1989

Family therapy and the treatment of alcoholism

Stephanie L. Lieder
University of Northern Iowa

Family therapy and the treatment of alcoholism

Abstract

The statistics relating to alcoholism indicate the seriousness of this problem within the United States. According to Kinney and Leaton (1983), an estimated 3.3 million adolescents between the ages of 14 and 17 years have serious drinking problems. Steinglass (1981) stated that nine million adults in our society either abused or were addicted to alcohol. The pervasiveness of this problem is demonstrated by Kinney and Leaton (1983) who estimated that "for every person with an alcohol problem, four family members are directly affected" (p. 25). These statistics have important ramifications for family therapy. Since family therapists generally work with two or more adults in conflict with each other or with their children, the likelihood is increasing that alcohol related issues will be of concern. Thus, the purpose of this paper is to present the important contribution family therapy can make in the treatment of alcoholism. The paper will be sub-divided into eight main sections: Overview of Systems Theory, Overview of Family Therapy Philosophy, Application of Family Therapy to Alcoholism, Family Therapy Goals and Treatment of Alcoholism, Role of the Therapist, Results/Efficacy of Family Therapy on Alcoholism, Methodological Limitations, and Research Implications. It is hoped that through the following overview and discussion, the important role of family therapy can be ascertained in the treatment of the family affected by alcoholism.

FAMILY THERAPY AND THE TREATMENT OF ALCOHOLISM

A Research Paper

Presented to

The Department of Educational Administration

and Counseling

University of Northern Iowa

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

---

by

Stephanie L. Lieder

August 1989

This research paper by: Stephanie L. Lieder

Entitled: FAMILY THERAPY AND THE TREATMENT OF ALCOHOLISM

has been approved as meeting the research paper requirement for the Degree of Master of Arts.

6-23-89
Date Approved

Ann Vernon
Adviser

June 23, 1989
Date Approved

Audrey L. Smith
Second Reader of Research Paper

June 26, 1989
Date Received

Dale R. Jackson
Head, Department of Educational Administration and Counseling

The statistics relating to alcoholism indicate the seriousness of this problem within the United States. According to Kinney and Leaton (1983), an estimated 3.3 million adolescents between the ages of 14 and 17 years have serious drinking problems. Steinglass (1981) stated that nine million adults in our society either abused or were addicted to alcohol. The pervasiveness of this problem is demonstrated by Kinney and Leaton (1983) who estimated that "for every person with an alcohol problem, four family members are directly affected" (p. 25). These statistics have important ramifications for family therapy. Since family therapists generally work with two or more adults in conflict with each other or with their children, the likelihood is increasing that alcohol related issues will be of concern. Thus, the purpose of this paper is to present the important contribution family therapy can make in the treatment of alcoholism. The paper will be sub-divided into eight main sections: Overview of Systems Theory, Overview of Family Therapy Philosophy, Application of Family Therapy to Alcoholism, Family Therapy Goals and Treatment of Alcoholism, Role of the Therapist, Results/Efficacy of Family Therapy on Alcoholism, Methodological Limitations, and Research Implications. It is hoped that through the following overview and discussion,

the important role of family therapy can be ascertained in the treatment of the family affected by alcoholism.

Overview of Systems Theory

Systems theory is rooted in the work of Von Bertalanffy and his general systems theory (Nichols, 1984). One of the basic concepts of systems theory is that the various parts of a system are interdependent and interrelated. In terms of the family, this means that individual members are involved in the behavior of the others, and thus one member cannot be viewed in isolation from the rest of the family system. The functioning of the family is not due to the sum of its members, but rather is the result of the dynamic interaction that occurs between them. This interaction is depicted as synchronous (not cause-effect), with a change in one family member affecting all family members simultaneously (Foley, 1984). This interaction within the family system is regulated by feedback, which Nichols (1984) defines as the input from family members or from the environment that is acted upon or modified by the family system.

According to Downs (1982), the concepts of homeostasis and interacting roles are also important to an understanding of family system interactions. The term homeostasis describes the family system's constant efforts to either achieve or maintain its equilibrium or balance in response to constant

demands for change. The methods employed by the family to achieve homeostasis are greatly influenced by the interacting roles each family member assumes within that family. These roles dictate the individual level and type of functioning of each family member and define and regulate the interchange among family members.

