The Role of Family and Significant Others in the Engagement and Retention of Drug-Dependent Individuals

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Family factors have been part of the drug abuse lore at least since Fort's early (1954) paper commenting on the parents of heroin addicts. Subse-quently, the literature on family variables in the process and treatment of drug problems has shown steady and increasing accumulation; there were nearly 400 such publications between 1954 and 1978 (Stanton 1978), and that total would appear to have at least doubled by now (Heath and Atkinson 1988; Kaufman 1985; Mackenson and Cottone 1992; Sorenson 1989; Stanton 1988).

While there have been publications and some solid research both on the marital relationships and on the children of drug abusers, the literature has preponderantly dealt with drug abusers in regard to their families of origin (e.g., their parents, siblings, and grandparents). This is partly because drug abusers have tended to be younger than alcoholics, for instance, and only a minority are married (Cervantes et al. 1988).

INVOLVEMENT WITH FAMILY OF ORIGIN

Living Arrangements and Frequency of Family Contact

Early views of drug-dependent individuals tended to characterize them as loners—people who were cut off from primary relationships and living a kind of "alley cat" existence. It was not until researchers began inquiring about addicts' living arrangements and familial contacts that the picture began to shift. For instance, Vaillant (1966), in a followup of New York narcotic addicts returning from the Federal narcotics rehabilitation hospital in Kentucky, found that 90 percent of the 22-year-olds whose mothers were still alive went to live with them, while 59 percent of the 30-year-olds with living mothers either resided with them or with another female blood relative such as a grandmother or a sister. A study in Detroit by Ross (1973) found that addicts (43 percent of whom were female) tended to operate out of two addresses, one of which was drug related and the

other family related, and were as likely to provide one as the other, or both, on admission to a treatment program. Perzel and Lamon (1979) found that among a group of New Jersey heroin addicts and polydrug abusers (age range 18 to 53, mean 30 years; 48 percent female), 45 percent of the former and 42 percent of the latter lived with a parent—figures that were substantially higher than the 7 percent reported by a normal comparison group.

Whether or not drug abusers actually live with their parents, the evidence that has accumulated indicates that most are closely tied to their families. For instance, in tracking addicts for long-term followup, Bale and colleagues (1977) noted that these clients usually have a longstanding contact person such as a parent or relative, and Goldstein and associates (1977) reported that addicts "tend to utilize a given household (usually their parents') as a constant reference point in their lives" (p. 25). The authors give examples of how even the street addict either regularly or periodically gets in touch with his or her permanent address, renews relationships with family, and the like. Further, Coleman (personal communication, March 1979), in a review of 30 male addicts' charts, noted that the person they requested to be contacted in case of emergency was invariably the mother, and was almost never the person with whom they lived (i.e., wife or girlfriend) for clients who did not live with their mothers. Finally, a Philadelphia study of 696 opioid addicts, ages 20 to 35, found that over a 30-month intake period 86 percent of the addicts reported seeing one or both of their parents face-to-face at least weekly (Stanton 1982).

A deficiency in most of the above-mentioned studies is that they asked only about face-to-face contacts, neglecting to inquire about telephone calls, letters, discussions with siblings that got conveyed to parents, and such. Addicts are frequently tied to the family system at many points, so that communication between them and other members is often routed through siblings, relatives, and spouses. Asking only about face-to-face contact provides inadequate information about the (not common) addict who talks to his or her mother on the phone every day or two for an hour or more. In fact, Perzel and Lamon (1979) found that 64 percent of heroin addicts and 51 percent of polydrug abusers were in daily telephone contact with a parent, compared to 9 percent of normals.

