines relapse as a set of behaviors that are the sobriety-based symptoms of alcoholism which they refer to as the "relapse dynamic." In their view of relapse, taking a drink or using drugs occurs at the end of a process which includes many other warning signs of relapse.

A lengthy list of factors that predict relapse has been identified in previous research. The key elements in most of the studies were stress and its related coping skills (Brownell, Marlatt, Lichtenstein, & Wilson, 1986; Chaney, O'Leary & Marlatt, 1978; Emrick & Hansen, 1983; Gorski & Miller, 1982; Gorski, 1985; Jurich, Polson, Jurich, & Bates, 1985; Litman, Eiser, Rawson, & Oppenheim, 1979; McCubbin, Needle, & Wilson, 1985; Moos, Bromet, Tsu, & Moos, 1978; Heather, Rollnich, & Winton, 1983; and Miller, 1980). Brownell et al. (1986) found that negative emotional states accounted for 30% of all relapses.

Gorski identifies stress events or high stress lifestyle as the factors that can activate the relapse syndrome (Gorski & Miller, 1982). Ludwig (1986) focuses on getting the recovering client to pay attention to the "bells" or cues that trigger craving and relapse. Both Gorski and Miller (1982) and Marlatt and Gordon (1985) emphasize the need for education as a basis for preventing relapse. The chemically dependent person needs to understand what is involved in relapse: what happens, how it feels and what to do as the relapse process is occurring. Relapse prevention planning takes into account the fact that a majority of chemically dependent people who go through treatment will be unable to maintain abstinence after the initial treatment. In anticipation of this, there is a need for treatment to focus on preventing relapse. The literature suggests that relapse education treatment programs could occur in group and individual therapy formats (Gorski & Miller, 1982) by utilizing a straightforward educational approach. Planning for relapse has been incorporated in some treatment approaches (Wachtel & Wachtel, 1986; and Gorski & Miller, 1982).

Historically, substance abuse treatment has been individually oriented, focusing on intrapsychic dynamics and giving little emphasis to or consideration of the

system in which the individual lived. Similarly, Gorski and Miller (1983) and Marlatt and Gordon (1985) focus on the individual with little consideration of the family system in the treatment approach. Also, these models are geared for adults and do not take into consideration the unique developmental needs of the adolescent.

Need for Consideration by Developmental Stages and Tasks

Even though adolescent addiction has many similarities to adult addiction, it is important to delineate the differences in order to gain an adequate picture of the problem and its particular dynamics. As McDonald (1984) has pointed out, adolescents have a preexisting natural dependency. Therefore, one must consider not just chemical dependency but also the adolescent's "dependency of immaturity" (p. 31). When working with adults who are chemically dependent, a major focus of the treatment is to remove the use of drugs as a coping mechanism and return the adult to functioning without the drug. For the adolescent abuser, removing drugs and alcohol as a coping mechanism leaves him/her with little or no avenue for coping. He/She cannot go back to previous ways of dealing with problems or dealing with uncomfortable feelings because other effective coping mechanisms have yet to be developed. McCubbin, Needle, and Wilson (1985)

differentiated between stressors and strains as motivators for dysfunctional coping tactics. This differentiation is of particular interest in assessing the use of alcohol and drugs by adolescents.

"Stressors are events which occur at a relatively distinct point in time and call for a change, such as an adolescent getting a driver's license (normative event) or having a car accident (non-normative event). Strains are the unresolved hardships of prior stressors (e.g. financial hardship due to loss of a job) or the inherent tensions of an ongoing role such as being the adolescent child of rigid parents" (McCubbin et al 1985, p. 53).

Stressors and strains could be developmental in nature, or could be related to the amount of support or lack thereof that the adolescent derives from his/her larger environment (i.e. home, school, peer network).

Need for Consideration of Adolescent's Larger Context

Understanding adolescent addiction is complicated because of the difficulty in sorting out the normative and non-normative problems of adolescence. (Amini, Salasnek, & Burke, 1976.) Discerning whether the problem has developed because of a conflict between parents and adolescent, because of a normal process in a

young person trying out new values, or because the adolescent is about to choose a dangerous lifestyle is at times very complicated. After struggling through this stage, normal adolescents end up with mastery or resolution of their problems. Although parents may not be comfortable with their choices, the adolescent who has successfully passed through this stage is comfortable with them.

In contrast with a normal developmental path, McCubbin, Needle and Wilson (1985) describe the situation in which family stressors and strains have a negative influence on the adolescent and inadvertently encourage him/her to utilize smoking, drinking and drugs as coping mechanisms. These coping mechanisms which are described as health risk factors can best be understood by using a family-oriented theoretical framework to organize concepts and ideas.

Systems theory has contributed to the understanding of chemical dependency in adolescents by focusing on how the individual's interaction with family members maintains the symptom. (L'Abate, Ganahl, & Hansen, 1986). From a systems perspective, alcohol and drugs are utilized by the adolescent as a means of coping with stress. The stress could be a response to marital discord (Orford, Oppenheimer & Edwards, 1976), parental

chemical dependency (Jurich, Polson, Jurich, & Bates, 1985), financial difficulties, illness, and/or a host of other problems that occur within a family framework (Jurich, Polson, Jurich, & Bates, 1985). The adolescent's stress could equally originate from outside the family system, and only secondarily become a "family problem" when the family is unable to adjust or change to handle its member's stress (Little & Gaffney, 1985).

Stress, according to systems theory (Carter & McGoldrick, 1980), occurs when old ways of coping are no longer functional and new ways of coping are not yet forthcoming. It is at this point, whether consciously or unconsciously, that a family member develops a symptom that serves several purposes for the family. Initially the symptom will distract the family members from the more threatening issue at hand such as divorce or leaving home (Haley, 1976). Then, because the symptom encourages family members to forsake their own needs and focus on a more obvious and demanding one, change is avoided and the family is able to maintain the "status quo" (Palazzoli, Boscolo, Cecchin & Prata, 1978).

Purposes of Study

The purposes of this study were to identify developmental issues that contribute to adolescent substance abuse and facilitate relapse; as well as family issues that contribute to and facilitate relapse, and to monitor family members' responses to a family-oriented relapse prevention program.

The treatment model that was developed for the purposes of this study (See Figure 1) utilizes a psychoeducational approach, drawing from the works of Gorski and Miller (1982) and Marlatt and Gordon (1985), as a way to enter into the family system and engage the family in treatment. (Refer to Appendix C for a detailed description of the Relapse Education Sessions.) In the next phase of the model, contingency contracting and family therapy techniques are utilized. (Refer to Appendix C for a detailed description of the Family Therapy sessions.) The process of contracting provides a model for negotiation and listening; it helps the family to identify the relapse concerns of the adolescent and other family members (Stuart, 1971; D'Zurilla & Goldfried, 1971). Family therapy as utilized in this study includes the key concepts of structure (Minuchin, 1974; Umbarger, 1983; Cleveland, 1981), hierarchy (Umbarger, 1983; Minuchin, 1974;

SYSTEMIC MODEL OF ADOLESCENT RELAPSE

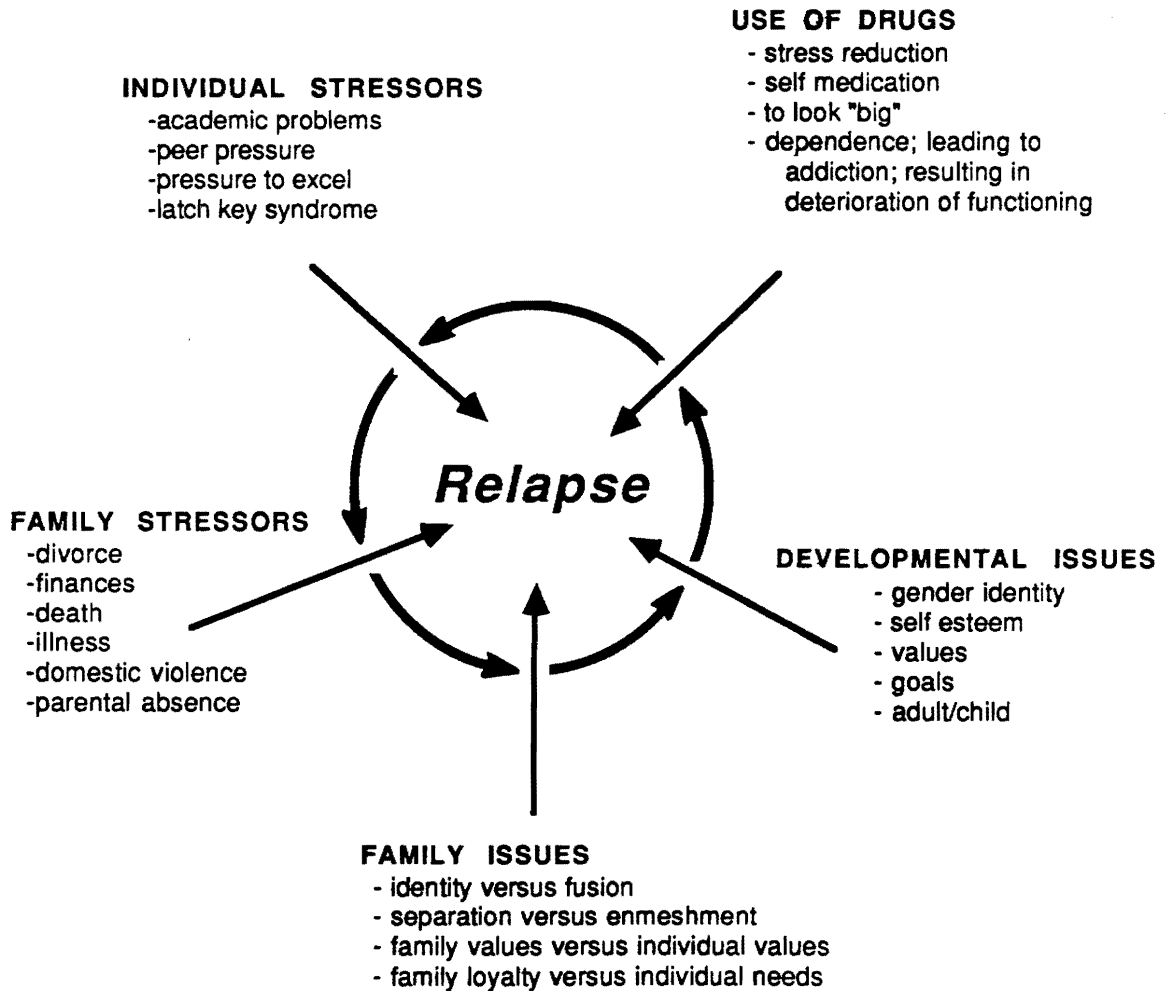


Figure 1. Systemic Model of Adolescent Relapse

Minuchin & Fishman, 1981), nodal point/event (Guerin & Pendagast, 1976; L'Abate, Gandahl & Hansen, 1986), over/underresponsibility (Bepko and Krestan, 1985; Pittman, 1987; Kaufman, 1985), homeostasis (Dell, 1982; L'Abate, Gandahl & Hansen, 1986), protective function (Minuchin & Fishman, 1981; Minuchin, Rosman & Baker, 1978), family strengths (Minuchin & Fishman, 1981; Walters, 1977), and family loyalties (L'Abate, Gandahl & Hansen, 1986; Minuchin, Rosman & Baker, 1978; Green & Framo, 1981). Understanding the concepts and intervening with the family around these issues were hypothesized to be the major components in adolescent relapse prevention within the family context. The focus of therapy is to bring about change in the drinking/ using behavior (Steinglass, 1976). The treatment model in this project suggests that the first role of the therapist in working with alcohol/drug-dependent adolescents is to come to an understanding of the relationships between alcohol, developmental issues and family life. Specifically, how is the drinking a stress signal for the whole family system? The task of the therapist is then focused on improving the functioning, flexibility, and growth potential of the family system as a whole, rather than on reducing the drinking behavior of the one alcoholic family member (Steinglass, 1976). Because of the small

number of participants in this initial testing and validation of a new treatment program, rather than focusing specifically on treatment outcomes, via statistical means, this thesis focused on the process of the treatment program, the individual and family dynamics of specific families who participated in the program, and recommendations for further program development. Specifically, four treatment families were chosen to be presented as case studies to illustrate their process of program participation, and their responses to treatment modes. The case studies present:

1. individual issues of adolescence.
2. family processes that were believed to contribute to substance abuse.
3. family history that were supported in the literature as contributors to substance abuse.
4. initial relapse concerns.
5. response to educational sessions.
6. contract negotiation.
7. follow-up relapse concerns.
8. other observations.
9. summary and conclusions.

This project was developmental, exploratory in nature, and established a foundation for future

scientific research. Findings are discussed accordingly.

Methodology

Participants

The treatment group was drawn from the population of Treatment Centers I and II, two county operated residential treatment facilities for adolescent boys located in a major suburban area of a large metropolitan city on the East Coast. All 12 current residents and all residents who were currently participating in Treatment Center I's aftercare program from the previous year were considered for inclusion in the treatment group. All current residents of Treatment Center II were considered for inclusion in the treatment group. The residents of both facilities were between the ages of 13 and 18 and were referred to one of the 7-12 month facilities by the juvenile court system, the school system, the Department of Social Services, or by the adolescents' parents. Based on the results of the MAST test, a valid, often used pre-screening measure, (Moore, 1972; Selzer, 1971), all the boys selected for inclusion in the treatment group were determined to be chemically dependent or in danger of becoming chemically dependent.

Treatment Center I utilized mandatory group and family therapy, and various behavior modification techniques in a structured residential setting. All residents diagnosed as chemically dependent were required to attend AA meetings two times per week.

Treatment Center II utilized group and bi-monthly family meetings. AA meetings were conducted in-house and were required for all residents diagnosed as chemically dependent. A total of eight boys and their parent(s) from Treatment Center I and four boys and their parent(s) from Treatment Center II participated in the treatment program developed for the purposes of this study.

Procedures

Treatment Centers I and II staff members administered the Michigan Alcohol Screening Test (MAST) to all residents and aftercare program participants. Consisting of 25 questions, the MAST is widely used screening device for alcoholism. Previous research has concluded that the MAST is accurate, easy to administer and an inexpensive way to determine the presence of alcoholism (Moore, 1972; Selzer, 1971).

A letter of information and invitation to participate in the proposed study was sent to all parents of residents and aftercare program participants

who scored five or higher on the screening test. A score of five indicates danger of becoming chemically dependent, and a score of eight indicates one who is chemically dependent. The treatment program was administered separately for Treatment Centers I and II. The procedures followed were identical for each program.

The parent(s) and target adolescent attended an evening information meeting and all agreed to participate in the study. They signed consent forms indicating their willingness to attend two education sessions on relapse prevention and two family therapy sessions which would focus on negotiating a relapse prevention contract. (See Appendix C) The two education sessions focused on the relapse process, the warning signs/high risk situations of relapse, coping strategies, and co-dependency issues for parents and other family members. The sessions were held on two weekday nights.

During the two weeks following the second education session, the family therapy sessions were conducted. The sessions focused on negotiating a family relapse contract. This process involved negotiation, bargaining, establishing rewards and consequences, outlining coping strategies for pertinent high risk relapse situations and stating expectations. After the

second session was completed, the therapist prepared the relapse contract and mailed it to the parent'(s) home. The parent(s) agreed to discuss it with their son, make additions/deletions/changes, and sign and return it. At this point, the therapist co-signed the contract and mailed back copies to the parent(s) and the adolescent son.

One month after the family therapy/contingency contracting phase of the study was completed the follow-up process began. All families were contacted and a follow-up meeting was scheduled to discuss the usefulness of the contracting procedure. (For a list of issues covered in these follow-up sessions see Appendix C.)

A urine screen was conducted during the two week follow-up phase of the study on all boys in the treatment group who were current residents of Treatment Centers I and II. Participants from Treatment Center I's aftercare program, who had included regular urine screening as part of their family relapse contract, were also tested.

Treatment Strategy

Education sessions. The two education sessions were conducted in a familiar setting (Treatment Center I or II) for parents and residents. The purpose of these

sessions was to provide information on the relapse process in a non-threatening manner and to encourage parents and young people to ask questions and voice their concerns. A semi-structured, lecture format was used. Interactive activities between parents and young people were included in the sessions. Parents and adolescents were directed to form small groups for these activities making sure that they would interact with someone other than their son or parent(s). The activities were structured in this manner to allow both parents and young people to discuss the issues of chemical dependency and relapse in a non-threatening format. Each attendee was given a workbook for these sessions which contained pertinent relapse materials and relapse exercises. Topics covered in the two education sessions included: myths about chemical dependency and relapse, Gorski's (1985) relapse process and relapse dynamic, relapse maps (Marlatt & Gordon, 1985), high risk situations, warning signs of relapse, coping strategies and co-dependency issues. (For a complete description of the education sessions see Appendix C.)

Family therapy sessions. To document the content and process of each session, process notes were written. The basic format of the session follows. Session one opened with the therapist briefly asking the

family how they felt about the MAST test results which indicated that their son was chemically dependent. This question typically focused the family on their view of the son's and/or the parent'(s) denial of the problem, the accepting proactive stance of the family in dealing with the problem; or a stance somewhere in between. Even though the boys had often been in drug treatment prior to coming to Treatment Centers I or II, often both parent(s) and the adolescent were still in deep denial. In most cases the parent(s) voiced more concerns than did the boys about the chemical dependency problem. At this point, the therapist explained the ground rules for the therapy sessions which were: (a) We would utilize a "here and now" approach to planning for a better future for the family rather than attempting to blame or find fault, and (b) No coercion would be allowed. The stated purpose of the sessions was to negotiate a contract: an agreement spelling out what each wanted from the other and what each was willing to give in return. The parent(s) and son were to negotiate the contract. The therapist's role was to be a helper. The therapist clearly stated to the families that the contract duration was for one month only.

The next question the therapist asked was, "Based on the two education sessions and any other thoughts

you've had, what are your relapse concerns?" As a result of interaction between parent(s) and son pertaining to this issue, several concerns were typically made evident. Family members would often bring up facts from the education sessions that were surprising information to the other family member, or they would explain the family's long history of obtaining treatment for the son, and their resulting frustration in dealing with the son's behavior.