All these various forms of family interactions can best be understood in relation to the overarching concept of equifinality. Nichols (1984) defined equifinality as "the ongoing organization of the family" (p. 131) and Foley (1984) described it as "the system's form of self-perpetuation" (p. 135). In essence, these interactional processes are but means to an end, i.e., the maintenance and continuation of the family system.

Overview of Family Therapy Philosophy

According to Nichols (1984), "family therapy is both a method and an orientation: as an orientation it means understanding people in the context of significant emotional systems; as a method, it usually means working with whole families" (p. 53). This expanded scope of treatment constitutes a major shift from treating the individual in isolation from the family, to treating the entire family as the patient, the basic unit of pathology.

The philosophical orientation of family therapy has been summarized by Steinglass (1981) in the following six key concepts which are basic to all family therapy approaches:

1) Family as a system: Minuchin (1981) stated that the human family is a social system operating through transactional patterns. In family therapy, these transactional patterns are viewed as on-going, circular processes within family interactions and interrelationships, as opposed to the traditional view of human interaction being determined by prior events and by linear causality. Thus, family therapy deals with the process, or "how," rather than the content, or "what" of family interactions.

2) Homeostasis: This concept describes the regulatory mechanisms used by the family to maintain their stability/balance when faced with disruption or change. The primary mechanism used to maintain family homeostasis is the "feedback loop," a series of checks and balances made by family members to insure that the family stays at its prior level of functioning, i.e., the homeostatic level. According to Meeks and Kelly (1970), this homeostatic level is directly related to the family's rules, roles, resistance, and their established equilibrium.

3) Identified patient or scapegoat: In family therapy terms, the identified patient is symptomatic in direct relationship to his/her behavioral setting, and thus represents the entire family's symptom of dysfunction. Usually, the IP status is "agreed upon" by all family members and often serves a homeostatic function within the family.

4) Communication patterns: Both verbal and non-verbal communication are important reflections of the family's basic structural and interactional patterns that govern their behavior.

5) Behavioral context: The fundamental premise of family therapy is that people are a product of their social context (Nichols, 1984). Thus, family therapy focuses on the patterns of interaction between members within the context of their family setting.

6) Boundaries: This concept describes and defines the interactional fields between subgroups in the family and also between the family unit and society.

These core concepts provide the backdrop for understanding and dealing with the family's presenting problem, i.e., the symptom. "Common to all schools of family therapy is the belief that intimate relationship systems function to maintain symptoms" (Russell, Olson, Sprenkle, & Atilano, 1983, p. 3). A presenting problem can then be viewed as the family's current

way of solving their difficulty and thus this symptom takes on functional consequences within the system in order for the family to maintain homeostasis. It is important to note at this point, that while symptoms might be similar within various family systems, their function can be radically different, since they are based upon each family's separate dysfunctionality. Thus, family therapy generally looks beyond the obvious symptom in an effort to understand and address the system dynamics that support and perpetuate the symptom.

Application of Family Therapy to Alcoholism

Our western society's position in regard to the problem of alcoholism has not been static over the years. Originally, alcoholism was viewed as a normal and individual issue, to be dealt with by the judicial system (Kinney & Leaton, 1983). Later, it was adapted to the disease model, still viewed only as an individual issue, and dealt with by the medical profession (Kinney & Leaton, 1983). Currently, alcoholism is increasingly being viewed as a family issue, with family therapists dealing with disturbed communication patterns and structural dissonance within the family (Steinglass, 1981).

In 1968, Ewing and Fox made the first major attempt to synthesize family therapy and the study of alcoholism (Steinglass, 1981). Basically, this research argued that the alcoholic marriage exhibited a rigid marital quid pro

quo based upon each spouse's complementary needs in order to resist changes in behavior. (For instance, the alcoholic's passive, dependency needs encouraged and complemented the spouse's nurturing, protecting needs.) Based upon the Ewing/Fox study and other clinical evidence, Steinglass (1981) concluded that:

> alcoholism can no longer be seen purely in terms of intrapsychic dynamics.... It is the family emotional homeostasis which seems to perpetuate the drinking and it is this behavior which must be changed if the drinking is to be controlled. (p. 162)

Kaufman and Pattison (1981) concurred with this view of alcohol as a family systems problem. They stated that drinking behavior defines the psychodynamics of the family and that this alcohol use is purposeful, adaptive, homeostatic, and meaningful.