Most of these studies dealt with either opioid addicts or polydrug abusers. The question arises whether the same pattern holds for individuals who are cocaine dependent. Three studies examined that

population. Douglas (1987) compared matched groups of male opiate addicts, cocaine-dependent individuals, and nondrug abusers, aged 20 to 40 (N = 90), and found opiate abusers were in face-to-face or telephone contact with their parents twice as often, and cocaine abusers three times as often (i.e., aver- aging four times per week), as the nondrug-using controls. In a study of fifty 30- to 42-year-old male opiate/cocaine abusers, Bekir and colleagues (1993) found 82 percent to be "in constant contact with their family of origin by phone or visiting. Eight visited daily" and 32 (64 per-cent) visited at least once weekly (p. 628). Further, 5 of the 12 married patients and their spouses each lived with their own families of origin and only visited each other. Finally, preliminary data have recently been gathered from 27 cocaine-dependent males and females (mean age 33.5, range 23 to 51; 61 percent noncaucasian) by the author and colleagues at the University of Rochester Medical Center. Of those with at least one living parent or parent surrogate (i.e., someone who raised them), 78.3 per-cent reported being in at least biweekly parental contact, and 56 percent in at least weekly contact at the time of treatment intake.

In a review of the studies on this topic, Stanton (1982) noted that the pattern is not restricted to North America. Reports from other countries have arrived at the following percentages of drug addicts who live with their parents: England—62 percent; Italy—80 percent; Puerto Rico—67 percent; Thailand—80 percent.

To be sure, most of the reports on this phenomenon derive from clinical populations rather than untreated drug abusers. However, Rounsaville and Kleber (1985) found no difference between untreated (community) addicts and those seeking treatment in terms of family-social problems. They did, on the other hand, obtain ratings indicating better functioning of community addicts in regard to relationships with the extended family. Whether this translates into more regular or less regular contact is unclear, because the investigators did not inquire about family contact.

Combining subsequent investigations of family contact with those included in Stanton's (1982) aforementioned review leads to a clear conclusion: 26 of 28 reports attest to the regularity with which most drug-dependent people entering treatment are in contact with one or more of their parents or parent surrogates. The two dissenting reports issued from Vancouver, British Columbia and San Francisco. The former study was later recanted by its author, while the second—in which 28 detoxi-fying addicts were interviewed—was directly

challenged 12 years later by Cervantes and colleagues (1988) on a sample more representative of the San Francisco addict population. Of the 26 confirming reports, all indicate that a clear majority of such patients are in at least weekly con-tact, while (depending on geographical location and other variables) from 35 percent to 80 percent either live with or see one or more parents daily.

Relevant Family Dynamics

Of course, living with or regularly contacting parents is not in and of itself pathognomonic. In fact, such practices are the rule in some ethnic groups. The development and maintenance of addiction in a family member stems from other family variables as well as nonfamily influences.

To this point, there is a body of research that independently corroborates the family contact studies and additionally examines the intrafamily processes relevant to drug dependence (Kaufman 1985; Mackensen and Cottone 1992; Stanton 1979). Some examples from this literature should help to clarify.

Madanes and associates (1980) administrated the Family Hierarchy Test (in which stick figures representing family members are moved about on a board) to families with an addict, a schizophrenic patient, or a high-achieving normal. The families of addicts were four times as likely as those with a schizophrenic disorder, and five times as likely as the normals, to place figures on the board so that they actually touched or overlapped. Over half of these instances for addict families were cross-generational (i.e., between a parent and child) as opposed to being close connections between those in the same generation (i.e., spouses and siblings). The implication is of alliances between an offspring and one parent against the other parental figure—a finding that also emerged in a study of families of alcoholics by Preli and Protinsky (1988). Madanes and colleagues conclude that their data add to the accumulating evidence that addicts "are enmeshed in dependent relationships with their families of origin or parental surrogates" (p. 889).

In an Australian study, Schweitzer and Lawton (1989) asked male and female opiate- and polydrug-dependent patients to complete a Parental Bonding Instrument. The subjects rated their parents, especially fathers, as being more cold and indifferent than did comparison groups, as well as grading them as intrusive and preventing independence. These results conflict somewhat with a

study by Ben-Yehuda and Schindell (1981), in which 70.2 percent of male and female methadone patients in Chicago rated their family as warm, 61.7 percent said they had a good childhood, and 70.2 percent felt they had a satisfactory relationship with their parents. Whether the differences between these two studies are due to culture, type of treatment program, the nature of the questionnaire, or other factors is not clear.

