Working Effectively with Families in Recovery.

Introduction:

During the last four years the concept of Recovery expounded by W W. White, (ref 1 and 2), has moved from a concept of addictions that focuses on highly variable and complex outcomes where the personal choice and responsibility of the addict is paramount, to an often simplistic debate between professionals about abstinence models v's maintenance or vice versa. This not only reduces the sophistication of the concept but also paradoxically shifts the focus from the addict to the treatment intervention or treatment ideology, implying that whatever the type of intervention, an often comparatively brief episode of treatment has enormous influence over the addictive lifestyle.

Despite the fact that Stanton (ref 3) demonstrated convincingly in the 1990's that most addicts have relationships with other people who they spend a significant amount of time with, this aspect of the addicts life seems to be largely ignored. Stanton and Haley (4) also highlighted that such relationships are capable of supporting change or reinforcing the continuation of addictive patterns. Families affected by addiction have a highly complex set of beliefs, needs and wants which not only are they often, frequently ignored they are often reduced to a simple focus on the families relationship to the addicts behaviour or drug use.

The recent Drug Strategy consultation document (5) is an ideal example of this reductionism with a question focusing on the recovery capital of the family, not by focusing on the wonderful abilities, capacities and desires that resides in families but by concentrating on what families can do to assist the addicts path towards the addicts recovery.

For anyone who has effectively worked with families in the addiction field, this seems an extremely limited approach. When asking a family what does recovery or meaningful change mean to them, there will be a range of different outcomes desired. Many of these may not focus on the addict or the addiction.

This paper seeks to argue that only by focusing on the myriad of outcomes and strategies identified by family members are we likely to harness the full recovery capital of families, helping families achieve their self-defined set of required outcomes but also assisting the addict's journey to their own recovery.

Fundamental to this discussion is that families can be powerful instruments of change and that the professional is simply a facilitator in helping such change exist. In this way the true meaning of recovery can be reclaimed. Namely a sense of hope and expectation that a family can make personal choices and take responsibility to achieve and maintain the outcomes that individual members strive for, in order to make the family a happier, healthier and more meaningful system to reside in.

We aim to do this by beginning a dialogue that starts to attempt to answer four important questions: How does understanding what happens in families assist in the process of recovery? What can be gained from questioning, "taken for granted" professional assumptions of the problem? How do practitioners turn understanding into action towards recovery? And finally what is the minimum a competent family practitioner should be doing?

How does understanding what happens in families assist in the process of recovery?

It is imperative that the family practitioner understands what all the individuals within families believe and how this belief influences each individuals patterns of behaviour. For example, some families have painful patterns of behaviour because they are entirely organised around the behaviour of the addict, whilst other families may have such painful family patterns that substance misuse is the only way some members can manage family relationships. In many cases addictive behaviour is so chronic and painful it is impossible to identify causal patterns. In other families drug use by the identified addict may in fact be less frequent and even less problematic than other members of the family not identified. In many families these beliefs may be the result of behaviours by family members, two or three generations in the past.

All of these patterns will influence the way the family will respond to changes in the addict or other families behaviour. Take a simple example: A family organised around an addict's behaviour may find that abstinence or stabilisation has an immediate effect on reducing painful family behaviours. This will need to be consolidated by all members of the family changing behaviours behaviour in order to support the new family order. However where substance use arises as a form of self medication due to painful family patterns , the change in the addict, may bring to the forefront the painful family behaviours perhaps once again putting pressure on the identified addict to take back the need to organise the family around his or her addiction in order to protect themselves.

Understanding of these beliefs does not occur always in the first session or during the assessment stage but the practitioner and the family become aware through the continuous reflection of statements and consequent actions by family. The advantage for the practitioner is that they are a new visitor to the patterns of the family and therefore can point out the difference between statements and actions within the family by asking reflective questions such as: "When we last met every member of the family stated that life would be better if A stopped drinking. Yet A, has stopped drinking but the pain in your lives seems not to have changed, what else needs to happen to other members of the family in order to reduce this pain?" Such questions enable the family to focus on other behaviours, besides the addicts, that need to change in order for the family to adapt. Often the above question allows the addict to contribute to ideas about family members behaviours immediately moving them from the role of victim that addicts are frequently given in family contexts.

The practitioner, by asking such questions, can help the family understand how beliefs within the family can change in order to allow family patterns to change. A simple example: Mrs B attended sessions with her husband. She believed he was not an alcoholic but every Friday he came back from work intoxicated and they then had a furious although non violent row. Mr B argued that he liked a drink on a Friday night but that he was rarely intoxicated. The 16 year old daughter indicated that although his drinking seemed to have got worse over the past 6 months he was rarely drunk. She suggested that her mother went to see friends on a Friday night rather than sit waiting anxiously for her husband to return intoxicated. This in fact was the coping strategy adopted by the daughter. The mother agreed to this and the father agreed to go out with his wife without friends during the week, although no mention was made about him cutting down his drinking. After a month mum had stopped going out on a Friday because the rows had stopped and husband was coming home earlier each Friday. He admitted that as the arguments had got worse on a Friday he had started staying out later to avoid coming home. During further family discussions mum revealed that every Friday night when she was a child her father had got drunk and beat her mum and the children. She believed that this anxiety had persisted into her marriage. Family discussions identified other areas where her father's abusive behaviour still influenced her relationships but also in voicing this in front of her husband he started to talk about how he often ignored the importance of some of her comments. He then identified ways that he could demonstrate that he was listening to his wife and also gave her permission to tell him when he was making her anxious. For example he came from a very voluble family who argued loudly and had always dismissed his wife's anxieties about his argumentative nature.