In his review of family therapy for alcoholics, Steinglass (1981) offered three major implications of family treatment in the field of alcoholism.

1) Redefinition of alcoholism: Historically, two major presuppositions have existed regarding alcoholism: (a) excessive drinking is maladaptive, and (b) ultimate causes exist to explain alcoholic progression. Family therapy refutes these beliefs and instead emphasizes the function of alcohol

ingestion and intoxicated behavior within family system interactions. In contrast to the maladaptive notion of alcoholism, family therapy focuses on the stabilizing or system maintenance function that intoxication serves. The presence or absence of alcohol can take on such a central position in the family that it can become an organizing principle of family interactions, creating what is called an alcoholic system. In clinical observational settings, Steinglass (1981) observed that family interactions during intoxication were actually highly patterned, predictable, and involved less uncertainty in comparison to the type of interactions previously predicted by the family during sobriety. Thus, while alcoholism may cause superficial disruption for the family, the more pervasive effect is one of stabilization and equilibrium.

The family therapy concept of circular causality addresses the second presupposition of ultimate causes of alcoholism. Within the alcoholic family system, linear cause and effect relationships cannot be established and thus the alcoholic cannot be blamed for creating the family's problems.

> Rather, it must be said that there is an interactive effect, meaning that the problematic family interaction and the behavior of the alcoholic are mutually potentiating and produce an increasingly negative,

destructive cycle of events in which the question of first cause becomes irrelevant. (Janzen, 1977, p. 127)

2) Redefinition of IP: Family therapy views the entire family as the identified patient, rather than individual family members. Therapeutic efforts are directed equally at both alcoholic and co-alcoholic interaction, with special emphasis placed upon the specific ways the family system makes use of the presenting symptom. Alcoholism is then redefined in terms of family issues, with drinking representing only one aspect of the family interactional process (Meeks & Kelly, 1970). Thus, instead of focusing upon the alcoholic for diagnosis, family therapy addresses issues of family structure, communication styles, and relationship systems (Steinglass, 1981).

Family relationships have proven to be a crucial variable within the alcoholism treatment setting. A functional family tends to be realistic, supportive and accommodating to the abstinent or changing alcoholic, while a dysfunctional family tends to compromise or sabotage any treatment gains made by the alcoholic. Thus, "treatment of the family as part of a total approach offers an opportunity for the addicted member and the family to take a new step, together or apart, with better understanding and less conflict" (Ziegler-Driscoll, 1981, p. 30). Of equal importance, the identification of the

whole family as the target of treatment allows the alcoholic to shed his/her label and have the chance to begin treatment on a more equal basis with the rest of the family.

3) Changing outcome goals: Traditionally, the treatment of alcoholism has been concerned only with the isolated behavior change of the alcoholic. Family therapy, however, focuses on alternative family outcome variables, such as improved communication, social functioning, extended family relationships, in conjunction with a reduction in drinking behavior. Whether family therapy is effective or not with the alcoholic, positive changes can nonetheless occur for the rest of the family. Of considerable importance in this regard, is the education of the co-alcoholics, helping them to have less guilt, enhanced self-esteem, and to learn more appropriate coping behaviors. The restructuring of parental roles can also have a very positive effect upon any children involved. Thus, a primary outcome goal of family therapy is for family members and the alcoholic to be actively involved in treatment and accompanying change in order for drinking to be successfully reduced while at the same time maintaining family structure (Steinglass, 1981).