ENGAGEMENT IN TREATMENT

The Problem

It has become generally recognized that a very small proportion of people with problems in drug dependency or abuse are actually engaged in treatment or self-help groups. Nathan (1990) estimated the figure to be 5 percent, while Frances and associates (1989) set it at 10 percent. An epidemiological study by Kessler and associates (1994) indicated that only 8 percent seek help within a given year.

Given the magnitude of the untreated population and the increasing contribution of drug abuse (through intravenous use and prostitution) to the spread of acquired immunodeficiency syndrome (AIDS), the means for engaging such people in treatment begins to assume signal impor-tance. Indeed, Frances and Miller (1991) have stated that the addiction field's "*major challenge* is helping substance abusers to *accept* and *continue* treatment" (p. 3; italics added).

Clearly, there is a need for procedures that both reach drug abusers and facilitate their induction into treatment or self-help groups. One approach that has received fairly wide use is the launching of an outreach effort. For instance, newspaper articles and announcements, television/radio public service announcements, personal appearances by staff, and other techniques have been used by treatment programs, churches, and com-munity organizations to induce substance abusers to get help (e.g., Orford 1987; Shapiro 1985; Stockwell 1991). Such efforts do tend to facilitate the direct engagement of a certain number of substance abusers, if for no other reason than that the abusers are made more aware of what is available and that there is hope for recovery.

Approaches to Engagement Through Family Members and Significant Others

Next to legal coercion (Collins and Allison 1983), one of the most potent avenues for engagement is through meaningful or significant others, such as spouses, parents, siblings, children, friends, clergy, and employers. As Resnick and Resnick (1984) put it, "...[T]he family can often be the key to forcing the patient to stop denial and avoidance and begin dealing with the cocaine problem" (p. 723). This author is aware of seven research teams or clinical groups that have taken a systematic approach to engaging sub-stance abusers, and these are described below. It should be noted that the thrust here is toward engaging the abusers themselves, not necessarily their family members: The induction of families has been reviewed elsewhere (e.g., Stanton and Todd 1981; Stanton et al. 1982; Szapocznik et al. 1988; Wermuth and Scheidt 1986).

Intervention. Originally developed in the 1960s by Johnson (1973, 1986) at the Johnson Institute in Minneapolis, intervention is a method for mobilizing and rehearsing family members, friends, and associates to confront the alcoholic with their concerns, strongly urge him/her to enter treatment, and lay out the consequences (such as divorce, loss of job) if he or she refuses. Interveners usually prepare in secret, using the element of surprise. Although the approach has mostly been applied with drinking problems, it has also been adapted for other chemical dependencies (Liepman et al. 1982).

Despite its widespread use, very little research has been undertaken on intervention. A search of "Psychological Abstracts" and "Dissertation Abstracts International," scanning the years since 1980, located only two studies, both of a preliminary nature (Liepman 1993); these are described below.

Using a quasi-experimental design, Liepman and colleagues (1989) reported on 24 cases in which an average of 4 people per case took part in preintervention counseling and/or confrontation of the alcoholic. Six of the seven alcoholics who were actually confronted entered (outpatient) treatment. However, 17 cases never reached the point of confrontation; they never engaged in treatment. In other words, the approach was successful in 25 percent of the total number of cases.

Logan (1983) combined intervention methods with the social network therapy approach of Speck and Attneave (1973) and

Garrison (Callan et al. 1975; Garrison et al. 1977). Each intervention network involved the 8 to 12 individuals deemed most important to the alcoholic. Of the 60 interventions attempted over a 1-year period, 54 (90 percent) resulted in the alcoholic entering treatment.

