TRAINING ON THE DIAGNOSIS, TREATMENT, AND REFERRAL OF SUBSTANCE ABUSERS AND THEIR FAMILIES IN AAMFT-ACCREDITED MASTER'S LEVEL MARRIAGE AND FAMILY THERAPY PROGRAMS

by

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(ABSTRACT)

Because of the prevalence of substance abuse in America and the association between this issue and common problems brought to the family therapist, it is important that family therapists be trained to diagnose and either treat or refer substance abusing clients and their families. This study gathered information from the Directors of Master's level family therapy programs accredited by AAMFT about the content and format of training that students in their programs receive preparing them to work with substance abusing families. Twenty of the 22 programs were represented by completed questionnaires. Five programs were reported as having a required substance abuse course; four, a popular elective. Three respondents reported plans to

increase their coverage of the topic in their curricula. The average of the responses for prevalence of substance abuse as a central issue in practicum cases was 30%. Although about 75% of the respondents believed that their graduates were ready to diagnose and refer these cases, only 25% believed that these same students were ready to treat substance abuse cases. Data showed that 40% of the respondents believed it advisable for AAMFT to require a separate course on substance abuse. Comments from those opposed to such a requirement noted the crowdedness of existing curricula, the importance of academic freedom, and the abundance of other topics to be covered.

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TABLE OF CONTENTS

ABSTRACT ii

ACKNOWLEDGEMENTS iv

TABLE OF CONTENTS v

LIST OF TABLES viii

ARTICLE: Training on the Diagnosis, Treatment, and Referral of Substance Abusers and Their Families in AAMFT Accredited Master's Level Marriage and Family Therapy Programs 1

Methods 11

Questions 11

Sample Population, Cover Letter, and Follow-Up 14

Response Categories 15

Statistics Derived 16

Results 17

Programs with a Required Class in Substance Abuse . 18

Programs Not Having a Required Class in Substance Abuse 19

Coverage in Practicum 19

Information Least and Most Likely to be Addressed . 22

Prevalence of Substance Abuse Issues in Practicum Cases 26

Estimates of the Adequacy of Training of Students Upon Graduation 26

Electives 27

Suggested Additions and Deletions in Coverage 28

Curriculum Changes 28

Comments on the Desired Role of AAMFT 29

Discussion 31

References 47

APPENDIX A: Review of Related Literature 52

Concurrence of Substance Abuse and Presenting Problems 53

A Closer Look at Marital Violence and Substance Abuse From a Systemic Perspective 56

Relevance of Family Therapy 58

Reviews on the Importance of Family Therapy in Treatment 58

Literature on Substance Abuse Treatment Not Highlighting Family Therapy 62

Literature on Additional Topics Addressed in the Questionnaire 64

Underlying Ethical Principles 65

Statements About the Polarization and Integration of the Addictions Treatment Field 67

Some Experts' Recommendations on the Content and Format of a Graduate Substance Abuse Course 71

Attempts to Integrate Various Branches of Addictions Treatment 73

References 75

APPENDIX B: Data 80

Percentages of Respondents Not Covering Items, by item 81

Estimates of Prevalence of Substance Abuse Issues in Practicum Cases 84

Estimates of Preparedness of Students Upon Graduation 85

Thoughts on AAMFT Involvement 86

Data by Program From the Twenty-one Respondents 87

Number of Responses in Each Category 89
--for all programs combined 89
--for the five with a required class 92
--for the fifteen others 95

APPENDIX C: Instruments 98

Original Cover Letter 99

First Follow-up 101
Second Reminder 103
Postcard Thanking Respondents 105
The Questionnaire 107
VITA 116

LIST OF TABLES

1. Items more likely to be addressed in practicum than in required courses 21

2. Information least likely to be addressed 23

3. Survey items covered by over two-thirds of the programs 24

TRAINING IN THE DIAGNOSIS, TREATMENT, AND REFERRAL OF SUBSTANCE ABUSERS AND THEIR FAMILIES IN AAMFT-ACCREDITED MASTER'S LEVEL MARRIAGE AND FAMILY THERAPY PROGRAMS

The pervasiveness of substance abuse in the American culture indicates that marriage and family therapists will encounter a substantial percentage of families for whom substance abuse issues are central (Blum, 1984; Bureau of the Census, 1987; Czechowicz, 1988; Gallup, 1982; Johnson, 1986; U.S. Department of Health and Human Services, 1989). It is important that the family therapist be able to recognize substance abuse and its relationship to other issues and then make a reasonable choice between treatment and referral. Ethics demand that the therapist who chooses to treat clients with substance abuse issues be familiar with the relevant available knowledge (American Association for Marriage and Family Therapists, 1988).

Several groups of professionals--including systemically trained therapists, addictions counselors, and medical personnel--have a great deal of information about the diagnosis and treatment of clients with substance abuse issues. A review of the literature of these groups of professionals reveals a great breadth of topic areas a comprehensive family therapy training program might cover. Because of the relative lack of attention paid to substance

abuse problems in the family therapy literature (French, 1987; Steinglass, 1976) and because of the lack of cross-fertilization between addictions professionals and family therapists (Bepko, 1985; Brown, 1985; Dulfano, 1978), students training to be family therapists may or may not be aware of this accumulated knowledge.

The therapist can expect to see many clients who abuse substances and many families directly affected by this use. The rate of alcoholism in America is frequently estimated to be between 5% and 10% (Blum, 1984; Johnson, 1986), although estimates vary greatly (Mulford, 1982). A recent estimate of current use in 1988, defined as use at least once in the month prior to the survey, was 6% for marijuana and 1.5% for cocaine (U.S Department of Health and Human Services, 1989). The rate of current use in 1985, as estimated by The Bureau of the Census (1987), was 9.4% for marijuana and 2.9% for cocaine. The incidence of families directly affected by abuse of alcohol and other drugs is much higher. In response to a question on a 1982 Gallup poll, over one-third of the participants identified that drinking had been a cause of trouble in their families (Gallup, 1982).

The literature shows a clear association between substance abuse and common presenting problems. Among the types of presenting problems statistically associated with substance abuse are suicide, sexual problems, adolescent problems, depression, and marital violence.

Studies link suicide and alcoholism by finding that both (a) the rates of alcoholism among people committing suicide and (b) the rates of suicide among alcoholics far exceed the corresponding rates in the general population. Goodwin (1973) reported that in 6 of the 11 studies he reviewed on the connection between alcohol and suicide, nearly 33% of those committing suicide had been alcoholics, a rate substantially higher than most estimates of alcoholism in the general population. Similarly, 13% to 50% of those who attempted suicide had been alcoholics in the Goodwin review. Another way to see the association between alcoholism and suicide is to review data looking at the population of alcoholics rather than the population of suicide attempters. Goodwin (1982) reviewed studies finding that 6% to 29% of alcoholics commit suicide. A longitudinal study by Miles following alcoholics to their death (cited in Goodwin, 1982) found that 11% committed suicide. This far exceeds the .01% rate of suicide among the general population (Bureau of the Census, 1985).

Another complaint of the client that suggests the therapist look into substance use is that of sexual dysfunction. Miller and Gold (1988) discussed the impairment of physiological and emotional sexual responses among drug users in the areas of desire, performance, and satisfaction. The clear physiological link between ingestion of chemicals and dysfunctional sexual responses

has also been shown empirically by Cocores, Miller, Pottash, and Gold (1988) who studied 50 males addicted to both cocaine and alcohol.

Substance abuse is common among a significant number of American youth. Figures in the National Institute on Drug Abuse report (1989) giving highlights of the 1988 National Household Survey on Drug Abuse show that the percentage of youth aged 12 to 17 using an illicit drug in the last month was 9%; the rate for use by these youths in the past year was 17%. According to The U.S. Department of Health and Human Services press release (1989) giving highlights of the 1988 National High School Senior Survey, 2.7% of high school seniors use marijuana/hashish daily, .2% use cocaine daily, and 4.2% drink alcohol daily. Almost 35% of students in the high school class of 1988 reported having five or more drinks in a row in the past two weeks. Not only the high incidence of drug use among adolescents but also the prevalence of associated problems is well documented. Various studies show a relationship between marijuana use and (a) poor coping mechanisms and lack of interpersonal skills (Labouvie, 1986), (b) poor academic performance and attendance (Kandel, 1982), (c) escape from competition and conflict (Hendrin, Pollinger, Ulman, & Carr, 1981-82), and (d) delinquency (Kandel, 1982). A study of high school students abusing drugs found a more than average number of negative behaviors within these families (Beschner &

Friedman, 1985). Whether these problems precede or follow drug use, the association of substance abuse with adolescent problems is clear.

There is an increasing awareness that many clients seeking therapy will have a diagnosis of both drug abuse and depression or other psychiatric disturbances. Studies show that for opiate users the figures for concomitant depression range from 15% to over 30% (Galanter, Castaneda, & Ferman, 1988; Weisman, Pottenger, Kleber, Ruben, Williams, & Thompson, 1977); for alcoholics, 28% to 70% (Galanter et al., 1988); for cocaine abusers, 30% (Mirin, Weiss, Sollogub, & Michael, 1984). Davis (1987) reported finding significantly greater use and more problem use among psychiatric patients than among medical-surgical patients when he examined quantity, frequency, and social consequences of use of alcohol and other drugs.

Studies regularly find a correlation between alcohol abuse and husband-to-wife violence (Kantor & Straus, 1987). Maritally violent men often report higher alcohol consumption than other men (Kantor & Straus, 1987; Van Hasselt, Morrison, & Bellack, 1985) or a higher rate of beer and whiskey consumption (Fagan, Barnett, & Patton, 1988). Reported rates of drinking at the same time as the marital violence occurs vary but are consistently high, being 31% in Fagan et al. (1988) and 22% in Kantor and Straus (1987).

The examination of these common problems presented by a family entering therapy shows that the therapist needs to be alert to the possible link between the presenting problem and abuse of alcohol and other drugs. Since causation is not shown, one cannot assume that dealing with the one issue will satisfactorily change the other. Furthermore, there are many patterns involved, including developmental, interactional, cultural, and intergenerational patterns. A systemic approach, therefore, appears to be an important part of treatment (Davis, 1987).

Several reviewers have written in support of the value of family therapy for abusers and their families (Finlay, 1974; Janzen, 1977; Kaufman, 1985a; Stanton, 1979; Steinglass, 1976). Steinglass (1976) commented that, although he had found relatively few studies on family therapy with alcoholics compared to the magnitude of the problem, he had "guarded optimism about the application of family therapy techniques in the treatment of alcoholism" (p. 116). Recognition is becoming wide-spread that substance abuse is not only an individual problem. In particular, it is a family problem as well. The abuser affects and is affected by other family members, and certain maladaptive patterns occur in families with an addicted member (Kaufman, 1985a; Stanton & Todd, 1982). An increasing flow of articles and books advances the value of a systemic approach to treatment.

In summary, this growing body of literature advocates family therapy to (a) increase the coping skills and emotional support of the other family members in addition to the abuser, (b) correct distorted communication and foster openness, (c) restructure the family that may be organized around the abuse by looking at roles and at patterns of responsibility, (d) identify family behavior patterns that maintain the abuse and encourage the development of alternative patterns, (e) retain a systemic perspective rather than search for causes, (f) foster beneficial use of the Twelve Step programs, and (g) keep the abuser in treatment longer.

For years alcohol and drug abuse treatment focused on the individual abuser (Bepko, 1985; Finlay, 1974). Although systemic issues were sometimes dealt with tangentially, most of the growing knowledge base dealt with medical aspects of chemical abuse, the genetic predisposition among alcoholics, stages of addiction, a search for causes of addiction, the pharmacology of specific drugs, the confronting of defense mechanisms, and psychiatric factors (Blume, 1983; Cohen & Callahan, 1986; Goodwin, 1976; Jellinek, 1960; Khantzian, 1980; Milam & Ketcham, 1981; Pattison & Kaufman, 1982). Years of research by addictions specialists and clinical observation by drug counselors and medical personnel have yielded a great deal of knowledge. This knowledge is available to the family therapist. It may not be familiar

to many trainees in systems programs, however, because of the lack of cross-fertilization between the two groups of professionals who have tended to develop along separate tracks (Bepko, 1985; Kaufman, 1985b).