In summary, involvement of the entire family system increases the chance of successful treatment of both the problematic drinking behavior and problematic family interactions. Thus,

> involvement of the family in treatment increases the awareness of both the alcoholic and other family members of problems other than alcoholism, such as relationship problems and the way they face reality. It reduces blaming tendencies, teaches new modes of interaction and permits a focus on a common goal. (Janzen, 1977, p. 122)

Family Therapy Goals and Treatment of Alcoholism

Based upon existing literature in the field of family therapy, the understanding and treatment of alcoholic families is no different from treatment of other families (Janzen, 1977). The task of therapy is consistent for all: namely to interrupt the disruptive cycle of interactive family behavior. This can only be accomplished by discovering and understanding the relationship between the alcoholism and the life of the family. Davis, Berenson, Steinglass, and Davis (1974) suggested a behavioral-adaptive model in order to assess the adaptive function the drinking behavior has for the family and to assess how the family reinforces the drinking behavior. Taking a slightly different angle, Russell, Olson, Sprenkle and Atilano (1983) concurred with the importance of identifying the relationship dynamics associated with specific presenting problems, but warned against

stereotyping symptoms with interactions. They stressed that since each family is unique in their interactional processes, similar symptoms will, by necessity, perform different functions. Thus, therapy must be formulated with specific family relationships in mind.

According to Pattison (1981), alcoholism is a behavioral problem that requires the unlearning of conditioned behaviors and the changing of social reinforcement patterns in order for treatment to be effective. This statement summarizes the broader goal of family therapy, although different family therapy approaches may vary slightly in their sub-goals. The goal of structural family therapy as Minuchin (1981) sees it is the attainment of new transactional modes of interaction, i.e., restructuring within the family system. For Ziegler-Driscoll (1981), the goal is healthier family interchange and improved marital dyad functioning. The stated goal in the Meeks and Kelly (1970) study is to help families communicate openly about areas of conflict and to mobilize their family strengths. Steinglass (1981) directed his attention to the restoration of communication, concentration on role conflicts, and removal of IP label and focus. In connection with this, Steinglass also sought to first establish the functional consequences of the alcoholic's behavior and then secondly, to help the alcoholic family system manifest

that functional behavior when sober. Davis, Berenson, Steinglass, and Davis (1974) operated from a similar treatment goal parameter, for having assessed the adaptive function of drinking for the family, they helped the alcoholic family manifest this adaptive behavior when sober, by helping them learn new behaviors. In summary, these various sub-goals all have a common denominator--the improved interactional processes within the family system for purposes of alleviating the presenting problem and improving overall family functioning.

Intervention into the family system for the purposes previously cited involves many levels of treatment. Therapy can be directed towards the needs of the family (spouse, siblings, individual), the education and enabling of positive social interaction, the problem-solving process, and the cooperation with community networks (AA, Al-Anon). Kaufman and Kaufman (1981) stated that "the wider therapy ranges into the individual's network in an adaptive way, the more likely the treatment will succeed" (p. 3). A number of family therapy writers have expressed the belief that treatment is most effective when family interactions can be altered, thus necessitating treatment interventions at the transactional level of family functioning (Nichols, 1984; Minuchin, 1981; Meeks & Kelly, 1970). For Minuchin (1981), this treatment

entails challenging family members' self perceptions, their experiences of reality, and their patterns of interaction. His techniques are goal-related as he seeks to explore the complementarity of family relationships.

Because family therapy cannot be identified by any one singular approach, Kaufman and Pattison (1981) have synthesized ten specific techniques from a variety of family therapy theoretical models which they believe to be important in treating the alcoholic family system.

1) Joining: At this initial stage, the counselor observes and tries to understand the family interactions in order to establish rapport and thus be allowed to enter the family's system of functioning. It is important at this stage that the therapeutic focus be upon all family members and that the counselor be regarded as each member's ally, supporting each one equally.

2) Therapeutic contract: This secondary phase is one of negotiation, relating to fees, family involvement, family expectations, mutually accepted goals, and proposed family responses to the alcoholic. It can be expected that family emotional reactivity towards the alcoholic will be high at this point. Thus, another important goal is to reduce the family's emotional pitch and have them instead focus on their mutually agreed upon decisions.

3) Task assignment: Within this stage, the counselor often assumes a more directive stance, by assigning certain tasks as homework to various family members in order to physically alter their transactional patterning process. It is crucial to bear in mind that whenever one behavior is terminated (or altered), another one must be substituted. For instance, a spouse who is overinvolved with the alcoholic could be assigned increased time with the children, thus reducing the amount of time devoted to the alcoholic.

4) Paradoxical directives: In essence, this technique involves directing the family to do the opposite of what they feel they are being pushed to do. In one respect, a crisis type situation is created, for the family is forced to make a decision regarding their own choice of behaviors. Thus, an alcoholic system might be encouraged to continue and even increase their overindulging of the alcoholic member instead of encouraging them to separate themselves as they know they should do.