Community Reinforcement Training (CRT). This method spun off the original community reinforcement approach (CRA) to alcoholism treatment developed by Azrin and colleagues (Azrin 1976; Azrin et al. 1982; Hunt and Azrin 1973; Meyers and Smith 1995) and has been applied to cocaine dependence by Higgins and associates (Higgins and Budney 1993; Higgins et al. 1993, 1994). CRT involves seeing the distressed family member (usually the spouse) the day that he or she telephones in to get help for a drinker. It also requires being available during nonworking hours and off days in case the family member reaches a crisis point when the drinker requests help. The program includes a number of sessions with the spouse in which checklists are completed and the spouse is taught how to avoid physical abuse, encourage sobriety, encourage the seeking of treatment, and assist in treatment. The approach is generally nonconfrontational and attempts to take advantage of a moment when the drinker is motivated to get treatment by immediately calling a meeting at the clinic with the counselor, even if it is in the middle of the night (Sisson and Azrin 1993). Sisson and Azrin (1986) examined effectiveness of this approach with 12 cases—7 in which a family member received CRT and 5 in which the person received traditional (Al-Anon) type counseling. In six of the seven CRT cases, the alcoholic entered treatment, while none of the traditional cases did.

Berenson's Approach. Berenson developed a method for working with the most motivated family member or members to get the alcoholic into treatment and Alcoholics Anonymous (AA) (Berenson 1976; see also Stanton 1981 for more detail). This approach strategizes with the spouse and works toward helping him or her detach from the drinker. While this approach has several fairly clear-cut stages and a number of specific techniques that could be codified in a manual, no research has yet been undertaken with it.

Unilateral Family Therapy. This approach, developed by Thomas and associates (Thomas and Ager 1993; Thomas and Yoshioka 1989; Thomas et al. 1987), has been applied with spouses (usually wives) of uncoop-erative alcoholics. The therapist meets with the spouse over some months, with a focus on spousal coping, reducing the abuser's drinking, and inducing the abuser to enter treatment. The method was influenced by intervention and CRA, although the intervention used is

normally by one person (the spouse) and termed a "programmed confrontation." By the fifth month, some open attempt (or a series of attempts) is made to get the drinker into treatment. At 6 months from first spouse contact, 39 percent of the drinkers in the group in which the spouse was treated immediately (versus a delayed condition) had entered a program, compared with 11 percent for the delayed group. When other cases were added in which the drinkers had not entered treatment but had achieved and maintained "clinically meaningful" reductions in their drinking levels, the percentages were 57 percent and 37 percent, respectively (Thomas and Ager 1993; Thomas et al. 1990).

Co-Operative Counseling. Yates (1988) described an experimental program in England using "affected others" to enlist alcoholics in treatment. The effort began with an active outreach component to get people to call the program. Over the 6-month period studied, calls were received from family members and others regarding 30 cases, three-quarters of whom had never been in treatment for their drinking. In 11 cases, the caller (and, of course, the drinker) never came in, while in 4 more the caller came for one visit but the drinker was not engaged. Five more did not want the drinker to know they had contacted the agency. Of the remaining 10, 4 actually entered treatment. However, five others reduced their drinking markedly, even without being formally inducted. In sum, 13 percent of the original 30 got into treatment. Of the 19 cases when the caller actually came in, 21 percent entered treatment and 26 percent reduced their drinking, meaning that 47 percent either showed up or showed improvement once the affected other appeared in person.

Strategic Structural Systems Engagement. A method for engaging adolescent substance abusers (and their families) has been developed by Szapocznik and colleagues (1988). They defined six levels of engagement effort by a therapist receiving a call about a prospective client. The levels ranged from minimal joining with, and inquiry of, the caller, to higher level "ecological" interventions—involving not only the family, but other relevant systems, such as the school and health center—and out-of-office visits to family members. The choice of level depended on the sort of resistance encountered; the authors identified four types. In 90 percent of the call-ins the caller was the mother of an adolescent drug abuser, so the telephone conversation usually concerned how she could get the adoles-cent and other family members in for treatment. Using this method, Szapocznik and colleagues were able to get 93 percent of the targeted adolescents to come to the clinic with their families for an intake

meeting, compared to 42 percent for an engagement-as-usual condition.