Historically, there has been a polarization of the addictions treatment field, with considerable tension existing between addictions professionals and family therapists (Bepko, 1985; Dulfano, 1978). Systemically-oriented therapists object to treatment that focuses on the substance abuse to the exclusion of other problems; individually-oriented addictions counselors object to treatment providers who, in their view, do not recognize the substance abuse or address it as primary (Davis, 1987; Kaufman, 1985b; Treadway, 1989). Recently, authors have increasingly attempted to integrate substance abuse treatment approaches (Bepko, 1985; Davis, 1987; Treadway, 1989). Heath and Atkinson (1988) and Stanton (1988) have explored this issue from the standpoint of designing a graduate course on substance abuse from a systemic perspective.

Ideally, family therapists will be familiar with the breadth of information available about substance abuse. Some of this is information on which there is consensus among writers of the literature on addictions treatment. In addition, there are issues on which evidence may be contradictory and on which people's opinions may differ, yet

therapists must be clear about their own beliefs so as to make decisions based on those beliefs. Family therapists, dealing as they inevitably will with substance abuse and related issues, have an ethical responsibility to be knowledgeable about the relevant factual information and to have thought through their positions on the controversial issues.

The American Association for Marriage and Family Therapists (AAMFT) issues a code of ethical principles binding on all its members (AAMFT, 1988). Several principles can be looked at in terms of therapists' knowledge of the field of substance abuse and therapists' ability to recognize, diagnose, and treat clients abusing substances. The code states that in order to practice ethically the therapist must "seek to remain abreast of new developments in family therapy knowledge and practice" (Principle 3.4) and must "not attempt to diagnose, treat, or advise on problems outside the recognized boundaries of their competence" (Principle 3.6). The third relevant ethical principle states that "therapists continue therapeutic relationships only so long as it is reasonable clear that clients are benefiting from the relationship" (Principle 1.5).

This last principle addresses how long it is beneficial for a therapist to continue to treat a client who is successfully working on other issues if the therapist

believes that the substance abuse is continuing. The decision is not simple. Some of the most common questions a therapist must consider are as follows: If the client is making changes in other areas, is continuation of therapy in the client's best interest despite continuing substance abuse? Might continuing substance abuse trigger a relapse in other areas that the therapy is addressing? Is short-term improvement in the presenting problem more important in the present than the potential harm from long-term substance abuse, particularly since the long-term use may be addressed later on? Is the therapist buying into the denial or is the therapist truly being effective? Is the stage of addiction relevant? Is the assessment about whether therapy is beneficial different if a family member of the abuser initiated treatment rather than the abuser?

Different therapists will decide differently. The question is: Has the therapist intentionally thought through the issues, being clear about the criteria used?

This research sought to ascertain to what extent family therapy programs are preparing students to deal competently with substance abusers and their families. Information was gathered on the content of the curriculum in Master's level programs accredited by AAMFT, reflecting the training that family therapists are receiving in the area of substance abuse.

Program Directors of these accredited programs were surveyed to determine the specific components of the training that students in their programs receive preparing them to recognize, diagnose, and treat both clients abusing substances and the families affected by substance abuse. The data collected by surveying Program Directors identify the specific factual knowledge typically taught and specific controversial issues typically covered. In addition, the data identify the format in which this training is done, individual variations among programs, and Directors' thoughts on the preparedness of their graduates and on the most helpful level of AAMFT involvement.

Methods

The Questions

The approach of this project was (a) to formulate questions reflecting possible coverage of a comprehensive training program on substance abuse issues in a systemically oriented therapy curriculum, (b) to use these questions to survey Directors of AAMFT-accredited Master's level programs concerning the training in each of their programs, (c) to gather the responses to this survey, and (d) to compile the data about the training described.

The information was divided into two categories identified as factual information and controversial issues. The category called factual information covered information on which there was a great deal of consistency throughout

the addictions treatment literature. This included topics such as the number of steps described by Alcoholics Anonymous (AA), the connection between drug use and common presenting problems, patterns frequently occurring in families with an addicted member, and the symptoms of use of a particular drug. It also included topics such as the customary division of the progression of addiction into three stages and the general recognition of relapse as a process rather than an event.

The second category covered areas in which there was less consensus or more subjectivity. Evidence may be contradictory and people's opinions may differ, yet therapists must be clear about their own beliefs so as to make decisions based on those beliefs. These questions related to therapists' stands on controversial issues, their meshing of potentially conflicting concepts, their views on the relative importance of various goals, their views on the importance or lack of importance of the search for causation, their attitudes toward abusers, and their levels of comfort with their own use of substances.

Following these items were several questions of a different sort on the following topics:

1. What was the prevalence of substance abuse among cases encountered by practicum students?

2. Did the respondent feel confident that graduates were adequately trained to diagnose, treat, and/or refer in substance abuse cases?
3. What was the coverage of substance abuse issues in electives?
4. What additional topics areas did the respondent believe should be included to represent comprehensive coverage of the topic?
5. What did the respondent believe was the most helpful level of AAMFT involvement in stipulating curriculum requirements?
6. Did the respondent have general comments on trends in their training program and impediments they have encountered?

The questionnaire is found in Appendix C. An attempt was made to keep the questionnaire as short and uncluttered as possible, requiring about 20 minutes to complete.

To identify questionnaire items that would represent what could be taught in a fairly comprehensive coverage of the field, the literature of diverse parts of the addictions field was examined. This literature included the writings of systemic family therapists, psychiatrists and medical doctors treating addictions, and addictions experts coming from the tradition of inpatient and outpatient addictions counseling. The collection of questions was then reviewed by nine professionals, including addictions specialists,

family therapists, and university faculty. Their suggestions on coverage, content, readability, and ease of response were incorporated in the final questionnaire.

The Sample Population, Cover Letter, and Follow-Up

The 22 directors of AAMFT-accredited Marriage and Family Therapy Master's programs in the United States were mailed surveys. Questionnaires were accompanied by a cover letter explaining the nature and purpose of the study. The letter requested their cooperation and promised a final report. The opportunity for accredited Marriage and Family Therapy (MFT) programs to share information about their handling of this training was considered to be the reward for responding. A return addressed, stamped envelope was included.

Three follow-up mailings were planned, following the method outlined by Dillman in Mail and Telephone Surveys (1978). The first, mailed after ten days, was a postcard to everyone, thanking those who had responded and serving as a reminder for those who had not. After three additional weeks, a follow-up letter was sent, accompanied by a replacement questionnaire. The final follow-up for those still not responding began after two additional weeks. Because of the small sample size, the use of certified mail for the final follow-up (as specified by Dillman) was replaced by a follow-up telephone call and the mailing of additional letters or questionnaires when warranted.

To ensure confidentiality, surveys were numbered before mailing and only the researcher was able to connect the numbers on the returned surveys to the respondents' programs. No reported data identified individual programs.

Of the 22 Master's level Marriage and Family Therapy programs accredited by AAMFT, 21 responded. One sent a letter explaining their extensive plans for curriculum changes. The other 20 completed the questionnaire. Many included detailed comments.

Not all the questionnaires were filled in by the Program Directors. The entire task was assigned to others by four Program Directors and the part of the questionnaire covering the specific content and format was assigned to the instructors of the substance abuse class by two other Program Directors. Responses, therefore, may or may not reflect the Directors' perceptions in those cases.

The Response Categories

The response categories were designed to be specific enough that coverage reported by different programs would be comparable. This was done by asking the respondents to specify where in their programs the information identified in each question was taught. The four response categories were as follows: (a) in a class specifically on substance abuse, (b) in another required class, (c) in that part of the practicum taken by most students, and (d) not addressed in the required program. The respondents were asked to mark

all categories that applied. One intent of this use of very specific categories was to reduce the tendency respondents might have to give positive answers seen as more desirable.

The Statistics Derived

Statistics were derived by item and by program. The percentage of respondents answering not addressed in the required part of the program for each item in the applicable sections was calculated. For each program, the percentage of items not addressed was calculated for the section called factual information and that called controversial issues.

The responses showed the percentage of programs having a specific course on substance abuse, the percentage having a popular elective, and where else in the programs the topic was addressed. Responses produced an estimate of the percentage of the practicum cases in which Directors believed substance abuse was a central issue. Data revealed how confident respondents were about the adequacy of their training in diagnosis, treatment, and referral. Another question was designed to gather people's views on the desirable level of AAMFT involvement in setting standards for curriculum coverage in the area of substance abuse.

The author identified specific questions indicating areas of particular strength and weakness by looking at the breakdown of data on programs addressing and not addressing specific topics. An arbitrary division was made at 33% in order to separate those topics more frequently covered in

programs from those topics less frequently covered. This division permitted items to be separated into two groups: those topics addressed by at least 67% of the programs and those topics addressed by less than 33%. The data also permitted an assessment of whether the programs were relatively stronger in coverage of specific factual information or of the more subjective areas requiring informed decision making. In addition, it permitted a look at whether programs were relatively stronger in the presentation of systemically oriented information or of information more oriented toward the medical model of addictions treatment.

Results

Of the 21 respondents, one said his/her program was making an extensive study of the very topic of this research; that is, what to include in a comprehensive systemically oriented substance abuse class and the format in which to do it. This respondent replied in a letter rather than returning the questionnaire. The data from the 20 who completed the questionnaire revealed that five programs (25%) had a required substance abuse class and four (20%) had a popular elective. Four (20%), including the program responding by a letter, reported plans to implement changes increasing their coverage of substance abuse issues.

The data also revealed the specific material most and least likely to be covered. Responding to the item about the desirable input from AAMFT, 40% stated that they would favor a decision by AAMFT to require a separate course on this topic.

The modal response for prevalence of substance abuse as a central issue in cases seen in practicum was 25%. Although approximately 75% of the respondents believed that their graduates were ready to diagnose and refer these cases, only 25% believed that these same students were ready to treat such cases.

Programs with a Required Class on Substance Abuse

Five programs (25%) reported having a required class on substance abuse. Some details about these programs follow.

1. In four of these programs, an average of 95% of the material included in the questionnaire was covered in the substance abuse class.
2. In the fifth of the programs having a required class, the class was on alcoholism and family systems. Its coverage appeared to be limited to the systemic aspects of the subject.
3. One program reported having two graduate level classes which addressed substance abuse issues plus a clinic certified in addictions treatment.

4. Three of these programs gave an unqualified "yes" concerning their students' preparedness for treating substance abuse cases, in addition to diagnosing and referring the cases. One said "no" and one was uncertain about preparedness in treatment.
5. Four of these programs were among the eight that believed AAMFT should require a substance abuse class.

Programs Not Having a Required Class on Substance Abuse

For the data from the 15 programs not having a required course, the coverage of content was uneven. The percentage of items not addressed in any required class or in the part of practicum taken by most students was calculated for each program. Among the 15 programs not having a required substance abuse class, the range of the percentage of items not addressed was 0% to 97%. The median was 34%. Among these 15 programs, the median percentage of items not addressed was 34% both for the subgroup of programs having an elective and for the subgroup of programs with no elective available.

Coverage in Practicum

Several items were more likely to be dealt with in practicum than in a required course. The items that were identified by at least 33% of the programs as being dealt

with in practicum and that were more likely to be covered in the practicum than in any required course are found in Table 1. The first four items in Table 1 were dealt with in practicum by at least 50% of the programs. These items were (a) access to a list of appropriate referrals (65%), (b) interviewing techniques to reveal substance abuse despite client's denial (55%), (c) ideas about how the family and the therapist can get the abuser into treatment (50%), and (d) the therapist as possible enabler (50%).

