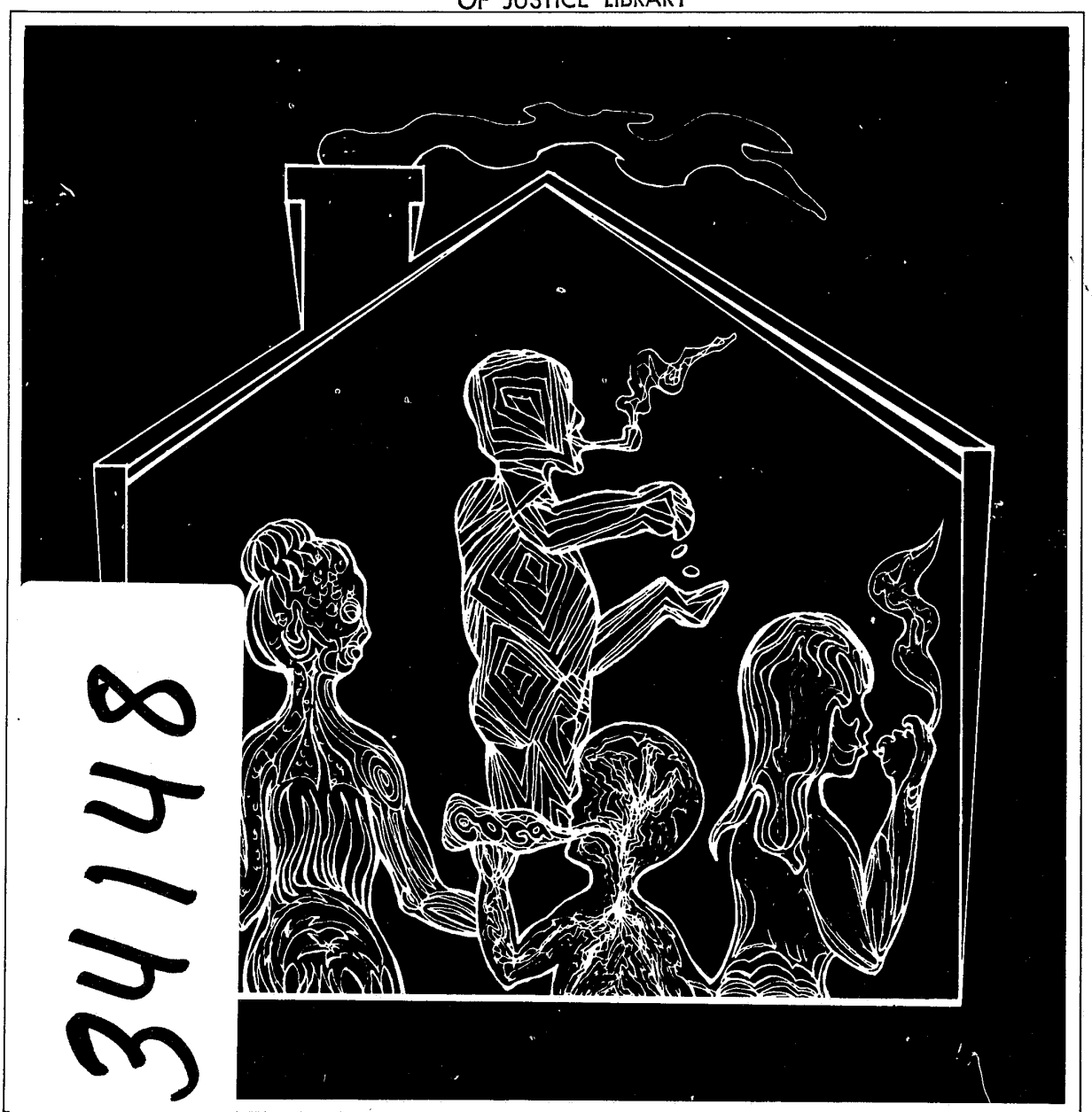
Research Issues 2

DRUGS AND THE FAMILY

National Institute on Drug Abuse



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

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DRUGS AND THE FAMILY

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Rockville, Maryland 20857 1981

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Foreword

The critical issues involved in drug use and abuse have generated many volumes analyzing the "problem" and suggesting "solutions." Research has been conducted in many disciplines and from many different points of view. The need to bring together and make accessible the results of these research investigations is becoming increasingly important. The Research Issues Series is intended to aid investigators by collecting, summarizing, and disseminating this large and disparate body of literature. The focus of this series is on critical problems in the field. The topic of each volume is chosen because it represents a challenging issue of current interest to the research community. As additional issues are identified, relevant research will be published as part of the series.

Many of the volumes in the series are reference summaries of major empirical research and theoretical studies of the last 15 years. These summaries are compiled to provide the reader with the purpose, methodology, findings, and conclusions of the studies in given topic areas. Other volumes are original resource handbooks designed to assist drug researchers. These resource works vary considerably in their topics and contents, but each addresses virtually unexplored areas that have received little attention from the research world.

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Preface

The goal of this volume is to provide researchers with an up-to-date survey of the literature concerning drugs and the family. This is the second volume in the Research Issues Series dealing with the role of the family in the drug use of one or more of its members. The first volume, Drugs and Family/Peer Influence, edited by Ferguson, Lennox, and Lettieri and published in 1975, was the fourth issue in the series. That volume was at the cutting edge of what has become a major focus of study among drug researchers. In 1974, when the literature search for the first volume was conducted, less than 40 articles and books were selected for inclusion in the volume, with an equally small supplementary bibliography. Six years later, during the 1980 literature search for this volume, over 400 articles and books were considered for inclusion.

The current volume is not intended to replace the earlier one but, rather, to supplement and update it. Thus, only three abstracts from Drugs and Family/Peer Influence are included in this volume. Each abstract is intended to be a faithful representation of the original study, conveying what was done, why it was done, what methodology was employed, what results were found, and what conclusions were derived from the results.

Drugs and the Family addresses the issue of what role the family may play in the prevention, initiation, maintenance, treatment, and/or cessation of drug use by one or more of its members. Although journal articles are clearly in the majority of the items selected for inclusion, abstracts of several pertinent books and book chapters are also presented. All the articles, chapters, and books selected for inclusion were chosen on the basis of the following general criteria:

- Empirical research studies with findings pertinent to the particular topic, or major reviews of theoretical approaches to the study of that topic.
- Published between January 1970 and the present, preferably in the professional literature, with the exception of certain older "classics" that merited inclusion.
- Not previously included in the Research Issues Series (with a few exceptions).
- Representative of the many social, psychological, and medical facets on the drug/family field.
- English language, with a focus on American drug issues.

The material chosen and abstracted on the basis of these criteria is thus intended to be a collection (in conjunction with Research Issues Series Volume 4) of the most representative, significant research and theory on drugs and the family published in the recent past. One area not focused upon here, but being considered for a future volume in the series, is family/drug research methodology.

The volume itself is divided into five topic areas:

Theoretical Issues
Research Reviews
Family Dynamics
Adolescents and Adolescent/Parent Relationships
Family Treatment Approaches

These divisions were considered the most logical categories within which present research could be classified. While a number of studies dealt with a variety of topics, each was classified according to major purpose and focus. The abstracts are arranged alphabetically within each section.

An extensive supplementary bibliography of additional reading is included at the end of the volume. Several indexes designed to meet the needs and interests of drug researchers are also provided.

An extensive and comprehensive literature search was carried out to identify materials for inclusion in this volume. Major clearinghouses, data bases, library collections, and special bibliographies were searched. A major resource, abstracted in this volume, was M. Duncan Stanton's comprehensive 1978 listing of the literature in this field ("The Family and Drug Misuse: A Bibliography." American Journal of Drug and Alcohol Abuse, 5(2):151-170, 1978). Also, numerous articles, chapters, and books were nominated for inclusion by NIDA's peer review group.

After a first review of citations and annotations, to weed out obviously irrelevant materials, the body of collected literature was subjected to two reviews: one to ensure that materials met the selection criteria; and a second, carried out by a peer review group, to ensure that studies representative of the universe were included. Each completed abstract was subsequently reviewed to ensure that it accurately reflected the contents of the study.

The talents and contributions of many individuals made this volume possible. Dr. Duke Stanton gave most generously of his time to provide suggestions and critical comments on the final selection of articles. Dr. Richard Clayton provided brief summaries of the material considered for inclusion.

Researchers who served on the peer review panel provided critical input in the selection of the articles and studies.

Peer Review Group

Richard H. Blum, Ph.D.
Richard R. Clayton, Ph.D.
Sandra B. Coleman, Ph.D.
David J. Huberty, M.S.W.
Edward Kaufman, M.D.
M. Duncan Stanton, Ph.D.

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Introduction

Research concerning the family and drugs has encountered a number of obstacles in the past. As the nature of these obstacles becomes less opaque, not only are creative means of overcoming them being developed but a more focused direction for the field may also be emerging. The comments below address these issues, building upon Stanton's (1979a) review of the literature and on Clayton's (1979) critical assessment and reevaluation of the Federal role in supporting the research on which much of this literature is based.

BACKGROUND

In 1974 Urie Bronfenbrenner published a prophetic article analyzing the growing estrangement between young people and adults in this country. He suggested that the roots of this estrangement lay in the evolutionary changes that were, and are, taking place in the American family. He cited numerous societywide trends fueling these changes. Among the trends he identified were the fragmentation of the extended family, dual-worker families, separate patterns of social life for different age groups, the delegation of child care to specialists, and the breakdown of neighborhoods.

In 1980, two (among many) concurrent national processes mirrored and extended Bronfenbrenner's concerns. One of these was the White House Conference on the Family and the other, targeted specifically to drug use, was the formation of the National Federation of Parents for Drug Free Youth.

White House Conference on the Family (WHCF)

During the winter of 1979-1980, planners for the WHCF sponsored forums throughout the country in order to give citizens the opportunity to express their concerns about the status of the family in the United States today. The over 100,000 contributors to these forums were not specially selected or elected but were individuals who chose of their own accord to attend and address issues of importance to them. The more prominent concerns and issues raised included the perceived insensitivity of the Federal Government to family life as reflected in the tax structure, health care, economic approaches and other Government policies, the availability and cost of day care, the relationship between work and family settings, parenting issues, and the impact of community institutions on the family. These and other issues formed the basis for discussions at the WHCF held in the summer of 1980. Strikingly, the issue on which there was the greatest consensus at these meetings concerned the need for a national effort to involve the family in the prevention and treatment of youthful drug use (WHCF 1980).

National Federation of Parents for Drug Free Youth (NFP)

The NFP, which provides a vehicle for more than 1,000 parent groups to share experiences and information, was formed in early 1980 as an attempt to give coherence to the grassroots parent groups that have been forming in response to increases in adolescent drug use. The interests of the NFP, although limited to the context of youthful drug use, include the impact of Government policies on the family, parenting issues, the effect of parental work patterns on children's behavior, the impact of community- and neighborhood-level social and economic policies on youths, and the role of education in strengthening families. This group, while petitioning the Federal Government for support and action, has pledged its cooperation and assistance in those actions the Government may take which attempt to curb youthful drug use through the family (Boin 1980).

As can be seen in the issues raised by both the WHCF and NFP, the themes developed by Bronfenbrenner in 1974 now appear to be of considerable concern to a growing number of people. The very breadth of the population expressing these concerns may have profound implications for future research in the family area. Until now, research in this area has been conducted by an informal coalition of funding agencies, institutions, foundations, and researchers in the field. The funding groups, with the aid of the scientific community, identified priorities and areas of interest, and the researchers have responded with well-conceived and well-conducted research. Now, however, a third element has been added to this coalition--the ultimate consumers of this research, the families themselves.

It is reasonable to speculate that neither the WHCF nor the NFP would have reached the conclusions they have reached if they felt past research had been responsive to the issues they are now raising. The legitimate concerns of these and similar groups, if not the enormous potential political power they represent, strongly suggest that funders and researchers should consider them and their ideas in the research planning process. Not to do so, to continue solely in the "science knows best" mode, may very well cause family researchers to run the dual risk of alienating their most vital constituency and proceeding on a research course that is perceived to be responsive primarily to their own needs and not those of their ultimate consumers. Nevertheless, until rather recently a number of obstacles have made research in this area difficult to carry out.

PREVIOUS OBSTACLES TO RESEARCH ON DRUGS AND THE FAMILY

There is now little argument that drug use not only takes place in the context of the family but that the family is heavily implicated in the initiation, maintenance, cessation, and prevention of drug use (e.g., see Seldin 1972; Harbin and Maziar 1975; Stanton 1979a). While this realization has certainly been accompanied by research in this area, as attested to by this volume, the amount and breadth of this research has only recently begun to be commensurate with the importance and implications the role of the family appears to have in drug-using behavior. A number of obstacles that may have retarded growth in this research area are considered below.

Emphasis of Research on Opiate Use

Clayton (1979) points out that until quite recently drug abuse, at least at the Federal level, has tended to be defined as opiate (and especially heroin) abuse. Researchers appear to have largely accepted this limited definition and responded with research focusing on heroin addiction and its most visible concomitants such as criminality, health effects, treatment costs, and the subcultural lifestyle in which the addict finds himself or herself. Since most research either studied addicts in treatment (where families were seldom included) or on the street (where families were absent), it was seldom possible for the researcher to view the familial context in which the heroin use may have begun or was being maintained. Making the problem more complex, as Clayton observes, was the prevalence of the notion that the addicts' life activities are solely devoted to drugs and the drug culture, leaving no opportunity for him or her to develop and maintain primary cultural relationships such as those involved in family life or parenthood.

Preference for Individual Approaches

A second obstacle to family-oriented research concerning drug use is, again, underscored by Clayton (1979). Drug abuse, he notes, has generally been considered to be a medical problem. This, in turn, has led to drug use being studied in the context of a medical model and its emphasis on the individual. Compounding this is the substantial role that psychology and its traditional emphasis on the individual has played in drug abuse research.

These two approaches to the study of drug use, the medical and the psychological, do not have traditions of investigating either the etiology or the current status of the abuser in a family context. Medical research, such as that carried out at the Federal facilities in Fort Worth and Lexington, has studied addicts who are physically removed from their families. Psychological research has also focused on abusers in treatment situations (which, until quite recently, included no families), thereby eliminating the context of the development of drug-using behavior from anything but retrospective study.

Closely related to this argument is Blum's (1980) description of ". . . the current culture of government science research: medical, prestigious, reductionist, hard, molecular" (p. 110). Blum quite correctly points out that research concerning the family and drugs would not be described by any of these terms. While the Federal Government does not dictate research priorities, its role as a principal funding source for scientific research in this country certainly gives it a predominant role in the setting of such priorities. The perceived (if not actual) preeminence of Blum's descriptors of Government research priorities has not substantially encouraged investigators to undertake studies in this area.

Clash of Values and Practicality

Until recently, there may have been some feeling that to seriously implicate the family in the drug use of one or more of its members was to attack the institution itself. Our society is able to acknowledge the origin of some problems within the family (e.g., poor health habits or learning difficulties) but drug abuse may have been viewed as behavior that is too objectionable to be attributed to the family in any way. Rather than risk the opprobrium that would accompany such an implication, researchers may, consciously or unconsciously, have chosen to mirror or bolster societal values by protecting the family from such research questions.

Methodological Hindrances

Any study that aims to focus on the family in any significant way must employ a sophisticated, multivariate methodology. Such sophistication is not a conceit of the field but is, rather, a necessity if the interactive effect of family members' behavior and the multiple, concurrent roles each family member plays as well as other complex research issues are to be adequately addressed. Until recently (e.g., Bentler et al. 1976; Bentler 1980), researchers in the drug field did not bring such methodology to their studies since, as discussed above, most studies focused on the individual and thus required a different set of approaches. Also, in many cases it is only during the past several years that instruments and analysis methods applicable to family and drug research have been available and widely accepted.

Lack of a Constituency

Many areas of research appear to have either a natural or a developed constituency. Most aspects of educational research, for example, enjoy the support of both consumers (e.g., parents) and researchers; research in heart disease is widely supported by both the public and researchers in the numerous fields whose expertise is applicable to this problem. Research with families and drugs, however, has been tendered comparatively little support by either researchers or the public until recently.

Consumer support for such research has been lacking for several reasons. First, it is only in the last decade that there has been any significant consciousness-raising concerning the hypothesized role of the family in drug-using behavior. Second, even where such consciousness-raising may have taken place, the idea that the family might be implicated in this behavior was repugnant and unpopular enough to essentially discourage significant research. Finally, and related to the second reason, it is only in the past several years that the public has become concerned about the widespread use of legal and illegal substances by youths. When the definition of drug abuse was considered to cover only opiate users, most families could look the other way. However, when marijuana, amphetamines, barbiturates, alcohol, and other substances are being used by adolescents and even preadolescents, most families, even if they do not take primary responsibility for their children's behavior, realize that they may be intimately involved in this behavior.

Need for an Evolutionary Period

Jay Haley (1971) has wryly observed that it was not until the late 1940s that therapists working with children who were diagnosed as schizophrenic discovered that these children had mothers, and not until the 1950s that their fathers were discovered. These "discoveries," he noted, contributed heavily to the widespread adoption of family therapy in the past quarter century. It is thus reasonable to suggest that, through the utilization of family therapy (e.g., Stanton 1979b), the basis for research concerning families and drugs has developed.

There is apparently no landmark event or study that initiated the idea of including the families of drug abusers in treatment or research. Prior to 1970, there was little encouragement for this notion; however, some practitioners had begun to consider applying the findings of other mental health fields that used family therapy to the field of drug abuse.

Hirsch, for example, advocated group therapy with the parents of adolescent addicts as early as 1961. He cited several studies that described the often disturbed nature of the relationship between an addict and his or her parents. Additionally, his own experience suggested that the behavior of an addict's parents had a significant effect on the child's "choice of symptom," namely, the abuse of drugs.

Hirsch reported that the parents and the adolescent were seen separately in therapy; while this is not the pattern of family therapy practiced most often now, it represents a significant step. Hirsch did not proclaim a new day in the treatment of drug abuse on the basis of this work, but he did note that applying family therapy to drug abuse problems appeared to be clinically sound and deserving of further clinical investigation.

Stronger support for this notion was offered by Ganger and Shugart (1966), based on their family therapy sessions with over 100 male addicts. They concluded that treatment of addiction could not be conducted successfully outside the context of the family unit. They referred to addiction as "a familiogenic disease," suggested "treatment of the addict within his family should constitute the treatment of choice," and recommended extensive clinical investigations on the effectiveness of this technique with drug-abusing populations.

By the beginning of the 1970s, enthusiasm about family therapy began to grow in the field of drug abuse. Although this increasing interest seldom included an adequate research component, it did provide support for practitioners who believed that new techniques were needed to deal with drug abuse, particularly in light of the burgeoning public focus on the problem. Data from a recent national survey indicate that family therapy is provided in numerous drug abuse treatment programs across the Nation (Basen 1977; Coleman 1976) and both Stanton's (1978) bibliographical listing of the literature and the large amount of research considered for inclusion in this volume also suggest that interest in this field has significantly increased.

These patterns suggest, then, that just as there was a necessary developmental period for family research in the schizophrenia field, there has been a similar period of evolutionary development in the drug field. If the schizophrenia research pattern continues to unfold in a similar manner in the drug field, it would be reasonable to expect that family-oriented drug research will not only be treatment focused but will also continue to branch out into other areas of study, such as research including families that appear to be "invulnerable" to drug abuse or research involving basic etiological investigations.

CONCLUSIONS

As seen above, it is quite possible to observe a conflicting course for past research in the area of the family and drugs. On the one hand, consumer interest in the direction and results of this research has grown in recent years. On the other hand, a number of obstacles have, until recently, impeded the free growth of research in this area. These obstacles, whether philosophical, bureaucratic, value-laden, or methodological in nature, may, nevertheless, be a necessary element in any area of research. Kuhn (1970), discussing the nature of scientific advances, speculates that no field can produce contemporarily influential theory and research until it is in tune with the Zeitgeist. While science certainly plays a role in influencing any culture, it rarely controls it. Consequently, most theory and research must develop and nurture its acceptance over a period of time. When such theory and research have reached a state of relative consonance with the Zeitgeist, obstacles that have previously seemed insurmountable will tend to dissipate. There are indications that theory and research concerning drugs and the family have begun to achieve that consonance. The interests of the White House Conference and the National Federation of Parents, the increasing governmental interest in viewing drug abuse from a family perspective, and the significant and growing literature base as represented in this volume point to a powerful push from within the research field and a concomitant pull from the consumers of that research. These indicators suggest that philosophies, values, methodologies, and even bureaucracies, which may have previously been obstacles, may now be contributing to the emerging acceptance of the family and drug field as both a legitimate and essential area of research.