At this point, the therapist asked the family if they would be willing to share with each other the high-risk situations that they had noted in their relapse workbooks during the second education session. They were handed a high-risk situation list to look over. They were encouraged to call out high-risk situations as the therapist wrote them down in a notebook. Most families volunteered approximately 10 high-risk situations that they considered to be of significant personal concern.

After compiling this list the family was directed to brainstorm coping strategies for each high-risk situation as the therapist again took notes and occasionally offered suggestions. The family members were in the process of compiling the coping strategies when the first session ended. The therapist closed the

session by telling the family that there would be time in the second session to finish brainstorming the coping strategies.

Session two began with the therapist briefly reviewing the progress made in the first session, enabling the family members to refresh their memory, and to focus attention on the task at hand. As the family continued the process of developing coping strategies for each of the previously listed high-risk situations, the therapist commented on competencies displayed, added clarifying questions and comments, noted significant process interaction (i.e., when they were able to make eye contact or when they appeared to stop listening to the other) and intervened when disagreement arose by refocusing their attention to the immediate task. After completion of this phase the therapist asked the family two leading questions: (a) "How do you want things to be different in your family during the next month?" and, (b) "What are your expectations of each other during the contract period?" These questions provided a process/content catalyst for the family to address issues of denial concerning chemical dependency, fears, unhappiness with the status quo in the family, and hopes for change. The therapist used the frame of "staying safe" as a way to conceptualize the recovery plans

negotiated during the session. At various points in the negotiation and bargaining, the therapist suggested some daily prevention strategies that the family might consider including in the contract.

The final phase of the session focused on consequences and rewards. Questions such as "What are you willing to give (or give up) to get what you want?", and "How difficult will it be for you to do this thing that your parent(s) is/are asking of you?" were typical of questions asked in order to facilitate the give and take process. The families responded with surprising creativity and variety to the challenge of establishing consequences and rewards. Their experiences with the residential treatment center's approach to assigning consequences for negative behavior made for a smooth transition to the task. The process of coming to and agreeing on a reward was a bit more novel and both parent(s) and sons overwhelmingly responded approvingly and enthusiastically.

As the session came to a close, the therapist explained to the family the procedure for reviewing and signing the contract when they received it from her in the mail, as well as the procedure for returning the signed contract. The family was informed that the therapist would contact them in one month to schedule a

follow-up session at which time they would briefly discuss whether or not the contract had been useful to them.

One year follow-up

In order to gain more information on the usefulness and effectiveness of the family therapy psychoeducation/contracting approach, four of the treatment families were contacted one year after completion of the treatment. The families met individually with the therapist to discuss their current status as it related to relapse and family functioning.

The therapist met with the families individually at Treatment Centers I or II for an agreed-upon 30 minute session. After making initial greetings the therapist said, "It has been a year since the last time we met together. At that time we talked about the contract that you negotiated and whether or not it had been helpful. Since that time, have you experienced a relapse, either a chemical dependency relapse (for the son) or a co-dependency relapse (for the parent)?" In order to obtain more of the details of the twelve month period as it related to relapse, the therapist asked, "When was the last time you drank alcohol or used drugs?" "Do you suspect that your son is using again?" "What signs of co-dependency relapse have you

experienced?" "What signs of chemical dependency have you experienced?" "Have you observed any of the 'old signs' of relapse in your son that might indicate substance abuse?"

Family members responded to these questions by talking freely concerning the events of the previous year. In all cases they appeared to be relaxed and open to discussing this subject. If the sons or parents answered affirmatively to any of the questions on relapse, the therapist responded with these questions: "How did the relapse happen?" "Who was involved and what were the circumstances?" "What was the reaction to the relapse in the family?" "Did you (the parents) learn about it right away?" "What did you do?" "Have you gone back into treatment?" As the family members talked about the relapse or about the events that helped to avoid a relapse, the therapist listened, asked clarifying questions, and commented on competencies displayed by the family.

After this segment of the session was completed, the therapist asked questions aimed at gaining information about the support systems the family had utilized during the previous year. She asked: "Do you attend AA or AL-ANON?" "If so, how often do you attend and do you find that the meetings are helpful?" "Are

you currently involved in individual, group or family therapy?" "If so, where and with whom are you obtaining therapy?" "Do you participate in the aftercare program of Treatment Centers I or II?"

At this point, the therapist gave the family members the list of relapse concerns that had been used in each phase of the program. She directed the parent(s) to select three to five co-dependency relapse concerns that applied to them currently. She directed the sons to do the same by selecting chemical dependency relapse concerns that applied to themselves. The families very carefully looked over the relapse concerns list and called out the items. The therapist wrote the items which they selected in a notebook.

At the close of the brief one year follow up session, the therapist asked the family members to talk about the future: what they wanted for themselves and what events they were looking forward to. This intervention served to end the session on a positive note and yielded some interesting and valuable information about the families.

Findings

Case Studies

Based on the information drawn from all of the phases of the research project, four case studies were written. The purpose of the case studies was to illustrate the treatment process and how it related to the current literature by showing some typical responses and outcomes of treatment. The case studies graphically revealed how differently families reacted to the treatment, subtle and not so subtle differences in the dynamics of substance abuse in families, and how raising the anxiety in the families through this treatment modality supported them in making some important changes.

Case Number One: The Case of the Eternally Optimistic
Mother and the Feet-Dragging Son

Introduction

A 44 year old mother and her 25 year old and 18 year old sons were the individuals in this family. Mother worked in an administrative position with a local business. She was married twice, each time to an alcoholic. A son was born of each marriage. The family no longer had contact with either father. The 25 year old son had a history of excessive alcohol and marijuana use and had been a resident of Treatment Center I during his last year of high school. Since that time he had continued moderate use of marijuana and alcohol. At the time of the study he was employed and attending college on a part time basis. He was in the process of moving out of the family home into his own apartment. The 18 year old son had been using marijuana since the age of 13 with his pattern being to begin using gradually at first, then slowly progress to daily use. As a result of his drug use, his school performance had dropped, he had begun to sleep excessively and developed lethargic behavior patterns, thus creating a crisis between himself and his mother. After the crisis he would avoid using marijuana for a while, but would always go back to using after several weeks. The same pattern had

occurred with the older son during his adolescent years.

Therapist Comment Based on prior work with this family a pattern had emerged indicating that alcohol and marijuana use served the purpose of giving the family a break from their excessive closeness with each other. Each time the 18 year old son returned to marijuana use, the mother would ignore the relapse signs including the immediate dip in school performance and lethargic behavior. Once the son's marijuana intake increased to daily use she would confront him and try either another treatment program, therapist, or alternative school. Within the context of the family interactional patterns, the son appeared to be threatened by the mother's pulling away from him. While her son was abstinent, the mother felt free to make clear her expectations for him to carry out his responsibilities at home and at school. This allowed her to begin to pull back from her overinvolvement with him by focusing more on her work and by spending free time with friends. At this time the son escalated his drug use, which allowed him to avoid taking responsibility, and to pull his mother back into excessive involvement with him.

The family had first worked with the therapist one year prior to this treatment when the younger son was a resident of Treatment Center I. During a span of six

months the son had been seen individually and in group sessions, and the family had been seen once a week for family therapy. After six months, the clinical staff at Treatment Center I had made the recommendation that the younger son be referred for evaluation to a psychiatric hospital because he was showing signs of extreme sadness, was unable to maintain a train of thought, and was potentially judged to be suicidal. He had been unable or unwilling to follow the most basic rules of the treatment program such as getting up in the morning, attending classes, and doing chores. There was a clear concern that he might not be able to cope in his current state. The son was subsequently sent to a psychiatric hospital for several weeks. Afterwards he had returned home and entered a special school where he could receive remedial support in those academic subjects in which he had fallen behind.

He and his mother had begun to participate in the monthly aftercare support group meetings at Treatment Center I. When the mother was contacted to participate in the Relapse Study Project, she enthusiastically agreed to attend and to bring her son with her.

Family Reaction to the Psychoeducational Sessions

The mother walked into the first session five steps ahead of her son. She was smiling, friendly, quick to

greet parents and staff members, and settle into the group. The son walked through the door slowly, looking tired, and seemed reluctant to be present. He hung his head down, only looking up to say a mumbled "hello" when someone who knew him offered a greeting. He slumped into a chair in the group room and assumed a bored countenance.

During the first education session the mother listened intently, took notes, read the printed material which was handed out, and participated actively in the small group activities. The son sat in his chair occasionally looking up from the floor indicating that he was listening for a while and then drifting off. During the small group activities he participated when others in the group asked his opinion. Some of the other parents in the small group reacted to his lack of energy and worked hard to draw him out.

The mother came for the second education session without the son. She stated that he had been unwilling to attend. Once again, she was very intense; participating in the process and listening to the content of the group, (much of which focused on co-dependency and substance abuse relapse). After the group, she expressed much concern and regret that her son had been unwilling to attend the session. She was

sorry that he had missed hearing information that she viewed as being very important to him.

Therapist Comment The family followed their usual pattern during this phase of treatment in that mother was overly responsible while the son under functioned. She attended the sessions and took copious notes. He either attended in body only or did not attend at all. By getting other parents to "help" him during the one session he did attend, the son was able to perpetuate the pattern of hardworking parent and needy son outside the family system.

Family Therapy

Session One For the first few minutes of the session, the mother and therapist chatted about the older son who was not present. The younger son sat huddled in his chair, clutching his coat and staring at the floor. The therapist gently began to tease him about "energizing himself," a frame that had often been used in individual therapy sessions the year before. He was fairly quick to relax and smile, put his coat aside, and enter into the session. In response to the therapist's direct questions, the son talked about his repeated reversions to marijuana usage over the past few months. After leaving Treatment Center I and spending several weeks in the psychiatric hospital, he entered an

alternative school. Several weeks after going back to school, he began to use marijuana again. As his use of the drug increased, he exhibited increasingly lethargic behavior, resulting in the school initiating urine screens. When the testing showed that he was using marijuana, he was expelled from the school. Prior to this session he had not used marijuana for several months. After the son finished talking about his marijuana use the mother looked surprised and remarked that she had not been aware of the frequent pattern of using, stopping, and then quickly returning to using. The son stated that he did not believe that he was chemically dependent. The mother responded by stating clearly that she believed that he was addicted. The son's explanation for his pattern of using, stopping for a short time, and then going back to using, was confused and contradictory.

When the therapist asked them to share their relapse concerns from the list of relapse concerns that had been used in the education sessions, the mother went quickly and efficiently down the list, calling out items by number. The son slowly followed along responding to the items that she selected with remarks like "no," "not at all," and "maybe."

The mother identified the following relapse concerns for her son:

1. Boredom or lack of constructive leisure interests.
2. Depression.
3. Exhaustion or fatigue.
4. Feeling helpless or hopeless.
5. Lack of meaning in life (nothing seems important).
6. Loneliness or isolating yourself from others.
7. Thinking alcohol or drugs are needed in order to "have fun".
8. Being invited to a social or recreational event where alcohol or drugs are likely to be used (parties, picnics, ball games, weddings, etc.).
9. Difficulty refusing alcohol or drugs offered by others.
10. Feeling that I don't want to be involved in treatment.
11. Painful memories.

The son identified the following relapse concerns for himself:

1. Anxiety or nervousness.
2. Exhaustion or fatigue.

3. Thinking alcohol or drugs are needed in order to "have fun."
4. Painful memories.

The son was much more involved in responding to the mother's list of concerns for him than in identifying his own list of concerns. There was a striking contrast in their level of energy: her's very high and his low. She progressed at a fast pace and he lagged behind, pulled along by her momentum. As time ran out in the session they focused on coping strategies for the list of relapse concerns. Again, the mother was in the lead, firing off suggestions which the son received with a shrug or silence.

Therapist Comment In the first session several patterns of interaction between mother and son emerged that served the purpose of maintaining the symptom. The mother tried hard, overwhelmed and moved fast. In response, the son lost what energy he had, tried to defend himself, gave up and slowed down. The pattern of overresponsibility/underresponsibility was most obvious in the list of relapse concerns that they selected. Mother identified eleven concerns while her son identified only four. Throughout the session the mother displayed high interest and high energy while the son responded with low interest and low energy.

Session Two When the family came for the second time, the mother presented the issue of their mother/son struggle over getting the son up in the morning. She expressed frustration and anger that over the years they had argued about this subject. They took turns, at the therapist's direction, describing the process. As the mother talked the son stared off into space and shook his head. When the son talked, the mother rolled her eyes and made grimaces, communicating her disagreement and discounting of his opinion. The frame used by the therapist was "the law of physics" in which one force pushed and the other force pushed back to maintain their place in the universe. As the session progressed and they were able to negotiate coping strategies, rewards, and consequences, the therapist used the same frame to focus on how the son did not get a chance to prove that he could do things on his own, such as getting up on time in the morning. The result was that they both felt stuck, hopeless and helpless. It was at this point that the process of the session shifted to the mother and son being more willing to listen to each other. They became more clear in communicating which elements they wanted and expected to be included in the contract. (A copy of the contract that the family negotiated and signed is in Appendix A.)

One Month Contract Period Follow-up

The family reported that the contract had been helpful to them. The son said that his mother had left him alone to get up in the morning and that he had been late to school once. He reported that he had fulfilled his commitment to play the guitar every day. The mother expressed relief and pleasure at the reduction of strain in the family over the "getting up in the morning" issue. She said that her son had been restricted for one weekend during the month for being late to school one day. She had given him his reward (paying for half of a new guitar) for completing the month long contract requirements. When asked, the mother said that she would be interested in renegotiating a contract for the future. The son was less enthusiastic in his response but did not completely reject the idea. At the end of the session the son smiled and made eye contact and participated in casual conversation.

One Year Follow up Session

One year after the family therapy sessions were completed the therapist met with the mother and son for a short family follow up session at Treatment Center I. The family presented themselves in a changed manner than they had the year before. The mother was somewhat less enthusiastic and optimistic. She expressed more of an

interest and focus on herself than she had previously. The son acted more energetic, making eye contact and acting more sure of himself.

The therapist asked them to identify current relapse concerns for the mother (co-dependent relapse) and for the son (chemical dependency relapse).

Mother offered the following:

1. anger expression problems (for example, holding anger in; expressing it inappropriately or violently)
2. difficulty trusting others

Son offered the following:

1. anger expression problems (for example, holding anger in; expressing it inappropriately or violently)
2. exhaustion and fatigue
3. impatience with "recovery plan" ("things aren't happening fast enough").

It appeared as if several things had changed in this family. The mother talked about and demonstrated letting go of her son to a certain degree, and had plans for letting go more in the future. The son had been expelled from a special school for violating a rule and the mother had reacted by giving him two weeks to find a job or to move out. She stated firmly that she would

spend no more money on special schools. She stated that she expected that he would finish high school eventually and that if he planned to live with her he would have to pay rent.

Formerly, the son's stance had been one of being hopeless and helpless. During this session he stated that he was feeling better about himself, and that he was capable of handling work and school at the same time. He talked about attending AA with a recovering friend and no longer seeing old using friends. Attendance at AA and new friends represented a significant change for the son.

Several issues and ways of operating in the family remained the same. The son reported several returns to using drugs with apparently little reaction from the mother. He had been in group therapy at the special school during the time of these lapses in abstinence. Mother's expectation that the son would go back to using, then be straight for a few months, remained the same. When asked about their wants for the future, both mother and son focused on what they wanted and expected for the son. Their hopes were centered on his finding a job and completing high school through adult education classes.

Therapist Comment The therapist's intent in asking the mother to identify co-dependency relapse concerns for herself rather than relapse concerns for her son was to shift her focus away from her son and onto herself. She appeared to accept this shift and seriously considered the list of relapse concerns as they applied to her. The son responded to this shift in focus by talking in a strong and direct manner, stating that he felt better about himself.

Clinical Review of the Case

A review of the family's patterns of interaction revealed a system that was enmeshed. There appeared to be very few secrets between them; each seemed to know what the other did, thought and felt. The mother was involved in nearly every aspect of the son's daily routine, from when he got up in the morning to what time he went to bed at night. Reciprocally, the son was very tied in with the mother; for example, he paid more attention to his mother's ideas about relapse concerns for him than he did his own thoughts about relapse concerns. Their interactions lacked clear communication as exhibited by the fact that they made assumptions about the other, and engaged in guessing the other's thoughts and motives. The mother would make a statement and virtually ignore the son's response, as if she had

not heard him speak. When he made a statement her nonverbal reactions, including grimaces and rolling her eyes, were ways she used to discount his opinion. The son would finally give up and lapse into silence. This pattern, which was clearly frustrating and tiring for both mother and son, also prevented them from ever coming to a resolution on their areas of disagreement.

The balance of power in the family was also confused. The mother made occasional comments about her son being "just like" his alcoholic father. Her actions and implied belief that the son would also be a failure pulled him into the role of quasi-spouse. In this role, he was left alone to use marijuana, put forth very little effort in school and lapse into oversleeping and lying around the family's apartment. This behavior then led to a confrontation between mother and son, resulting in the son resuming the position of subordinate child for a while. Very soon the cycle repeated itself. The dynamics of the system's homeostasis were evidenced by the mother's process of talking fast and moving the pace along quickly, in contrast to the son's slow pace: dragging his feet, and occasionally digging in his heels. The mother appeared very competent in comparison to her son. She dressed in a business-like manner and clipped through the sessions, pushing the son along. In

comparison, the son appeared much younger than he was, and his view of himself appeared to be that of a lazy, naughty little boy. The change that occurred in the second session was that they began to open up to the idea of letting go of the push-pull equilibrium and the son took a stand on being willing to get up in the morning on his own.

The family's process was a graphic example of the over/underresponsibility "trap." Mother acted responsible enough for both of them, taking notes during the education sessions and taking the lead in coming up with a list of relapse concerns and relevant coping skills during the family therapy session. The son's response was to underfunction and be present in body only. Her high energy made up for his low energy. When he took a stance of being responsible for himself in the second session he immediately began to back down. He gave the message, "don't start expecting much from me." He struggled against putting requirements into the contract that would make expectations of him.

The nodal point/event for this family involved the developmental stage of leaving home. The 25 year old son initiated the process of leaving home and living separately from the family. The time for the 18 year old son to leave home was approaching and this

meant that the mother would have no focus for her energetic care taking. For the son, leaving home would mean being forced to take responsibility for himself and risking falling on his face. The boy's father, who the mother compared the son to, had led a very dysfunctional life: living in a rented room, moving frequently, changing jobs, and drinking continuously. The mother's fears that her son would repeat this pattern contributed to her efforts to keep him underfunctioning and safe at home with her.