Comments by six respondents mentioned specifically that the expertise in treatment of substance abuse cases developed by an individual student depended greatly on the practicum experience. One respondent represented this sentiment by writing, "Depending upon the student's practicum placement, some have extensive experience with substance abuse treatment and some have very little (i.e. substance abuse clinic vs. child guidance clinic with school aged populations or with senior citizens". The campus-based clinic of one program was a state certified alcohol/drug abuse clinic. Another had an alcohol/drug abuse specialty and a third mentioned off-campus contacts with a substance abuse rehabilitation program. A fourth program reported being in the process of developing a separate Master's program in substance abuse counseling. For students in these four programs, access to specialized training in

Table 1

Items More Likely To Be Addressed in Practicum Than in Required Courses

Item	% of Programs Addressing Item in Practicum
Access to a list of appropriate referrals	65
Interviewing techniques to reveal substance abuse despite client's denial	55
Ideas about how the family and the therapist can get the abuser into treatment	50
The therapist as a possible enabler	50
Behavioral indicators of drug abuse	40
Warning signs of relapse and ideas on relapse prevention	40
Impact of therapist's own use of substances	40
When the therapist prefers to diagnose and refer rather than diagnose and treat	40
Criteria for deciding if detoxification in a medical setting is necessary to safely begin abstinence	35
The therapist's comfort with the client's dependency on sponsor and higher power vs. common therapy goal of self-control	35

Note. The items listed met two criteria. They were identified by at least 33% of the programs as being dealt with in practicum and they were more likely to be addressed in practicum than in any required course.

addictions treatment was readily available.

Information Least and Most Likely to be Addressed

Respondents reported that some of the concepts were not specifically being taught to MFT trainees. The eleven items that over one-third of the programs marked not addressed in the required part of the program are found in Table 2. The first six dealt with a diagnostic tool called the Michigan Alcoholism Screening Test, differences in treatment costs in various settings, how the therapist reconciles AA concepts such as the idea of a higher power with the common therapy goal of self-control, basic facts about specific drugs other than alcohol, and criteria for deciding if medical detoxification is necessary to safely begin abstinence.

On the other hand, many of the concepts referred to in the survey items were covered in the required part of MFT curricula. The items reported to be covered by two-thirds of the programs are listed in Table 3. The top eleven items, covered by at least 80% of the programs, included questions about having access to an appropriate list of referrals and the choice between referring and treating. Also included are systemic items about the family dynamics that often maintain the abuse, patterns transmitted intergenerationally, and connections between drug use and common presenting problems. Other items among those most frequently taught were questions about using the idea of the disease model therapeutically, interviewing techniques to

Table 2

Information Least Likely to be Addressed

Item	% of Programs NOT Addressing Item
Familiarity with written diagnostic tests or questions such as the MAST and CAGE	75
Differences in treatment costs considering type of treatment and current trends in reimbursement by insurance companies	60
Therapist's comfort with a client's dependency on sponsor and higher power vs. common therapy goal of self-control	60
Basic facts about specific drugs other than alcohol	56
Criteria for deciding if detoxification in a medical setting is necessary to safely begin abstinence	45
Impact of therapist's own use of substances	45
Models of recovery as a process with its own predictable issues and stages	40
If adolescent abusers are basically a different population from adult abusers	40
Whether a person's character defects and attitudes cause or contribute to the abuse	40
Compatibility between belief in the disease concept and the fostering of increased personal responsibility during recovery	35
Abstinence vs. controlled use for most recovering addicts	35

Table 3.

Survey Items Covered by Over Two-Thirds of the Programs

Item	% of Programs Addressing Item
How to recognize the family dynamics that often maintain substance abuse in one or more family members	95
Access to a list of appropriate referrals	95
How to recognize the family dynamics transmitted over generations even when there is no current substance abuse	90
Knowledge of disease model and its usefulness in therapy	90
Ideas about how the family and therapist can get the abuser into treatment	90
Interviewing techniques to reveal substance abuse despite client's denial	85
Connections between use of psychoactive drugs and common presenting problems such as sexual or adolescent problems, suicide, domestic violence, and depression	85
If family treatment can be an important adjunct to addictions-specific treatment	85
Whether unhealthy family systems cause substance abuse	85
The priority of treatment goals--in particular, when the therapist must opt for treating the substance abuse as primary	80
When the therapist prefers to diagnose and refer rather than to diagnose and treat	80
Behavioral indicators of drug abuse	75

Table 3 continued.

Survey Items Covered by Over Two-Thirds of the Programs

Item	% of Programs Addressing Item
Warning signs of relapse and ideas on relapse prevention	75
The therapist as a possible enabler	75
Definitions, especially of substance abuse, codependence, and enabling	74
Recognizing the three stages of addiction	70
If/when addictions-specific treatment (in groups such as AA or in treatment centers) is crucial	70

reveal the abuse and to get the abuser to deal with the addiction, and items about how family therapy and addictions-specific treatment fit together.

The responses do not show any clear difference in the coverage of the information on which there is consistency throughout the addictions treatment literature, called factual items, and topics on which there is less consensus and more room for debate, termed controversial issues.

Prevalence of Substance Abuse Issues in Practicum Cases

The questionnaire contained the following item: In what percentage of the cases encountered by students in practicum would you estimate that substance abuse is a central issue, although not necessarily the presenting problem? The range of responses to this question was 10% to 75%; the mean was 30%.

Estimates of the Adequacy of Training of Students Upon Graduation

Respondents were asked to identify whether they were confident that trainees were adequately trained to intervene with substance abuse cases upon graduation from the current program of studies.

1. Fifteen (75%) responded that their students would be adequately trained to diagnose.
2. Seventeen (85%) responded that their graduating students would be adequately trained in referral.

3. Five (25%) responded that their students would be adequately trained to treat such cases. One restricted that to outpatient treatment.
4. Four additional respondents (20%) were uncertain if their students would be prepared to treat these families; two left the item blank and two noted that some students fall into each category.

The data showed that although about 75% believed that their students were prepared both to diagnose and to refer in such cases, their assessment was dramatically different regarding competency in treatment. Only 25% were confident that their students were prepared to treat substance abuse cases.

Three of the programs considering their graduates ready to treat such families had a required class on substance abuse. For the five programs having a required substance abuse class, an average of 82% of the survey items were covered in the required part of the curriculum.

Electives

Four programs, including one having a required class, noted that they offered popular electives on this subject. Three additional programs had or were developing an alcohol/drug specialty or a separate degree program, and the MFT students took substance abuse courses from these programs as electives.

Suggested Additions and Deletions in Coverage

There was a place on the survey for comments about the coverage of topics identified by the researcher. Topics suggested for inclusion were

1. The prevalence of Fetal Alcohol Syndrome and of addicted babies.
2. Increased emphasis on breaking through the denial and emphasis on intervention as a technique to get abusers into addictions treatment.
3. More on strategies of relapse prevention.

The comment on what should not be included was as follows: "If AAMFT imposes a course on us that is a reflection of many of the questions in this survey, i.e., biology, addiction, AA type questions I will object strenuously. That information should be a prerequisite to admission to an accredited program."

Curriculum Changes

A very important footnote to these results is that many respondents recognized the need for more training in this area. One professor responded that he/she was making an extensive study of the field including visiting treatment and training centers, studying aspects such as codependency and multiple diagnoses, and training in group work. That program and two others reported that they will add courses in addictions in the fall of 1989, either as part of a systems class or as a separate course.

Comments on the Desired Role of AAMFT

The final question on the survey asked whether the respondent believed it advisable for AAMFT to require accredited Master's programs to offer a separate course on substance abuse covering such material as that addressed in the questionnaire.

1. Eight respondents (40%) answered "yes".
2. The other 12 (60%) answered "no".

For those answering "yes", the question went on to ask if AAMFT should stipulate the content of the class.

1. Three respondents gave a definite "yes" to that. One mentioned that content should be stipulated in order to ensure consistent quality of the course. Another wrote, "Yes. . .primarily because of the magnitude of substance abuse and codependency cases that prospective therapists will encounter in their practices. AAMFT should develop and distribute guidelines regarding the desired content."
2. On the other hand, two of those answering "yes" stated that AAMFT should stipulate "broad content areas, but not specifics."
3. Another stated that the instructor needs leeway to highlight issues specific to the locale such as the prevalence of addicted babies in urban areas.
4. Another noted the importance of the course being systemically oriented by writing as follows: "Yes,

but it must not be an undergraduate psychology or nursing course that deals primarily with phsiological-biological aspects. The courses need to be taught in the context of systemic family treatment."

Of those answering "no", that they would not support such a requirement by AAMFT, some expanded their answers.

1. Eight commented that there was no room for additional requirements. One stated, "It is a very important issue but we already require so much I just don't see how we can load more on." Another commented, "No. AAMFT already requires so much that the curriculum is very tight. Address it systemically, like gender issues." A third replied, "No--for monetary, space, and time reasons."
2. Two others remarked that there are too many important issues to single out substance abuse over other issues such as ethnicity, gender issues, domestic violence, and others. One comment along these lines was as follows: "No! Because to isolate substance abuse to the exclusion of other issues is short-sighted."
3. Certain knowledge could be required and then covered in several classes, as two respondents opposed to AAMFT requiring a separate course

suggested. "No. There are already too many required courses. I support the notion of requiring content on addictions in the existing framework." Another replied, "I think that a recommendation should be made for 'adequate' coverage--some guidelines for adequacy could be provided. No [not the content]--academic freedom is essential."

Discussion

Faculties of MFT programs are looking at coverage of substance abuse topics in their curricula. Three of the 21 respondents to the survey reported plans to have additional coursework in place by the fall of 1989. A fourth reported plans to develop a separate degree program in substance abuse counseling because the "topic is too broad to be covered in M. A. programs in M&F therapy". It was learned, after collection of the survey results, that the faculty of a fifth programs has decided to change its substance abuse elective to a required course in 1990.

There was no consensus on the issue of whether or not it is appropriate for programs to require specialized knowledge of substance abuse issues. The debate is reflected in the responses to the question of the most desirable level of AAMFT involvement. Eight (40%) responded that there should be a course requirement by AAMFT, a response that clearly reflects their favoring the teaching

of specific addictions treatment knowledge. As one commented, "I think that given the prevalence of substance abuse problems, all marriage and family students need specialized training in this area." The relationship between general systems learning and specific training in treatment of addictions is circular. One respondent in support of specialized training stated, "Training in working with alcoholism can be generalized to many other types of cases common in MFT eg. family violence. Also, learning to work with alcoholism is good training in learning to shift initiative for change, etc."

On the other hand, many responses reflect a very different position, that the appropriate goal for the Master's training programs is to prepare the student to deal with a broad range of issues by applying a systemic perspective. Thus offering, within a Master's program, sufficient specialized knowledge to prepare the graduate to treat substance abusing clients would detract from the goal of preparing the trainee to deal with the breadth of issues presented by clients. According to this line of thinking, if therapists know when they need more information or need supervision, they will be able to deal with specialized situations. Let us look at this argument in more detail.

Reflecting the idea of keeping the Master's programs general, one respondent wrote, "I am concerned that trainees, especially on the Master's level. will become too

narrowly focused. Why not keep programs broadly general (within limits) and develop specialties in postgraduate programs?" Another wrote that they have a "talented group of trainees, aware of social systems, who are encouraged to recognize destructive, non-growth producing behaviors in treatment contracts, i.e. suicide, homicide, craziness, and addictions." Another commented that substance abuse "problems are interactional, like other problems, so address it from a systemic perspective". In line with that thinking, this respondent said that his/her program "integrates substance abuse information into most courses . . . but doesn't highlight it to the detriment of everything else." Another noted their "strong focus on D. Berenson's approach to treating alcoholism as an issue, also on treating pursuer/emotional distancer patterns in relationships." Yet another "includes other aspects of addictive behavior (sexual addictions, eating disorders) to demystify alcohol or drug use." This line of thinking supports the application of theory and techniques of general systems therapy to problems, including substance abuse problems.

Continuing with the idea that students need general knowledge coupled with an awareness of when they need specific knowledge and/or supervision, there were two comments in this regard. One wrote, "I think our students have basic knowledge relevant to each area and they know

when they need to get ETOH [ethyl alcohol] problem-specific supervision. They lack practice and experience." Another commented, "Definitely addictions are common components of therapy. Students out of necessity need to have some knowledge. We are focusing on the need for specialized training more and more. Master's programs need to provide basics--groundwork for a lifetime of labor in becoming competent clinicians. Students knowing that they don't know enough is a first step."

The workability of this proposition depends on therapists' recognizing when they do not know enough, respecting the ethical responsibility to recognize when they would be practicing outside their area of competency. The survey results shed some light on the question of whether trainees know their limitations.