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Blum, R.H. An argument for family research. In: National Institute on Drug Abuse. Drug Abuse From the Family Perspective, Ellis, B.G., ed. DHHS Pub. No. (ADM) 80-910. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1980. Pp. 104-116.

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Stanton, M.D. The family and drug misuse: A bibliography. American Journal of Drug and Alcohol Abuse, 5:151-170, 1978.

White House Conference on Families. A Summary: Listening to America's Families. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1980.

THEORETICAL ISSUES

As interest and research in the interaction of families and drug use have grown, so also have the theoretical issues and perspectives that seek to explain it. The literature represented in this section not only addresses explanatory theories and concepts, but also theoretical perspectives on research, ethical, and policy issues.

Auerswald, E.H. Drug use and families--in the context of twentieth century science. In: National Institute on Drug Abuse. Drug Abuse From the Family Perspective, Ellis, B.G., ed. DHHS Pub. No. 80-910. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1980. Pp. 117-126.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Cross-cultural
GEOGRAPHICAL AREA	Cross-sectional
METHODOLOGY	Theoretical/critical review
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	1959 to date of article
NO. OF REFERENCES	None

PURPOSE

The argument is made that the problem of drug abuse should be attacked not by developing drug abuse programs but by lending support to family life.

METHODOLOGY

The author relies on his own impressions and experiences rather than on data collected according to the empirical standards guiding his colleagues. The interpretation of data is given within what the author calls Einsteinian reality: In Einsteinian reality, as opposed to Newtonian reality, space and time are not separated. The universe consists of expanding, contracting, interrelated phenomena. Data consist of descriptions of phenomenological relationships, and data analysis is also relational. The data the author presents are in the form of heuristic vignettes. In time, they range from 1965 to the present; in place, they range from the New Haven Railroad to New York City, to Greenwich, Connecticut, to Maui, Hawaii.

RESULTS

The author's experience in observing families, both professionally and informally, indicates that openly communicating, mutually respecting, well-organized, lovingly close families do not have actively participating members with serious, lasting drug habits, even if certain members experiment briefly with marijuana or alcohol. The experiences recounted suggest that the phenomena of the family and of consistent psychoactive drug use do not mix. At the same time, the phenomena of the family and of highly competitive, time-consuming striving for upward socioeconomic mobility also do not mix. The latter finding may only be valid for those families who lack day-to-day contact with extended family or highly supportive community networks.

The existing social organization creates conditions that fragment families and their support systems, leaving vacuums that become filled with chemicals. The chemicals cannot be legislated out of existence because they are needed to stabilize the social system. The problem could be solved by halting construction of isolation-promoting high-rise apartment buildings, by decentralizing the means of production and focusing on local industry to cut commuting time of fathers, and by modifying the educational system to deemphasize competitive ladder-climbing and to promote self-realization in a family context. Families could be released from rigid laws that divide families into camps, and helping systems could be developed to assist families rather than individuals. Resources presently allocated to programs without a family focus and to community mental health centers could be used to support a network of in-community teams whose primary task would be to undo crises in families and to construct family support networks.

Such actions will not, however, be undertaken in the near future because too many people continue to regard them as unrealistic. Clinicians can for the time being teach families that while they must live with the current thought patterns, they must not be owned by them. At the same time, clinicians must encourage others to modify their thinking.

CONCLUSIONS

The way to diminish the use of psychoactive chemicals within existing society is to introduce measures that support family life rather than to develop more drug programs. However, society is not yet ready to accept this conclusion and its implications, so clinicians must work for changes in public attitudes toward addiction factors and treatment modes.

Blum, R.H. An argument for family research. In: National Institute on Drug Abuse. Drug Abuse From the Family Perspective, Ellis, B.G., ed. DHHS Pub. No. (ADM) 80-910. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1980. Pp. 104-116.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Families of abusers
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Theoretical/critical review
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	15

PURPOSE

The study argues that there has been a demonstrable insufficiency of research on family factors in drug abuse origins and treatment. The reasons for this lack of research are not entirely scientific but arise from sociocultural variables affecting the choice of work areas by investigators and clinicians. Compelling reasons exist for expanding study that tests interventions with families, either preventively, concurrently with other approaches, or in clinical treatment and rehabilitation.

SUMMARY

Based on the early focus of anthropology on the importance of the family in society, one might expect continuing research on family conceptions, especially in connection with drug abuse and alcoholism. However, literature reviews support the contention that not more than a few family studies are published in a year, in decreasing proportion to the field as a whole. Furthermore, the studies that do exist are not controlled evaluations of the impact of family-oriented prevention or treatment.

The insufficiency of family research might be explained by evidence of the insignificant role of the family in drug abuse and alcoholism; by evidence that family factors make a low contribution to overall variance, causing researchers to turn to higher priority areas; by demonstration that previous evaluations of family factors have left nothing more to be said; by researchers' emphasis on other drug abuse variables about which a great deal is already known.

Examination of the literature on drug abuse shows that the importance of family treatment methods and their superiority to more traditional methods for treating addicts have been established. Even cynics suggest that family therapy for drug abusers has a respectable impact. Furthermore, data from several long-term, large-scale studies establish the impact of family internal features on children's drug use or nonuse. Such features include family strength, joy, and harmony; parents' own drug use and attitudes toward drug use; and families' views toward work and tradition. These studies have also established that family studies are not high-risk, low-yield endeavors and that family therapy can work.

Researchers' emphasis on other drug abuse variables is the best explanation for the dearth of family research. For example, 80 percent of all basic research funding from the National Institute on Drug Abuse goes into medical-biological grants, especially for endorphin research. Such areas are attractive because they evoke images of brilliant doctors making exciting discoveries that promise basic prevention and treatment through molecular pharmacology, a "real" science. Moreover, "real science" is easier to sell to legislators, and endorphin research in particular has fired the imagination of scientists and the public, even if the research results thus far have proved interesting but below expectations.

Fashion in research is more likely to follow than to lead public change, especially in the social sciences. As cultural themes influencing researchers' work may contain inherent errors, research choices will be biased against long-term success. Thus, relevancy may be wrong if current dominant themes are biased. For example, relevant themes of American social sciences hold that environmentalism is equivalent to sameness, desirable change must be immediate, and flexibility is preferable to commitment. Such themes counsel against family research, as families are not limited to immediate environments or amenable to rapid change. Conversely, the family, with its transgenerational, private, unequal, moral nature and rejection of instant gratification, is not likely to be a popular object for research according to current social science fashions. For similar reasons, the church has aroused no interest among drug abuse researchers, not even those who recognize the significance of spiritual experiences in the religious phenomenology of drug misuse.

CONCLUSIONS

The family therapist has been forced to pursue unpopular and unsupported research. The outcomes of the research investment have been good, but it is time to learn more about how the family prevents most youngsters from developing drug problems, to test how to reach and help parents of troubled children, to experiment with improvements in family therapy, and to convince social scientists to accept that the family is not boring or inconsequential.

Clayton, R.R. The family and Federal drug abuse policies--programs: Toward making the invisible family visible. Journal of Marriage and the Family, 41(3):637-647, 1979.

DRUG	Multidrug
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Adolescents; adults
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	United States
METHODOLOGY	Literature review; review of data from national and regional surveys
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	1971-1978
NO. OF REFERENCES	17

PURPOSE

Social scientists in the family area are becoming increasingly interested in having more direct input into the Federal policymaking process, but the structure of the Federal Government and other factors hinder entry into that process. Family specialists can have greater impact by becoming involved in agencies such as the National Institute on Drug Abuse (NIDA), for which the family is explicitly relevant, than by trying to affect Federal policymaking at the presidential or cabinet levels.

The purposes of this paper are to explain why the family is almost invisible in current drug policy and programing and to show why current conditions demand a conscious consideration of the family in the prevention, research, and service delivery efforts of Federal drug agencies, particularly NIDA.

METHODOLOGY

Current Federal policies and efforts regarding drug abuse were reviewed. Changes in parameters of drug abuse were examined through analysis of data from five national surveys conducted

between 1971 and 1977 on the prevalence of marijuana use among youths 12 to 17 years old and among adults 18 years or older. Figures from a nationwide survey (1978) of high school seniors were also analyzed. Other studies reviewed included an examination of heroin treatment admissions in Dade County, Florida; national data from the Client Oriented Data Acquisition Process of NIDA; and data from the Drug Abuse Warning Network compiled by the Drug Enforcement Administration from May 1976 through April 1977. Studies on social and demographic trends and their implications for drug abuse policy were also reviewed.

RESULTS

Federal drug abuse policies and programs have virtually ignored the family, for a variety of reasons. These include the almost exclusive focus on heroin abuse, the prevailing narrow view of drug abuse as interpersonal in origin and consequence, and the assumption that drug abuse is an all-encompassing lifestyle that precludes marital and familial commitments. Other factors include the medical categorization of drug abuse as a form of deviance and the research focus on hospitals and treatment clients.

Current Federal drug abuse policies are organized around the strategies of supply reduction, which emphasizes rigorous enforcement of drug trafficking operation, and demand reduction, which involves delivery of treatment services and auxiliary services to drug abusers. These Federal policies were formulated to deal with the unique sociohistorical and political conditions of the mid to late 1960s and early 1970s. However, drug abuse as a social phenomenon has since changed, and a fresh and new look at the old Federal strategy is needed.

Several kinds of data indicate the need for integrating familial units into Federal drug abuse efforts. The five national surveys indicate that drug use, misuse, and abuse, once rare, are increasingly normative and are found in all social groups in society. Among youths 14 to 15 years old in 1977, for example, almost one in three had used marijuana; among those aged 16 to 17, almost one in two had used marijuana. A nationwide survey showed that 59.2 percent of 1978 high school seniors had tried marijuana; 10 percent reported daily use of the substance. In addition, the population using drug treatment facilities is increasingly older and increasingly comprised of people who have previously used drug treatment facilities. Moreover, increasing proportions of first admissions to treatment centers for heroin abuse are women, and a majority of drug-related medical emergencies involve women who have abused drugs obtained via prescription from legal sources. Further, from May 1976 through April 1977, 59 percent of the 121,077 drug-related emergency room patients reported via the Drug Abuse Warning Network were female. Valium was the drug most frequently mentioned among the 20 drugs listed. Other data indicate that future drug abuse will follow changes in the population age structure as the "baby boom" population, which matured during the drug epidemic of the 1960s and 1970s, grows older.

Changes in behaviors related to marriage and the family are also potentially conducive to greater drug involvement in the general population, especially in women. These changes include the declining marriage rate, the increase in the proportion of couples who intentionally remain childless, and the increasing divorce rate, as well as other factors.

CONCLUSIONS

A research agenda that explicitly focuses on the role of familial and marital role transitions in the epidemiology and etiology of drug use, misuse, and abuse is needed. Greater emphasis on primary and secondary prevention efforts that are family-based will be crucial to the drug problem in the 1980s. The logical locus of such efforts should be family units, since most of those who begin to use illicit drugs, do so while still living within the confines of family roles and rsponsibilities and because the family is intimately involved in the life cycle of addiction.

Federal drug abuse strategies and policies are outdated, narrowly focused, and targeted for a drug problem that has changed dramatically since the 1960s and 1970s. In the 1980s, new programs and policies are needed to reflect changes in the parameters of drug abuse in the United States. Current treatment and prevention efforts should be modified and redirected. For example, heroin treatment programs should give higher priority to the special needs of drug-abusing youths and women, while continuing treatment for the limited pool of mostly male heroin addicts. Expanded attention to the abuse of marijuana, tranquilizers, and sedatives is needed. Greater emphasis should be placed on the treatment of marital and family units, although treatment of

individuals should also continue. Although educational and media prevention materials directed toward individuals are needed, prevention efforts targeted at the family need more emphasis.

Drug abuse is a costly social problem that affects both individuals and families. Thus, the family as a context within which drug abuse occurs should become more visible in the future Federal response to drug abuse.

Coleman, S.B. An endangered species: The female as addict or member of an addict family. Journal of Marital and Family Therapy, in press.

DRUG	Alcohol; multidrug
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Addicted women; women in families with addicted members
AGE	Not specified
SEX	Female
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Cross-sectional
METHODOLOGY	Literature review; site visits
DATA COLLECTION INSTRUMENT	Interviews; observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	29

PURPOSE

Traditional psychiatric theory has always disparaged women, and current efforts to explain human behavior by expanding personality theory to include psychosocial phenomena have not been much of an improvement. Thus, when a woman is the identified addict or is a member of a family that abuses drugs or alcohol, she often experiences considerably more psychiatric abuse than her male cohorts. This paper surveys some of the attitudes and practices imposed on female addicts or women who are in families with an addict member. The findings and conclusions are based on a literature review and site visits to 36 drug abuse treatment programs throughout the continental United States.

SUMMARY

Drug and alcohol literature places major emphasis on the mother-son dyad, which is often compared to the pattern found in schizophrenic families. A review of adjectives and descriptive phrases in 17 representative articles about families of addicts shows that the female member of an addict family, usually the mother, is viewed more negatively than the male member. More

references were made to females than to males; in no case was the female overlooked, although some articles did not refer to the male.

Relatively little of the literature on drug and alcohol abuse focuses specifically on female users. Gomberg's 1974 review on women and alcoholism cites evidence that the female alcoholic is the subject of severe criticism. Negative attitudes toward drunken women are shown by all socio-economic groups and by women as well as men, in contrast to the rather accepting position toward male intoxication. The popular image of an intoxicated woman as engaging in loose sex has been extended to the female heroin addict, whose lifestyle may include prostitution as a means of supporting her drug habit and, in the "easy rider" syndrome, her partner. Nevertheless, comparative studies on sex differences among heroin addicts and alcoholics show that although the proportion of women abusers is increasing, males still use more drugs of all types. Some research has also suggested that the women's movement and stress factors have influenced drug use by women.

Clinical attitudes toward female drug and alcohol abusers reflect the double standard found in the literature. For example, one fundamentalist program restricts the wives of addicts to child care and female staff to clerical roles, giving as its rationale the Old Testament. Another program does not give either conjoint marital treatment or family treatment. In a gay community treatment setting, attitudes toward women were especially negative.

To understand women's role and plight, it is necessary to explore relevant factors impinging on the addiction process in general. Death, suicide, and loss are highly significant variables associated with drug and alcohol problems for both males and females. Addict and alcoholic families may have heightened separation fears that may well exaggerate the usual separation-individuation dilemma in which all marital couples are involved. Yet, despite the evidence of the pathological influence of the addict's mother, addicts themselves generally view their mothers more favorably than their fathers. Addicts' strong ties with the family of origin could be attributed to a positive connection between the addict and the mother, a connection reinforced by the frequency of divorce and separation among addict families. The male role in initiating or promoting female addiction has often been overlooked. For example, the female alcoholic may be ignored, vilified, or abandoned by her husband but is rarely treated with understanding or compassion. However, the cultural trend toward viewing behavior as androgynous rather than sex-linked may eventually alter these findings and prevailing attitudes.

A study by Lewis et al. indicates reasons for the persistent trend toward viewing the mother as the family culprit. The study data suggest that in families that are less than optimal, the mother is the first to suffer from the family system's inadequacy. Data also indicate that with the exception of the most optimally functioning families, the marital relationship often reflects a modal pattern of a work-enveloped, distant, and uncommunicative husband, coupled with a needy, lonely wife. Comparisons between individually-derived and systems-derived data were remarkably congruent except in the analysis of family substructures.

CONCLUSIONS

Much of what is purported to be characteristic of women with addict backgrounds is untenable and undeserved. Family systems theory indicates that pathological symptoms should be considered a function of the family's relationship patterns and not in isolation. Both male and female interactions are part of the system's feedback mechanism. Only by understanding their complex transactions can the interlocking predictive variables for drug and alcohol abuse be identified. Emphasis should shift away from women as a subgroup; women need to be understood according to the complex interlocking transactions within family systems.

De Forest, J.W.; Roberts, T.K.; and Hays, J.R., Drug abuse: A family affair? Journal of Drug Issues, 4(2):130-134, 1974.

DRUG	Not specified
SAMPLE SIZE	31 plus control group
SAMPLE TYPE	31 mothers of adolescent addicts; mothers of nondrug users
AGE	Mature adults (mean: 43)
SEX	Female
ETHNICITY	White
GEOGRAPHICAL AREA	Houston, Texas
METHODOLOGY	Survey--exploratory/descriptive, comparative
DATA COLLECTION INSTRUMENT	MMPI; Interpersonal Check List
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	13

PURPOSE

There is growing evidence that modern adolescent drug abusers are substantially different from their predecessors. Drug abusers' parents might therefore be expected to differ from other parents, as drug abusers are different from other groups of disturbed children. For these reasons, the study focuses on characterizing the personalities and familial relationships of the mothers of adolescent drug abusers and comparing them to the mothers of adolescents without drug problems.

METHODOLOGY

The sample consisted of a group of 31 mothers of male and female patients at the Drug Abuse Clinic of the Texas Research Institute of Mental Science. Mothers ranged in age from 28 to 55 years (mean 43) and had had 10 to 16 years of schooling (mean 13.3). A total of 55 percent were in their first marriage, 43 percent had been married two or more times, and two were divorced. A matched control group was obtained from Houston area churches. A total of 90 percent of their first marriages were intact, and no drug abuse was evident in their families. Both groups were white and belonged to the professional or white-collar class.

Personal and interpersonal behavior were assessed objectively on multiple levels using the Interpersonal System. The four levels of the system are public behavior, conscious description of self and others, motives and actions as expressed in fantasy, and conscious ideals. Behavior at all levels is categorized by a set of interpersonal variables listed in a circular continuum. The interpersonal circle is represented as a two-dimensional grid with the horizontal axis measuring love-hate and the vertical axis measuring dominance-submission; the center of the grid is the normative population mean. The direction and distance of individual scores from the center reflect the kind of interpersonal behavior and deviation from the norm. The circle is divided into octants that represent the following interpersonal variables (the adaptive category shown first and the maladaptive second): (1) managerial-autocratic, (2) competitive-narcissistic, (3) critical-sadistic, (4) skeptical-distrustful, (5) self-effacing-masochistic, (6) docile-dependent, (7) cooperative-overconventional, and (8) responsible-overgenerous.

The levels of the Interpersonal System were measured by the Minnesota Multiphasic Personality Inventory and the Interpersonal Check List (ICL). The ICL encompasses 128 items with 16 items for each of the octants. For comparing the groups' octant ratings within a given level, two contrasts were used: affiliation versus opposition and socially acceptable behavior versus socially undesirable behavior. The variability indices reflect the amount of discrepancy between ratings. Fourteen discrepancy scores systematically indicate conflicts among the levels of personality organization. The indices used were those involving self-acceptance, self-deception, and parental identification. Chi-square analyses were performed on the data.

RESULTS

A majority of the women in both groups (80 percent) appear to others and described themselves as independent, striving individuals pursuing responsible goals in a conventional, socially desirable manner. Most women in both groups are also self-accepting (50 percent) and self-perceiving (65 percent).

In contrast, the two groups differ significantly in the degree of identification with their mothers and in their perceptions of spouses and children. Almost one-half of the experimental group, as opposed to one-third of the control group, do not identify with their mothers, viewing themselves as helpful followers and their mothers as respected leaders. The comparison mothers identify with the responsible, generous, and active behavior of their mothers. The experimental group of women see their husbands as hostile, critical, and arrogant men who use their power to humiliate others; they obey their husbands out of fear. In comparison, members of the control group consider their husbands strong leaders who are followed because they are respected. Almost half of the drug abuse mothers, compared [illegible].3 percent of the controls, describe their children as resentful, bitter, and hostile.

CONCLUSIONS

Patients' mothers do not appear to be seriously disturbed in their adjustment or insecure in their sex roles. They are productive and responsible members of society. However, unlike comparison mothers, mothers of drug abusers appear to have grown up in families with powerful, dominant fathers and actively helping mothers. The mothers had little power within the family and the fathers were pictured as less friendly and more powerful. Women raised in this environment of little interchangeability of roles and power probably learned that generosity and concern are desirable traits but not effective in dealing with male family members.

While comparison families are warm, cooperative, and responsible in their interpersonal roles, members of drug abuse families are rigidly fixed in their roles. In relation to their husbands, the wives in drug abuse families have worked out a compromise involving their passive cooperation and accommodation. They intervene as mediators to reduce tension between husband and child. Their cooperative helpfulness pacifies the demands of their husbands, and their passive conventionality protects against the child's hostile attacks, although their own interpersonal growth is inhibited.