The Albany-Rochester Interventional Sequence for Engagement (ARISE). Devised by Garrett of the Al-Care program (a sizable outpatient facility for substance abusers in Albany, NY), ARISE entails several stages in the mobilization of family and significant others toward patient entry (Garrett et al., submitted). It combines formal intervention (Johnson 1973, 1986), social network therapy (Speck and Attneave 1973), and the (integrative) Rochester approach to family and network therapy (Landau-Stanton 1990; Landau-Stanton and Clements 1993; Seaburn et al. 1995; Stanton 1984; Stanton and Landau-Stanton 1990). In essence, the method is an attempt to draw upon what are considered to be the strongest features of each of these approaches as well as some techniques from a few other therapeutic schools.

Developed with both alcoholics and drug abusers, the method evolved in response to three particular limitations of the more standard, formal intervention. First, an intervention requires considerable expenditure of time and effort, since it involves a good deal of instruction, the writing and public reading of letters to the substance abuser, rehearsal, and other activities, and it was felt that a sizable proportion of callers might not require something so ambitious and expensive.

A second reason for expanding engagement options was that confrontation can be very frightening to family members, possibly assuming the flavor of an ultimatum (Lewis 1991). Often the problem drinker is controlling things in the home—sometimes tantamount to a reign of terror—and the family is not ready to oppose him or her. In fact, if pushed too hard by professionals, the family may simply abandon the effort. Thus, a slower, nonescalating, less distressing induction is called for, at least initially. It can attract some families who are not prepared to risk a full-blown intervention.

Third, data by Loneck and colleagues (in press) coupled with clinical experience indicate that, although patients who undergo a formal intervention are as likely to complete treatment as those who do not experience intervention, they are twice as likely to relapse during the process. It is not clear to what this interesting conundrum should be attributed—it may be a rebellion against being coerced—and the subject is currently under investigation.

The ARISE model consists of three general stages. Each stage involves an increased commitment of therapeutic and familial/network resources compared to the stage that precedes it. The procedure is as follows.

Stage 1: Informal Intervention Without a Therapist Present. A concerned person calls the clinic, perhaps in response to an outreach effort or a friend's recommendation. He or she is worried about a family member or an acquaintance who has a drinking problem and either has not sought help or refuses to do so. The caller wants the person to enter treatment, and may even request a formal intervention. (For purposes of this discussion, the drug-dependent person is called the "DDP.") Upon hearing the caller's request, the receptionist contacts the intervention specialist on call, who either takes the call or gets back to the caller later that day.

As the 15- to 30-minute conversation unfolds, the specialist tries to determine who is in the family, who is in the natural support system, and what other people might be key. Related to this, the specialist also begins to clarify to the caller why it might be helpful and preferable to include all these other people in the induction effort.

Sometimes this stage takes more than one telephone conversation, but rarely more than two. By the end of the talk(s), the specialist wants to have: (a) identified the important players and secured a commitment for them all to be invited to come to the clinic together; (b) set a time for the meeting; (c) made it clear that the DDP is also to be invited; (d) estab-lished that even if the DDP agrees to come, and then backs out at the last minute, everyone else should come—that it would then be a kind of evaluation appointment involving coaching and strategizing as to how to persuade the DDP to come in.

Stage 2: Informal Intervention With a Therapist Present. It is Al-Care's experience that, following a telephone conversation such as that described above, about 90 to 95 percent of the time at least one person (but usually several, or many more) shows up for the first meeting. At that point, a chart is opened on the case. Normally the therapist who attends this meeting is the same person (the intervention specialist) who conducted the telephone interview.

The major agenda at this stage is, of course, to plan and strategize in detail as to how to get the DDP to enter treatment. Family and friends often hesitate to have a full-fledged confrontation, and the therapist guides discussion by statements such as, "We want to do

something that's really caring, and shows that you're worried." However, the therapist wants to keep the process moving, and will usually make a pitch to call the DDP directly right then, from the meeting.

This stage unfolds over a sequence of one to three sessions. Each session is viewed as an opportunity to bring in the DDP. If, after three (or, occasionally, four or five) such meetings, the DDP is not engaged in treatment, the therapist moves to the third stage—a formal intervention.