The son's substance abuse provided a careful protection function for the family by refocusing the mother's attention on the marijuana use rather than the more frightening issue of the son leaving home and facing potential failure. The symptom helped the mother to avoid looking at her own life problems, including a lack of a fulfilling sexual and emotional relationship with a mate. In fact, focusing on the son's symptom provided the mother with a supportive group of parents whom she met with regularly at Treatment Center I.

Despite the struggles in this family they displayed some obvious strengths. Their love and concern for each other helped them to keep trying to find something that would make things better in their lives: more therapists, more schools, and more programs were tried

to solve the son's multiple problems. Both mother and son allowed the other to express a range of emotions from sadness to anger which was useful in letting go of stress. Mother modeled persistence for the son in her long tenure with her company and her loyalty to Treatment Center I's parent support group. The son also modeled persistence in his willingness to try one more program or school. He was beginning to attend AA meetings with a recovering friend which indicated a search for something to make his life better.

The family is extraordinarily loyal to each other; to the family story, and to protecting each other. The two absent alcoholic fathers in the family, by many standards, were failures in society. The family story that men who drink (use) do not succeed in life was a powerful one. The son's efforts to step out of the standard cycle of using-stopping-using went against the expectation that he too would be a failure.

Conclusion

The treatment process of psychoeducation, family therapy and contingency contracting was used successfully in this family in raising awareness, challenging the power imbalance, questioning family stories and loyalty, and teaching clear communication and negotiation techniques. As has been stated

elsewhere in this paper, no matter what treatment is used, substance abusers continue to relapse at a very high rate. This was a family that experienced frequent and intense stress due to financial difficulties and the family conflict around the son's substance abusing behavior. Clearly, long term treatment success would require long term treatment. It has been proven repeatedly that substance abusers who agree to more long term treatment have a better chance of staying abstinent (Smart & Gray, 1978).

Case Number Two: The Case of the "Straight From the Hip"
Talking Mother and the Shy, "Gentle Giant" Son

Introduction

A 35 year old mother and her 15 year old son agreed to participate in the study. A 19 year old daughter no longer living at home chose not to participate. Mother was employed by a local high tech firm in an administrative supervisory position. The mother was married once to the father of her daughter; she never married the son's father. The family has no contact with the first husband and limited contact with the son's father. The 15 year old son was referred by the court system to Treatment Center II, as a result of charges for attempted car theft, breaking and entering, and running away from home. During the two months that he was a resident of Treatment Center II, the son remained in the first level of the four step progressive system, allowing him only a nine hour visit home on Saturdays.

During the last two years, the son had used marijuana, PCP and alcohol. His pattern of use appeared to be limited to the weekends when he drank or got high with friends. While intoxicated, he engaged in fights and other illegal activities. The mother admitted to

moderate alcohol use, which she defined as drinking a beer occasionally on the weekends.

Since childhood, the son had taken Ritalin to treat his hyperactivity. (Ritalin, is a stimulant when used by adults; it has a calming effect on children, in addition to increasing their concentration and enabling them to stay on task. The drug is generally less effective during the adolescent years.)

Family Reaction to the Psychoeducational Sessions

The mother arrived at Treatment Center II to attend the session, greeted her son, kissed him, and sat down next to him and chatted quietly. The son responded to her greeting with a smile and a hug. They appeared to be comfortable with each other. They sat next to one another in the group room during both education sessions. The mother's facial expressions were animated, she asked occasional questions, and contributed to the small group discussions. The son was somewhat less animated, choosing to listen and contribute an occasional comment to the small group discussion, usually when his opinion was elicited by another group member. At the end of the session, when the therapist asked for feedback on the information covered, the mother stated that she had learned a lot.

While she spoke the son nodded his head in agreement and did not offer further comment.

Therapist Comment

Prior to this education session, this family had had no contact with the therapist. They acted as one might expect them to act with a stranger. Their interaction with the group was also restrained owing, at least in part, to the fact that the parents did not know each other. Except for seeing each other coming and going at the treatment center for visits and therapy sessions, they had not met before in a group setting. As the parents were gathering for the education session, parents quietly introduced themselves and then sat down to listen. The son listened and was silent. He looked at his mother when she spoke, made eye contact with her occasionally, and otherwise listened along with the rest of the group.

Family Therapy

Session One

The therapist opened the session by asking the son about the events leading up to his referral to Treatment Center II. The son sat slumped in his chair, staring at the floor, looking uncomfortable. He spoke in a quiet voice, mumbling as he briefly stated the juvenile justice system charges against him. Periodically he

would stop, glance up at the therapist or the mother, and then begin to speak again. The son was a very tall and muscular young man who wore glasses. His physical presence was that of a quiet, very tall, gentle giant; he appeared very large for the age of 15. His glasses made it easier for him to avoid eye contact. He was still on Ritalin, which could be a contributor to his overall lethargic state in which he appeared bored and sleepy, exhibiting little energy. He did however have periods during the day when he was agitated, jittery and anxious. It was during this time that he was more likely to cause disruptions in school, or to get into a dispute with another resident of the treatment center.

After the son finished speaking, the mother began to talk, clarifying his remarks and offering more details. Her way of speaking was very strong, direct and in control. She described her son's physical problems including the hyperactivity and asthma, as well as his behavior problems, including fighting, running away from home, breaking curfew rules, and the illegal activities that had resulted in his placement in the treatment center. Her job demanded that she work in shifts, including some weekends. She also worked overtime, both to make extra income and to meet the demands of her workload. The demands of the mother's

work left the son at home unsupervised for a majority of the time, especially in the evening and on weekends. The mother set curfews and limits which she could not enforce and the son ignored. The mother stated that she cared for her son by reminding him to take his medicine, what time to return home, and when to do his homework, all of which were unsuccessful attempts at controlling his behavior.

She described her son as someone who was easily led astray by others and expressed concern about the fact that he hung around with the "wrong" crowd of kids. She worried that she did not know most of his friends, and the ones she knew, she did not like. In fact, she held his friends in part responsible for his getting involved in excessive drinking, and for his getting into trouble with the law by stealing cars, and breaking and entering. She believed that her son would not have done these acts on his own. As the mother spoke, the son looked at the floor, occasionally making comments to register his disagreement or to state his opinion. As she talked about these concerns she would glance at her son in ways suggesting genuine concern and affection. Her non-verbal message seemed to be "he's a great kid, I love him and he just keeps messing up."

The therapist asked the mother and son about their reaction to the MAST test results. The mother said that she was not surprised by the results of the test, and that she believed that her son did have a problem with alcohol. She compared the son's drinking habits to his father's misuse of drugs and alcohol and mentioned that her brother was also chemically addicted. Her father had been an alcoholic and she said, "I've been around drinking all my life." The son responded to the therapist's question with a shrug and a half hearted acceptance that maybe he did have a problem with drinking. He acknowledged that he had been drunk each time he had gotten in trouble with the law.

At the request of the therapist, the family shared their list of relapse concerns with each other. Both mother and son took a long time to carefully consider the list, and then began to quietly call out item numbers from the list.

The mother identified the following relapse concerns for her son:

1. Anger expression problems (for example, holding anger in; expressing it inappropriately or violently).
2. Anxiety or nervousness.
3. Thinking alcohol or drugs are needed in order to "have fun."

4. Being invited to a social or recreational event when alcohol or drugs are likely to be used (parties, picnics, ballgames, weddings, etc.).

5. Difficulty refusing alcohol or drugs offered by others.

6. Difficulty handling evenings or weekends.

7. Difficulty solving problems without getting overwhelmed.

8. Lack of constructive ways of spending my days.

The son identified the following relapse concerns for himself:

1. Anxiety or nervousness.

2. Denial ("I don't have an alcohol/drug problem").

Time ran out in the first session just as they finished listing their relapse concerns.

Therapist Comment

The family's interactional sequence that served to maintain the symptom became clear in this session. The mother set limits on her son's behavior, which the son passively ignored, especially when she was not at home. He then drank excessively and got into trouble. The mother bailed him out, forgave him, tried to set new limits and went back to working long hours. The process

then repeated itself. The mother believed that she was fulfilling her parental responsibility by showing affection and constantly reminding him to do things. She also worked very long and hard hours in order to provide adequate income for the family. The subsequent lack of supervision for the son had enabled him to run free and to get into trouble.

As an adult child of an alcoholic, the mother was accustomed to the role of taking care of others, working tirelessly and ignoring things that she felt powerless to change. This care taking pattern was reflected in the different energy levels between mother and son. She looked tired yet talked in an energetic manner. He appeared rested and talked very slowly with long pauses in between phrases, as if it required a real effort for him to breathe and speak. Throughout the session, he seldom moved.

Session Two

When the family came for the second session, the mother presented the issue of her concern about the son's lack of progress in Treatment Center II's program. She listed some things that he was not doing which he was supposed to, and expressed frustration at his apparent lack of interest in moving up to the next level in the program. Progressing to the next level was a

symbol to her of his willingness to start showing some initiative, and would entitle him to spend more time at home on weekends. In response the son weakly tried to defend himself and then stopped talking altogether. When the son stopped talking, the mother began talking in a very strong and sure manner about being "wise" to how her son "operated," stating that she was not fooled by how he chose to take the easy way out. The therapist smiled and joked with the mother, complimenting her "straight from the hip" way of talking. The therapist included the son in the conversation by catching his eye and teasing with him. In this way, the therapist sided with the son, stating that she would have a tough time standing up to a mother who was obviously so smart and "un-con-able." As the son began to come back into the process of the session, the mother began to express great concern about the effect that Ritalin was having on the boy, especially on his ability to function in school. The boy looked a bit embarrassed by his mother's concern and attention but did not challenge her.

At the therapist's direction, the family focused on the relapse concerns that they had identified in the first session, and was very creative in brainstorming coping skills for each item. The son contributed much

more to this segment of the session, talking about how he gets into trouble when he feels anxious. The therapist worked with the son for a few minutes in order to identify the anxious feeling and how he could make himself feel better. As they identified coping strategies, the mother made reference to the son's love of the outdoors and said, "outside is his heart." She beamed a smile at him and he responded by smiling back and relaxing even more. The therapist used the "outside is his heart" frame to suggest ways of spending free time, taking up new interests and as a metaphor for how he feels when he is comfortable and free from anxiety.

The therapist encouraged the mother to pay attention to her pattern of overworking and suggested some concrete ways that she could get support for herself in the future, including joining an ACOA or ALANON group. The mother expressed her appreciation at the end of the session which ended on a very positive note. (The contract that was negotiated and signed by the family is in Appendix A.)

One Month Follow up Session

The son started off the session by saying that the contract had been helpful to him, that he had tried several of the suggested coping skills including writing down his feelings when he felt anxious. As a way of

reminding himself of the coping skills, he looked at the contract every few days. He reported that he was finally starting to move ahead in the treatment center program. He said that he had been bothered by other residents in the program moving ahead of him, but now that he was moving to the next level, he felt better about himself.

The mother looked more relaxed and appeared to enjoy listening to her son report such obvious improvement in his progress. After the son finished talking, she said that she had cut down on the amount of overtime at work and was feeling more rested. She also talked about having carried out the consequence of the contract which was not to visit him when he wasn't holding up his side of the contract. Both mother and son said that they intended to renegotiate the contract with their Treatment Center II counselor. The mother said that she thought the changes in her son were due in part to the contract that they negotiated and agreed upon.

Therapist Comment

The timing of the family therapy and contingency contracting intervention for this family appeared to have been of particular benefit. The change in mood and reported behavior changes at one month were striking.

The contract seemed to provide just the structure and focus that the family needed at the time.

One Year Follow Up Session

Just as the change in the one month follow-up had been striking, the changes exhibited in this family after a year were remarkable. The son walked through the door with a smile on his face, made eye contact and sat up straight in his chair. The mother appeared relaxed and greeted the therapist warmly. In response to the therapist's questions about co-dependency relapse, the mother said that they had not relapsed, and that things were going well at home. She said, "Sometimes I think to myself 'What's he doing?'" referring to her old tendency of checking up on him frequently. She talked about the process of learning to trust her son again, noting that she sometimes felt shaky, but that the feeling eventually had subsided.

The son reported that he had not relapsed. In a quiet and confident sounding voice, he talked about his decision not to see old friends now that he was out of the treatment center and back in his regular school. He smiled broadly as he talked about his new girlfriend and described spending most of his free time with her. When the therapist asked him how he had avoided going back to using drugs and drinking he said, "I don't want trouble

anymore. I can't afford to mess up now." He stated that he rarely felt bored, tired or anxious anymore. He talked about having been suspended from school two weeks before because of getting involved in a hallway fight, and described how he got upset and then got over it, deciding that it wasn't worth dwelling on.

The family reported that they were participating in Treatment Center II's aftercare program, and were not attending neither AA, or ALANON, nor any other type of therapy or treatment. At the request of the therapist, the mother and the son looked over the relapse concerns list to identify co-dependency (for the mother) and chemical dependency (for the son) relapse concerns. After looking over the list for a minute or so the son said, "None, I don't see anything here that really concerns me."

The mother identified the following co-dependency relapse concerns:

1. Anger expression problems (for example, holding anger in; expressing it inappropriately or violently).
2. Difficulty meeting people or developing new relationships.
3. Specific stress or problems in a relationship (for example, "I just can't seem to get along with my

parents or spouse," "I can't seem to handle my responsibilities as a parent like I should").

4. Difficulty handling evenings or weekends.

The therapist focused with them on changes in the family during the past year. The mother said that she was not working overtime as much; that she had "slacked off." She said this with a smile, appearing to be proud of herself. She made a brief comment about a decision she had made concerning a relationship with a man. As a result of the decision she reported feeling better and relieved. She talked with obvious pride about the changes in her son saying at different points, "He follows his curfew well." "I was surprised, he doesn't need me to remind him." "He's learned to be responsible." She said that the son had "taken himself off Ritalin" two weeks after completing the Treatment Center II program and had decided not to go back on it. She reported no negative effect on his behavior at home; however, she had some minor concerns about his behavior at school, where he had acted silly and "goofed off."

The son said that he no longer needed to drink to have fun, which was really surprising to him. Instead of hanging out with old friends, he was spending time going places with his girlfriend, playing basketball, going to movies, and participating in other sports.

At the close of the session, the therapist asked the family about their thoughts, hopes and plans for the future. The son said, "I think I'm going to make it." He said that he was working on improving his grades at school, planning to play football the following school year and hoping for a scholarship to play football in college. The mother said she was looking forward to seeing her son graduate from high school. She also made mention of the changes in her relationship with a boyfriend, stating that she was feeling clear about what she wanted from him, and was able to set some limits about what she wanted and what she would accept.

Clinical Review of the Case

The economic hardship of raising a family with a very limited income caused this family to pull together into an enmeshed system in order to stay safe and survive. The mother focused on the smaller and more manageable issue, her son's hyperactivity, by frequently reminding him to take his medication. She was unable/unwilling to concentrate her energy on the larger and more important issue of supervising her son's activities through setting limits. The son also kept an eye on his mother, watching out for her safety when she was at home. During the education and family therapy

sessions he supported her point of view in most instances. If he disagreed, he tended to stay quiet.

The power hierarchy in the system was based on the son getting his power by being on his own for large amounts of time during the evenings and weekends. Mother exerted power by making the money and ineffectually trying to make the rules. Because of the mother's lack of companionship or mate-type relationship, the son was pulled into a role as partial companion/spouse. The relationship was not sexual but the mother wanted him to be at home when she was there to keep her company. In his absence, she was lonely and reacted by working even more hours.

Multiple stressors impacted upon this family, including financial demands and the loss of a husband and a father. The developmental issue of the son leaving home in the future was very significant for this family. His leaving home would have meant that the mother would have been even more lonely, and he, lacking self-confidence, would have been on his own to try and make it.

The issue of over/underresponsibility in this family system was complicated by the fact that both mother and son over and underfunctioned in some striking ways. Mother worked long hours to support the family

while trying to supervise a 15 year old son with creative ideas and the normal inquisitiveness of this age group. She tried to do the impossible by supervising him long distance. The son also overfunctioned by trying to operate on his own without much direct supervision for long stretches of time. Like many latch-key children, he fixed many of his own meals, made his own plans, etc. The mother displayed underresponsibility by working compulsively in order to avoid the loneliness of home and the stress of dealing with the son's substance abuse and acting out behaviors. The son displayed underresponsibility by not setting personal limits for his behavior and by allowing himself to be led by other adolescents into unlawful activities. Whenever he got into a jam, he sat back and let his mother "dig him out of the mess."

In the therapy sessions, as the mother focused on the son's hyperactivity or her concerns about the affects of the Ritalin, she talked about him as if he were a small boy. In response, the son looked at the floor, shook his head and appeared to be embarrassed. He did not openly protest the manner in which his mother was talking about him.

The mother's strong, "straight from the hip" talking gave her the appearance of being "un-con-

able." The son's listless, passive acceptance of the mother's caretaking are process indicators of the family system's homeostasis. Because her work schedule was long, the mother tried to control the son's behavior by making threats, calling to check on him and then giving up. The son ran free from supervision most of the time, drank to cope with his feelings of anxiety and as a result of peer pressure. The son was unable to step out of the pattern of being helpless and inept. Mother worked compulsively to avoid the loneliness of her single life. The son drank and got in trouble to get his mother pulled back into closer contact, thus getting her attention. When she was unsuccessful at controlling his behavior long distance, she worked longer hours to avoid the situation with her son over which she felt no control. The cycle went around and around.

The protective function of the son's substance abuse and the mother's compulsive over-working helped the family to avoid looking at their severe financial situation, the mother's lonely life, and the impending issue of the son's beginning the process of leaving home. As an adult child of an alcoholic, the mother was accustomed to dealing with irresponsible, acting out behaviors associated with chemical addiction. The stress of responding to the son's behavior was less

threatening than dealing with being alone, or her own contribution of compulsive overwork.

This family displayed many strengths. The contracting procedure demonstrated that both mother and son were able to say what they wanted and expected, and that they could carry through on their stated intentions. The son never had to guess what his mother was thinking because she spoke very directly with the tone of her voice supporting her intent. The love and concern of this close-knit dyad helped them to watch out for each other. In the absence of a husband/father, the son was a strong and comforting source of security to the mother. They both displayed a gentle and subtle sense of humor which appeared to help them to look at the upbeat side of situations even when they were experiencing significant stress.