Drug-abusing children feel that they have little impact on their family situation and may, as a result, become indifferent and passive. Although passively rather than actively resistant, these children tend to be oppositional and distant like their fathers.

To help the adolescent drug abuser, therapeutic intervention must focus on the family as a whole, even though family members are likely to resist. Further research on the nature of relationships between parents and their drug-abusing children is required.

Gorsuch, R.L., and Butler, M.C. Initial drug abuse: A review of predisposing social psychological factors. Psychological Bulletin, 83(1):120-137, 1976.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Initial drug users
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review; theoretical/critical review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	118

PURPOSE

The present study attempts to provide an organized, integrated developmental overview of the processes leading to initial drug use and to identify research methods for dealing with questions of initial drug use. Studies of habitual users and addicts are reviewed only if they relate to experiences concerned with initial use of illicit drugs, as conditions leading to initial use may differ radically from causes of heavy use of the same substances. Different models also explain drug use by subgroups that follow given pathways to drug use. Prospective longitudinal studies and retrospective studies with comparison groups are given more weight than retrospective studies in which subjects are asked to recall long-past material.

SUMMARY

Social Environment

While the influence of parents on their children's drug use cannot be accurately assessed because of the retrospective nature of the research in this area, enough literature does exist to suggest that the family plays the expected critical role. However, the presence or absence of parents

is less critical than certain other factors. The most important of these are the effectiveness of the child-parent relationship and family cohesiveness, the degree to which the family has respect for social institutions and is conservative in its ideology, and the degree to which parents themselves act as models for drug use through their own use of psychoactive drugs.

The relationship of peer usage patterns to a youth's use of drugs is clear: The more a youth tries a variety of drugs, the more it is likely that his or her friends will be users of drugs and vice versa. However, data are insufficient to determine whether drug-using friends encourage youths to initiate the drug experience, whether youths reform their friendships after their initial drug experiences, or whether youths pick friends like themselves, all with a high potential for drug use.

The subcultural theoretical perspective has stressed the importance of the social environment as the determining factor in drug usage. However, this appears unlikely, as drug users and other deviants tend not to be socialized to any particular group, except in the case of LSD-oriented cults. The lowest likelihood of drug abuse is found in traditional families and among youths with religious affiliations.

Personality

Personality traits considered of potential importance for drug use or nonuse are superego strength, responsibility, and conventional conformity to major mores of American society. Several studies suggest that not all those who initially use an illicit drug are necessarily less socialized; instead, they may be socialized in subcultures that advocate drug use.

Also, the state of physical pain may underlie initial use of some drugs. Mental anguish and boredom may be related to the use of particular drugs. However, mental states contributing to drug use are difficult to research because of their transitory nature. This area has been investigated primarily by retrospective studies that may reflect the attribution theories of the informants.

Evidence from prospective studies has established that attitudes toward drug use and expectations from it often predict the initial use of an illicit drug. While the modeling of parents and peers is undoubtedly important in the development of attitudes toward drugs, the user's own experience with drugs is probably more important. Moreover, positive use of some drugs appears to encourage the initial use of new drugs. Marijuana use generally precedes use of other illicit drugs but may have only the same relationship to other illicit drugs as can be documented for alcohol and tobacco.

Drug Availability

The availability of legal drugs greatly influences the amount consumed; when alcohol is more available, more people have an initial alcohol experience. However, availability is dependent on other factors that may appear as the important variables in a typical analysis (e.g., peer reinforcement, disposable funds, and the impact of parents or individual attitudes).

Models Accounting for Initial Drug Use

It is generally assumed that the individual whose characteristics are most like the mean characteristics that differentially identify drug experimenters will be most likely to use the drug. But the implicit linear regression model underlying this assumption may not be the most effective model, for interactions may occur between variables. An interactive model that involves prerequisites for the drug behavior as an initial analytical step may be more predictive than a model that simply adds up scores. Another factor that might produce interactions involves the individual's psychosocial development. Thus, interaction between psychosocial maturity and the peer group could be useful in predicting initial drug experience.

CONCLUSIONS

One type of initial drug use is iatrogenic (i.e., medically induced). Iatrogenic drug users are those for whom the usual expectations of parental background, peer groups, personality characteristics, and attitudes are less likely to hold true, and they thus warrant study as a separate group. Another type of drug user is the unsocialized person or one who receives no specific socialization concerning drugs or the norms of society that regulate those drugs; this type constitutes the bulk of abusers. A further type is socialized into a prodrug subculture; strong family relations, involvement with drug-using peers, and effective socialization are predictive of initial drug use among these individuals. All of these models interact with the availability of the drug. Because such a multiple model approach has definite methodological implications, different types should be separated and relationships of variables should be determined within each type, as the same factor may have a different impact in different contexts; separate statistical analyses may be necessary for each path. New categories must be sought for persons who do not fall readily into one of the previously identified groups. The types tentatively suggested are solely for determining the probability that an individual will engage in initial drug experiences.

Kupetz, K.; Larosa, J.; Klagsbrun, M.; and Davis, D.I. The family and drug-abuse symposium. Family Process, 16(2):141-147, 1977.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Theoretical/critical review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	0

PURPOSE

The report offers a brief overview of the Family and Drug Abuse Symposium held from July 10 to 12, 1975, and summarizes issues discussed in workshops on psychosocial research, clinical observations, clinical programs, and recommendations made to the National Institute on Drug Abuse.

SUMMARY

The conference was sponsored by the Center for Family Research and the Department of Psychiatry and Behavioral Sciences of George Washington University through funds allocated by the National Institute on Drug Abuse. The goals of the meeting were to bring together colleagues with clinical and research expertise in the fields of family research and substance abuse and to assess the current state of knowledge in these fields. Papers for workshops were distributed in advance, formally evaluated by selected individuals during the meeting, and then discussed in an open discussion period.

Psychosocial Research

The theoretical part of the open discussion centered on the factors involved in the genesis and maintenance of drug abuse in the individual and the family. Etiology may be defined by studying the historical factors in the drug abuser's family and by analyzing the current functioning of the family system. The developmental cycles of the family and cultural aspects of the society should also be weighed. Both controlled laboratory study of drug abuse-family relationships and observation within families' natural setting are critical in determining whether family patterns can be specifically related to drug abuse or whether each family with an abuser is essentially unique. Comparing the interactional behavior of a family in the presence and absence of drug use is a valuable approach for both laboratory and naturalistic studies.

Clinical Observations

Clinical and research studies of substance abusers in middle class and ghetto environments do not reveal a specific type of addictive personality. However, a number of useful clinical correlates of drug abuse exist at both the individual and the family levels (e.g., early childhood separation or abuse leading to inadequate development of coping mechanisms). The importance of prospective longitudinal studies of addictive and nonaddictive families was emphasized. This would permit testing of an alternating generational hypothesis of drug abuse and provide knowledge of events that occur prior to the onset of addiction. Family therapy is considered the treatment of choice. For such therapy, a variety of approaches geared to the needs of individual families and intervention within the addict's social network are advocated. Participants emphasized the need for both primary prevention and social reform using special programs at the community level.

Clinical Programs

Within clinical programs, changes should be acknowledged as they occur rather than retrospectively. Pretesting is a positive factor in decreasing dropout rates, but individual differences among therapists are a crucial problem in controlled evaluation of treatment outcomes. Further integration of a family approach into preexisting drug treatment programs is vital. Separation of identified patients and their families at the time of hospitalization may be detrimental to the family's later involvement in the program. Hospitalization of the family when the addict enters may be a fruitful approach. Finally, professional and community education are central to drug abuse prevention efforts.

Dialog With the National Institute on Drug Abuse

Discussions sought to determine more about the field and to identify work relevant to the area of service delivery and new knowledge. The study group recommends establishment of a task force composed of selected symposium participants to foster communication, to locate further experts, to disseminate information, and to arrange another meeting within 1 year. Emphasis of further workshop discussions is to be placed on preventive measures and research to help the family cope with drug-related problems inherent in the environment. Measures proposed include provision of residential care for identified patients, development of family-oriented helping networks, education of family physicians, and investigation of coping mechanisms such as relaxation techniques. Research and prevention can be furthered by identification of high-risk children and variables predictive of drug use; use of school studies to evaluate parent education; examination of community outreach programs and family life in general; identification of ongoing longitudinal studies with drug users in their populations; and investigation of families with high polydrug use, of mother-child interaction with drug-addicted mothers, of family-society relationships, and of crucial variables of family interaction.

CONCLUSIONS

The potential exists in the field of family therapy to develop methods of early intervention, perhaps even primary prevention of the substance abuse problem. However, further exchange of ideas on the forms and effectiveness of family therapy for drug abusers as well as on family characteristics related to drug abuse are needed.

Stanton, M.D. Some overlooked aspects of the family and drug abuse. In: National Institute on Drug Abuse. Drug Abuse From the Family Perspective, Ellis, B.G., ed. DHHS Pub. No. (ADM) 80-910. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1980. Pp. 1-17.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	77

PURPOSE

Only recently has the role of individuals' family systems in the maintenance of their addiction to drugs been recognized. Research has suggested that the addictive symptom functions as a homeostatic mechanism regulating family transactions; addicts are locked into a family pattern and cannot break out through nonsymptomatic means. Given this situation, treatment requires alteration of addicts' family systems. This review provides an overview of the predominant patterns and structures in the families of heavy drug users that have emerged from literature to date. The relevance of these patterns to treatment is also discussed.

SUMMARY

Addict Family Patterns and Structures

The importance of adolescence in the misuse of drugs becomes more apparent when the structure of the addict's family of origin is considered. In the prototypic drug abuser's family, one parent, usually the opposite-sex parent, is overinvolved with the addict, whereas the other parent is punitive, distant, and/or absent. Moreover, the abusing child may distract parents from their

own problems. When the threat of the adolescent's leaving looms, parents panic and fail to make the transition to a new developmental stage of the family. Trapped at this developmental stage, all family members contribute to maintaining the drug addict's dependent, incompetent role. Addicts in their late twenties and early thirties frequently still have close family ties and many even live at home despite periods spent away from home.

The dyadic relationships of addicts appear to be a repetition of the nuclear family of origin, with roles and interaction patterns similar to those seen with the opposite-sex parent. Significantly, the marriage rate for male addicts is half what would be expected, while the rate for multiple marriages is above average for both sexes. After an attempt at flight into marriage, addicts appear to be pulled back to their parents.

Distinguishing factors of addict families are multigenerational chemical dependency; primitive, direct expression of conflict; conspicuously unschizophrenic parental behavior; availability of a peer group retreat for the addict; symbiotic childrearing practices of mothers; preponderance of death themes within the family; pseudoindividuation of addicted individuals; and immigrant status of the family, possibly related to acculturation difficulties.

Treatment and the Drug Abuser's Family

Addicts' families may overlook and even support drug-abusing habits. Furthermore, the families may attempt to sabotage treatment efforts to assure that addicts remain addicted. Marital relationships are strongly affected by the interaction within the addict's family of origin. For these reasons, treatment must start with the parental-addict triad and move toward the family of procreation. The prognosis is better than average for addict families in which parents are able to release the addict to a spouse or outsiders during the course of treatment. The family can be a powerful force in helping addicts overcome their problems.

When compared to other modes of treatment for addicts, family therapy has emerged as superior in two-thirds of the studies undertaken and equal in the other third. The most impressive findings have been obtained using a structural approach. Thus, a majority of the drug abuse programs across the country have introduced family services, and, in some cases, it has been introduced as a mandatory component of treatment. Most of the programs use conjoint family therapy (i.e., treatment of individual families).

Low Drug Use Families

Information pertinent to reduction of drug misuse can be gleaned from families who do not use drugs. Nonusing families exhibit the following characteristics: offspring perceive love from both parents, little discrepancy exists between parents' ideal and perceived image of their children, children are seen as assertive, parents and their offsprings' friends are compatible, family members are efficient in solving problems, and families function democratically with shared authority. These families also prepare their children better for adult life, deny negative feelings, make the best of existing circumstances, and exhibit cohesion. In a study of families that were at low, medium, or high risk of misusing drugs, it was found that low-risk families tend to be benevolent dictatorships with religious involvement; emphasize firmness in child rearing and togetherness; are able to plan together; and exhibit dedication to control, obedience, reliability, and honesty. An important variable is the sense of family tradition. However, children of the lowest risk families tend to be rather inflexible and smug, while moderate risk families show better adaptation and less dogmatism.

CONCLUSION

Of the psychotherapeutic approaches, family treatment has the clearest implications for prevention because it includes family members who would not have sought help themselves. Furthermore, family therapy has the potential of changing a dysfunctional system that could affect other children in the family. Parents learn to be better parents, and drug abusers are set free of parents' needs so that they can themselves develop into competent persons.

Generally, education has been found to be an ineffective means of reducing overall drug use. However, drug information can be useful in small doses if presented in the family setting.

Information should broaden families' knowledge of patterns in dysfunctional family relationships and parental antagonisms that may be related to drug habits of children. Emphasis should be placed on strengthening the boundaries between the generations and on the positive ways that families can deal with drug-related problems.

Stanton, M.D. A family theory of drug abuse. In: Lettieri, D.; Sayers, M.; and Pearson, H.W.; eds. Theories on Drug Abuse. National Institute on Drug Abuse Research Monograph 30. DHHS Pub. No. (ADM) 80-967. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1980. Pp. 147-156.

DRUG	Opiates
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Theoretical/critical review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	0

PURPOSE

The study presents a theoretical model of drug abuse that explains phenomena not accounted for by extant theories (i.e., the recurrent nature of addiction and the high incidence of treatment dropouts). The concepts underlying the homeostatic model seek to alleviate shortcomings of static theories predominant in the field. Such theories tend to ignore the ongoing behavior in its context, changes and/or repetitive patterns that occur during a given time period, and the interpersonal and contextual functions of drug abuse.

SUMMARY

Theoretical Considerations

A major concern frequently overlooked in the drug abuse field is the context of the symptom as this relates to its genesis and maintenance. Consequently, the present model encompasses the total "gestalt" of the symptom, the treatment, those affected by the treatment, and the effects that these have on the treatment endeavor. The addiction/readdiction pattern must be viewed as a nonlinear process. The behaviors of the involved individuals or human systems are

sequential and cyclical, and researchers must therefore look at the components, elements, and specific behaviors that constitute the cycle. Families must also be considered in terms of their family life cycle; certain families may become stuck in a particular developmental stage because they are not able to make the transition to the next stage.

Drug Abuse as a Family Phenomenon

Accumulating data indicate that a high percentage of drug abusers' families have experienced premature loss or separation during the family's life cycle. For immigrant families this may mean the loss of the family left in the original culture, leading to excessive dependence of parents on children for emotional and other forms of support. In nonimmigrant families of drug abusers, the loss may be the unexpected death of a family member; the self-destructive impulses of the addict are part of the family's attempts to work through the trauma of loss. Abusers' families and the addicts themselves show an intense fear of separation. Contrary to what one might expect, addicts retain close ties to their families, even when in their early thirties.

The prototypic drug abuser's family is one in which one parent, usually the opposite-sex parent, is overprotective and intensely involved with the abuser, while the other is more punitive, distant, and/or absent. The abuser may serve his or her parents as a communications channel or as a means of distraction from problems. Assuming a sick state enables the abuser to draw his or her parents' attention. While the interaction is essentially triadic, other family members help to keep the drug abuser in a dependent, incompetent role. Distinguishing factors for addict families include multigenerational chemical dependency, primitive and direct expression of conflict, unschizophrenic behavior by addicts' parents, tendency of addicts to retreat to a peer group after conflicts, symbiotic childrearing practices by addicts' mothers, preponderance of death themes within families, use of addiction by addicts for pseudoindividuation, and immigrant status with possible acculturation problems.

Addiction provides addicts and their families with a paradoxical resolution to their dilemma of maintaining and dissolving the family. The influences of the drug, especially heroin, permit addicts to feel infantile closeness and distance at the same time, to assert themselves aggressively toward restraining families without having to assume responsibility for such behavior, to have quasisexual experiences without being disloyal to their families, to be successful even if in the limited world of the drug subculture, and to keep their families together by maintaining their incompetent, dependent status.

The Homeostatic Model

Drug addiction is portrayed as a cyclical process involving three or more persons, commonly the addict and the parents, who are involved in an intimate interpersonal system. When the equilibrium of this system is threatened, for example, by parental discord, addicts will create situations to focus attention upon themselves, such as an overdose of drugs. The parents will respond by shifting their focus from the longstanding marital conflicts to the addict, thereby avoiding a crisis. The addict may then adopt a less provocative stance and become more competent, functioning independently until marital tensions mount anew and separation threatens. The addict must then draw attention to himself, completing the dysfunctional cycle. Although the cycle may vary in intensity, it at all times serves the protective function of maintaining the family's homeostatic balance.

The onset of the addiction cycle frequently occurs during addict's adolescence; the problem grows as the addict seeks to leave home and parents are faced with renegotiating their relationship. Instead of making the transition, the family becomes trapped in this developmental stage. Addicts themselves fail to separate from their families, to develop stable heterosexual relationships, to become involved in a stable job or school, or to obtain appropriate work; they often engage in criminal activities and become severely addicted.

The marriages and families of procreation of abusers usually reflect the nuclear family of origin, with roles and interaction patterns similar to those seen with the opposite-sex parent. The marriage rate for addicts is half what might be expected, and multiple marriages are common for both sexes. Male addicts may even start fights with their wives as a means of showing parents that they have not lost the addicts as family members and as a pretext to go home and help resolve the conflicts there. In other cases, addicts periodically precipitate altercations so that

they can regularly go to their parents' home to complain about connubial problems. Marital battles thus become a functional part of the intergenerational homeostatic system, possessing both adaptive and sacrificial qualities.

Even in drug abusers' families with one parent missing, a triadic system usually develops. In addition to the addict and his mother, the triad may include the mother's boyfriend, an estranged parent, a grandparent, or some other relative. These alternative systems appear to exhibit patterns similar to those in two-parent families. However, achieving separation and independence is even more of an issue in single-parent families, since the mother may be left alone with few psychological resources if the drug abuser departs.

CONCLUSIONS

Addicts' roles and interaction patterns with both parents and spouses, as reflected by the homeostatic model of drug abuse, are dysfunctional and follow a recurrent pattern. Thus, drug abuse treatment strategies must take into account the family developmental life cycle and the addicts' reactions to the various stages of that cycle. Treatment does not take place in a vacuum, and if the external variables that impinge before, during, and after treatment are not changed or at least evaluated, both treatment and investigatory efforts will operate at a considerable disadvantage.

Stanton, M.D.; Todd, T.C.; Heard, D.B.; Kirschner, S.; Kleiman, J.I.; Mowatt, D.T.; Riley, P.; Scott, S.M.; and Van Deusen, J.M. Heroin addiction as a family phenomenon: A new conceptual model. American Journal of Drug and Alcohol Abuse, 5(2):125-150, 1978.

DRUG	Heroin
SAMPLE SIZE	100
SAMPLE TYPE	Addicts and their families
AGE	Young adults (mean: 27)
SEX	Male
ETHNICITY	Black; white
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Videotapes/observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	72

PURPOSE

Based on observations and research, the study attempts to establish a behavioral model for heroin addiction that permits therapist intervention. Emphasis is placed on often ignored family factors bearing on the maintenance of addiction. Since previous studies have shown certain patterns in family relationships; a prototypic pattern for male addicts' families is an overindulgent, permissive mother and a negative father-son relationship, whereas the reverse is true for female addicts. Female addicts appear to be overtly competitive with their mothers, and their relationship with their father is one in which the father is often inept, alcoholic, indulgent, and sexually aggressive. Death of or separation from a parent, usually the father, is not uncommon for both male and female addicts before age 16. The majority of addicts have also been noted to maintain close family ties even when separated from home or in the military. Moreover, the dyadic relationships of drug addicts have been seen as a repetition of the nuclear family, with roles and interaction patterns similar to those seen with the opposite-sex parent.

METHODOLOGY

Study observations derive from a 3-year research project investigating family characteristics and family treatment of heroin addicts. The project's data bank includes over 450 videotapes of interactional sessions with addict families, which were viewed by groups of 2 to 12 researchers to identify repetitive behavioral sequences, formation of coalitions, and other observable patterns. A total of 100 male heroin addicts and their families of origin and procreation were involved in the project. As in most such samples, all subjects had been addicted for at least 2 years, had tried to detoxify twice, were on methadone, and were urban dwellers. Most were of the working class, half were black and half white, and 35 percent were married. The group might be considered special in that all were under 35 years old, all had spent time in the military service, all had at least weekly contact with parents, and all had a poor prognosis for recovery.