Stage 3: Formal Intervention. This format is based on the Johnson Institute model briefly described earlier. However, it is a kinder, gentler, less negative approach—a direction also taken in later years by the Hazelden Foundation and even by the Johnson Institute itself. In addition, the approach incorporates a number of elements from the Rochester therapy model, including attention to the intergenerational patterns of the alcohol problems. That it has been utilized to get patients into both outpatient and inpatient treatment (including detox) has made it generalizable to a great many treatment contexts and made it particularly appealing to managed health care systems.

ARISE Engagement Data. Loneck and associates (in press) performed a retrospective analysis of engagement and retention in 332 Al-Care cases from the past 6 years. The full complement of cases was scanned for that period and all cases were categorized in one of five entry categories: The three ARISE stages (N = 195), plus those who were coerced to enroll (through probation, employee assistance programs, attorney, or other sources; N = 68), and those who enrolled on their own, without coercion or some level of intervention (N = 69). From this pool, approximately equal numbers of cases were randomly selected from within each category to allow comparisons. To be eligible for this study, all cases came in for at least one evaluative (get acquainted) meeting. For the cases dealt with through ARISE, this meant that one or more significant others attended the first meeting.

Most of the cases (258) were alcohol problems. For purposes of this chapter, attention will be given to the remaining 74 cases, who were drug (primarily cocaine) abusers. The percentages of cases in which the DDP entered treatment for each of the three ARISE stages were, respectively: stage 1 = 45 percent; stage 2 = 59 percent; stage 3 = 92 percent. Fifty-five percent were in some phase of the ARISE process. Although lower than the 70 percent level attained for alcoholics, this

rate compares favorably with the percentages of DDP treatment inductees attained through coercion (50 percent) or self-referral (also 50 percent). Given that the coercion and self-referred cases were, almost by definition, more motivated to enter treatment, the fact that ARISE achieved nearly equal results with resistant, highly ambivalent drug users (i.e., people who wanted nothing to do with treatment) is a testament to its utility. This point is perhaps further strengthened when one realizes this was not research therapy, with all the added benefits that might accrue to such (Weisz et al. 1992), but was conducted in a community clinic with no obvious expectation that, years later, engagement efforts would be scrutinized.

Conclusions. It is difficult to make definitive statements, given the scant number of studies, with generally small numbers, that have addressed this issue. The range in success rate is also wide: for intervention, it stretched from 25 percent to 92 percent. Two variables do give tentative indica-tions of importance, however. First, it would appear that the greater the availability of the counselor—for instance, after hours and on weekends— the more likely the DDP is to be caught at the right moment and induced to enroll.

The second dimension has to do with the size of the group of significant others collected for the intervention. Logan (1983) had twice as large a group assembled than did Liepman and colleagues (1989) (i.e., eight people versus four), and attained at least three times the success rate (90 percent versus 25 percent). The perhaps obvious (but still tentative) conclusion is: The more people gathered, the more potent the effect.

RETENTION IN TREATMENT

Recently, the author has been engaged in reviewing the controlled studies of family treatment for drug abuse (Stanton and Shadish, submitted). To date, 15 such studies have been conducted that used at least two comparison/control conditions and random assignment. An issue that has arisen from this effort pertains to whether the analysis of outcome for a given study incorporates all subjects assigned to treatment conditions, or only those who received some minimal amount of a treatment regimen. These different approaches derive from two different questions (Howard et al. 1990). The first is, "What are the expected outcomes for a group of clients assigned to a given treatment, whether or not they fully engage in or complete that

treatment?" The second question is more limited in scope: "What outcomes can be expected among those who receive (or partially complete) a given treatment?" In their influential and by now classic review of methodological problems in research on treatment of the addictions, Nathan and Lansky (1978) have taken a strong position on this question, stating that to exclude such dropouts is, whether intended or not, a deception, and that such cases "should be considered treatment failures regardless of the rationalizations some [investigators] may have given for the decision to terminate" (p. 717).

