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RESPONSE: FAMILIES, MODELS, RELATIONSHIPS

Eric McCollum, Ph.D., Margaret McMahon, LICSW, and Marlene F. Watson, Ph.D.

Marlene Watson: I was very pleased with the authors' appreciation of the critical importance of family involvement and a systems perspective. My own clinical practice and experience bear this out. I was very pleased that the authors took note of children as well, because sometimes they can get lost.

Margaret McMahon: I have worked as a family therapist and always believed the patient gets better faster if the family is involved. It's been disappointing to me that, in the outpatient addiction program where I work now, families just don't participate. They are offered the opportunity to come to a family counseling session once a week free of charge, but very rarely do we have family members attend on a regular basis. It seems that patients don't want to face their families, perhaps because they begin to understand the harm their disease has caused. And the families have gotten so entangled, they may feel animosity toward the patient.

Watson: Sometimes it takes legwork to get the families in. I directed a forensic family therapy program. We were able to involve families of substance-abusing inmates in treatment, but we had to go out to talk to them and help them understand the benefits that would be there for them as well. We didn't collect data, but I would estimate that we had at least an 80 percent acceptance rate when we did that. Sometimes, though, we had to go back for two or three visits.

Eric McCollum: I think the problem is system-wide. I have also seen treatment agencies reluctant to involve families. I have consulted at adolescent treatment centers, for example, where parents are never asked to attend.

The benefit of engaging families has to be recognized beyond the director's or the family therapist's level. The counselors who are working with the client also need to see it, to pitch it to clients, and to welcome families when they show up. I suspect the authors' ability to involve 80 percent of families in their program is due in part to very broad support for family involvement in their environment.

Watson: True. Each agency has its own area of interest. In the correctional offices, there was concern that patients would manipulate the system to bring in undesirable acquaintances.

McCollum: Families where one member is using alcohol or drugs can be fairly chaotic and can create a great deal of intensity pretty quickly. Substance abuse counselors often feel they don't have the skills to deal with it. That makes it hard to really encourage families to attend treatment sessions.

Rigidity versus flexibility

McCollum: I think part of the reason the authors are struggling to bring their model into the clinical arena is that it is too rigid, at least as presented in this article. As clinicians, we all pride ourselves on

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tailoring interventions to fit the people sitting in front of us. The outcomes the authors report are very impressive, but they are group outcomes, averages. Clinicians focus more on the individual experience of the person or people sitting across from them.

Watson: A major concern for me is that this kind of model could take our attention away from important issues of personal identity. I mean issues of race, class, gender, and so on. Clinicians might think it's simply a matter of just following the manual straight as it is. I think that would be a disservice to some of the gains we have made.

I work with many African Americans, and I believe this model could be adapted for my clients. However, sometimes at the core there are severe issues, such as internalized or external racism. Clients don't know how to talk to each other about these things. The authors' model prescribes so much to take place each session, I don't see where there would be room to educate and create dialogue around such issues.

McCollum: On the other hand, the highly structured session agenda, even though it may not appeal to clinicians initially, may be beneficial, particularly with more chaotic couples. Often couples come to therapy without much hope. A strict agenda may be a good first step that will settle the system down, instill some hope, and get drinking and drug-taking under control. And then at that point, it may be time to deal with some of the issues that Marlene is concerned about, such as the influence of racism and cultural issues on drinking, past histories of trauma, and so on. Treatment doesn't have to stop after 12 sessions.

McMahon: I think the model is a very helpful one, particularly for counselors with less experience, because it's so structured. But I think if you don't do it kind of free-form and go where you need to go, it could be frustrating.

Watson: I agree that the structure has benefits, but I'm concerned that patients may end up being excluded because of deeper issues that may, for example, keep them from doing their homework.

The exclusionary factors described in the paper gave me pause. The authors are dealing with a very specific group.

McCollum: True, those exclusion criteria would leave a lot of people out of couples treatment. I use a much wider net. We do not exclude everyone with a history of violence. We do exclude where there is active violence or one partner wants to end the relationship or is afraid to be with the other.

Watson: I usually have a couple of sessions where we talk about some of the issues, and I see whether I think it's better to keep the couple together or separate them for concurrent treatment.

McMahon: I recommend seeing each half of the couple separately at least once or twice at the beginning. That way you can try to get a bird's-eye view of what each is like. Are they angry? Could there be violence? Sometimes putting a couple together can be extremely bad.

McCollum: In my day-to-day practice I conduct an ongoing assessment of each situation. There are certainly times when it's appropriate to see the partners separately—particularly when bringing them together may exacerbate a potential for violence. Most therapists don't take the idea of couples therapy to mean literally that both people must be present all the time.

Relationships, relationship satisfaction

McCollum: Relationship satisfaction is a key concern. If we just focus on eliminating our patients' substance abuse without helping them with their relationships, we may be just hanging them out to dry.

McMahon: Relationship satisfaction can be an equal goal or it can be secondary. Sometimes both partners realize their relationship isn't viable anymore, and they start to work toward dissolving it. That can bring satisfaction in a different way.

Watson: I would be curious to know more about what goes into the authors' assessment of relationship satisfaction. Just from working with people, I can't help but wonder about women who may feel, 'Okay, my partner is not drinking, so I don't have reason to complain, so I should be satisfied.'

McMahon: I believe that in the early stages of couples' treatment there has to be a fair amount of

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education for both partners, including educating the nonuser on beginning to take better care of himself or herself. In the authors' model, the nonabuser seems to get kind of lost, in terms of their enabling and all the horror they went through. It seems to me that the co-alcoholic, co-drug-dependent person is made too responsible for the partner's recovery.

Watson: I had the same concern. For example, in the couple's daily dialogue, as prescribed by the authors, the substance-abusing partner talks about not using, and the nonabusing partner expresses his or her appreciation for that. I think there should be more mutual appreciation. The substance-abusing partner also should acknowledge that the partner is giving support and exercising some restraint in not being accusatory.

McCollum: The authors' data clearly suggest that broad changes occur in the couples' relationships as therapy progresses. The contract and other therapeutic activities do seem to be changing some of the interaction patterns that surround drug abuse, not just keeping the partner in an enabling or caretaking role.

McMahon: The authors also mention that later on there is a lot of relapsing in couples' behavior toward each other. People tend to slip back into their old ways. That's why I encourage couples, as these authors do, to seek out meetings and support after the treatment program. &