RESULTS

Observations Basic to the Model

To judge from the authors' observations and findings of other studies, addicts fear separation. The family similarly fears separation from the addict, and their need for him is as great as, or even greater than, the addict's. Any signs of autonomous development by the addict, which usually first surface during adolescence, precipitate a family crisis. Family closeness is an interdependent process in which the addict's failure serves a protective function in maintaining the family. The family endures terrible indignities rather than lose the addicted member and blames external systems for his problems.

In addition, addicts' families display a higher than normal frequency of multigenerational chemical dependency and are more direct than other dysfunctional families in their expression of conflict. Furthermore, addicts have stronger outside relationships to retreat to than other disturbed offspring, such as schizophrenics, and this provides the addict with the false aura of independence.

Addiction apparently provides the addict and the family with a paradoxical resolution to their dilemma of maintaining or dissolving the family. Drugs permit the addict to feel close to his mother while blunting separation anxiety. While high, addicts temporarily stand up for themselves in a process of pseudoindividuation. Heroin becomes a substitute for heterosexual relationships and provides the addict with a sympathetic subculture in which he or she can be successful even though dependent. By using heroin, the addict is neither in nor out of the family; he is nurtured when he is in and the drug is blamed when he is out.

Contrary to what one might expect, addicts' marital systems take second place to their relationships with their parents. Addicts seem to wait for an excuse to leave their spouses and return to their families.

Finally, there appears to be an association between the time of initial drug use and the untimely death of a significant family member. In this context, addiction resembles chronic suicide. The family tolerates the addict's suicidal game because in family mythology death is an acceptable resolution to the looming prospect of separation.

The Homeostatic Model

Heroin addiction may be described as a cyclical process involving three or more individuals, i.e., the addict and his parents, who are part of an intimate personal system. When the system is threatened by marital discord and impending separation, the addict creates a situation that focuses attention on himself and away from longstanding conflicts. Having averted a crisis, the addict demonstrates increased competence and improved independent functions until tensions mount and separation once again threatens, prompting renewed destructive behavior. The addict's behavior thus serves a protective function that helps maintain the family's homeostatic balance. The cycle varies in intensity but tends to begin during the addict's adolescence, becoming critical when he seeks to leave home. Often parents cannot renegotiate their own relationship and the family becomes stuck at this developmental stage. The addict lacks stable outside relationships or a steady job in keeping with his capabilities.

The addict is under pressure on the one hand to hold together the family and on the other to form intimate outside relationships. Addiction involves him in a pattern of shuttling back and forth between family and peers, but the drug culture actually reinforces family dependence by making him increasingly helpless. Paradoxically, the addict's outside relationships and departure are viewed by the family literally as a fate worse than death, which at least unites the parents temporarily in mourning. Even in single parent families another adult usually completes this triadic pattern.

The addict's marriage becomes a functional part of the homeostatic system. Marital conflicts between an addict and his wife may be precipitated by the addict to reassure parents of his loyalty and to provide an alibi for his return home to help.

Treatment Implications

This theoretical model suggests that the family must be included in addict treatment; just as the family maintains the addictive pattern, it can play an important supportive role in overcoming the addict's drug habit. Furthermore, the family structure and interaction pattern must be changed to improve parents' sense of competence and readiness to encourage their offspring's independence. The addict's parental situation must be resolved before treatment of his own marital problems can begin. Only intervention in the family homeostatic process can bring about a shift to a new stage in the family life cycle. A skilled therapist is required, and crises are to be expected.

CONCLUSIONS

For addicts with families, the family system is a crucial factor in determining whether addicts remain on drugs. The homeostatic model is not inconsistent with conditioning theories; such theories are simply not constructed to encompass family and interpersonal behaviors. Experience dictates that change in the family system can counteract conditioning factors.

Success or failure of treatment may be dependent on the family situation; the therapist becomes another outsider competing for the addict, forcing him to return to his family. Elimination of an individual's drug dependence must be associated with the addict's separation from parents, success in some activity, and achievement of stable outside relationships. Research is recommended on the specific contributions of family factors toward achievement of long-term, drug-free states in addicts.

RESEARCH REVIEWS

There has been an exponential increase in family/drug research since the first major review of this field in the early 1970s. The literature in this section reflects this growth and, essentially, presents two types of reviews: (1) specific topic areas such as family interaction, family-peer influence, and family treatment, and (2) broad approaches that attempt to survey the entire field. It is interesting to note, concerning this second group of reviews (i.e., Seldin 1972; Harbin and Maziar 1975; Stanton 1979), a perhaps predictive pattern in their development, viz, the focus of these reviews became progressively less restrictive through the 1970s.

Seldin, for example, titled his review "The Family of the Addict: A Review of the Literature" and examines this literature according to the subdisciplines of psychiatry, social work, psychology, and sociology. Harbin and Maziar titled their review similarly, but in a less targeted fashion, "The Families of Drug Abusers: A Literature Review." Their approach to the literature combined disciplines and in contrast to Seldin's review focused on types of studies, i.e., clinical studies, clinical studies with quantitative results, and controlled research studies. Finally, in the last review of the 1970s, Stanton approached the field from the broadest stance and titled his review "Drugs and the Family." His approach not only combined disciplines but, also, types of studies and focused on drugs (or classes of drugs) of abuse or abuse potential. The effect of this widening of the sphere of legitimate research interest concerning drugs and the family will only begin to be felt during the current decade.

Baither, R.C. Family therapy with adolescent drug abusers: A review. Journal of Drug Education, 8(4):337-343, 1978.

DRUG	Multidrug
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Adolescent abusers; families of abusers
AGE	Adolescents; mature adults
SEX	Both
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	29

PURPOSE

Although several different treatment facilities for adolescent drug abusers and their families have been established, few have had an acceptable level of success. This article reviews the literature concerning one integral part of many drug treatment programs: family therapy in the treatment of drug-abusing adolescents. The six areas explored include reasons for treating the family, the abuser's family life, approaches to treatment, the treatment process, treatment goals, and the treatment program.

SUMMARY

The basic reason for treating the family is that family disturbances are a major influence on the abuser's life. Dell Orto stated that the family is important in developing the problem and is therefore important in modifying it. Huberty stated that because most adolescent abusers return to the family the family structure must be changed prior to this return. Tec found that although parental drug abuse plays an important role in adolescent use, other family problems must also be considered.

Hirsch observed several traits of the abuser's family, including an unhappy marriage, a mother ambivalent toward the children, a relatively passive father, and similar personalities of mother and child. Frankel concluded that the relationship with the father is crucial; the abuser perceives the father as cold and is alienated from family life and lifestyle. Baer and Corrado studied heroin users and found that they had an unhappy childhood with harsh physical punishment, lack of parental concern for the child's goals or behaviors, and a lack of family cohesiveness. Seldin's study of addicts indicated that mothers were perceived as dominant, emotionally immature, conflicted, and ambivalent about their role in the family. Seldin also noted that one-third of parents and siblings of adolescent addicts needed psychiatric treatment. In a later study, Tennant found that parental drug dependency may have less of a relationship to the offspring's drug habits than previously demonstrated. Huberty found that the first drugs used are obtained within the home and that half of drug abusers came from drug-abusing homes. Other researchers noted that parents often condone the child's behavior, which becomes a vehicle for their own antisocial impulses. Further, drug abuse was found to cause financial hardship, emotional imbalance, and potential fragmentation of a family.

One treatment approach involves family seminars to teach decisionmaking, communication, interpersonal relations, and feeling exchange. Another program, developed by Gluckstern, Rollin, and Avey, involves training parents to counsel other parents of drug abusers. These methods may be useful for families without serious drug problems. Studies of the treatment process have shown that parents are reluctant to talk openly about drugs with their children and are often unwilling to get involved in treatment programs. Other potential problems include parental sabotage of the treatment program, parents' inability to cope with a healthy relationship with the child, and therapist's inability to counsel a child without the cooperation of the parents. The three prerequisites for treatment, as identified by Dell Orto, include family commitment, ability to see possible benefits from therapy, and overcoming feelings of failure and impending doom. Problems likely to occur in the later stages of treatment include the family's tendency to manipulate the counselor, to maintain the client's weakness, and to reinforce the problem.

Treatment goals include freeing negative feelings, increasing the commitment to the family, providing both freedom and responsibility toward the family, reducing substance abuse, building relationships, and inciting positive community involvement. Reinhardt describes two basic modalities of family treatment: family rap sessions about drugs and individual counseling. Five programs identified as useful with alcoholics include education, activity therapy, groups for self-growth and awareness, family involvement, and followup accompanied by family therapy. Other studies have focused on considerations relating to treatment, ideas that should be communicated to the abuser, and approaches to the abuser's parents. Dell Orto notes that the family's discovery of the drug problem and need for changing roles is traumatic. He also feels that the abuser should not be treated as a separate part of the family. Howe argues that every family member should realize that drug abuse has become as much of a solution as a problem for the family. Meeks and Kelly suggest that all must be involved in treatment, that shifts in family structure will cause disequilibrium, and that family members must be helped to accept compromise and to learn problemsolving techniques.

Seven mutual problems for the family and the abuser include ignorance about drugs, denial of chemical dependency, failure to accept responsibility, avoidance of all strong emotional expression, ambivalent feelings, lack of honesty, and the family as a model for drug abuse. In the later stages of treatment, Fox feels that family communication is the most important factor and that transactional analysis is helpful. Others have also found communication to be vital and believe that family therapy should focus on real life issues. Later stages of therapy are characterized by increased release of emotions, lowered anxiety, and other avoidance mechanisms.

CONCLUSIONS

The literature clearly indicates the need for family therapy in the treatment of adolescents who are abusing drugs. Some authors offer guidelines for treatment and note potential hazards, but the literature lacks systematic approaches to therapy.

Braucht, G.N.; Brakarsh, D.; Follingstad, D.; and Berry, K.L. Deviant drug use in adolescence: A review of psychosocial correlates. Psychological Bulletin, 79(2):92-106, 1973.

DRUG	Multidrug
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Drug abusers
AGE	Adolescents
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	102

PURPOSE

The paper is a critical review of the literature about the sociocultural and personality correlates of deviant adolescent drug use; it attempts to assess the level of psychosocial description and explanation that is presently available. Deviant drug use is defined as nonmedical use of consciousness-altering drugs and excessive alcohol consumption. Review material is categorized by drug types and is further divided into research on sociocultural correlates and personality correlates of use.

SUMMARY

Sociocultural Correlates of Adolescent Alcohol Use

The proportion of adolescent drinkers varies anywhere from 30 to 80 percent of the adolescent population, depending on regional variables; 2 to 6 percent of the adolescent population are problem drinkers. Knowledge of parents' drinking patterns is the singl most accurate tool for predicting adolescent drinking behavior. Furthermore, studies with college student peer groups, specifically fraternities, have supported the notion that peer influences on adolescent attitudes

toward drinking are substantial. Evidence on the relationship between religious affiliation and drinking behavior is also conclusive: the average drinker will probably be a Jew or a Catholic rather than a Protestant, but Protestant and Mormon students who drink are more likely to be problem drinkers than Jewish students. The differences are attributed to proscriptive versus prescriptive norms. Finally, adolescent problem drinkers are likely to have a loose affiliation with one of the abstinence-oriented religions. There has been little research on relationships between adolescent problem drinking and race, socioeconomic status, and living conditions.

Personality Correlates of Alcohol Use

There are a number of studies that address the issue of whether or not there is a pattern of common personality traits among adolescent problem drinkers. There is substantial agreement that adolescent problem drinkers lack personal controls, evidenced by relatively high aggressiveness and impulsiveness. There is some evidence that these adolescents have some neurotic tendencies in common: relatively low self-esteem, high anxiety, depression, and a general lack of success in achieving life goals.

Sociocultural Correlates of Adolescent Narcotic Use

Research indicates that the adolescent narcotic user is frequently a member of an ethnic minority and is often from an impoverished urban environment and a broken home. Further consensus exists on the importance of peer group enticement and availability of narcotics. While researchers agree that adolescent users frequently have deficient parental models, there is disagreement on the nature of this deficiency. One or both of the parents are characterized as being either overprotecting, overdominating, underdominating, or rejecting. The lack of consensus can be attributed to the heavy reliance on retrospective studies of the narcotic users' parents.

Personality Factors Related to Narcotic Use

There is fairly general agreement among researchers that most narcotic addicts have some mental problems or a disturbed personality, but beyond that there is little agreement as to the specific dynamics of the disorder. The authors note that the population of adolescent drug abusers, which is loosely defined, includes more than one personality type, and psychological predisposition to recruitment into this population may be different for the different sociocultural strata from which the adolescent abusers come, patterns of drug use, and differential involvement of various psychological functions of drug use. The authors question whether a psychopathology orientation is appropriate to primary prevention of drug use, and they cast doubt on the validity of the research findings.

Sociocultural Correlates of Adolescent Psychedelic Drug Use

Marijuana, LSD, and methamphetamine are the three major drugs considered here. Research in this area has centered on six major variables: sex, age, socioeconomic status, familial environment, peer group influence, and religious values. Researchers agree that adolescent psychedelic users come mainly from the middle and upper classes, but research regarding the role played by the five other sociocultural variables is plagued by either ambiguous or contradictory findings. As a result, no firm conclusion can be drawn as to the sociocultural correlates of adolescent psychedelic use, with the exception of the socioeconomic status findings.

Personality Correlates of Psychedelic Use

The authors describe a number of studies that suggest numerous preproblem use correlates of adolescent psychedelic use. Many of the findings were contradictory. They point out that even if all of the numerous personality traits described were valid, they would still leave unanswered the important questions of how the correlates fit together within any one individual, and why, given these person states, does an individual turn to psychedelic use. Difficulties with the data include often questionable accuracy of information, the heavy use of college populations, which excludes ghetto and other groups, and a nearly total reliance on male samples.

CONCLUSIONS

The research reviewed suffers from a number of methodological and theoretical shortcomings. Much of the sociocultural research is either retrospective or based on small-sample observational studies. For the large number of isolated statements that have resulted from the studies to be of explanatory value, they must be embedded in an explanatory theoretical framework. The theoretical approach should include both sociocultural and personality variables. The research also reflects a lack of coordination among alcohol, narcotic, and psychedelic researchers; the same variables may be involved in each kind of use.

Glynn, T.J. From family to peer: A review of transitions of influence among drug using youth. Journal of Youth and Adolescence, 10(4), in press.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Adolescents
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	129

PURPOSE

Although conflict between family and adolescents is one of the oldest, most predictable, and least avoidable of developmental conflicts, the specific focus on this conflict in the context of adolescent drug use is a more recent development. For this reason, the present study seeks to review the nature of family and peer influence on drug use and to outline conflicts presented in research thus far.

SUMMARY

Interactional and Independent Influences of Families and Peers

While a number of researchers argue that the family remains ultimately more influential than the peer group throughout adolescence, others support the view that during adolescence children move from identification with the family to seeking other sources of attitudes and values, leading to an almost exclusive adolescent peer orientation. A third group suggests that continuity or discontinuity between family and peers is neither total nor pervasive, and that adolescent and adult separateness is relative and varies with the issue involved.

Family and Peer Influences on Adolescent Drug Use

Kandel's developmental model considers each of three stages of drug use (initiation into hard liquor, marijuana, and other illicit drugs) from the perspective of four conceptual clusters (parental influences, peer influences, adolescents' beliefs and values, and involvement in certain activities). The elements of each of these clusters are viewed as additive sources of influence in a multiple regression analysis. Although the research conducted thus far on the influences of family and peers on adolescent drug use does not conform intentionally to this model, the bulk of the current studies in this area fall within these conceptual clusters. Findings relating to the complex matrix of interpersonal influences, especially those of family and peers, suggest that adolescents' drug behavior is at no point influenced by either family or peers alone. Family influence is not replaced by peer influence, although the overall balance of influence appears to shift toward the peer group. Adolescent acceptance of either family or peer influence with regard to the use of a particular drug does not mean rejection of the others' values and influence, since adolescents appear to rely on different resources at different times and in particular circumstances.

Family and peer influence seems to follow a predictable pattern across the stages of drug use: family and peer influences on adolescent alcohol use are about equal; peer influence is significantly greater than family influence on marijuana use; and family influence is stronger regarding illicit drugs other than marijuana. The most effective influences for delaying adolescent initiation into drug use (i.e., satisfactory family relationships, emotional support, and moderate alcohol use) are developed in advance of adolescence. Belated attempts by parents to make up for absence of these influences by strict control may increase rather than diminish drug use.

Peer influence is of a more limited duration than family influence and is directed at issues more immediate than long term. Peer influence is most evident in the first two stages of drug use. The last stage, in which the family has the most influence, often comes after the peak of peer influence and involves use of drugs such as heroin, which adolescents perceive as having great potential effects on their future.

Actual drug use patterns of family or peers have the strongest influence on adolescent drug use. Parental alcohol use is the best predictor of adolescent alcohol use, peer marijuana use is the strongest predictor of marijuana use, and family and best friend's use of other illicit drugs are strong predictors of adolescent use of the same substances. Despite marked peer influences, families may succeed in discouraging marijuana use when parents and children enjoy a good relationship before adolescence and when parents do not feel that the relationship will be ruptured by stating their exact position on their children's marijuana use.

Future Research

Areas warranting further research include changes in relative family and peer influence as age of first drug use drops; the dynamics of sex differences in family and peer influence on adolescent drug use; the nature of cultural, racial, and ethnic differences in family and peer influences; the predictability of peer influence on drug use; and the effects of activities by antidrug parent groups on the relative influence of family and peers. Research efforts should also consider the effects of parental developmental crises on their ability to exercise influence on adolescent drug use, the relative persistence of family and peer influence on adolescent drug use, means of using family and peer influence to delay adolescent initiation of drug use, and the issue of whether drug use leads to association with drug-using peers or vice versa.

CONCLUSIONS

The relative influence of peers and family on adolescent drug use varies according to a number of factors, although such influences follow fairly predictable patterns across the stages of drug use. Among the relevant factors, family and/or peer drug use habits and the nature of basic family relationships appear to be particularly important. Theoretical models such as that developed by Kandel provide a valuable basis for further research.

Harbin, H.T., and Maziar, H.M. The families of drug abusers: A literature review. Family Process, 14:411-431, 1975.

DRUG	Multidrug
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	46

PURPOSE

In drug abuse, as in other psychiatric problems, family treatment has been slow to develop, but family research has been even slower. The present study reviews all available literature that explores the family background of drug abusers. The goal is to enable future experimenters and financial backers of research to determine more effectively what studies should be done on families of drug abusers. While examining all research on the family of origin, the review focuses especially on the few well-planned projects that have tried to validate and quantify their data with the use of control groups. The articles are classified according to the methodologies used (i.e., clinical studies, clinical studies with quantitative results, and controlled research studies).

SUMMARY

Family Interaction Patterns

Family dynamics are instrumental to the development and maintenance of pathological drug use. A generalized pattern of interaction occurs between compulsive drug abusers and both their mothers and fathers. Mothers are indulgent and overprotective and tend to be involved with

their sons' addictions. Some studies, however, find either no increased agreement between mother-child dyads or even a small group of hostile mother-son relationships. The fathers are viewed in most studies as weak and ineffectual, although some studies characterize fathers as hostile and punitive. Overall, the addicts have no male figure with whom they can positively identify. The overprotectiveness of the mother and the absence of positive identification with the father are usually seen as separate variables in their contribution to the development of drug-abusing adolescents. The mothers' pathogenic presence is granted more significance as a causal factor, but this may or may not be a correct assumption. In any event, this is inconsistent with family systems theory, which considers these parental characteristics as interdependent. An increased percentage of absence of one of the parents during the addicts' childhood and early adolescence is noted by all studies as a significant factor in addiction of both males and females. Only three studies deal exclusively with females, and those that include both sexes make no differentiation of results by sex. However, one study reports that the fathers of female addicts tend to be inept, alcoholic, and sexually aggressive to their daughters, while mothers compete with their daughters.