Differential Attrition Rates

A major area of concern emerges from this research: differential dropout rates for different treatment conditions. In those studies comparing family/marital therapies to nonfamily approaches, almost without exception the nonfamily conditions had higher dropout rates. Put another way, significantly more family therapy cases stayed in treatment compared to nonfamily cases. For instance:

- 33 percent of Friedman's (1989) parenting group cases never engaged in treatment (versus 7 percent of the family therapy cases);

- Joanning and associates (1992) had dropout rates of 53 percent, 33 percent and 13 percent, respectively, for peer group therapy, family psychoeducation, and family therapy; and

- Liddle and colleagues'(1993) respective dropout rates for peer group therapy, multifamily therapy, and (conjoint) family therapy were 49 percent, 35 percent and 30 percent.

Therefore, this pattern warrants attention because, as Howard and colleagues (1986) note, it can serve to undermine the effects of randomi-zation.

Stark (1992) reviewed the literature on substance abuse treatment dropouts and concluded that "the fact that clients who use more drugs have higher attrition rates is true almost by definition and is overwhelm-ingly confirmed by the evidence" (p. 102). Stated differently, heavier drug-taking, poorer-prognosis patients (i.e., those at the less treatable end of the spectrum) are more likely to drop out early. Consequently, a therapy (call it treatment A) that incurs fewer dropouts is likely to be retaining a higher proportion of these less

tractable, possibly harder core (less motivated?) clients. Treatment A is thus left with the task of bringing about changes in an overall tougher group than, say, treatment B, because more of the "toughies" will have already defected from B. Consequently, if the outcome results of A and B are, for example, equal, A would have done it in the face of more difficult odds—like two people starting and finishing a foot race at the same time in which one of them additionally carries a 60-pound pack.

A specific example might illustrate. In a study by Stanton and associates (1984), 164 incoming methadone maintenance patients were deemed eligible for the research, signed agreements to participate, and were randomly assigned to one of two conditions (84 to family treatment and 80 to nonfamily), both of which at least initially involved methadone. However, because those members of the research team who administered methadone treatment felt that less than 2 weeks on methadone would be an unfair test of the efficacy of that modality, it was decided that only subjects would be retained in the study who remained on methadone for 14 days or more. As it happened, 55 patients defected before 14 days had elapsed, leaving 109 in the study. The problem was that a disproportionate number of them (35) came from the nonfamily condition, compared to 20 from the family condition, resulting in disparate dropout rates of 44 percent versus 24 percent. Whether or how this might have altered outcomes for the two groups cannot be determined, but it seems likely that if any effect came into play it would more likely be an adverse one for the family condition. In any case, such a problem cannot necessarily be overcome statistically, such as by introducing pretreatment covariates into an ANACOVA design, because it is difficult to know the key variables that are operating.

There is a certain irony when a treatment approach that effects better retention is penalized by being compared with modalities with lower retention rates. The problems in the aforementioned example could have been prevented by following Nathan and Lansky's dictum of including everybody in the analysis, that is, all 164 initial subjects. But of course that would have incited protest from other quarters (which might also have jeopardized support from the funding agency). Nonetheless, it appears that in a number of the studies reviewed by Stanton and Shadish (submitted), true differences between treatment conditions may have been obscured because the conditions differed in their attrition rates, and dropouts (and deaths) were not included as failures in the analyses. (In fact, a subsequent analysis by Stanton and

Shadish of the Stanton and associates' 1984 data, but with dropouts and deaths included, found that the family therapy condition did indeed yield significantly better results at the 0.01 probability level.) In the future, more researchers will need to take steps to account for or eliminate differential dropout rates among treatment conditions to avoid unnecessary confounding and ambiguous results.

Difficulties With Adult Clients

Getting adult opioid addicts to engage and remain in any kind of psychotherapy study has been notoriously difficult. Among controlled individual psychotherapy studies with this population, the rates tend to be low for eligibles who are contacted, agree to participate, and remain for a minimal period of, say, 3 weeks, ranging from 5 percent (Rounsaville et al. 1983) to 36 percent (Woody et al. 1983). In contrast, the rates for successful retention of adult patients in family therapy, as shown by the four studies that provided such data (out of five total), are: McLellan and colleagues 1993—73 percent; Stanton and associates 1982—71 percent and 1984—76 percent; Ziegler-Driscoll 1977—53 percent. The mean retention rate across the four studies, weighted by sample size, is 66.6 per- cent, which is almost twice the rate for the most successful individual study and 13 times larger than the least successful.