The data show that 15 respondents were confident that their students were prepared to diagnose substance abuse competently and 17 respondents believed their students were prepared to refer such cases. Thus although about 75% of the respondents believed that their students were prepared to diagnose and refer in such cases, only 5 respondents or 25% believed that their students were ready to treat these clients. An additional four, or 20%, were uncertain about competency to treat. The remaining 55% were clear that students are not ready to treat substance abusers and their families upon graduation from the Master's program. One

respondent, uncertain about whether students are prepared in treatment wrote, "Unless the student has completed in-depth clinical experience (internship) dealing with this focus I am not confident. I would require a minimum of 250 hours of direct service in all aspects of addictions treatment." This awareness among faculty members that trainees may not be prepared to treat substance abusers and their families is a starting point. The question remains as to whether the trainees, in addition to the faculty, are aware of the implications of a lack of treatment expertise.

Interestingly, the four topics more likely to be dealt with in practicum than in required courses all relate to diagnosis or referral. Comments indicate that the treatment expertise trainees develop varies from extensive to minimal. This depends greatly on practicum placement or on the particular cases the student works with.

The four programs with a popular elective on substance abuse were all among those reporting less than the median amount of coverage in the required part of the program, indicating that the substantial number of students taking the elective receive more training on the topic of substance abuse than is reflected in the reported coverage of required study. This additional coverage is, of course, uneven by the very nature of electives.

Respondents estimated that substance abuse was a central problem, although not necessarily the presenting

problem, for an average of 25% of the cases seen in practicum. An interesting statistic to compare this to comes from a 1982 Gallup poll question "Has drinking ever been a cause of trouble in your family?" For people 18 to 24 years of age, 40% answered "yes"; for those 25 to 29, 37%; for those 30 to 49, 35%; and for those 50 and over, 26%.

Since responses indicate that the items in Table 2 were not taught in the required part of the training programs surveyed, possible implications of a therapist's not being familiar with certain topics follow.

The survey item least likely to be covered is the use of the Michigan Alcoholism Screening Test, a standard test used by people in the addictions field, and the CAGE, a questionnaire used in a similar way and having four specific questions to identify abusers. Three-quarters of the respondents noted that their programs did not systematically acquaint students with this diagnostic tool. Studies have shown both the MAST and the CAGE questionnaires to be useful diagnostic tools for the populations studied (Selzer, 1971; Schofield, 1988). The MAST is familiar to people trained as addictions counselors; that is, it is familiar to those not necessarily trained from a systemic perspective. Interestingly, the item on interviewing techniques to reveal substance abuse despite client's denial was widely covered in the AAMFT-accredited programs. It appears that family

therapists are developing their own techniques independent of the tools of other experts on addictions.

The questionnaire item ranked second among those least likely to be covered--that referring to the differences in treatment costs and the trends in insurance coverage--refers partly to information needed primarily by the specialist in getting clients into addictions-specific treatment. Others, including most family therapists, have the option of referring clients to community substance abuse services that will then treat the addiction or refer to particular treatment programs. Awareness of the value of the many free Twelve Step programs is important for the general family therapist, however. Alcoholics Anonymous, Narcotics Anonymous, and the related groups for families and codependents are important resources to which clients can be referred for support, thus supplementing the work with the family therapist.

Continuing with questions that were least likely to be covered, the next is directly related to the therapist treating a client who is also involved with AA or another of the Twelve Step groups. Basic to AA is the concept that the alcoholic is powerless over alcohol and must find strength outside of him/herself. One source of this strength is termed the higher power. A common goal of much family therapy, however, is self-control. If AA and the belief in a higher power are part of the client's recovery program, a

therapist stressing self-control will be introducing an unnecessary element of tension (Brown, 1985). Sixty percent of the respondents said that their programs did not cover this information.

The data indicate that pharmacology is another rather weak area in the training of therapists in the surveyed programs. Survey results show that trainees graduating from over half the programs have not been taught basic facts about drugs other than alcohol. This includes symptoms of use of particular drugs. The literature on alcoholism and family therapy is much richer than the similar literature regarding other drugs and poly-drug use. Kaufman (1985b) noted that the bulk of the studies on alcoholics, including his own, had been conducted separately from those on drug abusers. Given the increasing prevalence of poly-drug abuse, this may indicate an important area needing attention.

Responses show that 45% of the programs did not teach criteria for deciding in what setting a client can safely stop using chemicals. It is conceivable that a client might actually follow a therapist's directive to stop using drugs when it is dangerous for that client to do so without medical attention. Lack of familiarity by the therapist of criteria for making the decision on the appropriate setting for detoxification puts the client at risk.

Forty-five percent of the programs reported that they did not address the therapist's own use of substances. Just as breaking through the denial is a key issue in working with substance abusers, so can denial of the impact of their own substance use occur among therapists. A hypothetical example is given by Treadway (1989) of a professional who has a blind spot about his own carefully controlled use of alcohol and Valium that "makes it highly unlikely that he will recognize and confront the similar patterns in his patients" (p. 196). Steinglass (1976) wrote that "since many therapists are unclear as to where their own drinking might fall [along a continuum from abstinence to addictive drinking], there is a natural reluctance to take a judgmental stance about a patient's drinking behavior" (p. 119). This was reiterated by French (1987) in her analysis of the reasons family therapists have paid so little attention to the problem of alcoholism. On a related theme, one respondent, who noted that substance abuse is dealt with in courses and in practicum, commented as follows: "I think this [training] needs to be addressed in the process of doing family of origin work, which our students do in their practicum. More than 50% of them discover significant alcohol/drug problems in their families. It helps sensitize them to the issues." Another response noted the great deal of difficulty students have with their own denial. He/she wrote, "Every student that I have ever instructed in a class

on substance abuse has been affected by the problem at some level, professionally and/or personally. Despite the commonality of this experience most have great difficulty with their own denial. As such, I have found that the incorporation of a substantial amount of information on the nature of denial and more importantly the breaking of denial is critical in this course."

Recently professionals have been recognizing recovery as a process with its own predictable issues and stages, recognizing that when a client achieves abstinence the battle is not over. Recent work by Kaufman and Reoux (1988) outlined three stages following the drinking stage--achieving sobriety, early recovery, and advanced recovery--all having specific goals. Brown's (1985) model integrating therapy with AA presented similar stages. The relative newness of this understanding of the dynamics of recovery may account for the fact that 40% of those responding did not cover models of recovery in their programs.

The considerable body of knowledge addressing diagnosis and treatment of substance abusers includes many ideas that are thought to be applicable to abusers in general. Adolescents, however, are believed to go through the stages of addiction for different reasons and at different rates than most adults. For example, peer pressure is thought to be more important (Babor & Berglass, 1981; Dulfano, 1978) and the addiction process is believed to happen more quickly

(Schaefer, 1987). That is, the dynamics of adolescent abuse are very different from those of adults. If one assumes that family therapists are generally aware of typical developmental issues and of common differences in family structures between families with adolescents and those without, the survey results probably indicate that Master's programs provide less coverage of topics such as (a) the dynamics of abuse specific to adolescents, (b) the literature adapting structural techniques to adolescent abusers, and (c) specific techniques such as use of the juvenile court system.

The issue about whether character defects and attitudes are causal factors in addiction has been of historical interest as the theories of addiction have evolved. Not only does the idea focus on the individual, but also it is a concept of linear causality in contrast to the notion of circularity. Some might exclude this idea intentionally because it does not reflect a systemic view.

Although 90% reported that they covered the disease concept and its usefulness in therapy, only 65% raised the issue of the compatibility between the disease concept and the concept of personal responsibility. Whether the therapist believes in the disease concept or not, he/she will encounter many therapists and clients who do. Since fostering personal responsibility is a common goal of therapy, it then becomes an issue of what the abuser is

personally responsible for--being an abuser, continuing to abuse, seeking treatment, or behavior when abusing and/or when not abusing? Davis (1980) gave an example of a family who, because of their interpretation of the disease concept, increased their resolve to be responsible for and to care for their alcoholic member. This continued until the therapist was able to help them reconcile the disease concept with the need to foster personal responsibility in the alcoholic.

The issue of abstinence versus controlled substance use as the goal for most addicts is left unaddressed by 35% of the programs. This is another item on which people, especially those who are not traditional addictions specialists, see the evidence as contradictory and have varying opinions. It is nevertheless imperative that therapists have considered the issue carefully in order to set treatment goals and respond to the goals of the client.

Many programs do cover the surveyed material in a required part of the curriculum. For items reported covered by over two-thirds of the programs, again refer to Table 3. Although the questionnaire was not designed to show statistically the difference between treatment of systemically and non-systemically oriented items, it was designed to contain some items from the systemically oriented authors, some from the more individually oriented authors, and some items that relate to concepts appearing

regularly in the literature regardless of the author's orientation. The distinction is admittedly subjective; readers can judge for themselves which items are systemically oriented and interpret the tables accordingly. In the researcher's view, a disproportionately large number of the systemically oriented questions, in contrast to the questions targeting areas of focus of the more traditional addictions approaches, are listed among the items commonly covered, and a disproportionately large number of items reflecting non-systemically oriented approaches are among the items less likely to be addressed.

This demonstrates the thrust typically found in the AAMFT-accredited Master's level MFT programs. A possible interpretation is that some family therapists are developing theories and techniques regarding the important questions in the area of substance abuse either without taking advantage of or without being aware of the wealth of knowledge already accumulated by the other specialists in the addictions field. Another possible interpretation of these findings is that some systemic therapists are openly rejecting the ideas and techniques developed within traditional addictions approaches as incompatible with a systemic treatment approach.

The survey results reported above have shed some light on the extent to which MFT programs are integrating systems and addictions fields in their coursework. This paper has

included quotes representing programs that dealt primarily with the systemic material and programs incorporating a significant amount of biological, medical, pharmacological, self-help material along with the systemic material.

If a systemic course in treatment of substance abuse is designed to augment the knowledge of those already in the field who are grounded in the medical model, where does the family therapy Master's student gain the prerequisite knowledge? Also, how is that student to integrate knowledge based on substance abuse as a progressive, treatable disease with knowledge based on systems concepts related to a family organized around substance abuse?

The dilemma is both one of philosophy and one of practicality. That is, survey results show faculty choosing between (a) focusing on systemic family therapy and (b) integrating systemic therapy with biopsychosocial aspects and pharmacology--with some making this choice in order to be congruent with their philosophy of addictions treatment and others emphasizing the constraints of time and lack of substance abuse knowledge on the part of their students.

Although the debate concerning how to treat substance abuse and how best to teach trainees to deal with issues in substance abusing families remains lively, there is consensus on the importance of being alert to substance abuse and the related family dynamics. There is an awareness that reports of family therapists paying

insufficient notice to substance abuse issues are justified. All but two of the respondents stated that their programs either train students to diagnose and refer such clients or need to do more in this regard.

The pervasiveness of substance abuse in our culture indicates that the marriage and family therapist will encounter a substantial percentage of families for whom substance abuse issues are central. It is crucial that the family therapist be able to recognize substance abusing families and either treat or refer them. Survey results show that faculty of Master's level MFT programs are grappling with this issue.

The systemically oriented faculty members represented in this survey have differing approaches to the field, as shown by the survey results. This parallels the tension between family therapists and traditional addictions specialists. Part of this tension may come from the experience of family therapists with treatment programs that focus on substance abuse to the exclusion of other important issues. On the other hand, part of the mistrust may come from the experience of addictions specialists who encounter addicts who were in therapy for years without being diagnosed as an addict or treated effectively for the addiction. Part of this tension may come from the lack of familiarity of each group of professionals with the knowledge base of the other--whether through lack of

awareness or through open rejection. Yet another aspect of this gap that is explored in this research relates to the heritage of addictions specialists that includes the acceptance of loss of control and the paradox of the giving up of control in order to recover. That heritage contrasts with a common belief in self-control among traditional therapists. Another factor contributing to this gap may be that this area of discovery is relatively new, so a comprehensive theory of abuse and treatment does not yet exist. There is limited cross-fertilization, and the various professionals speak different languages and read different journals. This study sheds some light on the ways in which family therapists are being trained to benefit from the wealth of knowledge available and encouraged to foster mutual respect between systems and addictions specialists.

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APPENDIX A

Review of Related Literature

Review of the Related Literature

Empirical studies have regularly shown a high prevalence of substance abuse in America and a clear association between substance abuse and common presenting problems. The therapist, therefore, can expect to see many clients who abuse substances and to be making decisions about referring and/or treating these clients and their families. A review of the literature also reveals a considerable and growing literature on the usefulness of family therapy for treating substance abusers and their families. The adequately trained therapist, therefore, may reasonably expect to beneficially treat these clients.