A Critique of Methodology

Clinical studies are the most theoretical and provide the greatest in-depth formulation of family interactional dynamics. However, without quantification and control these studies remain speculative; they are useful, however, for initiating systematic evaluation of family dynamics. Although clinical studies with quantitative results validate certain family patterns, the specificity of the findings for families with compulsive drug abusers cannot be established without controls. Controlled studies thus produce the most reliable data. The comparison of normal families with families containing a drug-abusing, schizophrenic, or neurotic individual provides a beginning for identification of specific interactional patterns within these various types of families. Even in this type of study, criteria for the types of drug abuse are sometimes unclear; subjects may be occasional rather than compulsive drug abusers, so that differences in family dynamics of the two groups are obscured.

The three kinds of studies share specific methodological problems. First, the studies rarely interview family members other than the addicts or examine interactional patterns directly. While this method facilitates understanding of the addicts' perceptions, the reality of family life is likely to be distorted when viewed from only one perspective. Additionally, many studies fail to specify socioeconomic status, race, and sex of the subjects. Finally, the family pattern characterized by an indulgent mother and a distant or absent father is consistently identified, but little attempt has been made to refine the classification. This same pattern has been found for families of homosexuals, school-phobic children, and schizophrenics, yet only one study attempted classification of overprotective mothers into types. This lack of specificity is likewise seen in the use of such vague terms as narcissism, masochism, and aggression, which are inapplicable to interpersonal transactions. At this point, specific subcategories of interactional patterns for families with a drug-abusing member must still be established.

CONCLUSIONS

Future studies should include exact data on the type, frequency, and duration of drug abuse, as well as on the sex of the drug abuser. Families studied should have similar socioeconomic backgrounds so that differentiation of specific interactional dynamics for various cultures is possible. The entire family of origin (i.e., parents and siblings) should participate in research to facilitate comprehensive assessment of family functioning. The relevance of particular family styles to the development and maintenance of a drug-abusing child should also be considered. Areas warranting further exploration are use of drug addiction by adolescents as a means of maintaining family involvement or by parents as a means of maintaining control over the addict and the effects of psychotropic drug use by parents on their children's drug behavior. Finally, control of comparison groups (e.g., families of schizophrenics or neurotics) must be used to assess the nature and degree of pathology in drug-using families.

Klagsbrun, M., and Davis, D.I. Substance abuse and family interaction. Family Process, 16(2): 149-164, 1977.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	108

PURPOSE

A small but steadily increasing flow of literature supports the notion that the family system has a significant role in maintaining a substance abuse problem. The present study is a selective one that focuses on functional relations between individual substance abusers and their families. As a conceptual gap has developed between therapeutic techniques and theory building, the authors also recommend further areas for research and methods of specifying and testing hypotheses.

SUMMARY

Literature Survey

A number of uncontrolled studies characterizing the substance abuser's family convey an image of a disturbed family with an emotionally distant father and a centrally powerful mother. Within this context, drug addiction is not only a manifestation of the adolescent's personality disturbances but is symptomatic of a wider family problem. The relationship between substance abusers and their families has been found to be extremely close. Family variables predictive of low,

middle, and high risk are value systems, including religious beliefs; characteristic patterns of interaction; and substance use of parents, especially alcohol. However, as interesting as such composite pictures of substance abusers' families are, they provide little insight into why a particular family should have a substance abuse problem rather than another type of disturbance.

Clinical-descriptive studies have delineated family patterns observed in families with a drug-using member. Drug use is considered functional for individuals in that they protect themselves in this way from painful feelings aroused in the family situation and provide themselves with some form of validating experience not available in the family. Drug use also serves a stabilizing function in the family by distracting attention from underlying conflicts, such as marital discord. Sons' addiction may be encouraged by weak fathers who do not want competition, and offsprings' periods of drug use increase the interaction between otherwise distant parents. General family communication may be increased by the behavior of the substance abuser. Addictive episodes appear to be triggered when the family reaches a critical level of anxiety. After the abuse episode has diverted the family's attention, the child's drug-abusing behavior will decrease until triggered once again by anxiety. Within the study of family systems, a number of studies are now devoted to family subsystems. Studies have shown that in certain dyadic relationships drugs appear to render interaction more satisfying.

Areas for Further Investigation

Certain basic assumptions can be made about the maintenance of substance abuse in the family. First, drug-induced psychological mechanisms alone are insufficient to account for the reinforcement of substance abuse. An explanation for drug abuse must be sought in the interpersonal contexts of drug abuse, particularly in family interaction. Furthermore, drug use is not usually simply incidental to interactional issues but rather is central in maintaining interactional equilibrium, at least once a chronic pattern of abuse has evolved. Chronic, self-destructive drug use is reinforced by a common set of factors and serves a continuous function. Thus, substance abusers and their families may become stuck in a self-perpetuating, self-aggravating cycle.

Given these assumptions, systematic understanding of the role of the family in substance abuse might be furthered by an analysis of different aspects of family characteristics relevant to drug use (e.g., behavioral conditions of the drug use situation, affective conditions of the use situation, self-perception and interpretation of the family under use conditions, and comparison with a normal situation). Special attention must be devoted to repetitive patterns, family members affected, and impact of the patterns on the abuser. Attempts must be made to measure signs of increased family disorganization prior to drug taking, such as anxiety, dyadic conflict, blurred role relationships, and changes in self-perceptions. Stereotyped behavior during drug taking and decreases in disorganization after drug taking should also be considered when testing hypotheses. The clinical-descriptive approach can contribute toward generating limited, testable hypotheses.

Problems of Method

Crucial problems for research are to what extent the family's functioning can be assessed by outsiders, how to allow for the impact of the research on the system, and how far the researcher can intervene in the family system. Furthermore, the problem of what aspects of the family system to focus on may be overwhelming. A compromise is necessary whereby a Gestalt view of the repetitive patterns in family interaction may be combined with a close microanalysis of the interaction in important contexts. Videotaping is essential to this approach. It is questionable whether substance abusers can be considered a homogenous group, but the issue of typology must await empirical investigation.

CONCLUSIONS

Efforts toward understanding substance abuse in terms of family contexts are still at an early stage. It is possible that the variables identified in these families will also be found to operate in other families for whom drug abuse is not a problem. By focusing on drug use episodes, researchers can sample processes that operate continuously in most families but are not readily observable unless highlighted by some affect-laden context.

Olson, D.H.; Russell, C.S.; and Sprenkle, D.H. Marital and family therapy: A decade review. Journal of Marriage and the Family, 42:973-994, 1980.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Cross-sectional
METHODOLOGY	Literature review; circumplex model of marital and family systems
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	1970-1979
NO. OF REFERENCES	212

PURPOSE

During the 1970s, marital and family therapy emerged as a significant and separate mental health field. It is now becoming the treatment method of choice for problems ranging from cases of adolescent delinquency to problems with alcoholism. The rapid emergence and acceptance of marital and family therapy has had a dramatic impact on the entire mental health profession. Professionals are increasingly finding that treatment of most problems can be more effectively accomplished if the client's significant others are involved in the treatment process. This paper reviews the major theoretical developments of marital and family therapy as well as the outcome research on the effectiveness of this therapeutic approach in the 1970s. The review is selective and highlights the major trends and studies.

SUMMARY

Theoretical Developments

The past decade has been characterized by the exploration and refinement of existing ideas rather than by the introduction of major new theoretical approaches. The identifying

characteristic of the field has been the emphasis on treating problems within a relationship context. The exploration of various theoretical approaches has been enhanced by several deliberate attempts at classification. For example, Guerin identifies two basic family groups, those with a psychodynamic and those with a systems orientation. Ritterman uses the mechanistic versus organismic views of systems to compare family therapy approaches. Gurman compares theories on the basis of the role of the past and the unconscious, the nature and meaning of presenting problems, the importance of mediating goals, and the importance of ultimate goals and various roles of therapists.

Attempts to integrate concepts and principles and develop theoretical models have followed classification attempts. A recent integrative model based on the classification systems is the circumplex model of marital and family systems developed by the authors of this paper. This model is used to organize and summarize the conceptual development in the field of family therapy and to demonstrate the conceptual similarity across the various approaches. The model focuses on three dimensions: cohesion, adaptability, and communication. The integrative nature of the dimensions in the model, particularly those of cohesion and adaptability, are illustrated by a brief discussion of the work of two outstanding therapists, Minuchin and Whitaker.

Schools of Family Therapy

Several schools of family therapy have come to the forefront during the 1970s. These include the highly influential structural family therapy that centers around Minuchin and the Child Guidance Center in Philadelphia; strategic family therapy, including Haley's approach; the Mental Research Institute communicational approach; and the strategic group approach. Experiential family therapy has as its proponents Whitaker, Napier, and Keith, and the social learning approach is organized around the tenets of social learning theory.

Treatment Strategies

Steinglass recently verified clinical observations that families are more willing to cope with their problems when the alcoholic member is drinking. Steinglass's studies on the treatment of families with alcoholics imply that therapeutic intervention should be aimed at increasing the behavioral repertoire of the interactional system (by increasing its flexibility during nondrinking periods, for example). Davis and others emphasize the value of focusing on factors that maintain alcoholic behavior. Investigators in this area have also helped sensitize professionals to the dangers of stereotyping families based on the presenting complaint and to the importance of observing the symptom.

When drug abuse is the presenting complaint, adolescents or young adults are most often the identified patients. Family therapists are increasingly interpreting drug abuse as part of the system's attempt to adapt to loss experienced through launching, death, or disengagement from a career. Despite the appearance of independence and distance, these adolescents are loyal to the family, which maintains its stability and homeostasis by defining the addict as dependent and as incompetent. The most common family treatment has been conjoint family therapy based on a variety of theoretical approaches. Other forms of treatment for drug abusers and their families include marital therapy, parent groups, concurrent parents and adolescent groups, sibling groups, multiple family therapy, and social network intervention. Research at the Philadelphia Child Guidance Clinic showed that conjoint family treatment was 1.4 to 2.7 times as effective as other forms of therapy in producing drug-free days. Therapy was also effective in reducing conflict and in increasing the involvement of fathers in family interaction. However, studies outcomes of structural family therapy and multiple family therapy are difficult to interpret due to methodological limitations. Other areas in which family therapy has been used include juvenile offenses, adolescent psychopathology, childhood conduct problems, work and school phobias, psychosomatic symptoms, adult depression, and marital distress.

CONCLUSIONS

Family therapy appears to be as effective as individual therapy for a wide range of presenting problems. However, the best type of family treatment cannot be specified for most presenting problems, and no one approach has been demonstrated to be effective with a wide range of presenting problems. Therapist relationship skills are important regardless of the conceptual

orientation or "school" of the family therapist. Moreover, methods for evaluating family therapy have advanced considerably in the 1970s. Future outcome research should include increased assessment of outcomes by practicing therapists, continued use of multiple outcome measures, and greater specification of treatment procedure applied to a narrowly defined client group. Future approaches should bridge research, theory, and practice; treating family systems rather than family symptoms is a promising future trend. Other theoretical and empirical typologies that facilitate the bridging process are being developed. Specialities such as sex and divorce therapy are emerging, and preventive and enrichment programs for couples and families are of increasing interest.

Salmon, R., and Salmon, S. The causes of heroin addiction--a review of the literature. Part II. The International Journal of the Addictions, 12(7):937-951, 1977.

DRUG	Heroin
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Addicts and their families
AGE	Not specified
SEX	Both
ETHNICITY	Cross-cultural
GEOGRAPHICAL AREA	Cross-sectional
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	56

PURPOSE

Many family factors have been associated with drug abuse, and conventional wisdom considers the family to be partly responsible when a child become addicted. The difficulty of enlisting family participation in dealing with drug addiction treatment is also widely acknowledged. Nevertheless, few works are devoted to the addict's family. This literature review considers the family of the addict, based on material from the disciplines of psychology, sociology, social work, and psychiatry. Most of the studies were conducted in the 1950s and 1960s.

SUMMARY

In a study of 1,844 boys involved with drugs, Chein found the presence of a weak ego structure, weak superego, inadequate masculine identification, lack of middle class orientation, and distrust of major institutions. He found that addicts' home environments were characterized by cool, hostile parent figures, a weak parent-child relationship, lack of clarity in disciplinary policies, vague or inconsistent parental standards, disturbed parent-child relationships, lack of strong father relationships, and an inability to maintain marital relationships. Rosenbloom's study of 32 Jewish patients showed that they had a lack of ego strength, inability to maintain marital

relationships, and a history of poor relationships with their fathers. Hill took the operant conditioning position that addicts' social deviancy has much to do with family background and poor family conditioning, which results in a lack of social controls. McCord also associated family disorganization with an inability to socialize the children or provide emotional sustenance. Davis noted the number of conflicts between parents and children, especially in urban areas, and emphasized that in cities young men dramatize their conflict with parental authority by joining a gang. This group becomes the norm-setting agent regarding drugs. Goode noted that the lack of emotional maintenance leads to family dysfunctions, which promote deviance in general and addiction in particular. Rosenfeld noted that a high percentage of addicts' families were broken by divorce, death, or desertion.

Rado, Erikson, and Fort have referred to oral regressiveness as part of narcotics abuse. Vaillant's study of 100 addicted treated at Lexington found that a significant number of addicts lived with their mothers throughout their twenties, which emphasizes the addicts' dependence on their families and underscores Fort's description of the addict's desire for a close association with women even though the addict's relationship with women is ambivalent. Thompson noted that addicts' families perpetuated juvenilization, and Rosenberg's studies of British addicts and their families indicated that drug addiction is not only a manifestation of the adolescent's personality disturbance but is symptomatic of wider family problems. Similarly, Bean, who also examined the British addict, found that about 30 percent of the study sample were from homes broken before the child was 15. Much of the available literature reports a consistent pattern of disturbed relationships with mothers and unsatisfactory fathers. Mothers were variously described as overprotective, dominant, and overindulgent, while fathers were characterized as weak or absent. Nyswander noted that addicts were infantile, unable to defer pleasure or to express healthy aggression, and did not surpass the family in achievement. Nevertheless, Nyswander found no outstanding characteristic in the family structure predisposing a member toward addiction. In relation to family structure, Crockett noted that the less structure in the immediate social circumstance of the individual's life, the more likely that the deviance of drug abuse will develop. An association between drug taking and a poor relationship with the father was also noted. Yet both Nyswander and Crockett indicate that while addicts may exhibit certain personality characteristics, and the family background may be pathological, there is no indication that specific environmental or psychological or constitutional features clearly predispose an individual to drug addiction. Roebuck found that addicts were not necessarily from broken or conflicting homes but experienced maternal dominance.

The stepping-stone theory is also discussed. Although this theory has been widely promoted, and although marijuana use often precedes hallucinogen or heroin use, several studies show that only a small percentage of marijuana users go on to use heroin. Despite this evidence, the stepping-stone theory, along with the myth of the pusher as a cause of addiction, persists.

CONCLUSIONS

The literature regarding the family in relation to drug addiction offers a variety of themes. These include the pictures of the addict as an immature person with an unstable family environment, the father as a shadowy figure, and the mother as a dominant force in the family. Poverty, a debasing environment, and other stresses are also felt to be influential. Nevertheless, many people exposed to such conditions do not become addicted. Thus, a combination of factors, including the nature of family life, may lead to addiction. Multiple causation needs to be accepted as a reality. Just as there are multiple causes of addiction, a variety of treatment techniques and procedures will be needed to reach addicts. However, the methodological limitations of the studies on which theories of addiction are based mean that conclusions must be highly tentative at best. Potential intervention agents need to consider such constraints and limitations as small sample size and the study's relevance to the contemporary heroin scene. Further research and efforts to move beyond the theories to try to achieve needed intervention goals are needed.

Seldin, N.E. The family of the addict: A review of the literature. The International Journal of the Addictions, 7(1):97-107, 1972.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Addicts and their families
AGE	Not specified
SEX	Male
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Cross-sectional
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	35

PURPOSE

This paper reviews material on addicts' families from the fields of psychiatry, social work, sociology, and psychology. The clinical data discussed refer to addicts who are "visible," or known to treatment agencies. Most of the studies cited are from the 1950s and 1960s, and several are from the 1930s and 1940s.

SUMMARY

Sociology

More literature focuses on the addict's family of origin than on the addict's marital life. Many family analysts have considered lack of emotional maintenance by the family to be a key factor in urban family disorganization and, as a result, in drug addiction. Goode presents the classical view of the family as socializing the individual but adds the function of "emotional maintenance," of particular importance to city dwellers. McCord found that most youthful addicts came from families affected by divorce, desertion, or open hostility between family members. Kingsley Davis relates parent-youth conflict to rapid social change in urban areas, and Ball verifies the

greater involvement of urban youths in addiction. Clinard, however, prefers to blame peer-group associations for addiction, and Lindesmith disputes any theory of an addiction-prone personality. Furthermore, Mowrer believes that researchers should look beyond sociological theory for an understanding of alcohol addiction and, by inference, drug addiction. Talcott Parsons takes a structural-functional view of the family that combines the psychoanalytic concept of psychosexual development with role theory. The drug addict is viewed as deviating from the normative pattern of relinquishing oedipal attachments to assume roles involving providing for others. Pollak also bridges formal disciplines by weaving social system theory into psychoanalytic theory. Thus, the addict is considered a passive individual. Finally, O'Donnell's study of 266 addicts showed that males tended to marry addicted or otherwise deviant mates, or cause their mates to deviate, especially into addiction following marriage; most of the marriages ended in separation or divorce.

Psychology

Chein's study of personal and community aspects related to young male addicts found that the mother was often seductive and emasculating, while the father was morally vague, pessimistic about life, easily swayed, and had a poor job history. The family process is inconsistent and arbitrary. Male addicts flee into marriage but frequently return to the mother in defeat. Rosenfeld reported that many addicts' families were broken by death, divorce, or desertion, and that the typical family was not very cohesive. She described the mother as an immature parent and the father as a remote, detached figure. The work of Hill focused on poor family conditioning; the addict, who cannot delay gratification, comes to drugs with a socially deviant personality. Drugs reinforce both psychologically and physically. The addict learns goal directive behavior to secure drugs.

Psychiatry and Social Work

Ackerman believes that social roles begin in the family process and that adolescent psychopathic conduct is contagious in a social sense. Rasor refers to adolescence as the most vulnerable period for engaging in drug addiction and describes the deficiencies of addicts' families in meeting youths' emotional needs. Erikson and Rado refer to addicts' regression to the oral phase of infancy. Fort, who worked directly with drug addicts, agreed that the young male addict's character is essentially oral and narcissistic. He found strong ambivalence toward the mother usually toward other females. Heroin served the need of taking away sexual urgency and removed the challenge of manliness. Nevertheless, Fort and Vaillant have both found that male addicts constantly need association with females. Vaillant found that a high percentage of addicts had remained with their mothers or another female blood relative as late as age 30. Nyswander found that mothers had intimate and overprotective relationships with addicts. Mason also found the mother to be the dominant family figure. Mother manipulation has also been described by Gerard and Kornetsky, who suspected that the addict mother provokes deviant behavior in her children and then disapproves in a sanctimonious manner. Wolk and Diskind reported that their clinical experiences indicated that most addicts' mothers were emotionally ill and fostered a parasitic dependence in the addict-child. In a study of 16 married couples in which the husbands were drug addicts, Osnos and others found the wives to be attracted to the weaknesses of their addict spouses. Seldin added that addicts sought the company of others who provided a consensus of sociopathic values. If they marry outside this group, they may run up against role expectations they cannot fulfill, and the marriage deteriorates in a short period of time.

CONCLUSIONS

The literature on the visible male addict emphasizes his immature personality development. Both learning theory and psychoanalytic theory indicate that the family plays a crucial role in the formation of the addict's personality. The typical family of an addict provides an unstable environment for emotional growth. The mother, who dominates the family, is emotionally immature, conflicted, and ambivalent about her family role; the father is detached and uninvolved with the family. This situation provides poor conditioning for addicts in their own assumption of the roles of husband and father. The addict is likely to repeat the original family dynamics by marrying a dominating, psychosexually ambivalent woman who perpetuates the addict's immature behavior patterns.

Sowder, B.; Dickey, S.; and Glynn, T.J. Family Therapy: A Summary of Selected Literature. DHEW Pub. No. (ADM)80-944. Rockville, Md.: National Institute on Drug Abuse, 1980. 41 pp.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	117

PURPOSE

The review summarizes selected literature written or published through 1977 on the subject of family therapy. Among its specific aims is to provide an overview of the findings from empirical research designed to determine the effectiveness of family therapy with drug abusers.

SUMMARY

Development and Approaches of Family Therapy

Family therapy has gradually gained widespread acceptance as a psychosocial intervention technique since its recorded beginnings in the early 1950s. According to this approach to therapy, deviant behavior of any one family member is viewed within the family system and should not be considered either an isolated act or a random set of occurrences. The definition of deviant behavior may vary from family to family, and causes and effects of deviant behavior in a family may involve several levels of the family system.