5) Relabeling: According to Ziegler-Driscoll (1981), this concept is designed to help the family shift its focus from the alcohol abuser to the family system itself. Kaufman (1981) concurred, stating that "the presenting and crucial problem is always the substance abuse of the IP but it must be restated in an interactional form which renders it solvable"

(p. 268). Thus, relabeling seeks to restate the meaning of a symptom in order to offer a different perspective or alternative explanation of its function within the family. For example, within a strained marital situation, the alcoholic's excessive drinking could be relabeled as an attempt to preserve the marriage either by avoidance of communication or by dependency needs that are met by the spouse.

6) Interpretation: This technique may be helpful when the counselor is able to point out repetitive family interactions and their consequences to the family. Kaufman and Pattison (1981) recommended this technique cautiously however, and suggested that interpretations of family interactions are preferable to interpretations of individual behavior.

7) Reenactment: Central to family therapy is the belief that present family interactions are more revealing than descriptions of the past. The goal of reenactment is to observe family interactions as they occur, through various techniques of role playing, manipulation of space, family sculpture, etc. This can be especially powerful when working with an intoxicated alcoholic and family members. The session can be videotaped and later replayed when the alcoholic is sober, to provide an accurate depiction of the family's present level of functioning.

8) Boundary marking: This technique involves the defining, establishing and reinforcing of individual boundaries and responsibilities within the family. This realignment of roles is often necessary in the alcoholic system in order to reduce enmeshment/overinvolvement common in these families and thus to facilitate the individuation-separation process (Ziegler-Driscoll, 1981). Kaufman and Pattison (1981) stressed, however, that the alcoholic should be treated as an individual, separate from any existing stereotype, which discourages the family from making predictions or assumptions about the alcoholic that could reinforce the drinking behavior.

9) Education and teaching: In the early stages of treatment, the counselor may often serve as an educator, by informing the alcoholic and family members of the varying aspects of alcoholism. The counselor can also be a very important model for the family as she/he interacts within the family system, either in executive, supportive, or self-responsible capacities (Kaufman & Pattison, 1981).

10) Countertransference: In family therapy terms, this concept refers to the counselor's emotional reaction to the family within therapy. It is necessary for the counselor to be aware of how the family replays their problems within the therapeutic setting and it is crucial for the counselor to avoid becoming another co-alcoholic within the system

(Kaufman & Pattison, 1981). The counselor's emotional reaction can also interfere with what Foley (1984) calls the consolidation process or the family's transition from dependency upon the counselor to reliance on themselves to function properly. And finally, it is advisable for the counselor to be aware of her/his own attitudes regarding alcoholism since any negative attitudes can undermine therapy from the start.

According to Kaufman (1985), the first priority in treatment is to interrupt the pattern of alcohol abuse, even if only temporarily. If the alcoholic refuses treatment, a variety of therapeutic responses can be made. One response is the intervention technique in which a crisis situation or planned confrontation is created for the alcoholic by using a team of significant friends, associates, and family members. Detoxification centers before therapy and on-going support groups such as Alcoholics Anonymous (AA) and Al-Anon for aftercare are strongly suggested. If this intervention is unsuccessful, a second technique suggested by Berenson (1981) could be used for working with the rest of the family members. The essence of Berenson's therapy rests in his non-reactive stance towards the alcoholic system. He stated, "The fundamental principle is that one can never change anyone else: one can only create a context in which another person

is allowed the possibility of changing" (p. 239). Berenson's technique involves presenting the spouse with her/his choice of three impossible options, designed to precipitate a crisis within the system. The goal is for the spouse and family members to realize their powerlessness over the alcoholic, resulting in their detaching from the alcoholic, and thereby modifying and taking responsibility for their actions only. A third therapeutic response could be unilateral family therapy designed for situations in which the alcoholic is completely uncooperative (Thomas & Santa, 1982). This unilateral therapy is in the early stages of conception but basically focuses on the spouse as the mediator of change to induce sobriety.

In summary, family therapy treatment centers on two key issues: (a) the functional nature of alcoholism, and (b) the family interactions within the alcoholic system. The goals of family therapy are two-fold: (a) to improve interactional family functioning, and (b) to alleviate the necessity of the presenting problem.