Concurrence of Substance Abuse and Presenting Problems

Substantial empirical evidence indicates that substance abuse is significant in a large percentage of cases seen by family therapists. Several types of family problems are clearly associated with substance abuse. These include suicide, sexual problems, adolescent problems, depression, and marital violence.

Studies such as those by Goodwin (1973, 1982) regularly find a correlation between alcoholism and suicide. Goodwin reported that nearly 33% of those committing suicide had been alcoholics in 6 of the 11 studies he reviewed. He found this rate "substantially higher than the 5% rate often estimated to apply to the general adult population" (1982, p. 655). These rates also exceeded the much higher estimate

of the rate of alcoholism in the population that "approximately 10 percent of the drinkers in America today will become alcoholic at some point during their lives" (Johnson, 1986). With either estimate, a substantial likelihood of alcoholism occurred with suicidal clients. Investigating alcohol use at the time of suicide, Galanter and Castaneda (1985) reported on two studies finding that about 25% of those attempting or completing suicide had been drinking alcohol at the time of the event.

Sexual dysfunction is another complaint of the client that suggests the therapist look into substance use. Miller and Gold (1988) found impairment of physiological and emotional sexual responses among drug users--specifically in the areas of desire, performance, and satisfaction--because drug use affected the limbic system, the production of hormones by the endocrine glands, and the mechanism of erection through the autonomic nervous system. The clear physiological link between ingestion of chemicals and sexual response has also been shown empirically by Cocores, Miller, Pottash, and Gold (1988) who studied 50 males addicted to both cocaine and alcohol and found sexual dysfunction, specifically decreased libido, in 62%. Other dysfunctions found were impotence among 52%, anorgasmy among 38%, delayed ejaculation among 30%, and premature ejaculation among 8%.

Figures in the National Institute on Drug Abuse report (1989) giving highlights of the 1988 National Household

Survey on Drug Abuse show that use of marijuana in the last month by youth aged 12 to 17 was 6.4%; of cocaine, 1.1%; and of alcohol, 25.2%. Use in the past year by these youths was 12.6% for marijuana; 2.9% for cocaine, and 44.6% for alcohol. According to the U.S. Department of Health and Human Services press release (1989) giving highlights of the 1988 National High School Senior Survey, 2.7% of high school seniors use marijuana/hashish daily, .2% use cocaine daily, and 4.2%% drink alcohol daily. Almost 35% have consumed five or more drinks on a single occasion during the past two weeks.

A survey of high school seniors by PRIDE, the National Parents' Resource Institute for Drug Education (Gleaton, 1987), found that 61% admitted trying an illicit drug in 1985, with 60% using marijuana and 40% using other drugs. Stimulant use was 30% and cocaine use was 17%. After surveying adolescents in a suburban Massachusetts community, Babor and Berglas (1981) suggested that by the time students reach high school drinking "may be normative" (p. 27). Combining that fact with Johnson's (1986) assertion that there is about a 25% chance of a person with an alcoholic parent becoming alcoholic if he or she drinks, the literature shows alcohol use as a significant issue with these adolescent clients.

Correlations are also found between alcohol/drug use and depression (Galanter, Castaneda, & Ferman, 1988; Mirin,

Weiss, Sollogub, & Michael, 1984; Weisman, Pottenger, Kleber, Ruben, Williams, & Thompson, 1977) and between alcohol/drug use and marital violence (Fagan, Barnett, & Patton, 1988; Kantor and Straus, 1987; Van Hasselt, Morrison, & Bellack, 1985). Despite the complexity of the association between alcoholism and marital violence, the research shows some clear patterns. A closer look at the link between the presenting problem of marital violence and alcoholism helps to demonstrate the importance of maintaining a systemic perspective.

A Closer Look at Marital Violence and Substance Abuse From a Systemic Perspective

The Fagan (1988) study found that maritally violent men drink more in certain contexts, especially at home after work. The maritally violent men studied tended to drink to forget the worries, pains, and stresses in their lives more than the control group did.

The Kantor and Straus (1987) study found that the combination of blue-collar occupational status, drinking, and approval of violence was significantly associated with the highest rate of wife abuse. Of the three factors, the cultural approval of violence by men against women was found to have the strongest correlation with wife abuse. Thus the link between marital violence and alcohol abuse is complicated and includes many other factors. The authors also stressed that, although the rate of marital violence

among binge drinkers is three times that among abstainers, there is (a) a substantial amount of abuse among abstainers and moderate drinkers, from 7% to 11%, and (b) about 80% of the men in both the high and the binge drinker categories did not hit their wives during the year of the survey.

Fitch and Papantonio (1983) surveyed 188 males who physically abuse their mates. They found alcohol abuse in 59% and abuse of other drugs in 18%. They also found that 71% saw or heard violence between their parents, 49% reported being abused as a child, and 22% were unemployed at the time of the interview.

In summary, there are many theories of possible parts of the violence-alcohol link: that alcohol reduces inhibitions, that society does not expect the alcohol user to follow the usual constraints on behavior, that alcohol abuse is accepted by society for males, that there is a cultural acceptance of marital violence as well, that the patterns are transmitted intergenerationally by the abuser's having seen or heard abuse between his parents and/or that the abuser's having been a victim of abuse as a child, and that the violence-alcohol link is greater among lower socio-economic classes and/or the unemployed. The link is very complicated. Even if the empirical association is clear, causation is in no way shown by the studies.

This examination of one of the common problems presented by a family entering therapy, that of marital

violence, shows that the therapist needs to be alert to the possible link with abuse of alcohol and other drugs. Furthermore, there are many patterns, including cultural and intergenerational ones. A systemic approach, therefore, appears to be appropriate.

Relevance of Family Therapy

After recognizing and diagnosing the substance abuse, the therapist must refer or treat the client. There is a growing body of literature supporting the value of family therapy in treating these clients. In summary, various authors advocate family therapy to (a) increase the coping skills and emotional support of the other family members in addition to the abuser, (b) correct distorted communication and foster openness, (c) restructure the family that may be organized around the abuse by looking at roles and at patterns of responsibility, (d) identify family behavior patterns that maintain the abuse and encourage the development of alternative patterns, (e) retain a systemic perspective rather that a search for causes, (f) foster beneficial use of the Twelve Step programs, and (g) keep the abuser in treatment longer.

Reviews on the Importance of Family Therapy in Treatment.

Several reviewers in the 1970's wrote in support of the value of family therapy for abusers and their families. In his review of family treatment approaches for 1950 to 1975,

Steinglass (1976) commented that, although he had found relatively few studies on family therapy with alcoholics compared to the magnitude of the problem, he had "guarded optimism about the application of family therapy techniques in the treatment of alcoholism" (p. 116). He wrote as follows:

> The pervasiveness of alcohol use and abuse in the United States is of such proportions as to guarantee that any mental health professional practicing in this country will be working with a significant number of patients whose use of alcohol has reached abusive proportions. For family therapists, who traditionally work with groups of two or more adults in conflict with each other or with their adolescent children, the likelihood that one member of this group abuses alcohol becomes even greater. It seems clear, therefore, that treatment techniques for alcoholism should be of primary concern to the family therapist.
>
> Whereas previously alcoholics were conceptualized as homeless, jobless, physically ravaged individuals with meager psychological resources, it is now clear that this "end stage" alcoholic is most unrepresentative of the patient population that abuses alcohol. A significant, if not major, proportion of the alcoholic population continues to function within nominally intact and stable family systems, a natural

> clientele for the family therapist. Therefore, whether or not the family therapist feels alcoholism per se is a condition appropriately treated by family therapy techniques, the symptom itself is so pervasive as to be virtually unavoidable. . .Despite these obstacles, family therapy techniques have been used with increasing enthusiasm in alcoholism treatment. In recognition of this trend, the Second Special Report to the U. S. Congress on Alcohol and Health called family therapy "the most notable current advance in the area of psychotherapy (of alcoholism)." (p. 98-99) (The Special Report referred to was published by the Department of Health Education and Welfare in 1974.)

Janzen (1977) also reviewed the literature of family treatment of alcoholism. From 24 studies prior to 1977 that describe a family treatment component, he noted the advantages of family treatment. Finlay (1974) reviewed several studies on alcoholism treatment and concluded that there is some empirical evidence showing the efficacy of involving family members and focusing on interactions. In a paper on family therapy and alcoholism, Dulfano (1978) wrote about how people are shifting from thinking about "alcoholism" and "the alcoholic's family" to "the family afflicted with alcoholism" (p.121). Although for years treatment was focused on the individual alcoholic, professionals are beginning to recognize that "alcoholism is

very much a family disease, and many professionals are beginning to deal with alcoholism on a family level" (p. 134). Dulfano demonstrated the value of the family approach through case examples.

In another review published in the 1970's, Stanton (1979) reviewed the existing studies, numbering 68, on the results and techniques of treatment for abusers of drugs other than alcohol. The bulk of these studies covered the following forms of treatment: group treatment for parents of abusers, outpatient oriented treatment with individual families, inpatient treatment with individual families, multiple family therapy, and marital therapy. Although the empirical evidence was not strong enough to make firm conclusions about specific modes of treatment, Stanton concluded that the "studies indicate that family treatment--in its various forms--shows great promise as a way of conceptualizing and intervening toward positive change" (p. 268). Stanton ended with and appeal to "develop methods that help families to feel more competent to change their patterns and to care for their own" (p. 274).

In 1985 Kaufman (1985a) provided a more current review of the literature on research and on clinical experience in the treatment of substance abusers. In addition to joining the proponents of the value of family therapy in treating substance abusers, he outlined various types of interactional patterns frequently found in substance abusing

families. With caution, the therapist can use this knowledge of such patterns in treatment.

A 1977 paper by Klagsbrun and Davis (1977) built on the idea that interactional processes within family systems in part maintain substance abuse in an individual family member. They advanced the theory in this regard by offering several hypotheses that might be tested in order to investigate this idea more systematically.

Another landmark paper of the 1970's giving a systemic theory of alcoholism is Bateson's essay "The Cybernetics of 'Self': A Theory of Alcoholism", reprinted in Steps to an Ecology of Mind (1972). He based it on the concept of idea of alcoholic pride by which he meant the "obsessive acceptance of a challenge, a repudiation of the proposition 'I cannot'" (p. 321). He then went on to use the systemic concept of feedback to explain the behavior.

Literature on Substance Abuse Treatment Not Highlighting Family Therapy.

There is a group of highly readable, easily accessible books about treatment of the abuser primarily from an individual perspective. The authors of these books frequently referenced each other and generally did not refer to the systemically oriented literature. One of the most popular books among those who treat the abuser primarily from an individual perspective is Under the Influence (Milam & Ketcham, 1981). This book, based on the disease concept,

outlined the physical and behavioral aspects of the progression of alcoholism through the early, middle, and late stages of addiction. Some of the other popular books in this group are Don't Help: A Guide to Working With the Alcoholic (Rogers & McMillin, 1984), AA publications such as Living Sober (Alcoholics Anonymous World Services, 1975), and Johnson Institute books such as Intervention (Johnson, 1986).

Alcoholism and drug abuse counselors often have a wealth of information on the pharmacology of commonly abused drugs. Sources of this information include A Primer of Drug Action (Julien, 1988), in its fifth edition since 1975, and Blum's Handbook of Abusable Drugs (1984) that details the classification and effects of these drugs.

The Encyclopedic Handbook of Alcoholism edited by Pattison and Kaufman (1982) is another of the well known sources of individually oriented information on alcoholism. Extensive information covering diagnosis, genetic factors, medical aspects influencing many organs and systems in the body, and psychological and psychiatric issues is given followed by chapters looking at the many types of treatment facilities and treatment methods. The Diagnosis and Treatment of Drug and Alcohol Abuse (Cohen & Callahan, 1986) also looks at the issue from an individual perspective. Information useful to the family therapist in recognizing abuse and helping the abusers to see the negative effects on

their lives includes discussions of dependence, physical signs and symptoms, and medical complications.