Among the major family therapy approaches are multiple impact therapy, structural family therapy, systems-oriented approaches, and existential approaches. Structural family therapy has been used with some success for treatment of heroin addicts' families and other families in which children are frequently the victims of shifting alliances. The process assumes that the context of individuals affects their inner processes, that changes in context cause changes in individuals, and that the therapist's behavior is significant in any movement toward change in family structure.

Family Therapy With Drug Abusers

Studies have tended to focus either on descriptions of characteristics of drug abusers' families or on treatment techniques. While the former provides useful background for practitioners, discussions of treatment programs relate directly to practitioners' practical concerns. Various types of multifamily therapy programs have been implemented as a means of providing treatment staff with a network of resources to reach clients and of consolidating and educating family members as allies in therapy, especially for postprogram rehabilitation. Systems approaches seek to identify the cyclic process involving addicts and their parents so that step-by-step therapy can modify the dysfunctional family patterns. Family therapy is considered especially useful for reaching adolescent drug abusers who still have formal family ties and are not longstanding drug users. Unfortunately, a thorough review of the literature suggests that research has provided little empirical data on the outcome of family therapy with drug-abusing populations. Existing studies are based on small sample sizes and different family therapy approaches; most studies lack equivalent comparison groups. While the findings cannot be generalized to family therapy services in the drug treatment field, they suggest that several approaches, such as structural and multifamily therapy, may be effective.

Effectiveness of Family Therapy for Drug Abusers

Clinical and administrative staff considering the introduction of family therapy as a treatment modality are likely to want to know whether the technique has proven successful. As outcome data on family therapy programs for drug abusers are limited, general outcome evaluations of family therapy can be substituted. A number of reviews suggest that evidence for the efficacy of family therapy is not overwhelming, but this may be the result of difficulties inherent in outcome measurement, such as multifactoral effects, continuous change in the unit of study, involvement of complex social and cultural variables, and lack of adequate success criteria or an acceptable method for comparing treatment systems as well as a universally recognized classification system for clinical conditions. The most recent comprehensive review gives family therapy a muted endorsement as possibly more effective than individual therapy for a wide variety of problems. Outcome studies dealing specifically with family therapy and drug abuse, although limited in number and scope, suggest more strongly than the general studies that family therapy may be an effective modality. Individuals interested in instituting family therapy programs can only be advised to keep abreast of current applications of family therapy to drug-abusing populations.

CONCLUSIONS

Any use of family therapy as exclusive or supplementary treatment for drug abuse should be regarded as an opportunity to evaluate the effectiveness of the method. There is a strong need for well-controlled longitudinal studies of the effects of family therapy with drug-abusing populations. Such studies are needed for drug abuse in particular because short-term studies may distort the actual effectiveness of the technique. To achieve the most accurate assessment of effectiveness of family therapy with drug-abusing populations, posttreatment monitoring should be conducted for several years. Research must also extend to different types of families; much research has thus far been devoted to white, middle class families, an unrepresentative group for drug abuse treatment. Further research must determine which forms of family therapy can best be used for the treatment of particular types of drug abuse for particular families. Finally, research is needed on the costs of different family therapy approaches and on the background, training, and experience required of therapists or counselors to deliver effective family therapy services.

Stanton, M.D. Family treatment approaches to drug abuse problems: A review. Family Process, 18(3):251-280, 1979.

DRUG	Multidrug
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Adolescent abusers; families of abusers
AGE	Adolescents; mature adults
SEX	Both
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	139

PURPOSE

In recent years, interest in the family's role in the genesis, maintenance, and treatment of drug misuse and dependence has increased. Thinking in the drug field has broadened to include viewing substance abuse relative to others involved, such as family and peers. Although family treatment approaches have long been used in the field of alcoholism, drug treatment programs began using family techniques only in the late 1960s and early 1970s. A recent survey by Coleman and Davis indicated that most drug programs provide family services; many appear also to have some knowledge of the techniques and theories prevalent in the overall field of family treatment.

At least 5 overviews of the family and drug abuse literature and over 370 related publications have been published. However, no review has covered the various forms of family treatment used for drug problems or their results. This paper aims to fill that gap and to discuss the implications of these approaches for treatment, training, prevention, and future research.

SUMMARY

Drug misuse appears initially to be an adolescent phenomenon. Kandel and others have noted three stages in adolescent drug use: the use of legal drugs, which is primarily a social phenomenon; the use of marijuana, which is also mainly peer influenced; and the frequent use of other illegal drugs, which appears to be contingent largely upon the quality of the parent-adolescent relationship. Thus, more serious drug misuse appears to be mainly a family phenomenon. Most of the literature describes the prototypic drug abuser family as having one parent who is intensely involved with the abuser and one parent who is more punitive, distant, or absent. Usually the overinvolved, indulgent, overprotective parent is of the opposite sex from the drug abuser. For addict families, the cluster of distinguishing factors seems to include a higher frequency of multigenerational chemical dependency, more primitive and direct expression of conflict, parental behavior that is conspicuously unschizophrenic in quality, and a peer group to which the addict retreats after family conflict. Other factors include symbiotic child rearing practices by the addict's mother, a preponderance of death themes, and the indication that addiction provides a form of pseudoindividuation at several levels. Accultural variables and parent-child cultural disparity may also play a major role in the development of addiction. Drugs may serve various functions in the family, including maintaining the family's dynamic equilibrium, aiding the labeling of a member as helpless and incompetent, and unifying the family.

A review of 68 studies and programs shows wide variations in the types of data collected, the method of analysis used, and the reporting of results. The main types of therapy used are marital treatment, group treatment for parents, concurrent treatment of the parents and the identified patient, treatment with individual families, sibling-oriented treatment, multiple family therapy, and social network therapy. An analysis of 18 papers that discussed efficacy of treatment did not have as much of a following or demonstrate the same level of efficacy as some other modalities. On the other hand, certain approaches within the following modalities appear quite promising: group treatment for parents, multiple family therapy, and outpatient therapy with individual families. Among the predominant philosophies of family therapy, the most impressive evidence of success has been obtained with structural or structural/strategic therapy. This finding may result from the tendency of nonstructured groups not to gather outcome data, although they may be using effective therapy methods. Groups should make at least a minimal effort to assess results, both to meet obligations to consumers and professionals in the field and to permit refinement of the techniques used.

CONCLUSIONS

Treatment from an interpersonal systems viewpoint rests on certain assumptions about relationships and behavioral patterns. These assumptions differ from those in other theories about human behavior and institutions. The diversity of family therapy approaches described in the literature is striking. Little attention has been given, however, to treatment effectiveness. Drug programs must focus on the problems of recruiting family members, providing effective treatment, and intervening directly in and changing the family process surrounding detoxification and readdiction. Confidentiality provisions, which complicate the process of family therapy, must be considered, and treatment delivery systems need to be better publicized. Further, the administrative handling of family treatment is currently oriented to individual therapies and should be changed to be responsive to family approaches. In addition, improved training in family therapy is needed; videotapes for family therapy training and supervision are especially in demand.

Of the various approaches to psychotherapy, family treatment has perhaps the clearest implications for prevention because more people are involved and treatment increases the chances of preventing problems among other family members. Specific target groups for which family treatment appears to be particularly appropriate as a preventive method are children of addicts, siblings of drug abusers, parents of junior and senior high school students, parents facing the "empty nest" syndrome, families in crisis, and families in which parents have immigrated from other countries or regions. Research should focus on outcomes of different therapies and on how to prevent families from abdicating responsibility for their addict members.

Stanton, M.D. Drugs and the family. Marriage and Family Review, 2(1):1-19, 1979.

DRUG	Multidrug
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Familes of abusers
AGE	Not applicable
SEX	Both
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	81

PURPOSE

An extensive body of literature on the role of the family in drug use and abuse has accumulated over the past few years. Reviews have focused on families of drug addicts, families of compulsive drug users, family interactional aspects of drug abuse, and family approaches to treating drug problems. The author attempts to update earlier reviews and to bring greater cohesion to a field that has been somewhat scattered in its efforts and perspective. Narcotics, depressants, stimulants, hallucinogens, cannabis, and polydrug use are considered.

SUMMARY

The quality of past studies varies. In general, the field is progressing from reports by users about their families to dyadic and triadic concepts and assessments of the entire family's behavior.

Narcotics

Heroin and narcotics have been studied more than other drugs from a family perspective. Literature reviews describe a generalized pattern for the families of male addicts. The mother is involved in an indulgent, overprotective, overpermissive relationship with the addict, who is put in the position of a favored child and never treated as an adult. Fathers of male addicts are reported to be detached, uninvolved, weak, or absent. In contrast to males, female addicts are in competition with their mothers and report their fathers as inept and sexually aggressive. Furthermore, most narcotics addicts maintain close ties to one or both parents up to and beyond age 30. Addicts' dyadic relationships tend to repeat the nuclear family, and many children of addicts are born addicted and experience the consequences of their parents' drug abuse.

Depressants

Few studies have been performed on family factors among people who misuse barbiturates and other depressants. Schwartzman claims that families of barbiturate addicts and heroin addicts do not differ significantly in behavioral interactions. Streit and others found that barbiturate users reported less love, more autonomy, and more hostility from their parents than did nonusers.

Stimulants, Hallucinogens, and Cannabis

Studies on family factors in stimulant misuse indicate that adolescent stimulant use is associated with parental stimulant use, early parental bereavement or separation, and perceptions of less love and more hostility with autonomy from parents in comparison to nonusers. The study by Streit and others showed that adolescent LSD users perceived more hostility with autonomy and less love from their parents than did nonusers. Other studies indicate that parents of LSD users had high expectations for their children but impeded their struggles for independence.

A literature review on family factors in marijuana use indicates that users are more likely to come from broken homes and have poor parental relationships, liberal parents, fathers who use alcohol and tobacco, and mothers who use tranquilizers. Several studies have found that marijuana use by peers is a better predictor of marijuana use than is parental drug use, but the highest rates of marijuana use are reported by subjects whose both best friends and parents are drug users.

Polydrug Use

The literature indicates that family variables in polydrug misuse include low parental supportiveness, low self-esteem, help-rejected mothers who are disidentified with their own mothers, and parental use of alcohol and other legal drugs. Moreover, adolescents seem more likely to follow the example of the parent of the same sex. Compared with scores of whites across several socioeconomic levels, lower class black families in which the woman is the main wage earner are least likely to use drugs.

Nondrug-Using Families

Reports on families with little or no drug use indicate that the offspring of these families perceive more love from both parents, particularly the father. In addition, there is less discrepancy between how the parents view their children ideally and how they actually perceive them. Moreover, parents and their children's friends are compatible; parents have more influence than peers; and less approval of drug use is voiced by parents and peers. More spontaneous agreement is observed in problemsolving, and the families are slower but more efficient in reaching solutions. Furthermore, the families function more democratically or quasidemocratically, with shared authority and better communication than in drug-using families.

Family Treatment

Studies on family treatment show that drug-taking behavior is often overlooked by other family members and even encouraged in some cases; it is not uncommon for the family to sabotage treatment efforts. Thus, family support for and involvement in treatment is crucial. To date, the most common treatment approach has been conjoint family therapy. Although few papers on family treatment approach present outcome data, results indicate that family therapy can be effective.

Data also indicate that drug use is a concomitant of adaptation to stages in the family developmental life cycle. The most pivotal stage is adolescence. Adolescent drug use has at least three stages. The first stage is use of legal drugs, such as alcohol, and is primarily social. The second stage, use of marijuana, is tied to the normal process of growing up and experimenting with new behaviors. The third stage of drug use revolves around the process of using drugs regularly, compulsively, and indiscriminately. At this point, the family appears to be of paramount importance as it is usually caught in repetitive cycles of behavior that help to keep the addict dependent and imcompetent. A simple modeling theory does not provide a full explanation of the phenomenon of this stage of drug taking.

CONCLUSIONS

Data on families with serious drug abuse problems suggest desperate clinging on the part of the family when the adolescent starts to turn to outside relationships. The implication for change in such a family might be to strengthen the relationship between the parents, thus mitigating the need for a third party (i.e., the adolescent). However, unless adequate compensatory support systems develop, prospects for the next few years are for an increase in the number of single parent families, with a resulting increase in the chances of parental overdependency on the child. The end result will be a greater proportion of families with offspring who misuse drugs.

Policies on drug use should be analyzed for their impact and implications on the family; policies that lead to the dissolution of family ties should be questioned. Drug use needs to be seen more as an interpersonal phenomenon occurring among people than as a purely chemical problem. Less concern about specific drugs and more concern about the familial functions served by drugs are needed. Research should focus on actual behavior of families and on the outcomes of different therapies. Treatment delivery systems should be modified to be responsive to family approaches. Education for prevention needs to be aimed more directly at parents and families rather than at school systems. Education should be based on sophisticated knowledge of family dynamics, patterns, and child-rearing practices and should focus on the adaptive role that drug use can serve in the family. Emphasis should be placed on the positive ways in which families can deal with drug-related problems. A sense of hope should be conveyed because there does appear to be hope.

Ferguson, P.; Lennox, T.; and Lettieri, D.J.; eds. Drugs and Family/Peer Influence. National Institute on Drug Abuse Research Issues Series No. 4, DHEW Pub. No. (ADM) 85-186. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1974.

This fourth volume of the Research Issues Series is a companion volume to the present one. Unlike the present volume, however, its scope includes peer influence. The book is divided into five chapters. The first two contain 19 abstracts of works that emphasize peer influence on drug use, although a few of these also discuss family influence. The last three chapters abstract 18 representative works from family literature. The concentration of the volume is primarily on articles published between January 1958 and January 1974. Certain "classics" are also abstracted.

The emphasis of the chapters on the family is on the influence and interaction of the addict's family, on parents as models, and on childhood experience. Many of the articles that appear in the volume are also cited in the bibliography to this work; these are denoted by an asterisk.

Stanton, M.D. The family and drug misuse: A bibliography. American Journal of Drug and Alcohol Abuse, 5(2):151-170, 1978.

This nonannotated bibliography contains 370 listings of nonalcoholic drug misuse and dependence reports published through early 1978. To compile the listing, the author used 14 existing literature reviews and computerized literature searches, which encompassed these data bases: MEDLARS II, MEDLINE, Psychological Abstracts, Smithsonian Science Information Exchange, and Sociological Abstracts. In addition, the author listed a number of papers known to him that were not identified elsewhere and reviewed bibliographies and references of the various publications, which resulted in additional listings.

The listing identifies articles dealing with treatment and denotes literature reviews, compendia, and bibliographies.

FAMILY DYNAMICS

The concept of family dynamics is a broad one, and that breadth is reflected in the variety of studies included in this section. While such seemingly diverse issues as decisionmaking, cultural disparity, family structure, child abuse and neglect, interpersonal relations, and the role of the mother are addressed here, the single research question, "What goes on within a family that either supports continued drug use or aids in bringing it to an end?" ties these issues together.

Alexander, B.K., and Dibb, G.S. Interpersonal perception in addict families. Family Process, 16(1):17-28, 1977.

DRUG	Opiates
SAMPLE SIZE	16
SAMPLE TYPE	8 addicts and their families; 8 control families
AGE	Young adults and their parents
SEX	Both
ETHNICITY	White
GEOGRAPHICAL AREA	Vancouver (British Columbia), Canada
METHODOLOGY	Survey--comparative
DATA COLLECTION INSTRUMENT	Q-sorts: Interperception Matrix
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	20

PURPOSE

Middle class addict families are not characterized by such features as physical cruelty, poverty, or extreme marital tension, which are commonly attributed to families of heroin addicts. Thus, it seems reasonable to examine middle class families' interactions and interpersonal perceptions for more subtle factors that might sustain addiction. Clinical observations of addict families indicated that they perpetuated rather than reduced addiction by impeding addicts' development of self-sufficiency, by accepting addicts' manipulations, and by perceiving addicts as failures. However, these clinically derived conclusions need experimental confirmation. Recent findings that addicts' families must be considered in dealing with addiction and that addiction may result from many causes indicate that understanding and treatment must be developed for specific groups, instead of searching for a universal formula.

This study developed and used a technique called the "Interperception Matrix" to compare interpersonal perceptions in eight families, in which addicted offspring maintained close parental ties, with eight matched control families. The study focused on the relationship between the addict, the father, and the mother.

METHODOLOGY

Addict families were defined as those in which the son or daughter was addicted to an opiate and maintained a close social and financial relationship to the parents. Addiction was defined as taking an opiate drug daily for at least 3 months and being regarded as an addict by themselves and at least one parent. A close social and financial relationship was indicated either by living in the parental home or by visiting at least twice a week and accepting money from the parents. Addicts and their families had all voluntarily entered family therapy at the Narcotic Addiction Foundation of British Columbia, Canada. Potential controls, who had graduated in what would have been the addicts' graduating class, were chosen from the appropriate high school yearbooks. They were then telephoned and asked to take part as controls in the study. All 16 families appeared to be stable, economically secure, and, with the exception of the addicts, free of legal problems. All the families were white and middle class. The testing procedure was identical for addict families and for controls. Subjects were asked to sort 60 cards, each with an adjective or short descriptive phrase on it, into 5 piles of 12 cards each, ranging from those best describing themselves to those least describing themselves. Subjects next described the other family members and the son's or daughter's ideal selves in the same way. Each family's 12 Q-sorts were reduced to a single correlation matrix. Differences between groups were investigated by comparing mean correlations between the addict family group and the control group. T-tests were used to calculate the significance of differences between means. Where data from a prior study were applicable to form hypotheses, one-tailed t-tests were used.

RESULTS

Several differences were found between the two types of families. Relative to controls, addicts were described, both by themselves and by their parents, as highly discrepant from their own ideals. Descriptions of the offspring's ideals were similar whether they came from offspring or parents, addict families or control families. Relative to offspring in control families, addicts were described as dissimilar to both their parents regardless of who in the family made the description. Relative to control families, parents of addict families agreed less often with offspring in describing the offspring. Addicts and their parents both described the discrepancy between the addict and the ideal with items that suggested passivity and dependence. However, addicts' descriptions differed from those of their parents on other factors. In addition, offspring in both addict and control families described their parents as similar to the offspring's ideal. Relative to control families, mothers in addict families described themselves in terms that were more discrepant from the ideal, although the statistical significance of this difference was marginal.

CONCLUSIONS

Data suggested that addicted offspring are perceived as having traits that are incompatible with success and independence in a competitive culture. Results extended and partially validated clinical observations that social perception in addict families serves to perpetuate opiate addiction by undermining addicts' self-esteem. These data, in conjunction with new understandings emerging from the addiction literature, support an approach to addiction therapy based on the reframing of family perceptions. The therapist should seek a way of reframing the addict as a person capable of self-sufficiency and independence and of reframing the problem by making addicts' independence, rather than abstinence, the main orientation of therapy. This requires changes in the entire family and should therefore make new behaviors possible. Part of the responsibility of professional therapists should be to actively promote more useful and accurate images of addicts than are now provided by the popular media. Results also contradicted the widespread notion that addicts' fathers are usually distant, brutal, or criminal. Findings indicated that the fathers were as likely as the mothers to be close to or overindulgent with the addict and not peripheral to the home. Moreover, middle class mothers, by virtue of a life of restricted housewifery, suffered from diminished self-esteem. Results also showed that family-by-family examination of interpretation matrices often serves as a constructive basis for discussion with families in therapy meetings.

Alexander, B.K., and Dibb, G.S. Opiate addicts and their parents. Family Process, 14(4): 499-514, 1975.

DRUG	Opiates
SAMPLE SIZE	18
SAMPLE TYPE	Families of addicts
AGE	18 young adults (mean: 21); adults
SEX	Both
ETHNICITY	White
GEOGRAPHICAL AREA	Vancouver, British Columbia
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations; program records
DATE(S) CONDUCTED	July 1972-August 1974
NO. OF REFERENCES	26

PURPOSE

The study attempts to establish the proportion of opiate addicts with close ties to their parents, characteristics of addict families, and the relation between process in addict families and the persistence of addiction. The discussion is limited to the dyad or triad of parents and addict.