In spite of the son's acting out behaviors and the mother's compulsive overworking, the family remained very loyal to each other. Mother was loyal to her son by repeatedly getting him out of scrapes with the law and continuing to support him. The son was caught between wanting to become more competent, eventually enabling him to leave home, and a strong desire to stay incompetent so he could watch over his mother. He drank to deal with his anxiety, and she overworked. The

family story that men cannot be counted on, that they are irresponsible and will eventually leave when the going gets rough, was a powerful motivator for the son to stay irresponsible and to continue substance abusing.

Conclusion

The family was able to make some significant shifts in their behavior during the course of the treatment program and follow-up. The mother let her son take over worrying about himself which resulted in the son becoming more competent. As he became more able to handle his own responsibilities, she accepted the change without sabotaging his efforts. The homeostasis of their family system shifted; the mother stopped working long hours and the son began to accept her limit-setting. The protective function of the son's substance abuse and the mother's compulsive overwork was no longer needed. The son stopped using drugs and alcohol and made plans to leave home in appropriate stages (commitment to a girlfriend and working toward a football scholarship to college). Mother stopped overworking and concentrated on the quality of the relationship with her boyfriend. She invested herself in this relationship by asking for what she wanted and setting personal limits about what she would and would not tolerate in the boyfriend's behavior toward her.

The family's strengths were even more evident at the end of the one year follow up. The son as well as the mother were "talking straight." Their sense of humor helped them to keep a positive attitude and they were supporting each other in very appropriate ways. Finally, the family loyalty was acted out in some new ways. Mother had found that she could be loyal to her son by expecting him to be responsible. The son discovered that he could be loyal to his mother by taking control of his behavior and making concrete plans for his future.

Case Number Three: The Case of the Smiling and Ignoring
Mother and the Smiling and Ignoring Son

Introduction

A 38 year old mother and her 16 year old son agreed to participate in the study. A 19 year old son who was living away from home while attending college did not participate. Mother worked as an administrator with a local business. Her one marriage, which produced two sons, had ended in divorce when the boys were under five years of age. The father was an alcoholic, and had not been in contact with the family for many years. One year prior to their participation in this study, the 16 year old son met his father for the first time.

Afterwards, the father disappeared again and had since initiated no contact. The 16 year old son was referred to Treatment Center I the year prior to this treatment by the juvenile court system. After six months in the Treatment Center I program, he went back to court, the charges were dropped, and he was not allowed to return to Treatment Center I, because of his perceived unwillingness to make any effort to effect the necessary behavioral changes.

Since the age of 14 the son had used alcohol, marijuana, PCP and cocaine. His pattern of use included cocaine binges on the weekend with occasional use during

the week. Often he got high with his older brother in the family home while the mother was at work. As the son's cocaine use escalated, he started skipping class and his school performance dropped dramatically. Inevitably, confrontations with the mother ensued. She would scream at her son, threatening dire consequences. After these scenes, they wouldn't talk to each other for a few days. However, during these "silent" periods, the son was always very cooperative, helping his mother around the house and attending school. When the tension subsided in the household, he would revert to using cocaine, gradually increasing his usage, and the cycle repeated itself.

The mother described herself as a social drinker, which was defined in the context of our conversation, as an occasional drink after work with a friend, or a glass of wine on the weekend.

After the son left Treatment Center I, they did not participate in the monthly aftercare groups. When the mother was contacted to participate in the Relapse Study Project she agreed, and brought her 16 year old son.

Therapist Comment

The substance abuse of the son appeared to serve an important function in the family system by providing a break from the mother and son's intense involvement with

each other. The 16 year old son was the "good son" who was always there to provide companionship and emotional support for the mother. The "bad" older son was more distant from the mother. Substance abuse provided the 16 year old the opportunity to pull away from his mother for short periods of time. He could stay very dependent while appearing to be rebellious. Dealing with the son's substance abuse was a role with which the mother was familiar: helping a chemically dependent man.

Family Reaction to the Psychoeducational Sessions

The mother walked into the first education session with her son following close behind. She had an open, pleasant expression on her face as she began to greet other parents and staff members. The son had on a pair of sunglasses and strutted in the door as if he were arriving at a party. He was successful in drawing attention to himself as he joked with some of the boys who had been residents at Treatment Center I with him.

During the education session, the son sat slouched in his chair, taking the sunglasses on and off, making it clear to everyone in the room that he wasn't planning to listen or participate in the content of the session. Mother sat quietly and listened, took an active part in the small group activities, and asked clarifying questions.

The mother came for the second education session without the son. She reported that he was unwilling to attend, resulting in a fight right before the meeting, and leaving her feeling very angry with him. During the session, she appeared to be preoccupied at first, and then appeared to settle down and participate in the content and process of the session.

Therapist Comment

Mother and son acted out some familiar patterns in the course of the education sessions. The son's manner when he walked in the door gave the message, "I am cool and I am handling everything just fine!" He was able to draw attention to his rebellious behavior using mostly non-verbal signals. The mother smiled and appeared to be mildly amused by the son's "cool" act. She took part in the program by listening and offering comments in the session, and by attending the second session alone. Her description of their fight prior to the second education session exemplified how they confront each other on many issues; they yell at each other and then pull away for a few days to allow tensions to subside.

Family TherapySession One

During the first few minutes of the session, the therapist asked the son to talk about how long he had been out of Treatment Center I and the circumstances around his leaving the program. He said that he had gone back to court the charges had been dropped, and Treatment Center I decided not to take him back into the program. He said all of this with a grin on his face. He reported in a bored, low energy manner that he was in school and that he disliked it intensely. When the therapist asked the son about his relationship with his father, he dropped the "bomb" that his father had died six months ago. His manner in reporting this information was likewise flat and unemotional.

The mother stepped in to say that her son had met his father only once the year before, prior to his death a few months later in an alcohol-induced motel fire.

The session moved on as the therapist asked the boy about his use of alcohol or drugs. He responded in an offhand manner that he now used cocaine "recreationally" and that he was doing some dealing of cocaine with his older brother. In a tone that suggested a much less emotional and volatile subject, mother and son described a "big blow out" which took place the weekend before in

which the son "spilled the beans" about his drug dealing. As the therapist explored the issue of the son using and dealing cocaine, and the mother's response to the son's behavior, she used the frame of "setting limits to help the son feel safer." The mother did not respond to this frame and smiled as she ignored the therapist's comment. The therapist then asked the son what he wanted from his mother. He said, "for her not to pay so much attention to me." The therapist then carefully described their situation as "a little boy standing on the top of a skyscraper with one foot over the edge saying, 'hey mom, don't look at me.'"

The therapist tried several ways to get the mother to state what limits she was willing to set and enforce with her son. She would not consider setting limits. The therapist stated that she believed the son thought he could go on using cocaine recreationally because he could "ride out the wave" of the weekend upset and wait for the tension between his mother and himself to calm down. Even when the son agreed that this was what he intended to do, the mother responded by smiling and not setting limits.

Most of the first session was spent dealing with the crisis situations presented by mother and son. The focus of selecting relapse concerns and relevant coping

skills was, at best, premature, and was scheduled for the following session. As time in the session ran out, the therapist suggested that mother and son consider what they were willing to do to set limits and become sober again. The therapist complimented the son on his honesty and insisted that even though he disagreed, he must want something for himself or he would not have been so honest. Both mother and son listened to the therapist as they smiled and maintained blank expressions on their faces.

Therapist Comment

The family's lack of emotion in describing the alcohol-induced death of the father was a dramatic example of just how much crisis their system could withstand without crumbling. Clearly, their lack of an emotional response was affected by the father's long absence from their lives. The son appeared to be caught in a double bind of wanting to be the good boy who took care of mommy yet wanting to rebel and be able to go out and do what he wished. Their family process of the son using cocaine, followed by a blow up with mother, and a calm after the storm, allowed the son to hold onto both views of himself. The frame used with the family of the little boy on the skyscraper saying, "Hey mom, don't look at me!" was a way to dramatize the contradictory

messages in the family. Mother and son's level of denial was very high. In the face of the alcohol-induced death of the father six months before, the son maintained that he could use cocaine recreationally as the mother smiled and refused to set limits on his behavior.

Session Two

The therapist opened the session by complimenting the family on how loyal they were to each other. She used the frame of loyalty meaning that the son stays needy (using cocaine) so that he can stay with mom to watch out for her and help her. The family listened and watched the therapist very closely as she spoke in a trance inducing manner. The therapist then asked the son if he knew what would happen if the situation were to get better; if he stopped using, began to work on recovery and was successful in finishing school. He looked confused and stated that he would not think about things "that far away."

The mother's role as enabler was very clear in the session. She could not or would not think of limits to set for her son, except for court involvement and jail. She reported that during the past week, her son had been "good," taking care of business at school, and helping out at home. The therapist suggested that the son

probably wanted her to calm down and believe that everything would be okay, so that the crisis situation would be smoothed over. The mother nodded her head in agreement.

The therapist asked the mother and son to identify relapse concerns for the son:

Mother identified the following relapse concerns:

1. Anger expression problems (for example, holding anger in; expressing it inappropriately or violently).

2. Denial ("I don't have an alcohol/drug problem").

3. Depression.

4. Excessive or impulsive behaviors (for example, gambling too much; overeating; spending too much money; overworking; excessive sex).

5. Guilt.

6. Lack of meaning in life (nothing seems important).

7. Painful memories (for example, from combat experience, death of a loved one, or from experiences growing up in a troubled family).

The son could not or would not identify relapse concerns for himself. He said, "I'm not going to relapse."

The mother took over and did most of the work for the rest of the session by identifying her expectations

of her son, brainstorming some coping strategies, and acknowledging that some limits needed to be set. She could/would not come up with negative consequences to include in the contract. She and her son appeared to enjoy coming up with an appropriate reward. Throughout the session, the son exhibited low energy, looking down at the floor and acting as if he was not listening.

Therapist Comment

One week after the second family therapy session, the mother contacted the therapist to say that she wanted to add weekly urinalysis to the contract, and that her son was furious about her intent to include the testing. She said that he was refusing to sign the contract and that she would not back down. The therapist took a very neutral, passive stance and told her that the addition was agreeable to the therapist, as long as the son agreed to it. One week later, the mother called again to ask the therapist for help in finding an inpatient substance abuse program for her son. She said that he had gone to a shopping mall, walked into a store, put a pair of tennis shoes under his teeshirt and walked out the door. A security guard had caught him and asked for his identification. The son had opened his wallet to get the I.D. and a package containing PCP had fallen out. The son had been taken

back to court and the mother wanted to locate a drug program so that the son would not go to jail. The therapist agreed to meet with the mother along with the Assistant Director of Treatment Center I. In the meeting, several substance abuse programs were recommended. The mother selected a program, and with the assistance of the therapist, placed her son in a psychiatric hospital's chemical dependency program, comprising a 30 day inpatient and a one year aftercare component.

One Month Follow Up Session

After the son had completed the 30 day inpatient phase of the treatment program, the therapist met with the mother and son. They took turns describing what the 30 day program had been like for them. The son was much more direct in talking and in making eye contact than he had been the month before. They both credited the family therapy and contracting process as being the vehicle that pushed them into crisis and then treatment. The son and the mother talked enthusiastically about being in the treatment program and about their hopes for how family life would be better in the future.

Therapist Comment

As a result of the family therapy/contracting intervention this family system was unbalanced, which

allowed change to happen. The mother, who had been unwilling in the past to talk about limits, took a stand and was firm about wanting her son to take a urinalysis weekly. The son reacted by stealing in such a way that he was sure to get caught. In the past he had used this technique of breaking the law in order to get some resolution of the chaos in his current situation. When things got so bad that he did not know what to do, he got in trouble with the law in order to get his mother and other authority figures involved to help him to straighten things out. By asking for a chemical dependency treatment program, the mother was also following a familiar path of trying to rescue her son and keep him out of the bigger trouble of juvenile detention. They both got into drug treatment the back way, which is very common when adolescent substance abusers enter treatment.

One Year Follow Up Session

The therapist met with the mother and the son at Treatment Center I, one year after they completed the relapse prevention study program. The family presented themselves in a very different way. The mother had a pleasant expression on her face and she did not look like the smiling and ignoring mother of the year before. The son smiled in a more subdued manner, and made eye

contact with the therapist and his mother. The mother described the first few months of the chemical dependency program as very difficult. She said that she went to ALANON and the chemical dependency program's aftercare along with her son. She reported that her expectations had been high and that she had learned to let his chemical dependency be his problem.

When asked about relapse, the son quietly and clearly said that he had relapsed a month and a half after leaving the inpatient center and moving to the aftercare portion of the treatment program. He had used PCP, came home after being out all night, and tearfully told his mother what he had done. That evening he had gone back to his aftercare group, told them what had happened, and followed their instructions for getting back on track. At Christmas he had used again and this time his probation officer had stepped in to initiate regular urine tests. Based on the probation officer's threat to lock him up, the son had not used for three months prior to this meeting. He said, "I cannot use and stay out of trouble."

Mother and son talked more about their participation in the chemical dependency aftercare program which included a young people's group, a parent's group, and a multi-family group. The son

attended regular AA meetings as required by the program.

The therapist asked them to share their current relapse concerns for co-dependency (the mother) and chemical dependency (the son).

The mother listed the following co-dependency relapse concerns for herself:

1. Exhaustion or fatigue.
2. Painful memories (for example, from combat experience, death of a loved one, or from experiences growing up in a troubled family).

The son listed the following chemical dependency relapse concerns for himself:

1. Difficulty solving problems without getting overwhelmed.
2. Fears which seem unreasonable.
3. Loneliness or isolating yourself from others.

It appears as if several things have changed in this family. Instead of being in denial about the severity of the son's chemical dependency and the mother's insistence on enabling his behavior, the family is actively involved in a treatment program to address these issues. The son is continuing to relapse and is being persistent in staying in treatment. They have broken out of their cycle of the son using, the mother confronting, and then both retreating into a silent

period to allow the tension to blow over. Instead, when a relapse occurs, both mother and son take it to the treatment groups for support and instructions about what to do next.

When the therapist asked mother and son about their hopes for the future the son talked about doing well in school and his plans to join the Navy after graduation in order to get further education. The mother talked quietly as she described the situation in which the older son was away at college and her younger son would be leaving soon. She described it as a "quiet time" in which she could enjoy the relationship with her boyfriend, doing things for herself and fixing up the house. The mood that they expressed was one of quiet, cautious optimism. The mother appeared to be very hesitant about what the future holds for her.

Clinical Review of the Case

This family system has been tied up in the powerful force of chemical addiction since the mother and father first formed a couple. In order to survive the departure of the alcoholic father and the financial hardship of a single income, the family pulled together into an enmeshed system. The mother enabled the son to abuse drugs by ignoring the signs of use and by allowing

the tension of their confrontation to blow over in her hope that things would just get better on their own.

The balance of power in the family hierarchy is confused. The mother does not have a satisfying mate-type relationship. She has a boyfriend that she sees occasionally. She responds to being alone and lacking in sexual and emotional companionship by drawing her son into a companion/friend relationship. The son is caught in the bind of wanting to help and protect his mother and wanting to be out on his own with his own friends. The son's substance abuse fits right into the mother's model of how men act in that she is accustomed to dealing with an irresponsible, drunk husband. She can forgive her son's cocaine binges as long as he will come back home, be good for a few days, and hide it from her for a while before the cycle starts again.

This family experienced many difficult stressors and survived crisis after crisis in the past. The mother raised two sons by herself, after surviving a disastrous marriage to an alcoholic. She struggled to support the family financially and to deal with two sons who abuse drugs and alcohol. From a developmental perspective, the issue of leaving home is relevant for this family system. The older son had maintained a more separate identity from the mother and had left home to

attend college. His lack of fusion with the mother resulted in his label as the "bad son." The younger "good son" is caught between wanting to stay with mom and be good, and wanting to begin the process of leaving home. If the son does not leave home, then he can continue to act irresponsible and needy and the mother will not have to deal with being very lonely and unneeded.

The dynamic of over/underresponsibility is very evident with this mother/son dyad. The mother works hard at her job to support the family, does all the leg work to check into treatment programs for her son, attends the education sessions alone when the son refuses to attend, and bails the son out whenever he gets in a jam. The son displays underresponsibility by using drugs, avoiding school responsibilities, acting helpless, avoiding his mother after a confrontation, and expecting her to help him after he has messed up.

The family's interactional pattern that maintains the system's homeostasis is one in which son uses drugs, mother ignores the behavior, son then escalates the drug use and mother confronts him. After the confrontation they retreat for a few days while son acts good and stays close to home. The mother enjoys his company while he is at home and hopes that everything will be

okay. The forces keeping this pattern intact are extremely strong. If the son stops using, the mother begins to expect him to be responsible, including doing his school work. If he succeeds at this, he will be expected to leave home where he may or may not succeed. The mother is threatened by the idea of losing her companion and by losing her role as the helper/fixer of the family.

Substance abuse and denial serve a very important protective function for this family. The mother pays attention to her son's drug using behavior instead of her own lack of a fulfilling emotional and sexual relationship. She avoids the issue of leaving home which would force her to cope with an empty nest. She was left once before by her husband many years ago, and the consequences of that desertion have been very stressful and painful. The son uses drugs to avoid growing up and acting responsible. He holds onto his place as the family baby, expecting his mother to take care of his wishes and needs. She expects very little of him as long as he is addicted to drugs, just as she expected very little of her husband when he was drinking.

In spite of living through crisis after crisis, this family has survived. Their strengths are evident

in the interaction between the mother and son. Their love, concern and affection for each other is very clear. The mother models determination for her son in her long tenure with her company. Her persistence at working and saving has allowed them to buy a townhouse, allowing the family to take pride in maintaining their home. The son has a terrific sense of humor which his mother appreciates. She is his audience for joke and story telling. Mother and son are able to enjoy each other's company and to have fun together.

Case Number Four: The Case of the Tired and Whining
Mother and the Overwhelmed and Polite Son

Introduction

The participants from this family were a 36 year old mother and her 16 year old son. An 18 year old sister and the maternal grandmother lived with the family but did not participate. Mother was employed by a local nursing home as a licenced practical nurse. The mother was married once to an alcoholic who subsequently left the family when the son was three years old. The son had been referred to Treatment Center II by the juvenile court system four months prior to the study for a charge of breaking and entering. During the four months that he had been a resident of the program, he had progressed to level two in this four level, progressive program. He anticipated moving to level three soon, at which time he would be allowed to go home from Saturday at noon until Sunday at noon. He recently had taken the General Equivalency Diploma test (GED) and was waiting for the results of the test.