Among the clearest attempts to demonstrate that recovery is a process rather than merely a static state of not drinking, is the work by Brown (1985). As a psychotherapist, she offered a model of recovery as a process and she attempted to ease the tension between AA and various groups of treatment professionals. Another well known writer on the related topic of relapse prevention is Gorski (1986) whose work has helped both professionals and recovering people to recognize (a) symptoms occurring after the acute withdrawal phase and (b) the early warning signs of relapse. Others have written descriptions of how AA works (Thune, 1977; Alibrandi, 1978) and ideas on how the therapist can integrate AA and family therapy (Bateson, 1972; Brown, 1985; Davis, 1980, 1987).

Literature on Additional Topics Addressed in the Questionnaire.

Other authors have taken one specific piece of the treatment issue, whether from a systems perspective or an individual perspective. The Stanton and Todd paper (1981) and the Wermuth and Scheidt paper (1986) identify specific ways to engage "resistant" families in treatment. Noone and Reddig (1976) noted that abusers, even as adults, frequently maintain close ties with their families of origin and that, since these families are often stuck at a transition point,

dealing with family loyalties is important. There is a large body of literature on the dynamics specific to adolescent abusers (Beschner & Friedman, 1985; Czechowicz, 1988; Labouvie, 1986; Quinn, Kuehl, Thomas, & Joanning, 1988; Schaefer, 1987; Schwartz, Cohen, & Bair, 1985). Compatibility of the disease concept and systemic work was discussed in a paper entitled "Treatment Priorities in a Family-Oriented Alcoholism Program" by Nace, Dephoure, Goldberg, and Cammarota (1982). In "Guidelines for the Successful Psychotherapy of Substance Abusers", Kaufman and Reoux (1988) looked at stages of recovery from an individual perspective.

Underlying Ethical Principles

The American Association for Marriage and Family Therapists issued the AAMFT code of Ethical Principles for Marriage and Family Therapists, binding on all Clinical, Student, and Associate Members of AAMFT (AAMFT, 1988). There are at least three ethical principles in the AAMFT Code that are relevant to the training of family therapists in preparation for cases with substance abuse issues.

Two of these principles can be looked at in terms of therapists' knowledge and therapists' ability to recognize, diagnose, and treat clients abusing substances.

3.4 Marriage and family therapists seek to remain abreast of new developments in family therapy knowledge

and practice through both educational and clinical experiences.

3.6 Marriage and family therapists do not attempt to diagnose, treat, or advise on problems outside the recognized boundaries of their competence.

Some of what the therapist needs in order to practice ethically is specific information "to remain abreast of new developments in family therapy knowledge and practice" to meet Principle 3.4. This also affects what therapists define as the "recognized boundaries of their competence" in Principle 3.6.

A third relevant ethical principle addresses whether it is beneficial for a therapist to continue to treat a client the therapist sees as making progress by working on other issues when the therapist believes substance abuse continues. The AAMFT ethical guideline that relates is as follows:

1.5 Marriage and family therapists continue therapeutic relationships only so long as it is reasonable clear that clients are benefiting from the relationship.

To decide about the efficacy of the therapy, a therapist must be conversant with and have thought through the issues

involved in order to be "reasonably clear that clients are benefiting from the relationship" as stated in Principle 1.5. Some of the most common questions a therapist must consider are as follows: If the client is making changes in other areas, is continuation of therapy in the client's best interest despite continuing substance abuse? Might continuing substance abuse trigger a relapse in other areas that the therapy is addressing? Is short-term improvement in the presenting problem more important in the present than the potential harm from long-term substance abuse, particularly since the long-term use may be addressed later on? Is the therapist buying into the denial or is the therapist being effective? Is the stage of addiction relevant? Is the assessment about whether the therapy is beneficial dependent on which member of the family initiated therapy?

Statements About the Polarization and Integration of the Addictions Treatment Field

Therapists working in the addictions field report many instances of substance abusing clients who, along with their therapists, did not deal with their abuse in therapy. Kaufman (1985b) gave the following example:

> A psychoanalyst friend of mine in another city referred a patient to me for continued treatment. In the first interview, I discovered that the patient was unable to perform his job because of his alcoholism. I

> asked him what had occurred in his prior five years of analysis in regard to his alcoholism, and he stated that he had never discussed it. (p. viii)

Similarly, Davis gave an example of a case and wrote:

> Alcohol abuse frequently goes largely ignored. Family members and previous therapists may have missed the diagnosis, or failed to make it stick. In fact, in this family we already know that the daughter thinks father has a drinking problem, but her opinion has been ignored or overruled. (1987, p. 2)

Later Davis referred to members of AA whose "memories are still strong of well-intentioned, individual psychotherapy techniques and particularly psychoanalysis apparently causing long delays in getting help (from AA) in achieving abstinence" (1987, p. 130). He explained,

> The book is directed toward all individual as well as family and marital therapists, since almost all of them work with alcoholics and/or with clients having an alcoholic family member. Portions of this book are geared toward sensitizing any therapist to the identification of subtler interactional ways in which alcoholism presents itself. . .(1987, p. xiv)

Dulfano stated, "Therapists may overlook alcoholism, either through lack of familiarity with its symptoms or through lack of training in how to cope with them" (1978, p. 133). In a similar vein, Treadway wrote, "As clinicians, we

sometimes collude inadvertently with the family system to avoid the issue of substance abuse by not looking for it, not knowing how to work with it when we find it, or pushing too hard at it" (1989, p. 8). He continued with the flip side of this observation.

> Both individual and family therapists tend to get into trouble by either not recognizing the substance abuse problem or not knowing how to confront it directly. For the chemical dependency specialist, the problem is often the opposite. Counselors who deal with serious addiction most of the time, may focus much too quickly on the drinking as the main issue, regardless of the presenting problem. They may believe that nothing can be done with either the individual or the family until the substance abuse problem is addressed and the client accepts the need to go to AA and practice abstinence. This position oftentimes leads to massive resistance, denial, and ultimately a stuck case. (1989, p. 10)

Thus the problem shows up in several ways.

In the preface to The Responsibility Trap, Bepko and Krestan wrote,

> Since we share both a commitment to the principles of Alcoholics Anonymous, as well as a commitment to approaching problems from a systemic viewpoint, it has always been a source of concern for us that the fields

> of alcoholism treatment and family therapy seem so polarized in their respective views on the nature of alcoholism as a symptomatic process. (1985, p. xiii)

Dulfano wrote as follows: "Up to now family therapy and alcoholism treatment have generally been kept separate. Professionals in both fields have been reluctant to work in the other" (1978, p. 121).

Several authors referred to in this paper believe in integrating the knowledge from both fields. Bepko, for example, wrote,

> While this focus on interaction is our primary context for viewing alcohol problems, we feel that it is equally important to have a basic understanding of the nature of alcoholism as it is defined medically and scientifically because it represents a specific type of symptomatic process. Alcoholism calls for family therapy approaches that may differ from those that are applied to a general range of nonaddictive, interactional, and communication problems in families . . .and it is important for the clinician to integrate many different levels of information and understanding about alcoholic behavior processes and events into her general repertoire of clinical technique. (1985, p. 4)

Another author who attempted to integrate the knowledge from both fields is Davis who wrote that "family therapy and self-help approaches to alcoholism contribute much that is

mutually reinforcing." After referring to a case in which the therapist paid insufficient attention to the drinking problem, he continued,

> Shifting the focus away from the identified alcoholic patient to shared problems and to relationships should not be done unless there is an implicit and an explicit understanding that eliminating the problem drinking has top priority. Without the explicit commitment, family therapy could take alcoholic and family through an endless series of frustrations. With it, family therapy has a great deal to contribute. (1987, p. 139-40)

Several Experts' Recommendations on the Content and Format of a Graduate Substance Abuse Course

In their paper "Systemic Treatment of Substance Abuse: A Graduate Course" Heath and Atkinson (1988) describe a course designed to "introduce students to the contributions made to the understanding and treatment of substance abuse by family researchers, theorists and clinicians" (p. 412). In it they discuss the differences between the family systems model and the disease model of substance abuse treatment. They attempt to understand the experience of abusers and others affected by the abuse, as well as to study family dynamics and treatment. Information on the experience of abusers and affected others "is included because the majority of students have not had previous

coursework in substance abuse or previous work experience" (p. 114), although the authors stated that the course is designed to supplement other university offerings on biopsychosocial precipitants of addictions and pharmacological effects of abused substances. The authors wrote:

> In considering the value of this course in a family therapy curriculum, the authors are reminded of a box that, when opened, explodes with spring-loaded toy snakes. Teaching a single course on systemic treatment of substance abuser seems to have resulted in a face full of questions about the course in particular, the substance abuse treatment community, the limitations on academic education, the hazards of teaching treatments for special problems, and the politics of family therapy, among others.
>
> It seems important, for example, to complement the exposure students get to the disease model of addiction with a systemic view. But should we as family therapists, focus on teaching the latter and leave the former to others? It also seems important to help students see beyond constructions which become labels and on to the interactional dynamics of human problems. (p. 416)

In his reply to the article just quoted, Stanton (1988)

questions the inclusion of the material on the experience of the abuser, calling it a second best alternative since students may not come to the course with this knowledge. An alternative would be to require students to have some knowledge both of substance abuse and of family therapy before entering a course integrating the two. It is a difficult choice. In his book on treatment, Davis (1987) stated, for example, that "the biological aspects are clearly beyond the scope of this book" (p. 8).

Attempts to Integrate Various Branches of Addictions Treatment

An increasing number of books complements the increasing flow of articles advancing the value of the systemic approach in treatment of substance abusers. The Family Therapy of Drug Abuse and Addiction (Stanton, Todd, and Associates, 1982) and Family Therapy of Drug and Alcohol Abuse by Kaufman and Kaufmann (1979) are collections of chapters by various authors with the common emphasis on basic systemic concepts. Although not particularly systemically oriented, Brown's Treating the Alcoholic: A Developmental Model of Recovery (1985) has as a primary goal integrating the approaches of psychotherapy and AA, and throughout her discussion of her model of recovery she worked to reduce the tension between the two approaches. In her book The Responsibility Trap: A Blueprint for Treating the Alcoholic Family, Bepko's (1985) central theme is that

alcoholism is a problem that affects and is affected by interaction and change at many systemic levels including the genetic, physiological, psychological, interpersonal, and spiritual. The pattern she described as the most significant in maintaining the abuse is that of overresponsibility and underresponsibility, and by focusing on this significant pattern she maintained a systemic perspective. Elkin's Families Under the Influence (1984) takes a parallel track, focusing who in the system controls the context in which behavior takes place, termed the interpersonal power dynamics. Alcoholism Treatment: An Integrative Family and Individual Approach by Davis (1987), one of the most recent books by proponents of paying attention to systemic aspects in the treatment of alcoholism, combines many approaches to therapy and shows their usefulness with specific case examples. Treadway's Before It's Too Late (1989) similarly demonstrates how to mesh systemic therapy and self-help groups in treatment of substance abusers. These and other recent books support the idea that systems therapy is a central part of substance abuse treatment and, in varying degrees, the authors integrate both systemic and individual approaches to treatment.