Some Explanatory Factors and Processes

Why the difference in retention between family and other types of treatment? At least part of the explanation may lie in the way that treaters handle real world events in a client's life (i.e., those occurring outside the treatment center). Such events assume special significance for people who are closely tied to their families of origin, as was earlier noted to be the case with the majority of drug abusers. Three areas, in particular, merit consideration.

The Family Life Cycle. A study of U.S. Army personnel who go absent without leave (AWOL) brings a different light to the issue. Hartnagel (1974) found that over half of AWOLs do not leave because they hate the Army. Rather, they are family problem solvers who go AWOL to correct family problems or to alleviate family-related financial difficulties. They go home to help. If they had a choice, they would rather be granted leave to go home, take care of business, and then return to their military duties.

It is the contention here that family problems (which, incidentally, are usually associated with family life-cycle events) can also provide motivation for drug abusers either to relapse or to abort treatment. For instance, there is evidence that onset of drug abuse and overdoses can be precipitated by family disruptions, stresses, and losses (Duncan 1978; Krueger 1981; Noone 1980). Further, the disruptions may not obviously involve the client directly, but may be of a more indirect nature (such as when his or her mother loses a boyfriend, or father loses a job). However, like the AWOL soldier, the drug abuser responds to the larger family crisis. Such a pattern is, of course, most likely to manifest itself with clients who are in residential programs and therefore physically less available to their family members.

The Family Addiction Cycle. Stanton and colleagues (1982) and others have noted a cyclical pattern in families of addicts in which, when the addict improves in some way, the parents begin to fight and to separate from each other. When the addict fails by taking drugs or losing a job, the parents come together around him or her; they involve themselves and each other with the addict's problems, thus becoming, in a sense, unified. In this way the addict's behavior serves a purpose of at least temporarily keeping the family together. Further, from this viewpoint, the drug-taking is simply one event within an interpersonal sequence of behavior; it is not an independent phenomenon occurring in a vacuum, but a response to a series of others' behaviors that precede (and succeed) it. That is the reason for the term "family addiction cycle."

Treatments that are not attuned to such sequences in a client's life put themselves at a disadvantage. They run the risk of being constantly mystified by onset and cessation of drug-taking. By not appreciating the plight of both the addict and his or her family members, they also risk losing their client's trust.

Triangulation. Some years ago Schwartzman and Bokos (1979) published a paper on a competitive process they observed taking place among drug treatment programs in a large city. Patients would appear at, say, program D requesting admission and complaining about treatment they had received at program C. The staff person at the new program would then commiserate with the client, disparage program C, and give assurance that no such problems would crop up at program D, where "we treat our clients right." Thus an interpersonal triangle would be established, with two of its parties (the client and program D) joined in opposition to the third (program C). This process has been termed "triangulation." It is common, to at least

some degree, in most interpersonal systems. (Schwartzman and Bokos also noted, incidentally, that in many cases the client would eventually become disenchanted with program D and would defect either back to program C or to a new program, thus setting up a new triangle and repeating the process.)

Likewise, staff in drug programs have been known to fall into the trap of triangulation vis-a-vis a client's parents or family members. This is a particular risk for individual-oriented approaches to therapy. Campbell (1992) performed a content analysis of therapists' writings regarding their patient's family members and found that 90 percent of the time family members were referred to in negative terms. In a description of an effort to expand their drug treatment program to be more inclusive of parents and families, Balaban and Melchionda (1979) reported that staff often got into awkward and destructive triangles in which they would compete with a client's family over the client—at times reaching the point of open disparagement of the parents or even fostering defection from the family.

When binds of this sort occur, they can put tremendous pressure on clients. Torn between their loyalties to parents or family members versus treatment staff, clients may choose an option that relieves the pressure: aborting treatment. For this reason, and with apologies to Hippocrates and grammarians, it may then be wise, when attempting to engage and retain drug abusers in treatment, to subscribe to the oath "First of all, do no triangulation."

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