METHODOLOGY

The sample consisted of 18 addict families from Vancouver, British Columbia, under treatment from 1972 to 1974. In these families a son or daughter between 18 and 26 years old was addicted to an opiate drug; these addicts maintained a close relationship to their parents. In 15 of 18 cases the addict was receiving methadone maintenance treatment and individual counseling. Subjects selected were those agreeable to family therapy. In 13 of the 18 families the addict was male, and all were white. All families but one had steady incomes from employment of a parent; one mother was on welfare. Both parents were living at home in 11 of the 18 families; in the remaining 7 there was no father. In several families, one parent was a heavy drinker.

Five families were seen individually and 13 in groups of families. Most families participated in 5 to 8 sessions of 1 to 3 hours each with a range of 2 to 30 sessions. Information on the incidence of the addict-family relationship among addicts was taken from 450 files on male and female addicts at the Narcotic Addiction Foundation of British Columbia.

RESULTS

Incidence of Addict Families

A substantial minority of addicts who applied for methadone maintenance still lived with their families of origin, the proportion being highest among young males. The percentage of addicts living with parents declined with age. For males, the proportion was 61 percent for addicts under age 19, 26 percent for addicts 20 to 24, 19 percent for those 25 to 29, 8 percent for those 30 to 34, and none over 35. For females, figures were 16 percent for addicts under 19, 22 percent for those 20 to 24, 5 percent for those 25 to 29, 4 percent for those 30 to 34, and 11 percent (only one case) for those over 35.

Characteristics of Families

Despite differences in lifestyles, addict families displayed an astonishing number of similarities. In spite of underlying frustration and disappointment, relations between addicts and parents, as well as between parents themselves, were congenial, calm, and conventional during therapy. Addicts did not comply with their parents' urgings to help with household chores, meet financial obligations, or discontinue their use of drugs and associations with drug users. However, addicts were able to obtain concessions from parents through nagging. According to conventional expectations, husbands appeared to dominate wives. The parents used their money and energy extravagantly to indulge addicts, and the addicts relied heavily on the parents to meet their needs. Both parents were frequently involved in the overindulgent relationship. Although parents strove to control many aspects of the addicts' behavior, they did not help the addicts to acquire adult skills and attitudes or to take realistic steps toward independence. Parents and addicts shared a perception of the addict as a failure by conventional standards. Families attributed the failure to the heroin habit or to some form of ego weakness in the addict.

The Parent-Addict Relationship and Addiction

The relationship between opiate addicts and their parents reduces the possibility of addicts' developing a satisfactory lifestyle without addiction. The addicts' acquisition of adult skills is impeded and their social development distorted as conditions in the parental home perpetuate lack of self-esteem and dependency in the addict. For addicts opiates provide relief from awareness of failure and a kind of glamour within the family circle. For parents the addicts' problem serves as a rationalization for their involvement in an overindulgent, overdependent relationship. For the family as a whole opiate addiction supplies an excuse for impoverished family relationships and for delaying attention to other domestic problems.

CONCLUSIONS

Although clear family patterns exist in the addict-family group, characterizations cannot be generalized beyond this special group. Classification of types of addiction and addict families must precede analysis of the etiology of addiction. For this specific group, however, literature generally supports the notion of the overindulgent addict family, although in contrast to the distant father noted in other reports, fathers in the middle class sample of this study are as overprotective as mothers. Furthermore, prior to addiction the addict appears to serve a vital function as a stabilizing force in the addict family. Addiction perpetuates this function and protects the ill-prepared addict from separation and from the need to fulfill unrealistic parental expectations. The addict family's syndrome thus challenges family therapists to develop methods powerful and subtle enough to change families in which resistance is high, in which the connection between the family process and the presenting problem is easily denied, and where the need for intervention is great.

Binion, V.J. A descriptive comparison of the families of origin of women heroin users and nonusers. In: National Institute on Drug Abuse. Addicted Women: Family Dynamics, Self Perceptions, and Support Systems. DHEW Pub. No. (ADM) 80-762. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1979.

DRUG	Heroin
SAMPLE SIZE	248
SAMPLE TYPE	73 addicts in treatment; 175 nonaddicts
AGE	Young adults (mean: 25)
SEX	Female
ETHNICITY	Black; white
GEOGRAPHICAL AREA	Detroit, Michigan
METHODOLOGY	Survey--comparative
DATA COLLECTION INSTRUMENT	Questionnaire; interviews
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	52

PURPOSE

A number of studies have documented the importance of certain family patterns, such as the dominant mother and absent father relationship in the lives of young drug addicts, particularly males. Personal trauma and alcohol or drug addiction have also been found to be more prevalent in the families of such drug addicts than in the rest of the population. However, little is known about the female drug user as compared to her nondrug-using peer, and until recently many public and professional assumptions have been tempered by myths and theories. This study focuses more closely on psychosocial aspects of the family of origin of female heroin users and nonusers, their family structures, their relationships with their parents, their attitudes about their childhood, and their attitudes about themselves while growing up.

METHODOLOGY

The experimental sample consisted of 73 women enrolled in drug treatment programs in low income areas of Detroit, Michigan. The control sample of 175 women was recruited from a Michigan Employment Security Commission branch office that drew from similar low-income, inner-city communities in Detroit. Subjects in both groups were about 25 years old on the average. Racial

differences between the groups were not statistically significant; the addicted sample was 80.8 percent black and 19.2 percent white, and the nonaddicted sample was 70.7 percent black and 26.4 percent white. Women in the control group were more likely than the addicted women to have graduated from high school.

Questionnaires eliciting demographic, situational, and psychosocial information were administered to all subjects during personal interviews. The social history section of the questionnaire covered six general areas: living arrangements, perceptions of significant others, family interaction patterns, childrearing experiences, religious experiences, and self-perceptions as a child. Control group women were asked questions about their general feelings on the use of alcohol, medicine, and other drugs but were not questioned on drug treatment.

RESULTS

Family Organization and Interaction

A majority of both groups of women had lived in a large city from birth until age 16. The households of both groups had moved infrequently. Both groups of women were raised in similar family constellations until they were 12 years old, most often with both parents or less often with their mothers. Household sizes were also similar, with two to five members for 61.4 percent of the addicted women and one to six members for 67.4 percent of the control women. Both groups described their relationships with parents and siblings as very close; parents were reported to be on friendly terms. The two groups of women were fairly equally distributed across economic categories, with control women slightly more likely to report extreme conditions. Although descriptions of family life while growing up did not reveal any significant differences between addicted and control women, the educational levels of the two groups' mothers and fathers differed greatly. Parents of the control women were more likely to be college or high school graduates than parents of addicted women although parents of both groups held blue-collar jobs. Most women of both groups described their parents as loving but were more positive about their mothers than their fathers. The two groups felt that they resembled their mothers in neutral physical characteristics, positive personality traits, emotionality, or neutral personal traits, and their fathers in positive or neutral physical or personality traits. While both groups enjoyed activities with their mothers, they shared few activities with their fathers. On the whole, both samples cherished warm memories of their parents and their relationships with them.

Socialization Issues

There were major differences in the ways the two groups of women were disciplined, with addicted women being significantly more likely to be made to do extra work, given a lecture, not being allowed to do something they wanted to do, or being screamed at. Addicted women were more likely than control women to feel that they received more punishment than other children, while nonaddicted women felt that they were punished less than other children. Moreover, control women were allowed to go out alone somewhat younger than addicted women but were less likely to have run away from home or to have left home for good before 18 years old. Most women in both samples attended church or Sunday school while growing up, and families of both groups were religious.

The majority of women in both samples viewed themselves as having been good children, but the addicted women were significantly more likely than control women to describe themselves as having behaved badly. Both groups reported having had no trouble making friends, having been popular with their peers, and having participated in numerous school activities. While the women in both samples had enjoyed school, the control group reported having had more teachers who treated them as special students. Moreover, addicted women were twice as likely as the control group to have quit school without a diploma, with boredom or drug use cited as the reasons.

Drug Use and Family Problems

Family members of addicted women were more likely than those of the control group to have drinking problems. Addicted women tried marijuana before heroin, barbiturates, and amphetamines. The majority started on drugs when they were between 14 and 18 years old and were most frequently offered drugs for the first time by a friend (usually male) or a boyfriend.

Approximately 54.3 percent used heroin the first time it was offered and 46.6 percent began using it regularly between 17 and 20 years old. Primary reasons given for heroin use were avoidance of personal and family problems, enjoyment, and association with users. Primary motives for entering treatment were displeasure at setting bad examples for their children and feelings of self-disgust.

CONCLUSIONS

The findings indicate that the drug treatment literature has grossly overstated the differences in family dynamics of heroin users and nonusers. Both test groups had enjoyed relatively happy, stable childhoods, often with both parents. Both groups were reared in extended family networks with family and neighborhood solidarity. Mothers of both groups were perceived as warm, relaxed, supportive parents; fathers were viewed somewhat less positively but were not rejected. While punishments of the two groups during childhood varied, addicted women were not physically punished more often than the control group. Such factors as blocked aspirations, encouragement from teachers, peer influences during adolescence, and alcohol problems within families may influence addiction, but absolute causative factors cannot be identified. While the family of origin of the addicted person must still be considered a significant factor in addiction, this study suggests that the notion of multigenerational transmission of pathology in the families of heroin users is a myopic and inaccurate view.

Black, R.; Mayer, J.; and MacDonall, J. Child abuse and neglect in families with an opiate addicted parent. In: Smith, D.E.; Anderson, S.M.; Buxton, M.; Gottlieb, N.; Harvey, W.; and Chung, T.; eds. A Multicultural View of Drug Abuse: Proceedings of the National Drug Abuse Conference, 1977. Cambridge, Mass.: Schenkman, 1978. Pp. 397-403.

DRUG	Opiates
SAMPLE SIZE	81
SAMPLE TYPE	Addict parents
AGE	Not specified
SEX	Both
ETHNICITY	Black: 63 percent
GEOGRAPHICAL AREA	Boston, Massachusetts
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Interviews; MMPI; Survey on Bringing Up Children; Schedule of Recent Experience
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	13

PURPOSE

Recent interest in child abuse and neglect has produced concern about the extent to which families with an opiate-addicted parent abuse or neglect their children. New laws about the adjudication of unfit parents have been enacted and these laws particularly affect heroin addicts. In New York State, for example, one of the legal definitions of an abused child is any child of an adjudicated heroin addict. In several States, babies born addicted must be reported to protective services. Apart from shocking individual examples, however, little actual evidence is available on the care of children by opiate addicts. In addition, little information is available on the status of children of addicts after early childhood. Studies on addiction at birth indicate, however, that many of the children of female addicts do not receive appropriate prenatal care or adequate parenting after birth. Studies have also shown that families with an opiate addict share characteristics with families in which a child has been abused. Nevertheless, few child abuse or neglect studies have attempted to assess the extent to which drug addiction is involved. However, the studies conducted indicate that the connection between child abuse and neglect and opiate addiction may not be with addiction per se, but rather with the social, psychological, and situational factors often associated with addiction.

The present study gathered information on opiate addicts caring for children to (1) investigate and compare the nature of child care and the frequency and types of child abuse and neglect associated with addiction; (2) examine the relationship between stages in the cycles of alcohol and drug abuse, adequacy of child care, and the presence or absence of child abuse and neglect; and (3) determine the extent to which social and situational factors associated with child abuse and neglect are present in families of alcohol and drug addicts with different patterns of child care.

METHODOLOGY

The study is being conducted by the Washingtonian Center for Addictions, a private, multimodality treatment center for alcoholism and drug addiction in Boston, Massachusetts. Information is being gathered on 100 alcoholics and 100 opiate addicts caring for children under age 18. Data are being gathered via interviews and the use of the Minnesota Multiphasic Personality Inventory, the Survey on Bringing Up Children, and the Schedule of Recent Experience. All subjects were patients in treatment for alcoholism or opiate addiction at the Washingtonian Center. Subjects had been caring for a child for at least 6 of the last 12 months or, if the child was under 6 months of age, for at least 2 of the last 12 months. About 75 percent of the eligible patients were invited to participate; about 95 percent agreed to participate. Subjects were individually interviewed and tested in two 2-hour sessions. Interviews were structured and instructions standardized. Testing of the five interviewers showed that interrater reliability was 86 percent. A total of 81 opiate-addicted parents have been interviewed to date.

RESULTS

Three-quarters of the subjects are female, 63 percent are black, and 73 percent have been married. The families form a mobile and socially deviant population. Almost one-third have moved at least twice in the past year and 76 percent have an illegal income source. Preliminary data analysis of 54 of the 81 parents revealed 9 families in which a child had been physically abused, based on parental reports of intentional injuries, reports of loss of control resulting in marks or serious bruising, and reports of injuries where the explanation did not seem feasible. Results of the Survey for Bringing Up Children showed that 45 of the 63 parents for which data were available were identified as being at risk of having severe problems in interacting with their children. Answers to questions on the use of physical punishment showed that 74 percent used physical punishment to discipline children at least once a month. Female parents were more likely than male parents to use spanking as a means of correcting their children, to use an object other than their hand for spanking, and to lose control while spanking.

CONCLUSIONS

Results suggest that these parents have significant difficulties in child care and are potential child abusers, although most families with an opiate-addicted parent successfully avoid physical abuse of their children. Since opiate-abusing families constitute a group in which a variety of factors operate to create the risk of child abuse, it is not surprising that the incidence of abuse was found to be higher than the current estimate for families in the general population. The Survey on Bringing Up Children indicated that the potential for child abuse or neglect appears to be higher than the actual occurrence of physical punishment. Data also suggest that female opiate-addicted parents are more likely to use harsh discipline than are male parents. The unexpected finding that parents who reported losing control while disciplining were likely to be using heroin at the time suggests that opiate ingestion may not calm all addicts sufficiently to prevent child abuse incidents. Although these preliminary data prevent drawing firm conclusions, the subjects' eagerness to take part in the study and to discuss their children suggests that discussion of the addiction's effects on the care of children has too often been neglected as part of treatment for addiction.

Black, R.M.; Mayer, J.; and Zaklan, A. The relationship between opiate abuse and child abuse and neglect. In: Schecter, A.; Alksne, H.; and Kaufman, E.; eds. Critical Concerns in the Field of Drug Abuse: Proceedings of the Third National Drug Abuse Conference, Inc., New York, 1976. New York: Marcel Dekker, 1978. Pp. 755-758.

DRUG	Opiates
SAMPLE SIZE	200
SAMPLE TYPE	Alcoholic parents; addict parents
AGE	Not specified
SEX	Not specified
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Boston, Massachusetts
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Interviews; MMPI; Survey on Bringing Up Children; Schedule of Recent Experience
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	7

PURPOSE

Definitions of child abuse and neglect often are vague because it can be difficult to distinguish between acceptable cultural norms and child abuse or neglect. Although courts have always removed children from abusive parents, recent interest in child abuse and neglect has resulted in new laws about adjudication of unfit parents. These laws often single out heroin addicts. In New York State, for example, one of the legal definitions of an abused child is any child of an adjudicated heroin addict. In Massachusetts, an infant born addicted is considered abused and is required to be reported as such. Thus, the parent addicted to heroin is often assumed to be guilty of child abuse or neglect. Apart from shocking individual examples, however, little evidence is available associating heroin abuse with child abuse and neglect.

Studies of child abuse and neglect have indicated that situational factors such as parental history of abuse or neglect as a child and stressful life circumstances are associated with abuse and neglect. Many of these factors also occur in families in which a parent is a heroin addict. Personality characteristics such as low frustration tolerance and immaturity have also been associated with both addiction and child abuse and neglect. Other studies have shown that characteristics of children that detract from their acceptability to the parent have led to child abuse and neglect and have also been related to opiate abuse. Thus, although some child abuse and neglect can

be expected in families in which a parent is a heroin addict, few studies have tried to assess the extent to which drug addiction is involved, and the results of these studies have been varied and confusing.

The present study, only the initial results of which are reported in this paper, was designed to assess the relationship between opiate addiction and child abuse and neglect. Specific goals are to (1) examine frequency and types of child care, abuse, and neglect associated with alcoholism and opiate addiction; (2) examine the relationship between the stages in the cycles of substance abuse and child care, abuse, and neglect; and (3) determine the extent to which social and situational factors associated with child abuse and neglect are operative among alcohol and drug addicts.

METHODOLOGY

Study data are being collected from patients at the Washingtonian Center for Addictions, a private, voluntary, multimodality treatment center for drug addiction and alcoholism in Boston, Massachusetts. Data are being collected via interviews with 100 alcoholics and 100 opiate addicts caring for children under age 18. Information collected covers demographic data; history of drug and alcohol abuse; childhood history; the care, abuse, and neglect of children; and the relationship between stages in the cycle of alcohol or opiate abuse and child care, abuse, and neglect. Additional measures include the Minnesota Multiphasic Personality Inventory, the Survey on Bringing Up Children, and the Schedule of Recent Experience.

RESULTS

Initial results indicate that not all opiate addicts seriously abuse or neglect their children, although many appear to have difficulties in child rearing similar to those expected from a sample of low-income parents, parents from disturbed backgrounds, or chronically ill parents. Many addicts are concerned about their children and have tried to obtain help with child care. Most mothers are aware of the dangers of drug use during pregnancy and tried to limit or end their drug use during this period.

The treatment process sometimes interferes with child care since treatment may involve separation, exposure of children to the drug subculture, or risk of the child being taken away by the courts. Addicts report that they present themselves to their children as "sick" and report such consequences in their children as preoccupation with illness, guilt, and attempts to care for the parent. Secrecy, especially with younger children, may block discussion of problems, while older children often receive parental confessions. Play is the child care activity that is most disrupted by heroin addiction. Addicts report that they are not able to pay the attention to their children that play requires or that play is severely limited.

CONCLUSIONS

The patients were eager to take part in the study and were interested in helping their own children and the children of other addicts. Because their relationship with their children was infrequently mentioned in their treatment, they welcomed the chance to discuss their children and their relationship with them. That not all opiate addicts are abusive or neglectful parents is evident in the initial findings.

Blechman, E.A.; Berberian, R.M.; and Thompson, W.D. How well does number of parents explain unique variance in self-reported drug use? Journal of Consulting and Clinical Psychology, 45(6):1182-1183, 1977.

DRUG	Multidrug
SAMPLE SIZE	3,690
SAMPLE TYPE	High school students
AGE	Adolescents (mean: 14.8)
SEX	Both
ETHNICITY	Black; white
GEOGRAPHICAL AREA	New Haven, Connecticut
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Questionnaires
DATE(S) CONDUCTED	1972-1973
NO. OF REFERENCES	5

PURPOSE

High school students were surveyed to assess how much of the unique variance in self-reported drug use by adolescents can be accounted for by the number of parents and cause of parental absence as compared to other variables (i.e., age, peer use, sex) often associated with adolescent drug use.

METHODOLOGY

Questionnaires were administered at random in 1972 and 1973 to 4,540 students sampled from the total school population of 33,629 in 37 junior and senior high schools in and around New Haven, Connecticut. A total of 853 students with incomplete responses were eliminated, as were 41 Oriental and Puerto Rican students and 65 students living with neither parent, because of their small numbers. The mean age of the resulting sample of 3,690 students was 14.8; 1,759 were male and 1,931 female; 283 were black and 3,407 white. The mean parent occupational score on Duncan's Scale was 53.12.

The questionnaire included 66 questions on demographic variables as well as smoking, drinking, and drug use by students, peers, and family members. Two critical items were (1) reported drug use (i.e., whether respondents use alcoholic beverages outside their home with friends and whether respondents had used any of a list of drugs for the experience) and (2) peer use of drugs (i.e., whether respondents' five best friends use amphetamines, cocaine, mescaline, glue, LSD, hashish, marijuana, barbiturates, or heroin. Stepwise multiple regression with drug use as the dependent variable was independently applied to responses of black students and white students because inspection revealed different patterns in the two groups. Early analysis showed that age and peer drug use contributed most to the variance, so subsequent analyses considered these variables first. The variable contributions of the remaining independent variables determined their order of selection.

RESULTS

Among white students, significant contributors to unique variance in reported student drug use were peer use, age, parent occupation, and parent remarriage. Many friends using drugs, advanced age, higher parent occupation score, and remarried parents were associated with high levels of white students' drug use and these values accounted for .351 of drug use.

Among black students, significant contributors to unique variance in reported student drug use were peer use, age, sex, and parent unemployment. Variables accounting for .267 of the variance in drug use associated with high levels of drug use by black students were many friends who use drugs, older age, being male, and parental unemployment.

Two stepwise regressions with drug use by peers as the dependent variable indicated that age, students' drug use, and parents occupation accounted for .335 of the unique variance in peer drug use among white students, and that age and students' drug use accounted for .173 of the variance in peer drug use among black students. Neither group showed a relationship between peers' drug use and number of parents after the variables mentioned above were partialed out.