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APPENDIX B

Data

PERCENTAGES OF RESPONDENTS NOT COVERING ITEMS, by item

Percentage of respondents answering "d", not addressed in required curriculum, for each item.

	average % of subitems	
Definitions of		
(1) substance abuse	20	
(3) tolerance	30	
(4) physical dependence	25	
(5) cross addiction	40	26
(6) alcoholic blackouts	35	
(7) codependency	20	
(8) enabling	15	
Familiarity with the		
(1) basics of Alcoholics Anonymous (AA)	30	
(2) Twelve Steps	30	
(3) concept of a higher power	35	32.5
(4) relatively high success rate of AA	35	
How to recognize the signs of		
(1) early stage addiction	30	
(2) middle stage addiction	30	30
(3) late stage addiction	30	
Basic facts about specific drugs other than alcohol, including		
(1) families of drugs	55	
(2) legitimate uses of particular drugs	60	56
(3) symptoms of use of specific drugs	55	
(4) withdrawal symptoms of specific drugs	55	

Familiarity with written diagnostic tests or questions such as the MAST and CAGE	75	
Interviewing techniques to reveal substance abuse despite client's denial	15	
Behavioral indicators of drug abuse	25	
Criteria for deciding if detoxification in a medical setting is necessary to safely begin abstinence	45	
Connections between use of psychoactive drugs and		
(1) sexual problems	20	
(2) suicidal ideations	15	
(3) adolescent problems	10	15
(4) domestic violence	10	
(5) depression	20	
Models of recovery as a process with its own predictable issues and stages	40	
Ideas about how the family and the therapist can get the abuser into treatment	10	
How to recognize the family dynamics that often maintain substance abuse in one or more family members	5	
How to recognize the family dynamics transmitted over generations even when there is no current substance abuse	10	
Knowledge of the disease model and its usefulness in therapy	10	
Warning signs of relapse and ideas on relapse prevention	25	
Differences in treatment costs considering type of treatment and current trends in reimbursement by insurance companies	60	
Access to a list of appropriate referrals	5	

Abstinence vs. controlled use for most recovering addicts	35
The therapist as a possible enabler	25
The therapist's comfort with a client's dependency on sponsor and higher power vs. common therapy goal of self-control	60
Impact of therapist's own use of substances	45
If family therapy can be an important adjunct to addiction-specific treatment	15
If/when addiction-specific treatment (in groups such as AA or in treatment centers) is crucial	30
Compatibility between belief in the disease concept and the fostering of increased personal responsibility during recovery	35
If adolescent abusers are basically a different population from adult abusers	40
Whether a person's character defects and attitudes cause or contribute to the abuse	40
Whether unhealthy family systems cause substance abuse	15
The priority of treatment goals--in particular, when the therapist must opt for treating the substance abuse as primary	20
When the therapist prefers to diagnose and refer rather than to diagnose and treat	20

ESTIMATES OF PREVALENCE OF SUBSTANCE ABUSE ISSUES IN PRACTICUM CASES

In what percentage of the cases encountered by students in practicum would you estimate that substance abuse is a central issue, although not necessarily the presenting problem?

10%	2 respondents
10 to 15%	1 respondent
20%	3 respondents
25%	5 respondents
30%	2 respondents
35%	1 respondent
50%	3 respondents
70 to 80%	1 respondent
unknown	2 respondents

ESTIMATES OF PREPAREDNESS OF STUDENTS UPON GRADUATION

The survey item was as follows:

Please mark the areas in which you feel confident that your trainees will be adequately trained to intervene with substance abuse cases upon completion of the current program of studies.

The responses were as follows:

diagnosis	yes = 15	no = 5 [a]	
treatment	yes = 5 [b]	no = 11 [a]	other [c] [d]
referral	yes = 17	no = 3	

---

[a] One respondent commented that trainees taking the elective in substance abuse would be in the "yes" category instead.

[b] One respondent restricted this to outpatient.

[c] Two respondents left this item blank.

[d] Two respondents said some students fall into each category.

THOUGHTS ON AAMFT INVOLVEMENT

The survey item was as follows:

Do you think that AAMFT should require accredited Master's level programs to offer a separate course dealing with these issues? If not, why not? If so, should AAMFT stipulate that content of that class?

The responses were as follows:

yes	8
no	12

Comments from those answering "no":

There is no room for additional requirements.	8
There are too many important issues to single out one.	2
Certain knowledge could be required, but not a separate class.	2

DATA BY PROGRAM FROM THE TWENTY-ONE RESPONDENTS

Percentage of items for which respondent marked "d", not addressed in required curriculum.

Program	% of factual items not addressed	% of issues not addressed	comments
1	18	33	b
2	29	0	
3	12	17	
4	53	58	c
5	0	0	a
6	12	8	
7	35	33	c
8	76	83	b
9	35	33	a
10	6	0	a
11	35	50	
12	0	0	a, b, e
13	53	17	c
14	35	33	
15	18	8	b
16	12	50	d

a The program has required course or "virtually" a required course.
b The program has an elective on substance abuse in MFT Department.
c The respondent noted the existence of an alcohol and drug abuse specialty.
or
a degree in addictions and substance abuse counseling
or
the insitution has a separate degree program in substance abuse.
d The clinic has off-campus contacts with an alcohol and drug rehabilition clinic.
e The clinic is state-certified in alcohol and drug treatment.

DATA BY PROGRAM FROM THE TWENTY-ONE RESPONDENTS, continued

Percentage of items for which respondent marked "d", not addressed in required curriculum.

Program	% of factual items not addressed	% of issues not addressed	comments
17	12	c	
18	35	91	
19	18	17	a
20	94	100	

21 Respondent stated that the curriculum is being totally revised and that they are doing extensive research, including field research, on how best to deal with substance abuse training. They are looking at both systemic and Twelve Step approaches.

a The program has required course or "virtually" a required course.

For questions having subitems, the entire question was scored by the following criterion:

--"d" marked if at least half of the subitems were marked "d"
-- otherwise, "d" not marked

NUMBER OF RESPONSES IN EACH CATEGORY

FOR ALL PROGRAMS COMBINED

	Where in Program			
Definitions of				
(1) substance abuse	4	11	5	4
(3) tolerance	4	8	4	6
(4) physical dependence	4	10	6	5
(5) cross addiction	4	4	6	8
(6) alcoholic blackouts	4	7	5	7
(7) codependency	4	10	7	4
(8) enabling	3	11	7	3
Familiarity with the				
(1) basics of Alcoholics Anonymous (AA)	4	9	6	6
(2) Twelve Steps	4	10	4	6
(3) concept of a higher power	4	9	5	7
(4) relatively high success rate of AA	4	8	4	7
How to recognize the signs of				
(1) early stage addiction	4	8	4	6
(2) middle stage addiction	4	8	4	6
(3) late stage addiction	4	8	5	6
Basic facts about specific drugs other than alcohol, including				
(1) families of drugs	4	2	3	11
(2) legitimate uses of particular drugs	4	1	2	12
(3) symptoms of use of specific drugs	4	2	3	11
(4) withdrawal symptoms of specific drugs	4	3	3	11

Familiarity with written diagnostic tests or questions such as the MAST and CAGE	2	1	3	15
Interviewing techniques to reveal substance abuse despite client's denial	3	6	11	3
Behavioral indicators of drug abuse	4	7	8	5
Criteria for deciding if detoxification in a medical setting is necessary to safely begin abstinence	3	3	7	9
Connections between use of psychoactive drugs and				
(1) sexual problems	3	12	7	4
(2) suicidal ideations	3	12	7	3
(3) adolescent problems	4	12	8	2
(4) domestic violence	3	12	8	2
(5) depression	3	11	7	4
Models of recovery as a process with its own predictable issues and stages	4	4	6	8
Ideas about how the family and the therapist can get the abuser into treatment	5	7	10	2
How to recognize the family dynamics that often maintain substance abuse in one or more family members	5	11	7	1
How to recognize the family dynamics transmitted over generations even when there is no current substance abuse	4	10	6	2
Knowledge of the disease model and its usefulness in therapy	4	12	5	2
Warning signs of relapse and ideas on relapse prevention	4	5	8	5
Differences in treatment costs considering type of treatment and current trends in reimbursement by insurance companies	3	1	5	12
Access to a list of appropriate referrals	5	5	13	1

Abstinence vs. controlled use for most recovering addicts	4	6	6	7
The therapist as a possible enabler	3	7	10	5
The therapist's comfort with a client's dependency on sponsor and higher power vs. common therapy goal of self-control	2	1	7	12
Impact of therapist's own use of substances	3	2	8	9
If family therapy can be an important adjunct to addiction-specific treatment	4	11	8	3
If/when addiction-specific treatment (in groups such as AA or in treatment centers) is crucial	4	8	7	6
Compatibility between belief in the disease concept and the fostering of increased personal responsibility during recovery	4	6	5	7
If adolescent abusers are basically a different population from adult abusers	4	4	5	8
Whether a person's character defects and attitudes cause or contribute to the abuse	4	7	5	8
Whether unhealthy family systems cause substance abuse	4	12	7	3
The priority of treatment goals--in particular, when the therapist must opt for treating the substance abuse as primary	4	8	8	4
When the therapist prefers to diagnose and refer rather than to diagnose and treat	4	6	8	4

NUMBER OF RESPONSES IN EACH CATEGORY

FOR FIVE PROGRAMS WITH A REQUIRED SUBSTANCE ABUSE CLASS

	Where in Program			
Definitions of				
(1) substance abuse	4	2	2	0
(3) tolerance	4	1	1	0
(4) physical dependence	4	2	2	0
(5) cross addiction	4	0	2	1
(6) alcoholic blackouts	4	0	1	1
(7) codependency	4	2	2	0
(8) enabling	3	2	2	0
Familiarity with the				
(1) basics of Alcoholics Anonymous (AA)	4	1	2	1
(2) Twelve Steps	4	1	2	1
(3) concept of a higher power	4	1	2	1
(4) relatively high success rate of AA	4	0	1	1
How to recognize the signs of				
(1) early stage addiction	4	1	2	1
(2) middle stage addiction	4	1	2	1
(3) late stage addiction	4	1	2	1
Basic facts about specific drugs other than alcohol, including				
(1) families of drugs	4	0	0	1
(2) legitimate uses of particular drugs	4	0	0	1
(3) symptoms of use of specific drugs	4	0	1	1
(4) withdrawal symptoms of specific drugs	4	0	1	0

Familiarity with written diagnostic tests or questions such as the MAST and CAGE	2	0	2	1
Interviewing techniques to reveal substance abuse despite client's denial	3	1	2	0
Behavioral indicators of drug abuse	4	1	2	0
Criteria for deciding if detoxification in a medical setting is necessary to safely begin abstinence	3	0	1	2
Connections between use of psychoactive drugs and				
(1) sexual problems	3	3	2	0
(2) suicidal ideations	3	3	2	0
(3) adolescent problems	4	3	2	0
(4) domestic violence	3	2	2	0
(5) depression	3	2	2	0
Models of recovery as a process with its own predictable issues and stages	4	1	1	0
Ideas about how the family and the therapist can get the abuser into treatment	4	1	2	0
How to recognize the family dynamics that often maintain substance abuse in one or more family members	5	1	1	0
How to recognize the family dynamics transmitted over generations even when there is no current substance abuse	4	1	1	0
Knowledge of the disease model and its usefulness in therapy	4	0	1	0
Warning signs of relapse and ideas on relapse prevention	4	0	1	0
Differences in treatment costs considering type of treatment and current trends in reimbursement by insurance companies	3	1	1	1
Access to a list of appropriate referrals	5	1	2	0

Abstinence vs. controlled use for most recovering addicts	4	1	2	0
The therapist as a possible enabler	3	1	3	0
The therapist's comfort with a client's dependency on sponsor and higher power vs. common therapy goal of self-control	2	1	3	0
Impact of therapist's own use of substances	3	1	2	1
If family therapy can be an important adjunct to addiction-specific treatment	4	1	1	1
If/when addiction-specific treatment (in groups such as AA or in treatment centers) is crucial	4	1	2	1
Compatibility between belief in the disease concept and the fostering of increased personal responsibility during recovery	4	0	2	0
If adolescent abusers are basically a different population from adult abusers	4	0	0	1
Whether a person's character defects and attitudes cause or contribute to the abuse	4	1	0	1
Whether unhealthy family systems cause substance abuse	4	2	1	0
The priority of treatment goals--in particular, when the therapist must opt for treating the substance abuse as primary	4	1	2	0
When the therapist prefers to diagnose and refer rather than to diagnose and treat	4	0	2	0

NUMBER OF RESPONSES IN EACH CATEGORY

FOR 15 PROGRAMS WITHOUT REQUIRED SUBSTANCE COURSES

	Where in Program			
Definitions of				
(1) substance abuse	0	9	3	4
(3) tolerance	0	7	3	6
(4) physical dependence	0	8	4	5
(5) cross addiction	0	4	4	7
(6) alcoholic blackouts	0	7	4	6
(7) codependency	0	8	5	4
(8) enabling	0	9	5	3
Familiarity with the				
(1) basics of Alcoholics Anonymous (AA)	0	8	4	5
(2) Twelve Steps	0	9	2	5
(3) concept of a higher power	0	8	3	6
(4) relatively high success rate of AA	0	8	3	6
How to recognize the signs of				
(1) early stage addiction	0	7	2	5
(2) middle stage addiction	0	7	2	5
(3) late stage addiction	0	7	3	5
Basic facts about specific drugs other than alcohol, including				
(1) families of drugs	0	2	3	10
(2) legitimate uses of particular drugs	0	1	2	11
(3) symptoms of use of specific drugs	0	2	2	10
(4) withdrawal symptoms of specific drugs	0	3	2	11