For the last four years, the son had used alcohol and marijuana. His pattern of use was to get drunk or high on the weekends resulting in his getting into trouble while under the influence. The mother states that she was totally abstinent. Both of her parents

were addicted to prescription drugs. Her father had died a few years ago and shortly thereafter, the mother who complains of constant illness and continues to abuse prescription drugs, moved in with the family.

Family Reaction to the Psychoeducational Sessions

The mother arrived at Treatment Center II, greeted her son with a "Hello", and very politely came over to introduce herself to the therapist. Her son smiled at her and said "Hello" in return. They appeared to be a bit tentative with each other. During the education session, they sat side by side and did not interact. Neither of them spoke throughout the sessions. Their changes in facial expression indicated that they both appeared to be listening. During the small group activities they participated by offering their comments, quietly and unobtrusively. They both acted very polite with the small group members and the leader. At the end of the second session, the mother and son scheduled their first family session, thanked the therapist, and left the room.

Therapist Comment

Prior to this session, the family had had no contact with the therapist. Their reserved manner was thought to be in part due to their unfamiliarity with the therapeutic relationship. It was also believed that

politeness was a very important value in this family. The mother and son acted somewhat neutral with each other; neither warm nor cold. They acted as if they were casual acquaintances rather than mother and son.

Family Therapy

Session One

The therapist opened the session by asking the son about the events leading up to his referral to Treatment Center II. He made eye contact while answering in a straight-forward manner, with an open expression on his face. He appeared to be relaxed and willing to answer any question. He is a tall, overweight boy who has a mild mannered way of speaking. The mother is also overweight, giving her the appearance of being several years older than her actual age.

The son described going out on the weekend with friends, drinking and then getting into trouble. He hated his school where he also got into trouble with his peers. He often got into fights at school and would use that as an excuse to get drunk with friends in the evening. The mother stepped in to talk about how hard she tried to provide a good home for her family, her financial worries, and her troubles with her hypochondriac mother who abused prescription drugs. In a tired and whining voice, she accused her son of

embarrassing her by his irresponsible actions and complained that in spite of all that she did for him, he did not help her enough. The therapist worked with them for a while on communication, including not having them guess what the other was thinking, and having them listen and repeat back what was heard.

The mother described their family as very "polite." She said that both of their children were polite and that they tried not to fight. She said that "arguments are dangerous," while making reference to growing up in a violent and argumentative home. At the therapist's direction, mother and son described their view of how differences of opinion were handled in the family. The interactional pattern that emerged was that they would try not to fight, tensions would build, and a fight would occur in spite of their efforts. During the fights which involved yelling and slamming doors, neither listened to the other, nothing got resolved, and they both ended up feeling terrible.

The therapist asked the mother and son about their reaction to the MAST test. The mother was hesitant and not sure if she believed that her son's drinking problem was really so bad. The son agreed that he had a drinking problem and stated that he was involved in AA through Treatment Center II's program.

At the request of the therapist the family agreed to share their relapse concerns. Mother listed the following relapse concerns for her son:

1. Difficulty refusing alcohol or drugs offered by others.
2. Not going to AA/NA meeting regularly.
3. Not getting family involved in recovery activities.

The son identified the following relapse concerns for himself:

1. Anger expression problems (for example, holding anger in; expressing it inappropriately or violently).
2. Guilt.
3. Difficulty meeting people or developing new relationships.
4. Lack of constructive ways to spend days.
5. Painful memories (for example, from combat experience, death of a loved one, or from experiences growing up in a troubled family).
6. Excessive or impulsive behaviors (for example, gambling too much; overeating; spending too much money; overworking; excessive sex).
7. Anxiety or nervousness.
8. Argumentativeness with others.

Time ran out for the session as they completed the

process of identifying the relapse concerns.

Therapist Comment

The interactional pattern that maintained the substance abuse was revealed in this first session. The mother, who is an adult child of substance abusing parents, would try hard, get overwhelmed, complain, and not set personal limits. She placed great stock in her family being different than her family of origin, specifically that her children were polite, and that they avoided arguments in their family. In her overwhelmed state, she would nag, blame, and lay guilt on her son. He would try to be polite, get overwhelmed, erupt in anger and leave the scene to get drunk or high.

Session Two

Mother and son arrived for the session looking tense and uncomfortable. At the beginning, the mother talked in a low energy monotone about their nice family, and how everything would be just fine as soon as the son got straightened out. After listening for a while, the son began to squirm and then disagreed with her. In a shrill voice, she began complaining about how her son never tells her anything, resulting in her getting embarrassed by hearing things from other people about him that he had not told her first. She referred to an issue with Treatment Center II staff in which the son

had broken a rule, had his weekend denied, and put off telling his mother about it. When a staff person had informed the mother she had gotten very upset that her son had not told her first. The son listened to his mother, sat slumped in his chair, looked at the floor and shook his head. Her comments were made with a sarcastic edge, which seemed to trigger preparation for a fight in the son. For a few minutes, as she talked on, the son did not interact with the mother. He finally started exchanging comments with her and was drawn into an argument. The interchange ended with the mother in tears and the son looking embarrassed and defeated.

The therapist talked with the mother about how sad and angry she must feel, and about what she did to "fill herself up" while taking care of so many people. She talked with her within the frame of "the caretaker needing care." As the therapist talked, the mother cried harder and talked about feeling tired and worn out. They explored different avenues that the mother could pursue including individual therapy, Overeaters Anonymous, ALANON, and an ACOA group. As the mother calmed down, the son relaxed, and they were both able to spend the last part of the session brainstorming coping skills for the relapse concerns, deciding on rewards and

consequences, and coming to an agreement on what they wanted from each other in the month ahead. The mother continued to talk in a wining voice and the son listened as she stated specific wants and requests to which he could respond.

Therapist Comment

The mother in this family was an enabler who had too many people on which to focus her care. She was in real danger of running out of steam in her efforts to control her teenage son and her prescription drug-abusing mother. The stress of caring for two substance abusers, supporting the family, working with elderly patients and taking almost no time for herself was overwhelming her. She gave and gave and when her controlling efforts did not work, she blamed everyone around her, nagged and caused the family members to run for cover. The family rule about being a nice family, being polite, and not arguing helped to keep this cycle in motion. Instead of being able to let off steam gradually and more effectively, she was forced to hold onto it until she erupted in a tirade that solved nothing. The son mirrored her process. Drinking, drugging, and overeating were his way of letting off steam, stepping out of her control and exerting his independence. The mother tried hard, overate,

complained, and over controlled the household.

She listened as the therapist talked about how she might need something for herself; to be "filled up" and she did not buy it. It was easier for her to think about trying hard to fix her son than to look at how she could help to fix herself. She had been in a caretaking role with her parents for so long that she might not have known what it felt like to concentrate on herself. The mother interpreted the son's concentration on himself and his recovery as selfishness on his part. Her words, tone, and actions demanded that he help her instead.

One Month Follow Up Session

Mother and son appeared to be more relaxed at this session. They both said that the contract has been useful, and that they planned to renegotiate it with their Treatment Center II counselor. The son said that he had read the contract several times during the month and had used it as "a guide to know what to do." As he spoke, the son sounded pleased and proud of himself. He reported that he had passed his GED, started a full time job at a carpet store and was happy to be living at home again. He mentioned following several of the coping strategies in the contract, including talking to his mother about his feelings for ten minutes on the

weekend, calling his sponsor every day, and writing in his journal when he felt sad or overwhelmed. As he spoke, the mother smiled at him yet looked like she was preoccupied or not listening.

When the therapist asked for the mother's opinion on the contracting procedure, she said in a quick and offhand way that she thought it had been helpful. In a defensive tone of voice, she said that she had attended one ACOA meeting and had not been back. She said "I just don't have time for meetings at night." Her view was that her son was feeling better and that having a job seemed to make him happier. She reported that she and her son had talked more than usual during the month. With a big smile and a laugh she said that she had followed the therapist's suggestion of going into the bathroom to scream. She said, "I felt really silly, but I did it." The mother and son thanked the therapist at the end and were formal and polite in saying "goodbye."

Therapist Comment

The mother made it clear that she was unwilling to give up even a small part of her role as martyr and ultimate caretaker in the family. The shift in the family occurred as a result of the son deciding to tell his mother about his feelings, to develop a support

network outside the family, and to begin the process of becoming more independent.

One Year Follow Up Session

The son looked like a new person as he walked into the room. He had lost 35 pounds and was regularly lifting weights. His tone of voice was much stronger and the overall impression was that of an outgoing young man, rather than a shy, retiring young boy. The mother looked tired and had gained more weight. When she would begin to whine in the session, the son would look at her, grin and begin to be playful with her. Instead of looking embarrassed as he had the year before, his attitude was "that's just how she is, don't let it get to you!"

The mother proudly told the therapist that the family had moved to a newer and large condominium and that she and her mother were working on decorating it. She was not involved in any therapy or self help group, yet she attended Treatment Center II's aftercare group with her son.

In sharp contrast to his mother, the son talked about moving up in his job to supervising the carpet installations and making more money. He reported attending AA twice a week and seeing his sponsor at the meetings. He reported that he goes to a 12-step club to

meet people, often accompanied by his sponsor. When the therapist asked about relapse, the son said that he had not taken a drink or used any drugs. He said, "I don't seem to need it anymore. I have new friends and we have fun without it." With an appearingly embarrassed grin on his face, the boy said that he had met a girl a few months before and that they were currently dating. He had not had a girlfriend before and was enjoying spending time with her.

At the request of the therapist, the mother and son selected relapse concerns for co-dependency (the mother) and for chemical dependency (the son). The mother identified the following concerns for herself:

1. Exhaustion or fatigue.
2. Difficulty solving problems without getting overwhelmed.
3. Excessive or impulsive behaviors (for example, gambling too much; overeating; spending too much money; overworking; excessive sex).

The son identified the following concerns for himself:

1. Impatience with "recovery plan" ("things aren't happening fast enough").
2. Difficulty trusting others.

When the therapist asked the family about their plans for the future, the son talked about wanting to own his

own business someday and his plans to take a two week camping trip with some AA friends over the summer. The mother focused on plans for her daughter's upcoming wedding, getting their home ready for the wedding activities and company, and the possibility of finding a better paid nursing job.

Clinical Review of the Case

The individual members of this family interacted within an enmeshed system. The mother tried to control the son's behavior by whining, nagging and attempting to make him feel guilty. Presumably she interacted similarly with her daughter and the grandmother. The system had pulled together to withstand the loss of the father, financial hardship, the substance abuse of the son and grandmother, and the death of the grandfather. They watched out for each other, maintained a polite stance and escaped by occasionally taking a drink or pills and by overeating.

Because the grandmother and sister did not participate in therapy, the hierarchical picture is incomplete. Based on the interactions of the mother and son alone, it appeared that the son was pulled into a quasi-spouse role, expected by the mother to "help" run the household. In this position, his drinking and getting into trouble were endured by the mother, just as

she endured the father's alcoholic behavior. Their interaction was much the same as the wife who nags and complains and the father who avoids and drinks. By getting into trouble with the juvenile justice system, the son declared his true place as the child who requires reprimanding and punishment.

The mother told a stressful story when she recounted the family history. From the very beginning, this family had survived constant chemical addiction-related stress. When the children were very young, the father had drunken heavily and finally left the family altogether. During the years that the children were growing up, the mother had struggled to parent the children and to support them on a very limited income. Throughout these trying years, she also had dealt with numerous crises and calls for help from her prescription drug abusing parents. After the death of her father, the grandmother had moved in with the family and the mother had been trying to take care of her and control her behavior ever since. The father's leave taking certainly had been a significant nodal event for the family, one that created family stories and myths. Another nodal event was the anticipated leaving home of the daughter and the son. For the son, the process of leaving home would involve losing daily contact with his

primary caregiver and taking responsibility for working and supporting himself. For the mother, the children leaving home would put her in the position of being alone with her mother, with no one to "help" her to "help" her mother.

It would have been difficult to compete with the mother in her overresponsibility role in the family. She worked fulltime, took care of a hypochondriac mother, watched over and cared for the detailed needs of her two children, and never asked for time for herself. She told the son what to do , how to do it, and how he had not done it to her satisfaction. The son made a weak attempt to stand up to her, gave up and did nothing, or escaped to drink.

The homeostatic balance in this family system was based on the mother getting her power by nagging, demanding, reminding, and otherwise taking care of everyone in the family. She controlled their actions temporarily by watching over minute details and inducing guilt. The son listened, then ignored, finally argued and then escaped to drinking and getting in trouble. The cycle then repeated itself with the family members feeling guilty and defeated.

The protective function of the substance abuse was crucial to the family's view of themselves. This was a

family that did not argue and was polite at all times. By focusing on the son's substance abuse the mother could ignore her lonely life, avoid her own compulsive eating and overworking, and avoid dealing with her mother's hypochondria. One could hypothesize that the grandmother focused on the son's drinking problem in order to take the heat off her own problems. The son felt guilty about the trouble that his substance abuse had caused the family and continued to escape his mother's whining, by acting irresponsibly, drinking, and getting into trouble.

The mother and son obviously loved and cared for each other which was a significant strength of this family system. Despite multiple crises, the family had stayed together and established a safe and functioning home. The rule of politeness in the family had helped to instill some useful social skills and to assist them in making friends. The mother demonstrated a strong work ethic, which the children had modeled. By participating actively in the Treatment Center II program, the family has showed their willingness to get help for themselves and an openness to learning new ways of operating as a family unit.

When the father left the family during the children's young childhood, a family story was created.

The family had maintained their loyalty to each other and to the story. The story was that men who drink are irresponsible and cause the women around them to overwork and suffer. Mother was loyal to her family by caring for her mother through years of uninterrupted prescription drug abuse. She complained and whined about the son's substance abuse and continued to help him. The son was loyal to his father's memory by mimicking his pattern. He was loyal to his mother by giving her many opportunities to help him, bail him out, nag him, and support her martyrdom.

Conclusion

The family was able to make some important changes through the course of the year. In particular, the son began to separate from the family through his job advances, completing his GED, and establishing relationships outside the family (the girlfriend and his AA sponsor). He even let go of the family "image" by losing weight and getting in shape. He learned to turn off his mother's nagging and to make choices for himself and to take care of his responsibilities. At the age of 17, he was helping to support the family, had a responsible job and had laid the groundwork for a secure future for himself. The mother had either not tried to sabotage the son's efforts to gain competence, or had

been unsuccessful at doing so. She had not stopped taking care of everyone and had not learned to focus on herself. As her nest finally empties she may be pushed into crisis and treatment for herself. In the meantime, despite the mother's refusal to change, the son has been able to make some necessary changes and to begin to move forward on his own.

Discussion

What follows is an overview of trends and commonalities identified as developmental issues, family systems issues and treatment issues which emerged during the course of the treatment program. These are presented here as further support for the developmental/systems perspective used in this program of interventions for this population of substance abusers.

Developmental Issues

The four families that were described in the case studies showed significant similarities in the sons' lack of progress in the task of separation/individuation. In all four cases, the sons did not take adequate responsibility for their own school performance, and had become behavior problems in the classroom. The mothers in these families closely monitored various aspects of their sons' behaviors in ways that would be more appropriate for a latency age child. For example, one mother took responsibility for monitoring her son's medicine intake, and another monitored when her son went to bed at night and got up in the morning. By not being held responsible for these basic tasks, the sons were able to stay dependent on their mothers.

Through their substance abusing behaviors, the sons had avoided the risks, freedoms and responsibilities that typically come with the adolescent stage of development. In three of the cases, the sons were old enough to have drivers licenses, but had not applied for them. The mothers then had to drive them where they wished to go, or they needed to depend on friends--most of whom were substance abusers. The sons did not follow curfew rules that were established by their mothers. This resulted in more restrictions placed by the parents which were equally ignored.

The majority of friends of the sons in this study were substance abusers. These relationships were based on a mutual search for drugs and alcohol, obtaining the money to buy the drugs/alcohol, or being with each other while high or drunk. The sons had not been successful in establishing relationships outside the home that were supporting and mutually satisfying.

These adolescents had not begun to make plans for the future. They were predominantly present oriented. The concept of planning for college, trade school, or establishing other options of supporting themselves after leaving home appeared foreign to them. Such concepts of separation/individuation were framed as

irrelevant and "a long ways off" by each son in the study.

Family Systems Issues

All four case study families were single parent families with the mothers in the position of "head of household". All of the absent fathers had been alcoholics, and had left the families when the children were very young. In response to the stress of losing the father, struggling to survive on a limited single income, and a host of other stressors, the families had pulled together into enmeshed systems. The enmeshment was appropriate in that it had helped the families to stay together under extremely adverse circumstances. It had been inappropriate in that it resulted in the mothers taking most of the responsibility in the families and the sons being allowed to act irresponsibly and to maintain age inappropriate dependence.

The hierarchy in each of the case study families was skewed. None of the mothers had a significant emotional or sexual relationship. Lacking such an adult relationship they pulled the adolescent sons into quasi-spousal/companion roles. In this position, the sons escalated their substance abusing behaviors until a crisis developed and the mothers set limits and returned the sons to the position of children in the families.

Thus the sons fluctuated in being treated as equals and as dependents. In this manner, the homeostasis of the families were returned to the balance that had existed during the time that the fathers lived in the households. Fathers had been equals, yet dependent and incompetent. The balance of the original family depended on the mothers being in charge of minute details as well as the larger roles of bread winner and parent. The sons maintained their power in the families by acting irresponsibly while being a companion to their mothers.

Each of the four sons had experienced the physical and emotional loss of his father. This loss comprised a pivotal nodal event in the histories of the families. Surrounding the loss of the fathers, the families experienced severe financial strains and multiple additional problems. The leave taking of the fathers had also initiated family stories and myths about the roles of males which held significant power over the family members. Family members maintained their loyalty to the family by responding to the family myths that men are irresponsible, that they become substance abusers, and that they leave when times get rough. The sons were in actuality caught in the no win situation of following in their fathers footsteps and staying dependent on

their mothers through their own incompetence, or becoming competent and independent and leaving their mothers alone.