Role of the Therapist

While family therapists may differ in their treatment approaches, most therapists themselves appear to be in basic agreement as to their involvement within the therapeutic relationship. Kaufman (1985) listed four therapist variables he believed were associated with successful treatment:

(a) empathy, (b) interpersonal functioning, (c) therapist's experience with method, and (d) a directive, forceful style. Minuchin (1981) describes the therapist as disengaged--the director and orchestrator of new family alliances and change. Pattison (1981) viewed the therapist as a catalyst, a system intervenor, and a social change agent. Meeks and Kelly (1970) promoted the therapist as an enabler of solutions and not the resolver of family problems. And finally, Berenson (1981) warned against therapeutic isomorphism (the replication of family interrelationships within the therapeutic setting) and the danger of the therapist becoming another co-alcoholic (Kaufman & Pattison, 1981).

Results/Efficacy of Family Therapy on Alcoholism

Any attempt to evaluate the success or failure of family therapy is extremely difficult, since methods of family therapy vary, as well as techniques within these specific methods (Kaufman, 1985). However, studies do indicate the advantages of involving the spouse and family of the alcoholic in treatment, both for the family and for the therapist. Whenever the family is involved in treatment, the chances for successful treatment outcome are increased, for both the subject and for the family (Ziegler-Driscoll, 1981). Thus, while it remains impossible to say that family therapy is a superior method of treatment, "there is sufficient evidence to suggest

that family treatment, either in conjunction with other forms of treatment, or by itself, can produce positive outcomes for both alcoholics and their families" (Janzen, 1977, p. 124).

Methodological Limitations of Family Therapy Research

The methodological limitations of family therapy research are many. One major limitation involves the sampling procedure used within existing family therapy studies. Most samples are extremely small in size, not subjected to any rigid criteria, often have no control group (Meeks & Kelly, 1970), typically focus on middle class to upper-class intact families, continue the bias of focusing on those families having a 40 year old white male alcoholic and an overinvolved spouse (Kaufman, 1985), and work with biased subjects, i.e., those already labeled as an IP.

Another major limitation of family therapy research involves procedure. Within many studies, no objective measures are taken regarding family functioning, no follow-up studies are done, and often therapist variables are very confounding, as in studies in which the therapist has been newly initiated to family therapy techniques (Steinglass, 1981; Kaufman, 1985). Also, many studies are either descriptive (Janzen, 1977) or exploratory (Meeks & Kelly, 1970) in nature, using no testable hypothesis.

A third major limitation of family therapy research involves inconclusive data and results. Because of the many and varied approaches within the scope of family treatment, it is difficult to generalize results to all family therapy. Of equal difficulty is the lack of consensus regarding (a) what contributes most to improvement (Janzen, 1977), and (b) what constitutes an acceptable goal, i.e., abstinence, reduced intake, improved family functioning, improved communication, etc. (Ziegler-Driscoll, 1981).

Research Implications

Due to the relatively recent emergence of family therapy upon the psychotherapeutic scene and due to the methodological limitations of existing family therapy research, the following suggestions have been made for further research. Meeks and Kelly (1970) proposed further investigation into (a) differing techniques for men and women alcoholics, (b) the ability of parents to include children in therapy when one parent is alcoholic, and (c) family therapy upon admission of the alcoholic, rather than as aftercare. Russell, Olson, Sprenkle, and Atilano (1983) suggested (a) pre-test and post-test measures of family interaction variables, and (b) studies related to outcome differential affected by family interaction changes or by spouse's involvement in therapy. And finally, Thomas and Santa (1982) urged (a) a determination of

appropriate conditions for the use of the unilateral approach, (b) specified treatment models for spouse and family of uncooperative alcoholic, and 3) evaluation of outcome of this approach for all family members, including nonparticipating alcoholics.

Summary

The existing statistics previously cited in this paper indicate the pervasiveness of alcoholism within our present day society. Therefore, there is increased likelihood that family therapists will be encountering alcohol-related issues as they work within families. Because of this, family therapists will not only need increased awareness and knowledge of the nature of alcoholism, but will also need to develop their own treatment philosophy of working with the alcoholic family system.