Familiarity with written diagnostic tests or questions such as the MAST and CAGE	0	1	1	14
Interviewing techniques to reveal substance abuse despite client's denial	0	5	9	3
Behavioral indicators of drug abuse	0	6	6	5
Criteria for deciding if detoxification in a medical setting is necessary to safely begin abstinence	0	3	6	7
Connections between use of psychoactive drugs and				
(1) sexual problems	0	9	5	4
(2) suicidal ideations	0	9	5	3
(3) adolescent problems	0	9	6	2
(4) domestic violence	0	10	6	2
(5) depression	0	9	5	4
Models of recovery as a process with its own predictable issues and stages	0	3	5	8
Ideas about how the family and the therapist can get the abuser into treatment	0	6	8	2
How to recognize the family dynamics that often maintain substance abuse in one or more family members	0	10	6	1
How to recognize the family dynamics transmitted over generations even when there is no current substance abuse	0	9	5	2
Knowledge of the disease model and its usefulness in therapy	0	12	4	2
Warning signs of relapse and ideas on relapse prevention	0	5	7	5
Differences in treatment costs considering type of treatment and current trends in reimbursement by insurance companies	0	0	4	11
Access to a list of appropriate referrals	0	4	11	1

Abstinence vs. controlled use for most recovering addicts	0	5	4	7
The therapist as a possible enabler	0	6	7	5
The therapist's comfort with a client's dependency on sponsor and higher power vs. common therapy goal of self-control	0	0	4	12
Impact of therapist's own use of substances	0	1	6	8
If family therapy can be an important adjunct to addiction-specific treatment	0	10	7	2
If/when addiction-specific treatment (in groups such as AA or in treatment centers) is crucial	0	7	5	5
Compatibility between belief in the disease concept and the fostering of increased personal responsibility during recovery	0	6	3	7
If adolescent abusers are basically a different population from adult abusers	0	4	5	7
Whether a person's character defects and attitudes cause or contribute to the abuse	0	6	5	7
Whether unhealthy family systems cause substance abuse	0	10	6	3
The priority of treatment goals--in particular, when the therapist must opt for treating the substance abuse as primary	0	7	6	4
When the therapist prefers to diagnose and refer rather than to diagnose and treat	0	6	6	4

APPENDIX C

Instruments

Original cover letter

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

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

March 30, 1989

Program Director
Address

Dear :

The pervasiveness of substance abuse in our culture guarantees that marriage and family therapists will encounter a substantial number of families for whom substance abuse issues are central. The purpose of this survey is to gather information on substance abuse training in the curricula of Master's level programs accredited by AAMFT. Your reply is important so that the results will reflect a comprehensive view of this training.

The data collected will show the information typically taught, the controversial issues most often discussed, the format in which this is done, individual variations that might be interesting to other programs, and Directors' thoughts on the most helpful level of AAMFT involvement. We believe that this data will be useful in program planning.

We assure you of complete confidentiality. The identification number on the questionnaire is for tracking which programs have yet to respond, and the principal researcher alone will keep this record. Only the range of responses from the group will be reported; no results will identify individual programs.

The survey takes only about twenty minutes to complete. We expect to have the results tabulated by the end of the summer and will be happy to send you a copy.

Thank you very much for your cooperation. We believe that the results of this survey will be of use to the top programs in family therapy.

Sincerely,

Katherine C. Jones
Principal Researcher

Linda F. Little, Ph.D.
Approved Supervisor
Committee Chair

2990 Telestar Court, Falls Church, Virginia 22042 - 1287

First follow-up on a postcard for those who have not responded

Date

Dear :

Last week we mailed you a questionnaire exploring how graduate programs in Marriage and Family Therapy are addressing substance abuse training.

As of today, we have not received your response. Your response is important to our overall knowledge of this issue. Please take a few minutes to complete the survey so that information on your program will be included and so that we may accurately reflect coverage of the addictions field among accredited programs.

If you have any questions or need a questionnaire, please call collect (703-281-3895).

Sincerely,

Katherine C. Jones

Second reminder

(Replacement questionnaire included in mailing)

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

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

April 14, 1989

Program Director
Address

Dear :

We are writing you about the survey we mailed several weeks ago on substance abuse training in the curricula of Master's level programs accredited by AAMFT. As of today, we have not received your completed questionnaire.

Substance abuse is becoming increasingly pervasive in our culture. This study explores how you and your colleagues are addressing graduate training in the diagnosis and treatment of substance abuse. The data collected will show the information typically taught, the controversial issues most often discussed, the format in which this is done, individual variations that might be interesting to other programs, and Directors' thoughts on the most helpful level of AAMFT involvement. We believe that this data will be useful in program planning.

The responses received so far from over half of your Director colleagues show interesting and varied results. Your program may differ in significant ways from those already responding and we want to incorporate this information. For this reason, we are sending you a replacement questionnaire. Please take the twenty minutes to respond as soon as possible.

We assure you of complete confidentiality. The identification number on the questionnaire is for tracking which programs have yet to respond, and the principal researcher alone will keep this record. Only the range of responses from the group will be reported; no results will identify individual programs. We expect to have the results tabulated by the end of the summer and will be happy to send you a copy.

We are writing you again because the inclusion of your program is important to the thoroughness of this research. Your response will be greatly appreciated.

Sincerely,

Katherine C. Jones
Principal Researcher

Linda F. Little, Ph.D.
Approved Supervisor
Committee Chair

2990 Telestar Court, Falls Church, Virginia 22042 - 1287

Postcard thanking respondents

Date

Dear:

Thank you very much for returning the questionnaire concerning substance abuse training in your graduate program in Marriage and Family Therapy. Your contribution to the thoroughness of this research is greatly appreciated.

I will share the results with you during the summer.

Sincerely,

Katherine C. Jones

The questionnaire

A Survey of Substance Abuse Training in AAMFT Accredited Master's Level Marriage and Family Therapy Programs

Virginia Polytechnic Institute and State University
Department of Family and Child Development
Northern Virginia Graduate Center
Falls Church, Virginia 22042

About this Questionnaire
==========

The purpose of this survey is to gather information on the substance abuse training in the Master's level programs accredited by the American Association for Marriage and Family Therapy. Data collected will reflect both the range of approaches and the range of facts and issues deemed primary by the faculties of these twenty-one programs.

You may be assured of complete confidentiality. Neither your university colleagues nor anyone at AAMFT will be able to connect your individual responses with your program.

We hope that you will take the twenty minutes to respond and that you will find the results, to be ready this summer, useful.

If you have any questions, please call 703-281-3895 or 703-698-6035.

Linda F. Little, Ph.D.
Approved Supervisor
Committee Chair

Katherine C. Jones
Principal Researcher

Survey on Substance Abuse Training in Required Classes

Please consider whether the specific information referred to in each question is addressed

(a) in a required class on substance abuse,
(b) in a required class not specifically on substance abuse,
(c) in that part of practicum taken by most students, or
(d) it is not addressed in the required curriculum.

Each faculty will emphasize different content areas and teach in various formats. Some programs will probably cover material about substance abuse in electives. We will ask you to comment on electives later in the questionnaire.

CIRCLE ALL CATEGORIES THAT APPLY.

First, we would like you to think about what specific factual information your faculty has chosen to teach in your program. Please circle all letters that apply.

	Where in Program			
Definitions of				
(1) substance abuse	a	b	c	d
(3) tolerance	a	b	c	d
(4) physical dependence	a	b	c	d
(5) cross addiction	a	b	c	d
(6) alcoholic blackouts	a	b	c	d
(7) codependency	a	b	c	d
(8) enabling	a	b	c	d
Familiarity with the				
(1) basics of Alcoholics Anonymous (AA)	a	b	c	d
(2) Twelve Steps	a	b	c	d
(3) concept of a higher power	a	b	c	d
(4) relatively high success rate of AA	a	b	c	d
How to recognize the signs of				
(1) early stage addiction	a	b	c	d
(2) middle stage addiction	a	b	c	d
(3) late stage addiction	a	b	c	d
Basic facts about specific drugs other than alcohol, including				
(1) families of drugs	a	b	c	d
(2) legitimate uses of particular drugs	a	b	c	d
(3) symptoms of use of specific drugs	a	b	c	d
(4) withdrawal symptoms of specific drugs	a	b	c	d

Please continue circling all categories that apply.

(a) means in required substance abuse class
(b) means in another required class
(c) means in part of practicum common to most students
(d) means not addressed in required part of program

Familiarity with written diagnostic tests or questions such as the MAST and CAGE	a	b	c	d
Interviewing techniques to reveal substance abuse despite client's denial	a	b	c	d
Behavioral indicators of drug abuse	a	b	c	d
Criteria for deciding if detoxification in a medical setting is necessary to safely begin abstinence	a	b	c	d
Connections between use of psychoactive drugs and				
(1) sexual problems	a	b	c	d
(2) suicidal ideations	a	b	c	d
(3) adolescent problems	a	b	c	d
(4) domestic violence	a	b	c	d
(5) depression	a	b	c	d
Models of recovery as a process with its own predictable issues and stages	a	b	c	d
Ideas about how the family and the therapist can get the abuser into treatment	a	b	c	d
How to recognize the family dynamics that often maintain substance abuse in one or more family members	a	b	c	d
How to recognize the family dynamics transmitted over generations even when there is no current substance abuse	a	b	c	d
Knowledge of the disease model and its usefulness in therapy	a	b	c	d
Warning signs of relapse and ideas on relapse prevention	a	b	c	d
Differences in treatment costs considering type of treatment and current trends in reimbursement by insurance companies	a	b	c	d
Access to a list of appropriate referrals	a	b	c	d

Now we would like you to consider issues on which evidence may be contradictory and on which people's opinions may differ.

You may have provided a forum for consideration of some or all of these issues. Please think about the required portion of your program and mark all categories that apply.

(a) means in required substance abuse class
(b) means in another required class
(c) means in part of practicum common to most students
(d) means not addressed in required part of program

Abstinence vs. controlled use for most recovering addicts	a	b	c	d
The therapist as a possible enabler	a	b	c	d
The therapist's comfort with a client's dependency on sponsor and higher power vs. common therapy goal of self-control	a	b	c	d
Impact of therapist's own use of substances	a	b	c	d
If family therapy can be an important adjunct to addiction-specific treatment	a	b	c	d
If/when addiction-specific treatment (in groups such as AA or in treatment centers) is crucial	a	b	c	d
Compatibility between belief in the disease concept and the fostering of increased personal responsibility during recovery	a	b	c	d
If adolescent abusers are basically a different population from adult abusers	a	b	c	d
Whether a person's character defects and attitudes cause or contribute to the abuse	a	b	c	d
Whether unhealthy family systems cause substance abuse	a	b	c	d
The priority of treatment goals--in particular, when the therapist must opt for treating the substance abuse as primary	a	b	c	d
When the therapist prefers to diagnose and refer rather than to diagnose and treat	a	b	c	d

Finally, a few questions to help us interpret the results:

In what percentage of the cases encountered by students in practicum would you estimate that substance abuse is a central issue, although not necessarily the presenting problem?

_____%

Please mark the areas in which you feel confident that your trainees will be adequately trained to intervene with substance abuse cases upon completion of the current program of studies.

diagnosis	yes	no
treatment	yes	no
referral	yes	no

Please comment on the rationale for your answer.

Is there anything you would like us to know about your coverage of substance abuse topics in electives?

Are there additional facts or topic areas that you believe are important to incorporate? We also welcome your reaction to any items we have included.

Do you think that AAMFT should require accredited Master's level programs to offer a separate course dealing with these issues? If not, why not? If so, should AAMFT stipulate the content of that class?

Your general tnoughts on the subject may be one of the most valuable parts of your response. We request your comments on topics such as

--trends in your training program
--pitfalls or impediments you've encountered and
--how best to transmit substance abuse training.

Please continue your response on the back.

Would you like a copy of the results? yes no

Thank you for responding.

The vita has been removed from the scanned document