The families shared similar patterns of over/under responsibility. The mothers worked full-time, managed the household, tried to police the day to day, hour by hour responsibilities of their sons, and rescued them from jams at school and with the courts when their earlier efforts failed. They each also showed a consistent theme of being unwilling to set realistic and consistent limits for their sons, and carry out consequences when limits that were established were not maintained. The sons stayed in the roles of dependent young boys as they ignored school responsibilities and continued in substance abusing behaviors that kept them in trouble with the juvenile justice system. In most incidences the mother acted over competent and the sons helpless and inept.

In spite of all that these families had lived through, they had developed some important strengths that enabled them to keep going. In all cases, the love and concern displayed in the families were remarkable. The sons appeared to sense their importance to the mothers in the role of supporter and protector. Both mothers and sons displayed willingness to try more

avenues for getting help for the son and had been doing so for years.

The families focused on the sons' substance abuse instead of paying attention to other problems in the family. Some of these other problems/issues were the mother's compulsive behaviors (overworking or overeating), financial strain, lack of involvement in the outside world and their reported loneliness.

Treatment Affect Commonalities

As a result of the treatment program the families learned some new and important information, were offered alternatives for problem solving and made some changes in how they operated within their family system. Prior to their participation in the project, the families either did not know about their sons' chemical dependency or did not view it as a central problem. Prior to treatment they had narrowed their view of the problem and seen it as an individual issue. An affect of the program was that their view of the problem was broadened to include the other members of the family. The mothers also obtained some positive experience in setting limits and applying consequences consistently.

All of the families displayed some movement toward the middle in the enmeshed/disengaged continuum. The mothers began to let go of some of their control over

the sons and the sons responded by acting more independently. The homeostasis of the families was altered as the sons were allowed to show more competency and the mothers did not act to sabotage their newly accepted freedom.

The concept of relapse was changed for the families as they were introduced to the idea of relapse as a process which ends with continued drug and alcohol use. They reportedly gained a better understanding of the signs of relapse and displayed increased ability to recognize the danger signs. In addition, their communication patterns altered to allow for listening and understanding what the other was saying. The interactions between mothers and sons were judged to be more positive as they participated in this process.

What Was Learned in the Process

The systemic model of relapse prevention offered the families an opportunity to learn about relapse prevention and to focus on a family problem that concerned them. The families who were asked to participate agreed to do so and did not appear to be threatened by the process. The components of the treatment model fit together in such a way that allowed for a seemingly smooth, non-threatening progression. The education sessions introduced them to the therapist

and provided information that they were interested in and judged needed. The education sessions then set the stage for the family therapy sessions which followed. The family therapy sessions focused on negotiating a contract and was time limited and behavior specific. The follow-up sessions monitored progress, and provided intermittent reinforcement for continued behavioral change.

Limitations

The relapse prevention study project included twelve families from two residential treatment centers for adolescent boys. The case studies focused on four of the twelve families. Based on the small number of subjects, conclusions and findings cannot be generalized to a larger population. The purpose of the study was to concentrate on the process of the relapse prevention model, not to measure results.

In working with the families over a year long project, it is impossible to control for the variables that affect the families including issues within the families, extended family input and demands, the school, workplace, community and world events. It was also impossible at this stage of exploration to pinpoint precisely what about the therapeutic intervention made a difference, offered a viable option or pushed the

families into crisis, which allowed for change to happen. Based on clinical experience with substance abusing families, the therapist observed changes in the families and reported the changes she observed.

Implications for Future Research

While this study laid the theoretical groundwork for a therapeutic intervention program with chemically dependent adolescents that is developmentally, and systemically oriented; it did not test for the validity of this approach as compared to others. These components, education on relapse, behavioral contracting in a family therapy context, were combined with existing treatment modalities that included residential treatment program components and participation in self-help dependency groups. No comparisons were made with the subjects who participated in this treatment modality and others whose programs did not contain these components. Future research could focus on replication of this study under experimental conditions with pre-test/post test, and treatment and control groups. A less vigorous approach could be tried by clinicians by introducing components of the model (i.e. education sessions on relapse; contracting for change) and monitoring rates of relapse over treatments across time.

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APPENDIX A

Copies of the Four Case Study Contracts

CONTRACT NUMBER ONEParties

This is an agreement between the son and his mother.

Duration of Contract

This agreement is to become effective immediately upon signature and will terminate on month, day, year after which it may be renegotiated by unanimous written agreement of the signature parties.

High Risk Situations and Coping Strategies

Understanding that he is powerless over drugs and alcohol and that when he uses these chemicals that his life becomes unmanageable, son agrees to pay close attention to these high risk situations and to try to use the coping strategies listed for each situation below:

1. Boredom
 - * Call a friend.
 - * Play the guitar.
 - * Plan the day to include some fun things.
 - * Play basketball or go for a walk.
2. Anxiety/Nervousness
 - * Walk around outside.
 - * Go and shoot baskets.
3. Depression/Feeling Sad
 - * Talk in aftercare group about feeling sad and down.
4. Fatigue
 - * Turn out the lights at 10:30 every night and allow myself to go to sleep. If I have difficulty sleeping, I will try some relaxation exercises.
5. Helpless/Hopeless

Recognizing that I set myself up to feel bad about myself, I will concentrate on going after things that I want for myself, particularly pursuing skills that make me more independent. I will begin by practicing my guitar for one hour every day after school.
6. Lack of Meaning in Life
7. Isolation from others/
Loneliness
8. Painful Memories
9. I think I need drugs/alcohol in order to have fun.
10. Social Group made up of people who use drugs and alcohol.
11. I don't want treatment.

For items 6 through 11 above I will think about ways to cope with these feelings and write them down. If I need help with this, after I have worked on it myself for a while, I will ask for help.

Daily Prevention Strategies

Recognizing that relapse prevention requires a daily recovery program in order to be successful, the son and his mother agree to the following items:

1. Son will attend AA meetings three times per week.
2. Mother will attend AL-ANON meetings once a week and will continue with her own personal therapy.
3. For the next month, son will submit to a weekly urine screens, to be conducted at Treatment Center I on Monday night, to coincide with the Aftercare meeting.
4. Son will be responsible for getting himself up in the morning, on time. He will set his own alarm clock the night before and get up when it rings in the morning. Mother will not call him, check on him or wait for him when she is ready to leave. If he is not ready to go in time, she will leave without him and he will have to make his own arrangements to get to school. At the end of each week during the month, son and mother will review how this procedure is working.

Procedure to follow if Drug/Alcohol Use is about to occur

With full knowledge that the use of alcohol or drugs is a danger to his life and a very serious threat to his ability to function effectively, the son agrees to the following steps to use if he is about to use drugs/alcohol:

1. I agree to delay taking the first drink/using the drug for 20 minutes. This delay will give me time to make a clear decision.
2. I agree that the first use will involve a single dose.
3. I will wait one hour before using/drinking again.

Rewards and Consequences

If the son follows this contract for one month, mother agrees to pay half of the cost of a guitar for son.

For small infractions of the contract, to be determined by mother, son's consequence will be to do a chore at home as assigned by his mother.

For major infractions of the contract, as determined by mother, son will be restricted to stay home the following weekend.

Specifically, if the son is late getting ready for school, that evening he will be restricted to home and not allowed to watch television.

CONTRACT NUMBER ONE - CONTINUED

Amendments

Any amendments or deletions to this contract must be made by unanimous written agreement by the signature parties.

Son's Signature

Mother's Signature

Witness (Therapist)
Myra Binns Bridgforth

CONTRACT NUMBER TWO**Parties**

This is an agreement between the son and his mother.

Duration of Contract

This agreement is to become effective immediately upon signature and will terminate on Month, xx, 1988 after which it may be renegotiated by unanimous written agreement of the signature parties.

High Risk Situations and Coping Strategies

Understanding that using drugs and alcohol cause problems in the family and put him at risk for further involvement with the legal system and extremely serious health consequences, the son agrees to pay attention to the high risk situations and to utilize the coping strategies listed below:

1. Anger
 - * Come to group sessions at Treatment Center II ready to discuss feelings and situations that make him angry. Utilize individual therapy sessions to talk about feeling angry.
 - * Play basketball.
 - * Call a friend on the phone.
2. Anxiety/nervousness
 - * For the next month, when I begin to feel tense/nervous/anxious I will pay close attention to how I feel; where I feel it in my body. I will write down words to describe how it feels or tell it to a friend or staff person and ask them to write it down. I want to be able to recognize this feeling when it happens.
3. Denial
 - * When I begin to feel like I don't have a problem with drugs or alcohol I will talk about these feelings in group and in AA meetings.
 - * Whenever I find myself not asking for help and downplaying the seriousness of my problem with alcohol I will stop and think about how denial causes me trouble.
 - * As soon as possible I will get a sponsor in AA and talk to him on the phone and at meetings about my feelings.
4. I think I need alcohol and drugs in order to have fun.
 - * In the past the price I payed for "fun" with alcohol has been too high. In order to practice having fun without alcohol and drugs I will plan one fun event for the time I have at home.
5. Being invited to a party where drinking/drug use will occur.

* I know that being in a social situation where alcohol is present is a very dangerous situation for me. In order to keep myself safe I will say "No thanks, I can't come to the party, I don't do that stuff anymore."

* I want to learn to make fun for myself that is safe fun. During the next month I will invite a friend to do some activity with me that will be enjoyable and that will help me to feel good about myself.

6. Difficulty refusing alcohol.

* People who offer me alcohol may not realize it but they are threatening my future and my health. I will say, "No thanks I'm sober". I do not need to explain myself to them. If I am having a hard time saying no I will walk away and get to a phone to call for help; either my counselor, AA sponsor, my mother or another sober friend.

7. Difficulty handling evenings and weekends.

*

8. Difficulty solving problems without getting overwhelmed.

*

9. Lack of constructive ways of spending my days.

*

The mother agrees that compulsive working and pushing herself is a problem that she must address. Work can be an addiction; that is, a way to deal with uncomfortable feelings that can harm her health and her relationships with others. She may decide to bring up this issue at an ALANON meeting and to ask for help.

Daily Prevention Strategies

Recognizing that relapse prevention requires a daily recovery program in order to be successful, the mother and son agree to the following items:

1. Both mother and son will read over the high risk situations list in their Journey workbooks every day during this month. They will pay attention to the items that are a problem for each of them for each day.
2. The son agrees to let his Mom know that he is paying attention to her when she speaks to him by looking her in the eye and repeating back what he has been told.
3. During the weekend time at home the son agrees to stick with whatever agreement he has with his mother about his responsibilities when she is out of the house.

CONTRACT NUMBER TWO - CONTINUED

4. The son agrees to take responsibility for taking his medicine without being reminded.

5. The son agrees that getting involved in other people's business can cause problems for him. He will walk away when he feels tempted to get involved in someone else's hassle.

6. In order to begin a new life for himself, the son needs to develop new interests and new ways to spend his time. During this month, he will write out a list of potential hobbies/activities/interests that he might want to pursue. He will go over this list with his counselor and then his mother. He will choose one of the items to look into or try this month.

7. The mother agrees not to remind the son about taking his medicine. If she feels tempted to mention it to him she will say to herself "No, that's not my job."

8. Recognizing that the son wants a better relationship with his father, both mother and son will talk about inviting him over to spend time with the son during his weekend time at home or to visit him for a specific time at Treatment Center II.

9. The mother will look into an ALANON group for herself and begin attending at least one meeting every week. She will make an attempt to find a group that is made up of parents of substance abusers who will then understand her situation and be able to be supportive of her.

Procedure to follow if drug/alcohol use is about to occur.

With full knowledge that the use of drugs and alcohol is a danger to his life the son agrees to the following procedure if he is about to drink or use drugs:

1. I agree to delay taking the first drink or using the drug for 20 minutes. This delay will give me time to make a clear decision and to call for help.

2. I agree that the first dose will involve a single dose.

3. I will wait for one hour before drinking/using again.

Rewards and Consequences

If the son follows this contract for one month, his mother agrees to allow him to go to the store and pick out any one item of clothing (not including tennis shoes).

For minor infractions of the contract to be determined by the

mother, the son will receive the following consequence:

For major infractions of the contract to be determined by the mother, the son will receive the following consequence:

Amendments

Any amendments or deletions to this contract must be made by unanimous written agreement by the signature parties. _____

Signatures

Mother

Son

Witness (Therapist)
Myra Binns Bridgforth

CONTRACT NUMBER THREE**Parties**

This is an agreement between the son and his mother.

Duration of Contract

This agreement is to become effective immediately upon signature and will terminate on Month, xx, 1987, after which it may be renegotiated by unanimous written agreement of the signature parties.

High Risk Situations and Coping Strategies

Understanding that using drugs and alcohol causes problems in the family and puts him at risk for further involvement with the legal system and even more serious consequences such as jail, the son agrees to pay attention to the high risk situations and to utilize the coping strategies listed below:

1. Anger

* Come to Aftercare sessions and talk about feelings and situations that make me angry. Talk to mom about these feelings as well.

* Check into available sports activities for the summer. Set up a schedule of regular physical exercise as an outlet for energy and frustration.

2. Denial/I don't have a problem with drugs and alcohol.

* When I begin to feel this way, think back to times I got into trouble and remember whether or not drugs and alcohol were related to the trouble.

* Attend Aftercare and talk about my feelings of denial. Find out in the group is anyone else feels this way and what they are doing about it.

3. Depression

* Confront the person that I am angry with instead of stewing and getting depressed.

* Do something physical, like sports to stimulate some energy.

* Talk to someone about feeling sad.

4. Impulsive behaviors

5. Guilt

6. Lack of meaning in life

7. Painful memories

* For items 4 through 7 above consider coping strategies that might be effective including attending AA, asking for help, developing new interests and ways to spend my free time and to combat boredom.

Daily Prevention Strategies

Recognizing that relapse prevention requires a daily recovery program in order to be successful, the son and

his mother agree to the following items:

1. The son and his mother will attend the Treatment Center I Aftercare program meetings on Monday nights at 7:00.

2. For the next month, the son will not cut any classes at school.

3. He will make every effort to pass everything except Geometry.

4. Every day he will bring his list of assignments home and go over the list with his mother. After dinner each evening he will spend at least one hour studying. After this study hour he will go over the completed assignments with his mother so that she can check them.

5. He will follow the curfew set for weekends, 12:00. When the son goes anywhere he will tell his mother where he is going, who he will be with and expected time of return. If plans change, he will call home to inform her of these changes.

Procedures to follow if drug/alcohol use occurs

With full knowledge that the use of alcohol and drugs is a danger to his life and a dangerous risk to his freedom, the son and the mother agree to sit down together within the next week to discuss and come to a mutual understanding of the consequences that will occur if the son decides to use again. The mother is responsible for setting the limits and notifying the son of the potential consequences. The son does not have to agree with the consequences, only to understand what the set limits are and the consequence if he decides to step beyond the limit

Rewards and Consequences

If the son follows this contract for one month, as determined by the mother, she will agree to do what is necessary to fix the moped.

For small infractions of the contract, to be determined by the mother, the following consequence will be used

For major infractions of the contract, to be determined by the mother, the following consequence will be used

CONTRACT NUMBER THREE - CONTINUED

Amendments

Any amendments or deletions to the contract must be made by unanimous written agreement by the signature parties.

Son

Mother

Witness (Therapist)
Myra Binns Bridgforth

Date _____

CONTRACT NUMBER FOUR

Parties

This is an agreement between the son and his mother.

Duration of Contract

This agreement is to become effective immediately upon signature and will terminate on Month, xx, 1987, after which it may be renegotiated by unanimous written agreement of the signature parties.

High Risk Situations and Coping Strategies

Understanding that using drugs and alcohol cause problems in the family and put him at risk for further involvement with the legal system and extremely serious health consequences, the son agrees to pay attention to the high risk situations and to utilize the coping strategies listed below:

1. Anger
 - * Come to group sessions at Treatment Center II ready to discuss feelings and situations that make him angry. Utilize individual therapy sessions to talk about feeling angry.
 - * Lift weights.
 - * Listen to the radio.
2. Guilt - "all the stuff that I've done that has hurt people."
 - * During the next month, the son agrees to spend 10 minutes while at home on the weekend, talking with his mom about his guilt feelings, telling her how he feels; telling her that he feels sorry about the past.
3. Difficulty refusing drugs and alcohol.
 - * When the offer is made to me to drink or use drugs I will just say, "No thank you", understanding that no explanation is necessary. I can also say "No, I don't do that stuff anymore."
 - * Recognizing that I sometimes get into fights with others as an excuse for drinking alcohol, when I feel myself wanting to pick a fight I will walk away and go relax and cool down.
 - * When I am tempted to accept an offer of drugs or alcohol or of putting myself into a dangerous situation where I might be offered drugs or alcohol, I will call Friend #1 or Friend #2 to ask for help.
4. Difficulty meeting people and making new friends.
 - * I will talk to my sponsor during this month about wanting to make friends with people who are sober. I will ask his help and advice about making new friends.
 - * Recognizing that I need to develop new interests in order to make my life more interesting and to meet

new friends, I will prepare a list of interests/hobbies/activities that I would like to look into. Once this list is pulled together I will go over the list with my counselor and then my mother. I agree to pick out two activities/hobbies/interests to try.

5. Lack of constructive ways of spending my day.

* Using the list from #4 above, I can begin learning new ways to spend my time. When I feel bored I will read over this list to see what I can plan to do.

* During my time at home I will plan one special and fun activity to do that I will enjoy and that will help me to feel good about myself.

6. Painful memories.

* When I become aware of thinking about sad times in the past I will share these feelings in group and/or individual.

* I will write down in a notebook/journal my memories of the painful time or event. This will help me to get the feelings out and really feel them. Ignoring the feelings is a way that I miss an opportunity to deal with my pain and then move on.

* If I am remembering a certain person or event I can write a letter to someone who also knew the person or who shared in the experience and tell them about what I remember.

7. Impulsive behavior.

* Recognizing that I sometimes do things without thinking about the consequences, I will practice making a list of my options for a particular situation. Using this strategy I will be able to carefully decide on the best course of action.