What practitioners can gain by questioning, "Taken for granted professional assumptions "?

Questioning the family's beliefs is only one part of the investigation stage. In the addictions field there are some extremely concrete beliefs held by society, professionals and also family members that will also influence the way behaviours are regarded. By examining their own and other professionals attitudes to a family, family practitioners', may provide an opportunity to explore new ways of working rather than reinforcing labels and judgements that frequently freeze and incapacitate families rather than move them on.

Mr and Mrs C were in their late 50's. Their son Z was 35 and had been in treatment for alcoholism for 12 years. Mr and Mrs C were referred for family interventions because Mrs C was co-dependent and could not understand the concept of "tough love", thereby constantly rescuing her son and not allowing him to take responsibility for his drinking or to become independent. During the first interview without Z, both parents described how painful their lives were and also how guilty they felt because everyone told them to let go and yet they couldn't. In the second interview, with son Z present, the family discussed love and nurturance between parents and children,

eventually acknowledging that responsible parents allowed children to develop and leave the nest. Son Z also described how easy it was to relapse knowing that his parents would eventually come through and rescue him. When mum was asked, what an outsider would make of Z's comment, she replied by stating that he was not being given an opportunity to leave the nest. After further discussion Z was asked to write a letter explaining what he wanted his parents to do if he relapsed once he had left his parents home. This would have been ideal, but Z refused because it was a step too far, but he did allow the practitioner to summarise what he wanted. After this session Z left the family home to his own flat, relapsed many times with his parents remaining supportive but non interventionist. Z attained a recovering lifestyle through AA involvement with the parents receiving monthly, bi-monthly and then 6 monthly sessions over a 3 year period from family services.

How do practitioners turn understanding, into action towards recovery?

Identifying some common addictive patterns can be helpful in understanding what is happening in families. This will not provide answers because families will need to find their own solutions which may be different to those adopted by other families or even the practitioner. However what they can provide is an insight for the family and sometimes a set of more useful questions for the family to consider. Again this description of interventions in an introductory paper is only scratching the surface of the range of possible interventions and is provided simply to begin the dialogue.

For an intervention to be successful it usually requires all members of the family to change and adapt. In this sense members will not only have different expectations of what a successful family intervention means, but success will occur at different times for different members. This may mean that family members may have to change their goals in order to accommodate other member's reactions to changing circumstances. Reviewing how all family members are living with the changes occurring in families needs to be voiced in every session to ensure that the stated outcomes for family members are actually what they want. Through group reflection the family becomes mutually supportive which in itself may remove the addict from central stage.

The practitioner has an expectation that the majority of recovery activity happens between, rather than in, sessions. Therefore a family intervention must be based on the expectation of change which can be observed and reviewed through changing behaviours. Such change need not necessarily be substance focused. For example a person on a long term stabilisation programme could be asked by a family practitioner the following question: " If you become stabilised on methadone what would other family members see you doing differently?". This could be done on a very short term basis, medium and long term. Of course other family members would need to be asked follow up questions such as " Now that A is stabilised and has started doing X, how will that affect you, what will you now be doing differently, how will that affect A?" and so the questions can go on.

The importance is that the questions may arise out of an understanding about family beliefs but they are all couched in terms of behaviour not concepts, ideas or belief's.

Recovery in this sense transcends discussions about substances, disease, cure or "car parking", it's about the need for individuals within their family relationships to continually change and adapt to others change. This will happen long after family interventions have finished. However, the skilled practitioner will have provided a framework for family members to regularly review and reflect on their activities either as an individual or in terms of their relationship.

What is the minimum a competent family practitioner should be doing?

We hope that this paper has started a discussion about the power of families to initiate, stimulate and consolidate change. Family dynamics are powerful not only to create change but also to maintain hubris. Throughout our experience as observers of ourselves and other family practitioners we have become very aware of the danger of family practitioners becoming collusive with family dynamics and becoming part of the family problem making change even more difficult.

For this reason alone regular supervision from a family therapist with knowledge of addictions is imperative. Such supervision should be consistent with standards identified by the UKCPP and the BAC (6&7).

In addition, family practitioners need to be ambitious for their clients, expecting change to occur, allowing families to discover their own solutions rather than to provide answers themselves. They must also be able to assist families to become reflective and aware of family resilience, strengths and successes. Such an approach also requires good professional supervision but also requires good care planning skills. Each session a recap about what has been achieved since the last session, what these changes mean for each family member what each family member hopes to achieve before the next session and how they know this will be acknowledged, has to take place. It is also essential that the practitioner recognises their role - as an expert in identifying open and reflective questions that change the actions and the perceptions of family members. The experts in developing family or individual solutions are the family members themselves. When practitioners find themselves doing this or, indeed, doing most of the talking it is likely the engagement of family members has hopefully temporarily diminished. Again, another reason for quality supervision.

Review and Conclusion:

This paper started with the concept of Recovery in the context of families and ended with a description of good practice based on good care planning. We hope that this paper has started a process that places discussions about recovery especially within the family context as a debate based on outcomes and definitions of success that are relevant for all family members. That the essence of recovery is one of hope,

ongoing change, and ambition based not on organisational, political or professional expectations but on family expectations.

The role of the practitioner is that of facilitator who, through good care planning, encourages family members to review their expectations in line with the changing behaviour of themselves and other family members in the time between sessions.

Most importantly though, is that family work cannot be conceptualised as a one dimensional aid that contributes to addicts recovery, (see ref 5 & 8) but is an intervention that focuses a range of needs, beliefs and actions in the family that the addict relates to.

References:

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