From this paper, it is evident that a variety of family therapy methods can be used in the treatment of the alcoholic family system. While no singular family therapy approach can be judged more effective than another, it appears to be generally accepted that whenever the entire family is involved in treatment, the chances for successful resolution of the presenting problem are improved. Thus, the alcoholic is not isolated from the family or regarded as the primary problem, but is instead viewed as one aspect of the larger problems

within the family system as a whole. While the family is in treatment, issues include the functional nature of the alcohol within the family and how the family interacts within this setting. Treatment goals include the alleviation of the presenting problem and the improvement of family interactional patterns. Thus, family therapy addresses the interrelationship/interdependence of the alcoholic and the family system, and can be helpful in assisting the family to develop new methods of interaction.

References

Berenson, D. (1981). The therapist's relationship with couples with an alcoholic member. In E. Kaufman & P. Kaufman (Eds.), Family therapy of drug and alcohol abuse (pp. 233-242). New York: Gardner.

Davis, D. I., Berenson, D., Steinglass, P., & Davis, S. (1974). The adaptive consequences of drinking. Psychiatry, 37, 209-215.

Downs, W. R. (1982). Alcoholism as a developing family crisis. Family Relations, 31, 5-12.

Foley, V. D. (1984). Alcoholism and couple counseling. In R. F. Stahmann & W. J. Hiebert (Eds.), Counseling in marital and sexual problems: A clinician's handbook (3rd ed.) (pp. 131-145). Lexington, Mass: Heath.

Janzen, C. (1977). Families in the treatment of alcoholism. Journal of Studies on Alcohol, 38(1), 114-130.

Kaufman, E. (1985). Family systems and family therapy of substance abuse: An overview of two decades of research and clinical experience. The International Journal of the Addictions, 20(6 & 7), 897-916.

Kaufman, E. (1981). The application of the basic principles of family therapy to the treatment of drug and alcohol abusers. In E. Kaufman & P. Kaufman (Eds.), Family therapy of drug and alcohol abuse (pp. 255-272). New York: Gardner.

Kaufman, E., & Kaufman, P. (1981). Introduction. In E. Kaufman & P. Kaufman (Eds.), Family therapy of drug and alcohol abuse (pp. 1-5). New York: Gardner.

Kaufman, E., & Pattison, E. M. (1981). Differential methods of family therapy in the treatment of alcoholism. Journal of Studies on Alcohol, 42(11), 951-971.

Kinney, J., & Leaton, G. (1983). Loosening the grip: A handbook of alcohol information (2nd ed.). St. Louis: Mosby.

Meeks, D. E., & Kelly, C. (1970). Family therapy with the families of recovering alcoholics. Quarterly Journal of Studies on Alcohol, 31, 399-413.

Minuchin, S. (1981). Constructing a therapeutic reality. In E. Kaufman & P. Kaufman (Eds.), Family therapy of drug and alcohol abuse (pp. 5-18). New York: Gardner.

Nichols, M. P. (1984). Family therapy: Concepts and methods. New York: Gardner.

Pattison, E. M. (1981). Forward. In E. Kaufman & P. Kaufman (Eds.), Family therapy of drug and alcohol abuse (pp. ix-xi). New York: Gardner.

Russell, C. S., Olson, D. H., Sprenkle, D. H., & Atilano, R. B. (1983). From family symptom to family system: Review of family therapy research. The American Journal of Family Therapy, 11(3), 3-14.

Stanton, M. D. (1979). Family treatment approaches to drug abuse problems: A review. Family Process, 18, 251-280.

Steinglass, P. (1981). Family therapy with alcoholics: A review. In E. Kaufman & P. Kaufman (Eds.), Family therapy of drug and alcohol abuse (pp. 147-186). New York: Gardner.

Straussner, S., Weinstein, D., & Hernandez, R. (1979). Effects of alcoholism on the family system. Health and Social Work, 4(4), 112-127.

Thomas, E. J., & Santa, C. A. (1982). Unilateral family therapy for alcohol abuse: A working conception. The American Journal of Family Therapy, 10(3), 49-58.

Ziegler-Driscoll, G. (1981). The similarities in families of drug dependents and alcoholics. In E. Kaufman & P. Kaufman (Eds.), Family therapy of drug and alcohol abuse (pp. 19-39). New York: Gardner.