8. Anxiety/Nervousness.

*

9. Not attending AA/NA. _____

10. Argumentativeness. _____

The mother agrees that anger is an issue in the family that causes much pain for everyone. She is often successful at dealing with angry feelings by working in the garden or taking a solo drive in the car. The mother also expressed that she feels helpless and hopeless at times and is concerned about getting her family involved in a recovery program. As a way to model positive behavior, the mother has agreed to consider individual therapy for herself in

CONTRACT NUMBER FOUR - CONTINUED

order to work on her own issues, to gain some needed distance from family problems and to replenish her own sources of energy.

Daily Prevention Strategies

Recognizing that relapse prevention requires a daily recovery program in order to be successful, mother and son agree to the following items:

1. Both mother and son will read over the high risk situation lists each evening as a way to take stock and be aware of where their trouble spots may be.
2. Son agrees to tell he mom the names of his friends who drink and use drugs as a way to protect himself. He agrees not to be with these people for the next month.
3. When a problem comes up, the son agrees to tell his mother about it so that she hears it from him first.
4. When she wants or needs something from him, the mother agrees to ask for it directly in a calm voice. She will avoid the temptation of assuming that the son "should" know what she wants or expects of him.
5. The son agrees that in an argument with him she will let him know that she is hearing his side of things by saying "Tell me your side of this". She will then stop talking and listen until the son is finished talking. She will then restate what she has heard him say.
6. When she gets angry or frustrated, the mother agrees to try going into the bathroom, closing the door and screaming. When she is finished she will come back out and ask directly for what she wants.
7. The mother will look into an ALANON or ACOA group for herself.

Procedure to follow if drug/alcohol use is about to occur.

With full knowledge that the use of drugs and alcohol is a danger to his life the son agrees to the following procedure if he is about to drink or use drugs.

1. I agree to delay taking the first drink or using the drug for 20 minutes. This delay will give me time to make a clear decision and to call for help.
2. I agree that the first dose will involve a single dose.
3. I will wait one hour before using/drinking again.

Rewards and Consequences

If the son follows this contract for one month, his mother agrees to the following reward

For minor infractions of the contract to be determined by his mother, the son will receive the following consequence:

For major infractions of the contract to be determined by his mother, the son will receive the following consequence:

Amendments

Any amendments or deletions to this contract must be made by unanimous written agreement by the signature parties.

Signatures

Son

Mother

Witness (Therapist)
Myra Binns Bridgforth

APPENDIX B

Review of Related Literature

Review of Related Literature

Overview

The adolescent stage of development and how it relates to drug misuse is addressed by Stanton (1979).

"Drug use appears initially to be an adolescent phenomenon. It is tied to the normal but often troublesome process of growing up, experimenting with new behaviors, becoming, self-assertion, developing close (usually heterosexual) relationships with people outside the family, and leaving home" (p. 253).

Stanton refers to research by Kandel, Treiman, Faust, and Single (1976) in which the authors propose three stages of adolescent drug use. In the first stage, adolescents use legal drugs, such as alcohol, primarily for social purposes. In the second stage drug use is progressive and includes the use of marijuana. Peer pressure is seen as a motivator in this stage. The third stage is characterized by the more frequent use of illegal drugs. The adolescent's more serious drug use appears to be most affected by the quality of his/her relationship with parents and is predominantly seen as a family phenomenon.

The complex and stressful tasks of adolescence require new and ever-increasing responses from the young

person in the form of coping mechanisms and coping skills. Alcohol and drug use as a coping mechanism for adults is well documented (Brownell, Marlatt, Lichtenstein, & Wilson, 1986; Chaney, O'Leary, & Marlatt, 1978; Emrich & Hansen, 1983; Gorski & Miller, 1982; Gorski, 1985; Jurich, Polson, Jurich, & Bates, 1985; Litman, Eiser, Rawson & Oppenheim, 1979; McCubbin, Needle, & Wilson, 1985; and Moos, Bromet, Tsu, & Moos, 1978). Labouvie (1986) states that "adolescence may be an important period when individuals begin to explore the usefulness of alcohol and drugs for emotional self-regulation" (p. 334). Adolescence is a time when an individual is unsure about how to regulate his/her emotions. The situation is then complicated by an increased ability to think about possibilities and ideals as opposed to reality. This may increase the likelihood that the adolescent will experience negative feelings of distress, anger and fear (Izard, 1977), and the associated feelings of powerlessness and hopelessness (Smith, 1983).

Our society encourages the use of alcohol as a way to be social, and self medication as an appropriate reactive coping mechanism. It is understandable that adolescents choose to deal with their uncomfortable emotional states by turning to drugs and alcohol

(Labouvie, 1978). Research supports the assumption that adolescents copy the behavior of adults and pattern themselves after role models. Peer and adult models exert strong influences on the initiation of adolescent drug use (Huba & Bentler, 1980). Fiske-Lowenthal (1977) comments on the adolescent's use of drugs and alcohol to regulate emotions and his sense of powerlessness. Both factors contribute to an environment in which the adolescent will make fewer personal commitments, and will prefer instant gratification over the attainment of long-term goals. As a consequence of this, the developmental tasks of adolescence as identified by Havighurst (1953) are seen as "problems and demands" rather than "opportunities and challenges." The downward spiral then continues as the adolescent copes with fewer positive emotions by engaging in what Zuckerman (1979) calls "sensation-and-experience-seeking behaviors."

In order to understand how the developmental stage of adolescence is uniquely affected by addiction it is helpful to consider Schenk and Schenk's (1978) view of adolescence in which the individual is in "a caught in the middle stage" (p. 39) between childhood and adulthood. The authors describe this as the "NQA stage; the not-quite-adult, not-quite-adolescent stage" (p. 44)

in which the adolescent and the parents go back and forth between perceiving the adolescent as a grown up and as a child. The adolescent who is in the NQA stage will vacillate from using coping skills learned in childhood to reaching for coping skills seen in adulthood (in the case of the addicted adolescent these "adult" coping skills will include the use of drugs and alcohol.)

Erikson (1964) identified the developmental stages of the individual throughout the life cycle including those for adolescence. Adolescent tasks include the renegotiation of the separation-individuation process. This process may include beginning to separate from parents and family, seeking more support and friendship outside the home, making decisions about who they are, what they want to be, and accepting and rejecting values of their parents. These tasks may be overwhelming for many adolescents and their families because the demands for change exceed their coping abilities (Rosenstock, 1975).

Adolescent Substance Abuse in a Family Context

From a systems perspective, causality of addictive behavior is not a major issue of concern. Rather, the focus is on how the symptom is maintained through established, routinized and interactive patterns

(Duncan, 1974; Steinglass, 1976). Rueger and Liberman (1984) point out that family members cope with the adolescent abuser's behavior by responding with "anger, transient rejection, nagging, babying, conciliation, guilt or sympathy" (p. 404). These responses serve to reinforce the behavior because the adolescent perceives the attention as concern or interest. The authors assert that in drug-abusing families there is often little positive interaction around normative issues and family members are often isolated from each other. When the adolescent then exhibits behaviors such as intoxication, hangovers, arrests, incarceration and pleas for help, the family's response is experienced by the adolescent as massive attention and concern. In effect, according to Rueger & Lieberman (1984), the family is saying, "so long as you continue to be helpless and irresponsible, we will be interested and concerned about you" (p. 404).

Addiction in the adolescent is supported by the ways in which families interact and parenting styles that are used, such as undermining the adolescent's sense of self-sufficiency, accepting the addict's use of manipulation, and diminishing the adolescent's sense of self-esteem (Alexander & Dibb, 1977; Little & Thompson, 1983).

Wegscheider-Cruse (1983) identified a paradox which is familiar to family therapists and is commonly found in alcoholic families: they live by one set of rules while pretending to live by another. In sum, the pretend set of rules dictates that the addictive behaviors must stop, while the real rules dictate that the addictive behaviors must continue. The author describes some typical rules of families with chemically dependent members that demonstrate the conflicting messages about the roles of chemical abuse within the family setting:

1. Drug/alcohol abuse of a family member becomes the focal point of family life.

2. At the same time, the family denies that chemical dependency is a real problem.

3. Open discussion of the obvious problem is avoided at all costs and while the family is fixated on the issue it does not openly address it.

4. The chemically dependent person denies responsibility for the disease.

5. Denial by the individual is facilitated by family members' "enabling" behaviors. Enabling behaviors overprotect and infantilize the chemically dependent individual.

Another pertinent interactional pattern in the substance-abusing family is provided by Bepko and Krestan (1985). They frame the pattern of concern in terms of over/underresponsibility which then functions to maintain alcoholic behavior. Bepko and Krestan also examine the ways that family members do or do not assume individual responsibility.

Yet another way of understanding the interactional patterns in substance-abusing families is by looking at the adolescent's developmental issues of separation and individuation (Cooper, Grotevant & Condon, 1983). These normal developmental tasks are experienced by many families as stressful. Noone and Reddig (1976) view stagnation in this stage as a protective maneuver on the part of the family to avoid further stress. When the anxiety over separation increases and is experienced by the family as intolerable, the drug abuser will respond by offering up his or her problem as a way to avoid separation and the resulting shift that would occur in the family structure. The symptom becomes the focus of the family's problem solving energy. The authors suggest that as a symptom, drug abuse offers several advantages to the family and the abuser:

- "1) the abuser remains dependent on the family while appearing rebellious, 2) siblings and

extended family member are pulled into the system to help, 3) the drug problem postpones the lines of separation, and 4) drugs are seen as the problem, not separation and individuation" (p. 327).

Alexander and Parsons' (1973) research in the area of delinquency is also relevant to the issue of adolescent addiction and family interactional patterns. They found that families of delinquents had a lack of structure which was a result of too many rules that were inconsistently enforced. As a consequence, an unstructured environment provided an atmosphere conducive to acting out. Brook, Lukoff and Whiteman (1978) support the concept that family structure, and the adolescent's acceptance/rejection of that structure, were significantly related to the adolescent's use of marijuana. They found that a more active, demanding, and involved parent who monitored children's interactions at home and with peers was less likely to have children who used marijuana.

Jurich, Polson, Jurich and Bates (1985) considered a wide range of factors present in the families of drug abusers. Their review of the literature found these factors to be significant: "Parental absence, discipline, scapegoating, hypercritical morality, parent-child communication gap, parental divorce,

mother-father conflicts, family breakup, and the use of psychological crutches to cope with stress" (p. 143). They went on to examine many of these factors in their research and found that parent-child communication gaps, inconsistent discipline, lack of coping skills, and low parental self-concept were significantly related to the maintenance of drug abuse in the family. They also found that in the absence of positive coping skills normally learned from parents, children followed a more negative model provided by the parent. In many cases this model included coping with stress through alcohol.

Other studies have shown the role of negative parental models as contributors to adolescent misuse of drugs and alcohol (Beschner & Friedman, 1985). By using drugs and alcohol, parents model escaping personal responsibility and as a result transfer their own deviant norms to their children. By avoiding responsibility the parents utilize a psychological crutch, defined by the authors as, "any behavior such as drug-taking, psychosomatic illness, or manufactured psychological disturbances, which allows exoneration of responsibility for the situation and relief from the pressure created without dealing with the situation itself" (p. 149). A major finding of this study was that if a child had a model of the most powerful family

member being able to do without a psychological crutch, the child might use drugs but would not tend to become an abuser of drugs. In sharp contrast, if the child's model was of the most powerful family member needing a psychological crutch for coping with stress, the child was more likely to abuse drugs.

Family Therapy

Family treatment is acknowledged as an effective clinical intervention for problems related to an adolescent's abuse of drugs and alcohol (Cleveland, 1981; Reilly, 1975; Wermuth & Scheidt, 1986; Klagsbrun & Davis, 1977 and Lawson, Peterson, & Lawson, 1983). What follows is a review of key concepts involved in family treatment of abusing adolescents from a systemic perspective.

Structure. Structure refers to the interactional patterns (Umbarger, 1983), or the invisible set of functional demands (Minuchin, 1974), that dictate how family members interact. Based on the work of Salvador Minuchin (1974, 1981), structural family therapy considers the social context in which family members work and live. Therapy is focused on changing the organization of the family, and thereby changing how individuals in the family experience relationships with other family members. In families who come for therapy,

often one person has been labeled as the identified patient or the "sick" one. Once the selection has been made the symptoms of the sick one serve to maintain the existing rigid, inadequate family structure (Minuchin, 1974). Therapeutic approaches to adolescent substance abusers and their families are based on the assumption that families with symptomatic adolescents are families with dysfunctional structures. These structures may be characterized as enmeshed, overprotective, rigid, and exhibiting lack of conflict resolution (Cleveland, 1981).

Hierarchy. Hierarchy refers to a rule of ordering within the system in which some subsystems are subordinate to other subsystems (Umbarger, 1983). Within the context of a family system, hierarchy most often refers to the children being subordinate to parents. When there is a problem in hierarchy the distribution of power within the system is confused. All families have a particular hierarchial structure, some functional and some dysfunctional. Umbarger states that "the inversion of power hierarchies is often labeled as the single most destructive force in a family's structure" (p. 29). Hierarchies exist and are maintained by the repetitive interactional patterns within the family as demonstrated by distribution of

power, role identification and coalition formation and maintenance. When the family has organized itself around a symptom (such as adolescent substance abuse) the goal of therapy is to alter the repetitive interaction patterns by challenging the confused power hierarchy (Minuchin and Fishman, 1981). Using the authors' technique of unbalancing, the therapist sides with one family member or subsystem and persists with the alliance until the family is pushed into crisis or change (Minuchin & Fishman, 1981).

Nodal point/event. A nodal point or event is characterized by those significant occurrences in the life cycle of a family which are experienced as a crisis. Resulting from the crisis is a change in the structure of the relationships within the family (Guerin & Pendagast, 1976). In order to understand the affect that nodal events have had on the family, L'Abate, Gandahl and Hansen (1986) suggest asking the family questions in regard to their ability to cope with a particular crisis, developmental change, or catastrophe, and concerning what supports they have been able to use. Pittman (1987) makes reference to "snag points," which are the inflexibilities that prevent the family system from making changes when faced with the stress of an existing crisis. He outlines the following questions

which help the therapist to gain an understanding of the meaning of nodal events or snag points: "What above all is the change this family must prevent? What is there in this family's structure which is so precious that it must, at all costs, be protected?" (Pittman, 1987, p. 18).

Over/underfunctioning. In Bepko and Krestan's book, The Responsibility Trap (1985), patterns of over- and underresponsibility were identified in substance-abusing families as those patterns which serve to facilitate and maintain the substance abusing behaviors. The substance abuser uses chemicals and as a result underfunctions. In order to keep the family operating, other family members step in and overfunction. Thus a cycle is set in motion whereby the substance abusers get stuck in the role of helpless irresponsibility, and the other family members are stuck in the role of overburdened helpers. Pittman (1987) defines the role of the substance abuser's spouse as the co-alcoholic who overfunctions: "Even though this concept runs the risk of implying that the overfunctioning causes the alcoholism rather than permitting it to continue, family therapy for alcoholism has increasingly focused on the family's overfunctioning as a factor which can and must be changed in solving the problem" (Pittman, 1987, p.

269). L'Abate, Ganahl and Hansen (1986) define the cycle of over/underfunctioning as the interaction between two persons with low levels of differentiation in which one assumes an inadequate role. The inadequacy of this person is then balanced by the adequacy of the other. The authors assert that if one of the two desires to change, the other person will also have to change. An imbalance of family functioning is demonstrated by the adolescent substance abuser who underfunctions and uses drugs to maintain his or her role as a family baby. He/She is dependent on parents, and on getting attention through drug-abusing behavior (Kaufman, 1980, 1985). For the overfunctioning parents, the drug-abusing adolescent serves an important role by keeping their attention on the child rather than on the parental conflict, or the unhappiness in the spousal relationship (Kaufman, 1985).

Homeostasis. Homeostasis refers to an idealized period of balance (Umbarger, 1983), a stable balance (L'Abate, Gandahl & Hansen, 1986), the propensity within the family to keep a certain established equilibrium (Wachtel & Wachtel, 1986) and a tendency to seek a steady state (Dell, 1982). Family systems have a tendency toward homeostasis; therefore they create a set of rules, usually implicit, which serve to maintain the

interactions of family members within a set range. If a family member's behavior steps outside of the accepted range, other family members will behave in such a way as to counter the imbalance and bring the family back to a steady state (Green & Framo, 1983). Jackson (1957) explains that some symptoms within the family will persist in order to maintain the homeostasis. He asserts that family interactions will serve to pressure the identified patient to stay the same (Miller & Sobelman, 1985).

The affect of alcoholism/drug abuse on the family is stress. Stress may take the form of financial hardship, lack of job security, or conflict. The general affect is one of escalating crisis throughout the family structure. A reverse dynamic also occurs in which the stress of marital problems and family conflict supports and maintains substance abuse as a way to cope with constant crisis within the system. For example, perpetuating drinking in a family is a way of maintaining homeostasis within the system.

Protective function. Symptoms are behaviors that signal dysfunction in the individual as well as in the family (Umbarger, 1983). A symptom can be viewed as a protective solution for a family crisis. The individual who exhibits the symptom protects the family balance by

sacrificing himself or herself. This sacrificing of self is viewed systemically as a reaction of the family system to the stress (Minuchin & Fishman, 1981). Typically as a result of stress family members are mobilized to protect the system by pressuring the family member whose need for change is threatening the balance. The symptom protects the family because it serves to detour conflict, thus enabling the family to pull together in concern for the symptomatic member which in turn rewards the symptoms (Minuchin, Rosman & Baker, 1978). Furthermore, the authors state that "the experience of being able to protect the family by using the symptoms may be a major reinforcement for the illness" (p. 31).

To conceptualize the dysfunctional family system, the therapist may frame substance abuse in the family as a family problem; one in which the abuser protects the family. If the abuse problem improves, or if the family member abstains, other family members are predicted to respond in ways which undercut his or her success, thus maintaining the status quo and keeping the abuser drinking or using (Stanton & Todd, 1981).

Family strengths. Minuchin and Fishman (1981) define family strengths as those elements which, when identified, can be used to initiate behavior and to

expand the current repertoire of behavior present in the family. They refer to the "unsung characteristics of families -- the nurturing, the caring, the supportive transactions -- that insure survival in a complex world" (p. 265). When families come for therapy, they are stuck in a narrow way of viewing the problems within their family, frequently labeling one member as the sick one. Minuchin and Fishman suggest that a way to challenge the narrow view is by focusing on family strengths, thereby changing the family's view of its current situation.

Marianne Walter's (1983) method of working with families is based on the concept of competency. She states that families start to change when they begin to feel competent. Focusing on individual and family strengths is the tool used to initiate change in the family system.

Family therapy with substance abusing adolescents involves focusing on family strengths, and utilizing the family as a positive influence; one that can help the abusing member overcome the addiction rather than maintaining the addiction.

Family loyalty. Family loyalty refers to the emotional commitment an individual has for his/her family as a whole. L'Abate, Gandahl & Hansen (1986)

outline reinforcers which affect family loyalty including the freedom to act in ways not permitted outside the family, family stories, and relationships with other family members. The authors suggest that family loyalty issues occur on a continuum from too restrictive to too loose, and that family members seek a balance between their own needs and the needs of the family without feeling that they are breaching family loyalty. Minuchin, Rosman and Baker (1978) state that in enmeshed families, loyalty and protection become more important than autonomy and self-realization. Green and Framo (1981) discuss the lengths that children will go to in order to gain approval from their parents and thereby to remain loyal to the family. Children will

"accept unrealities, accept an irrational identity or role assignment, be persecuted, be overindulged, be scapegoated, be parentified, what have you, this price will be paid; to be alone or pushed out of the family either physically or psychologically is too unthinkable" (p. 369).

Family therapy with adolescent substance abusers must include an affirmation of the family loyalties and provide an opening for family members to express these loyalties. Noone and Reddig (1976) found that drug-abusing families continued to support their drug-abusing

member despite their chronic drug use and the resulting crisis events. The family's reaction to each crisis was one of intense loyalty. Drug abuse and associated deviant behavior then became a way for the abuser to intensify family bonds.

Family Therapy With Other Treatment Modalities

Family therapy in conjunction with self-help groups provides a multifaceted and multi-systemic approach to the serious problem of substance abuse. Alcoholics Anonymous (AA), the most popular and long standing self-help treatment approach for chemical dependency, or one of its more recent off-shoots (CA, NA, ALANON, AL-ATEEN), and family therapy are believed by many clinicians to be the crucial components in the recovery of the addicted individual and the family (Davis, 1980; Esser, 1971). For an indepth review of Alcoholics Anonymous and the guiding principles of the program refer to Alcoholics Anonymous (1938; 1957; 1973). Habitual drug and alcohol use affects the individual immensely and the therapeutic work needed to gain control over the physical craving for the drug must be respected (Nace, Dephore, Goldberg, & Cammarota, 1982). Although alcoholism is frequently maintained by dysfunctional interactions with others, it is primarily viewed by many experts as a disease which is individual

in nature, and must first be cured on an individual level. The main therapeutic goal of AA is abstinence from alcohol starting with the individual coming to terms with the sustained belief that he/she is powerless over the influence of alcohol. Focus on relationships and the interactions between family members is not a primary treatment strategy.

The double-pronged approach of combining self-help groups and family therapy in the treatment of adolescent addiction coincides with the belief held by many that neither approach in and of itself is sufficient. AA may provide the individual support and structure needed to overcome the physical, spiritual, and chemically addictive aspects of the symptom. Family therapy may be used to identify cues within the family interaction patterns that trigger drinking, to teach alternative behavior, and to help the family develop new ways of resolving conflict (Davis, 1980).

Contingency Contracting

Contracts negotiated between two or more people provide a means of facilitating the exchange of positive reinforcements (Stuart, 1971), aid in the decision-making process (D'Zurilla & Goldfried, 1971; Jayaratne, 1978), help provide a means to deal with school problems (Cantrell, Cantrell, Huddleston & Wooldridge, 1969),

enable the natural progression towards reestablishment of independence and self-sufficiency, and aid in improving family relationships (Frederickson, Jenkins, & Carr, 1980). Contracts have been used effectively in families where reciprocity has broken down. In substance-abusing families which are characterized by lack of structure (Parsons & Alexander, 1973), inconsistent rule setting and enforcement, and a communication gap between parents and children (Jurich, Polson, Jurish & Bates, 1985), contracts have been used successfully by providing structure for reciprocal exchanges through specifying who is to do what, for whom, and under what circumstances. In this way, family members know what is expected of them and are more likely to fulfill their stated responsibilities (Stuart, 1971).

Contingency contracting with families is an effective technique in that it utilizes the strengths of the family to reverse the cycle of alienation and breakdown in communication. This is accomplished by the use of positive and rewarding interactional exchanges that pull the family together (L'Abate, Ganahl, & Hansen, 1986; Rueger & Lieberman, 1984). In a very concrete way, contracts change the contingencies through which a drug abuser in the family gets attention and

care from other family members. Rewards and reinforce are made contingent on adaptive and constructive behavior instead of on maladaptive, antisocial, drug-seeking behavior (Rueger & Lieberman, 1984).

The therapist's role in working with the substance-abusing family is to negotiate a contract, to make explicit the everyday expectations that family members have of each other, and to provide incentives for carrying out responsibilities. The process modeled in contract negotiation is one of establishing goals, and responding to a family member's desirable behavior with positive feedback. Desirable behavior would include negotiating, bargaining and compromising with each other (Rueger & Lieberman, 1984). Weathers and Liberman (1975) point out that contracts are useful in families where years of conflict have cemented a system of negative exchanges and mutual withdrawal. In these troubled families there are very few positive exchanges exhibited. The authors state, "relations in such families are marked by coercion rather than cooperation and helpfulness. In these families, the focus is on what is NOT liked or wanted, rather than on what IS liked and desired" (Weathers & Liberman, 1975, p. 209).

In addition to fostering positive exchanges and making explicit expectations of family members,

contracts provide a way for families to learn problem solving skills. Blechman, Olson, Schornagel, Halsdorf, & Turner (1975) developed their "Family Contract Game" for this purpose. Their premise is that families do not solve their problems because they do not have the necessary skills. Furthermore, their antagonistic behavior interferes with acquiring these needed skills. Even those skills that are successfully used to solve problems at school or work are often not used at home. The goal of contracting with families is to temporarily suppress antagonistic behaviors in the family to allow for the family to learn problem-solving skills.

One key consideration is that the content of the contract does not really matter. Rather the existence of the contract and the process used to negotiate it may actually predispose family conflicts toward resolution (Stuart & Lott, 1972).

The family is often in great conflict when they are referred to therapy. Initially the therapist engages the family by encouraging its members to accommodate (to a degree) the requests of each other in order to receive more of the privileges than they have previously enjoyed. The therapist then leads the family through the process of compromising, giving to get what they want, listening and negotiating. This process happens

with the therapist as mediator. By focusing on problem solving and utilizing an action-oriented approach, contracting does not allow for name-calling, fault-finding, scapegoating, blaming and emotional outbursts (Martin, 1977). The author further supports the notion that adolescents have strong feelings of being overly controlled by authority figures, and make demands for total, unquestioned freedom. At the same time, they have a need for structure and direction and often end up in situations where they have little power to negotiate. Contracting in the family provides a structure and means for adolescents to negotiate within the family system.

The issues of rule setting, hierarchy in the family, and reinforcement are ones that Patterson (1982) has extensively researched. The importance of the parents' role of being in charge, setting and enforcing the rules, is a key issue for the author. In order to bring about change, Patterson refers to the need to utilize rule setting, reinforcement, and contingent punishment. He states, "It is the absence of rules plus the absence of contingent punishment that generate the problem" (p. 222).

Contracts provide a non-threatening, problem-focused, practical approach to negotiating family problems in which family members are allowed to save

face. From the perspective of adolescents, the use of contracts which are binding for all family members, appeals to their developing sense of autonomy (Rosenstock, 1975). Contracting also encourages the evolution of the second separation-individuation phase described by Erikson (1964). By outlining specific family tasks, expected times of completion, and resulting reward or punishment, the contract is helping to facilitate the adolescent's sense of responsibility and appropriate independence.

In substance-abusing families where prolonged conflict coexists with a cycle of negativism and unwillingness to negotiate, the therapist assumes the role of consultant and mediator, and helps the family to save face (Pruitt & Johnson, 1985). Instead of being forced to make concessions, family members can move toward agreement while shifting responsibility for the concession to the therapist, thereby saving face. The family member/negotiator is then able to perceive that he/she is being intelligent to follow the lead of the consultant, rather than weak for caving in to pressure to change. The direct, non-threatening, teaching model used in contingency contracting helps the client family to define problem areas and to utilize self-help strategies. This learning process can empower the

family members to deal competently with their problems and expand their use of coping skills (Martin, 1977). Weathers and Liberman (1975) offer four general guidelines for generating effective contracts. They are:

- "1) The negotiation of a contract must be open and honest, free from explicit or subtle coercion. 2) The terms of the contract should be expressed in simple, explicit, clearly understood words. 3) For a contract to be effective it has to provide an opportunity for each participant to optimize his/her reinforcement or minimize his costs and losses in the areas of his life covered by the contract. 4) The behaviors contracted for must be in the repertoire of the person agreeing to them" (p. 209).

It is reasonable to conclude that contracts have proven useful in working with problematic families. Many techniques for intervention have been researched, employed, and critiqued in the treatment of substance abusing families.

In summary, alcohol/drug abuse of adolescence has been linked to developmental issues and family system issues. Little has been reported in the literature on specific relapse presentation programs with abusing

adolescents that consider both of these crucial dimensions while focusing on relapse prevention. The literature does suggest that a combined treatment program of family therapy with an educative self-help group is a treatment of choice. Evidence was also established for the use of contracts with family members, as means of disrupting dysfunctional interaction patterns within the family while circumventing adolescents' disdain for authoritarian parenting.

APPENDIX C:

Outline of Programs Developed for Purposes of This Study

Outline of Programs Developed for Purposes of This Study

What follows in an informal presentation outline of the relapse education sessions, family therapy sessions, and the one month and one year follow-up interviews developed for the purposes of this thesis. Much of the content of the educational sessions was based on the works of Gorski (1985) and Gorski and Miller (1983).

Educational Sessions

The sessions were begun with informal introductions, and gathering together of participants. Sons were requested not to sit with their parents.

The content of the first session focused on the relapse syndrome and relapse warning signs. Participants were led through a series of exercises that experimentally demonstrated concepts. What follows is an outline of activities and discussions of concepts held in the initial education session.

Participants completed an adaptation of Gorski's (1985) "Relapse Misconceptions Quiz". The quiz contains 10 commonly held misconceptions and truisms of what constitutes relapse, and provides a base line for level of understanding of participants. After discussion of participants' responses the didactic portion of the session was begun. Topics covered included (a) the relapse syndrome, (b) Post Acute Withdrawal (PAW)

syndrome which includes a review of sobriety based symptoms of the disease of chemical dependency (Gorski & Miller, 1983), and (c) high risk situations and warnings signs of relapse. Use of Daley's (1983) "Relapse Prevention Workbook" to identify symptoms of relapse and co-dependency relapse provided another experiential learning tool that facilitated discussion of participants current interactional patterns around the issue of drug use/relapse.

Session 2 of the educational sessions began with an overview of the concepts presented in the previous session. The group was read "The journey from addiction alley to freedom mountain" (adapted from Marlatt & Gordon, 1985). This story illustrates the process of relapse recovery, and provides a metaphor for the development of healthy functioning.

The group was then led in an exercise of identifying the high risk situations that were targeted in the relapse work books at the previous session. Participants were to rank order the top five high risk items, and in small group settings were to identify three coping strategies for each of the high risk situations. Poster presentations giving examples of high risk situations and possible coping strategies were presented.

Family Therapy Sessions

The family therapy sessions were begun with an investigation of stage of treatment for the chemically dependent son, and the son's and parent's reaction to the known dependency. The purposes of the sessions were presented: (a) to negotiate a relapse prevention contract, (b) to discuss particular relapse concerns of the family, and (c) to complete a contract that would be followed for a one month period that specified actions and reactions for each family member in efforts to prevent relapse.

Ground rules of (a) a here and now approach to therapy, (b) no blaming or fault finding, (c) and the therapist as negotiator for what the family wanted to accomplish, were established.

Parents and sons were guided to share high risk concerns that they had previously identified in the education sessions. Additional coping strategies were developed as warranted, and a contract was developed that prescribed how each person would react/act in specific situations.

Parents were encouraged to establish consequences for both major and minor infractions of the contract. Parents and sons negotiated a reward system for successful completion of the contract. Sometimes the

rewards were material rewards and sometimes were in the form of a privilege or opportunity. The first therapy session generally ended while the family was developing coping strategies for the risk situations.

The second session generally allowed enough time for the family to talk specifically about their anger, fears and hopes, and about the past breach of commitments that had previously been negotiated. The therapist focused on family strengths, times when they had kept commitments, family loyalties, and their ability to be creative and adaptive as a family. At the end of the second session the therapist explained what the parents and son were to do when they received the contract by mail. The one month follow-up session was also discussed and schedule.

One Month Follow-up Session

One month follow-up sessions were established to evaluate the effectiveness of the program that was developed for the purposes of this study. Typically these sessions lasted less than an hour, and focused on, (a) had the overall program worked, (b) which aspects had been most helpful, (c) had they followed their contract, and (d) would they renegotiate a contract again with their existing (Center I or II) counselor. The relapse process was explored, as were the parents'

persistence in carrying out consequences and providing rewards.

One Year Follow-up Session

The one year follow-up sessions averaged 30 minutes in length. The son's relapse history during the one year period was explored, as was the mother's co-dependency relapse history. Relapse signals, coping strategies, and treatment interventions sought were also explored. The therapist requested that the family choose from the identical relapse concerns list as was initially completed by the family during the previous year. After relapse concerns were identified the therapist ended the sessions by questioning families about future plans and concerns.



VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

DEPARTMENT OF FAMILY AND CHILD DEVELOPMENT—
NORTHERN VIRGINIA GRADUATE CENTER (703) 698-6035

INFORMED CONSENT

I _____ freely and voluntarily consent to participate in the study, "The Utilization of Relapse Prevention Contracting with Adolescent Substance Abusers and their Families" being conducted by Myra Binns Bridgforth from Virginia Tech University, Northern Virginia Center, Falls Church, Virginia. The purpose of this study is to gather information on the use of relapse prevention contracts with adolescents who are chemically dependent and their families.

I understand that the study involves the following procedures:

1. I agree to attend two education sessions to be held on successive Monday nights, April 20 and April 27 from 7:00 - 9:00 p.m. The sessions will be attended by all study participants made up of Treatment Center I residents, aftercare participants and their families. The sessions will highlight important information on relapse prevention which can be valuable to me and my son. Each session will be held at Treatment Center I. I am free to withdraw from the study at any time without pressure to continue and without prejudice to me.

2. After the education sessions are completed, I agree to participate in two family therapy sessions with Myra Binns Bridgforth who is conducting the study. She is a trained family therapist with experience in working with young people and their families. The family sessions will explore the relapse concerns of the family and will culminate in the completion of a contract between parents(s) and the young person.

3. I understand that the risks involved in my participation in this study are no larger than those one normally takes when seeking to learn new material and engaging in family therapy. These risks include that my behavior and attitudes toward myself and my son might change.

4. I understand that the content of the family sessions will be totally confidential. Myra Bridgforth will be the only person with access to the names of those who participate in the study. At the end of the study, the list of names of those who participated will be destroyed. After the list of names is destroyed, Myra Binns Bridgforth will be free to report the information she finds without connecting my name to the study. This information can then be evaluated. If it has implications for persons who work with chemically dependent young people and their families the researcher

can submit the findings for publication in professional journals.

5. I have asked and had answered all questions I have about the study and my participation in it. I have read and understand the preceding statements and have received a copy of this form.

Date Parent's Signature

Parent's Signature

Treatment Center I Resident or
Aftercare participant's Signature

I have explained in detail the research procedure in which the aboved named person(s) have agreed to participate.

Date Myra Binns Bridgforth, M.S. Candidate
Principal Investigator
698-6035 (Virginia Tech)
938-4263 (Home)

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EDUCATION

Currently pursuing an M.S. in Marriage and Family Therapy at Virginia Tech, Northern Virginia Graduate Center.

B.A. in English and Religion, Westhampton College, University of Richmond, Virginia. Completed on academic year in Foreign Studies, Schiller College, Heidelberg, West Germany.

PSYCHOTHERAPY EXPERIENCE

Fairfax County DUI-DAART Program (October, 1987 to Present). As a Contract SAC II Counselor, conduct family, individual and group therapy with these chemically addicted clients and their families referred by the county criminal justice system.

Dominion Psychiatric Hospital, Aftercare Program (September, 1986 to May, 1987). Conducted family and group therapy with chemically dependent young people and their families. Clients had completed the inpatient phase of treatment and were in the beginning stages of recovery. Work included indepth assessment, education and crisis intervention.

Fairfax House (September 1985 to June 1986). As a Family Therapist Intern, I conducted family, group and individual therapy with the adolescents residents and their families.

OTHER PROFESSIONAL TRAINING

Gestalt Therapy Institute (1984 to Present). I have completed approximately 100 hours of Gestalt Therapy Training.

OTHER PROFESSIONAL EXPERIENCE

Consultant (August 1982 to August 1984). As a private consultant, provided expertise to corporate clients in the areas of personal management and technical proposal preparation.

VITA

Myra Binns Bridgforth

Computer Sciences Corporation (June 1979 to July 1982).

As Personnel Manager was responsible for providing personnel support for 700 employees in 27 locations nationwide. Supervised a staff of nine professionals and support staff. Responsible for employment, benefits administration, compensation, EEO/affirmative action, management and supervisory training.

Harrison Management Company (April 1978 to May 1979).

As an account executive was responsible for selling company services and capabilities to potential clients, as well as fulfilling service commitments to established clients. Managed a national fundraising/public relations program. Served as Assistant Director of several small national associations. Developed and implemented membership drives and responded to daily requests from the memberships of the association.

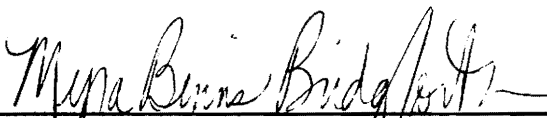
Marine Technology Society (November 1976 to March 1978).

As a Legislative Assistant, developed a grants program to obtain assistance for programs of this interdisciplinary society. Efforts including identifying appropriate institutions, writing technical proposals and developing contacts with the granting institutions. Responsible for all conference planning and coordination.

PROFESSIONAL MEMBERSHIPS

Student Member, American Association for Marriage and Family Therapy

Student Member, American Association for Counseling and Development



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