CONCLUSIONS

Drug use by peers and age make the most significance contributions to unique variance in drug use. The importance of peer drug use supports the view that peer group pressures outweigh adult pressures and coincides with reports that peer group influence on drug use outweighs parental influence. This finding does not preclude the possibility that student drug use leads to selection of a drug-using peer group. In addition, the significance of increasing age for drug use is interpreted as a result of growing access to drugs and money for drugs as well as the consequence of escape from school and parental supervision. Older students may also feel compelled to report more drug use, believing that drug use is normative. While the number of parents may be a mediating variable causing children from one-parent families to select drug-using peer groups, data analysis does not support this hypothesis. Only age and student's drug use make significant contributions to the unique variance in the number of friends using drugs: older students reporting heavy drug use have many friends using drugs.

Clark, J.S.; Capel, W.C.; Goldsmith, B.M.; and Stewart, G.T. Marriage and methadone: Spouse behavior patterns in heroin addicts maintained on methadone. Journal of Marriage and the Family, 34:496-502, 1972.

DRUG	Methadone
SAMPLE SIZE	73 families
SAMPLE TYPE	22 addicted wives; 51 nonaddicted wives
AGE	Adults
SEX	Female
ETHNICITY	Black; white
GEOGRAPHICAL AREA	New Orleans, Louisiana
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Interviews; observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	8

PURPOSE

Addiction to habit-forming drugs places a severe and unusual strain on family relationships. This strain is different from that caused by alcohol because of the social and legal stigmatization attached to hard drugs. Heroin addiction is of particular importance because it often requires commission of crimes and progressive departures from many of the conditions essential for a stable family life. To date, methadone is the only treatment modality for which convincing data about a return to a more stable and law-abiding life are available. Since heroin addicts are usually males who might be inclined to rationalize their rehabilitation toward expected normative values, this study examines the effect of methadone on family life as perceived by the wives of addicts in rehabilitation programs.

METHODOLOGY

Seventy-three families of known heroin users on methadone maintenance programs in New Orleans, Louisiana, were interviewed. All the males were heroin addicts or ex-addicts; in 22 of the families, the wife was also addicted. Nine-tenths were born and reared in New Orleans, and an additional 5 percent came from contiguous States. The final interviews were all conducted by a

trained social investigator in the homes of the respondents. In addition to asking structured questions, the interviewer made a subjective evaluation of the respondents' demeanor, home maintenance, and other factors not amenable to objective scaling. Whites were slightly overrepresented in the sample because the methadone maintenance program began in New Orleans with white patients of a white doctor.

RESULTS

Analysis of work patterns shows that regular employment of husbands doubled after they and their wives entered methadone programs. Other studies have also shown increasing self-support as a function of increased time in the program. Results also indicate a marked change in family discipline. Before the methadone program was available, discipline tended to be the responsibility of the wife; after the program began there was a shift to a greater sharing of responsibility and to a greater participation by the husbands in disciplinary decisions and activities. Husbands also increased their participation in household chores. Only one respondent indicated that the husband was spending less time with his wife and family since beginning the methadone program. Almost half of the nonaddicted wives (45 percent) and 7 of the addicted wives (32 percent) reported that their husbands spent much more time with the children; higher percentages of each group reported that their spouses spent more time with them than before they began to take methadone. Over half of the nonaddicted wives reported that their husbands slept more soundly and were more relaxed following entry into the methadone program; much smaller percentages of addicted wives reported this result. Nonaddicted wives also noted greater reductions in daytime sleep than did addicted wives.

An unexpected result was that both sets of wives reported greatly increased sexual activity on the part of their husbands after stabilization on methadone. The increase was more marked in the nonaddicted group. The general belief is that the use of methadone produces varying degrees of impotence as a standard side effect. Results also indicated that a large majority of the nonaddicted wives and almost half the addicted wives felt much less fear of harassment by police after they or their husbands entered methadone programs. Nonaddicted wives also differed from addicted wives in their perceptions of drug laws. More of the nonaddicted wives thought that the drug laws were adequate and less thought that there should be no laws against drugs.

Both on the scales and in subjective evaluations, nonaddicted wives found the methadone program more satisfactory than did addicted wives, who experienced the same physiological problems with methadone as did their spouses. Addicted wives tended to gain unwanted weight, remain constipated, and suffer some changes in their sleep habits.

CONCLUSIONS

Results show that some family relationships changed after addicted spouses entered a methadone maintenance program. Most of these changes were in the direction hoped for by advocates of the programs. Both regular employment and time spent with the family tended to increase; these changes indicated increased family stability.

Differences in perceptions concerning sleep probably relate to changes in the family's living patterns that results in the nonaddicted wife becoming more relaxed and sleeping more soundly; she in turn projected a sounder sleep onto her husband. The addicted wife's perceptions were probably more accurate. Increase in sexual activity is probably due to an increase in propinquity and opportunity. The greater increase in sexual activity reported by nonaddicted wives is possibly due to a greater incidence of initiation by the wives, indicating that it is the sexual drive, not performance, that has been inhibited in the male.

Findings indicate that methadone programs relieve many family strains and improve family relationships. Results also indicate that as an interim measure, methadone programs offer immediate social rewards for the married addict living with his family. These rewards may offset any failure to accomplish a complete cure of the addiction. Long-term studies to assess the durations of these benefits in comparison to other forms of treatment and in other social groups are needed.

Clark, J.S.; Capel, W.C.; Goldsmith, B.M.; and Stewart, G.T. Wives, families and junk: A comparative study of wives of heroin addicts maintained on methadone. Journal of Drug Issues, 2(1):57-65, 1972.

DRUG	Heroin; methadone
SAMPLE SIZE	73
SAMPLE TYPE	Wives of addicts
AGE	Not specified
SEX	Female
ETHNICITY	White; black
GEOGRAPHICAL AREA	New Orleans, Louisiana
METHODOLOGY	Survey--comparative
DATA COLLECTION INSTRUMENT	Questionnaire; Eysenck two-factor scale; IPAT anxiety scale
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	9

PURPOSE

Several studies have shown that deviant behavior has a disturbing effect on family life, regardless of the form of deviance. Although much research has been done on the disruptive and pathological effects of addiction or the personality characteristics of wives, little research has focused on relationships internal to the families of addicts. This study of 73 families, in which all the husbands and 22 of the wives were addicted to heroin, focused on characteristics observable in the behavior of addicts' wives, the influence of the husband's addiction on the wife's chances of becoming addicted, and effects of addiction on normal family activities. Other questions examined included nonaddicted wives' state of knowledge regarding their husbands' drug addiction at the time of marriage, the relationship of age and education of both spouses to drug addiction, and psychological charateristics of addict spouses' wives.

METHODOLOGY

Demographic data, age relative to spouse, education relative to spouse, and other objective measurements were obtained from a sample of 73 wives of heroin addicts stabilized on methadone maintenance programs at the time of the investigation. Of the 73 wives, 51 were not themselves

addicted. Subjects were all living in New Orleans, Louisiana; most had grown up there. The sample is representative of all married addicts in the city.

After preliminary contact in the methadone clinics, further interviews, partly structured and partly unstructured, were conducted by an experienced social investigator once or more in the respondents' homes. All couples living in permanent homes were assumed to be married, and no proof was required. In addition to the structured questionnaire, the interviewer made subjective evaluations of the respondents' demeanor, type of home, maintenance of household discipline, and other observations not amenable to objective scaling. A comparison group of wives whose husbands were not addicted was compared on two psychological measures. This group was drawn from patrons of a local beauty shop in the neighborhood with the highest concentration of addicts. The comparison group was matched by age and race, although it had somewhat higher income than the study group. The psychological tests used were the Eysenck two-factor scale, which measured the degrees of introversion-extroversion and neuroticism-stability, and the IPAT anxiety scale, which would reflect dimensions such as fear of police and arrest, fear of social disapproval of drug use, and economic stress.

RESULTS

For the nonaddicted wives, the racial distribution was 20 whites and 31 blacks, while the addicted wives included 13 whites and 9 blacks. In appearance and location, there was little difference between the homes of addicted and nonaddicted wives; all were working-class rented homes. It was evident that the nonaddicted wives could have easily married other men. Over two-fifths of the nonaddicted wives and all but two of the addicted wives knew that their husbands were drug users when they married. A total of 14 percent of the nonaddicted group knew that their husbands were not addicted at marriage, while 43 percent knew nothing of their husbands' drug habits at marriage. The median age difference between spouses was 3 years for the nonaddicted wives and 2.2 years for the addicted wives. Addicts had much lower educational levels than those found in O'Donnell's 1969 Kentucky study; only 36 percent of all whites and 17 percent of all blacks in all New Orleans methadone programs have completed high school.

The number of children in the families demonstrated one of the few abnormalities in family patterns. Almost one-third of the wives had no children; there were also a higher percentage of one-child families than in the national population. In addition, a higher percentage of the addicted wives than nonaddicted wives reported that they did not belong or go to church; almost one-fourth of the nonaddicted wives and none of the addicted wives mentioned that religion played a large part in their lives. The work habits of the two groups were quite similar. Nonaddicted wives expressed greater fear that their children might become addicts, and a much higher percentage of husbands of nonaddicted wives objected to the idea of their wives' using drugs. Some of the addicted wives became addicts after learning of their husband's addiction.

Results of the IPAT anxiety scale showed that the nonaddicted wives and the comparison group had significantly lower levels of anxiety than the addicted wives but did not differ significantly from one another. Extroversion was significantly greater for the comparison group. The addicted wives showed a greater introversion than the nonaddicted wives, but the difference was not significant. Addicted wives and nonaddicted wives had similar responses to a question regarding wishes for additional children; this question was considered a measure of marital satisfaction.

CONCLUSIONS

None of the study's measures indicated any startling differences between the family life of heroin addicts maintained on methadone and the family life of other persons in similar socioeconomic conditions who are not involved with addiction. Results suggested that marriage to an addicted spouse could increase the chances of becoming addicted but would not inevitably lead to addiction. Religious attitudes did not seem to differ from those of other people of this social class. Furthermore, ignorance of spouse's drug behavior played only a minor part in these marriages. Results also indicated no consistent drive toward dominance or submission in wives' decisions to marry addicts, and the extent to which the husband and wife accept the deviant label seems variable. Results may have been influenced by selection of the sample from a methadone maintenance program, which is, of itself, a stabilizing influence. Nevertheless, use of such a sample provided a chance to examine addict families as they would be without the constant threat of arrest. Results indicated the inherent strength of the family under very trying conditions.

Coleman, S.B. Incomplete mourning in substance abusing families: Theory, research and practice. In: Wolberg, L., and Aronson, M., eds. Group and Family Therapy--An Overview. In press.

DRUG	Not specified
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Theoretical/critical review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	38

PURPOSE

Within the framework of family systems theory, the family is expected to alter some of its transactional patterns as it wrestles with marriage, birth, child rearing, mid-life, retirement, old age, and death. No family escapes the vicissitudes imposed by the death of a member, and when death is not successfully mastered, pathological conditions such as drug abuse may appear. The present study explores theoretical perspectives on incomplete mourning in substance-abusing families and the implications of the theory for treatment.

SUMMARY

The Theory of Incomplete Mourning

The theory suggests that addictive behavior is related to an unusual number of traumatic or premature deaths, separations, and losses that occur within critical or transitional stages of the family's developmental cycle and that are not effectively resolved. Drug use also serves to keep the abusing member helpless and dependent on the family, a process that unifies and sustains

family intactness. Within the complex set of interpersonal relationships, an overall sense of hopelessness, despair, and lack of purpose dominates.

Data indicate both a high incidence of early deaths of at least one of the addict's parents and a large number of addict deaths at an early age. Addicts proceed through death-related phases, suggesting that addiction facilitates the family's participatory behavior. By treating drug abusers as if they are experiencing a slow death, family members are able to perpetuate the unresolved death of a former member. The addict thus becomes a substitute for the deceased; if the addict dies, another member will probably start using drugs.

The family's religious beliefs or philosophical systems are apt to be the major interface between death and the family's adaptive behavior. Belief in any system, whether deism or atheism, is in itself a resolution and represents a philosophical religious construct regarding life and its experiential meaning. The lack of such a system leads to a state of noncommitment that induces a feeling of powerlessness and frustration. If the loss of a significant family member takes place within the vacuum of an amorphous religious belief system, certain other family members may resort to drug use as a defense against mortality.

Treatment Implications

The extension of incomplete mourning theory to clinical practice is best accomplished within the context of family therapy. Therapists conducting such therapy must possess expertise in treating drug abuse problems, must be able to maintain control of the family in treatment, and must adhere to definite guidelines stated explicitly to the family at the outset of treatment. Furthermore, the therapist must create an interesting therapeutic environment to increase the probability that the family will attend sessions and comply with rules. Finally, the therapist must be adaptable to the family's needs and flexible enough to change strategies and interventions when required. Incomplete mourning can be resolved through oblique measures, such as restructuring the family system, confronting addicts and their families with the possibly fatal consequences of drug use, planning the funeral and post mortem activities of the still-living addict, transferring the idea of death to the drug itself, visiting the grave site of the deceased, or carrying on mock conversations with the deceased. A sense of religiosity can be stimulated by asking family members to write answers to questions on the meaning of life, by having family members discuss with each other the meaning of their separate lives, and by requiring them to read and to discuss V.E. Frankl's book Man's Search for Meaning. Discussion of the purpose of life inevitably leads to the issues of death and mortality. Such intervention techniques are largely designed for use with middle and upper class families.

CONCLUSIONS

According to the incomplete mourning theory, drug abuse results from unresolved mourning of a family for a deceased member. In such families deaths and loss occur at unexpected points on the life cycle continuum, causing the family to become stuck in a particular developmental stage. By using drugs, the addict approaches death as a means of fulfilling the family's need to perpetuate the initial loss experience and to maintain the family's homeostatic balance. Addicts themselves become trapped in the drug-sustaining cycle of family interaction. Family therapy and the proposed interventions provide a model for releasing the family's growth mechanisms so that one generation can individuate while the other generation achieves ego integrity.

Coleman, S.B., and Stanton, M.D. The role of death in the addict family. Journal of Marriage and Family Counseling, 4:79-91, 1978.

DRUG	Multidrug
SAMPLE SIZE	4
SAMPLE TYPE	Families of addicts
AGE	1 adolescent; 1 young adult; 2 mature adults
SEX	Both
ETHNICITY	White
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Case study; literature review
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	25

PURPOSE

Death has conventionally been regarded as the logical cessation of life and has most often been associated with the terminally ill or the elderly. In recent years, however, views of death have begun to change. Researchers are now giving more attention to the family system of the dying person. This paper examines the importance of death as a participatory phenomenon in the families of drug addicts. Such families are of particular interest because drug abuse is a potentially life-threatening problem with suicidal ramifications. The paper focuses on the impact of past deaths upon the present and on the means by which family members may become involved in an ongoing death-like process. Strategies for treatment are presented, with particular emphasis on a case example that unites theory and technique.

SUMMARY

The death rate among drug addicts is much greater than would be expected for comparable groups in the population. In addition, addicts' families apparently experience more early deaths and tragic losses than would be expected actuarially. Moreover, several authors have proposed that addiction is an alternative to or equivalent of suicide. The onset of addiction or heavy

drug abuse usually occurs around the time of adolescence and involves issues of autonomy, leaving home, and the development of outside relationships by the drug-using adolescent. The inability to allow individuation of the drug-using member seems to correlate with unresolved and premature deaths experienced by one or both parents. The parents are still undergoing a sort of mourning process because they have not worked through the loss. Families appear to use the addict for a reenactment of previous deaths of significant others; the addict becomes the deceased member. The addiction becomes analogous to a slow dying process and is another example of the way families vest a dying member with special status and view that member as a symbolic representation of deceased ancestors.

In clinical experience, addict families often bring up issues of death whether or not the therapist mentions them or even has them in mind. The therapists usually meet with drug abusers and their families of origin because these families almost always display cross-generational coalitions that are best handled directly rather than by proxy. Several treatment strategies and techniques may be effective, including exclusion of death, confronting the reality that the addict will die if the drug use continues, and having the family plan exactly what they will do after the addict dies. Other techniques include planning and perhaps enacting the addict's funeral, transferring the idea of death to the drug, having bereaved members visit the grave of the deceased person the family mourns, and dealing directly with deceased significant others as if they were present.

A case example of a middle class, white family illustrates the involvement of death in the addiction problem and treatment. The 20-year-old son and the 17-year-old daughter were the identified patients. Both were polydrug users, with a preference for heroin and hallucinogens. Other problems included truancy and drug dealing. The parents were unable to control or set effective limits for either child. The two children were from the mother's previous marriage, in which the husband had died in an accident shortly after a heated argument with his wife. Following seven family therapy sessions, three marital sessions were held without the children, ostensibly to focus on the husband/wife sexual dysfunction. The session revealed that the wife remained strongly affected by the death of her own mother, who had died shortly after a hostile interchange with her, at that time 15 years old. The therapist, who had not anticipated that the therapy session would take this direction, used a Gestalt technique to help the woman say goodbye to her mother and to liberate herself from the past.

This family illustrated the characteristic conflicts involved in families with drug-abusing members. The wife had suffered a severe loss at a most critical period of her development as a woman and adult. The feelings of hostility that surrounded her mother's death were unfortunately duplicated when her first husband met with tragedy. Because she did not mourn her mother's death, she was not able to attach herself to new love objects. Following this session, the mother was able to talk with other family members about her mother. Therapy ended after a few additional sessions. A 6-month followup revealed that the children's drug abuse had almost completely ended, and that they had moved out of the house to achieve their own goals.

CONCLUSIONS

This case example supports researchers' beliefs that impaired mourning prevents families with drug-abusing members from expressing affection to each other. Individual boundaries become blurred, and no members can ever separate. Without therapeutic intervention, they continue to prolifically acquire an extended family of ghosts. In this case example, the shared death experience in the therapy session became the means by which the husband and wife were joined. The couple reestablished the generational boundary between themselves and their children and reduced the possibility that cross-generational coalitions would continue to exist. The husband and wife no longer needed the children as parental surrogates and could allow them to grow up. Treatment can deal with the issues of death and unresolved mourning by making the mourning explicit; the death issue can also serve as a vehicle for family change.

Collado-Herrell, L.I. Hispanic family factors and drug abuse. In: National Institute on Drug Abuse. Drug Abuse From the Family Perspective, Ellis, B.G., ed. DHHS Pub. No. (ADM) 80-910. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1980. Pp. 32-48.

DRUG -	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Drug abusers and their families
AGE	Not applicable
SEX	Both
ETHNICITY	Hispanic
GEOGRAPHICAL AREA	Cross-sectional
METHODOLOGY	Theoretical/critical review; literature review
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	36

PURPOSE

Drug abuse and the family are two topics that have had profound impact on the mental health professions in the 1970s. Although much of the public hysteria over drug abuse has abated, the use of drugs has not. Marijuana and cocaine are increasingly accepted in the adolescent culture. Moreover, understanding of drug use has not increased appreciably, despite much research. The family, or the breakdown of the family, has become the explanation of drug abuse as well as of other problems. Despite equivocal definitions of terms and data supporting contentions about the family, these contentions are seldom questioned. In view of this situation, this paper examines the relationship between drug abuse and the Hispanic family. Three topics are discussed: the research and theories on general conditions of family functioning; the relationship of these data to the Hispanic cultures in the United States; and recommended directions for future research, prevention, and treatment programs on behalf of Hispanics with drug problems or at risk of such problems.

SUMMARY

A synthesis of principles from social learning theory and structural family therapy provides a cohesive framework for viewing drug abuse. These approaches contribute to understanding the socialization process and family factors that account for its success and maintenance. According to social learning theory, the amount of observational learning by a child from parents depends on parental availability, children's attention to the parent, and consequences to the child of imitating the parent. In addition, the quality of the child's observational learning depends on the competence of the parent and the competence of alternative models. Moreover, parental influence on children is a combination of direct influence and indirect influence through control of the child's access to other sources of influence. Anything that strengthens parents' social reward power will promote parental influences; this power depends on both parental dominance and parental nurturance. The basic concepts of family structure discussed include hierarchy, boundary, coalition, the enmeshed family, and the disengaged family.

The reasons for drug abuse may be conveniently grouped into three categories: (1) self-medication/sensation seeking, (2) peer pressure and acceptance, and (3) symbolic protest. The self-medicating function may stem in part from imitation of parental reliance on medication. The sensation-seeking function has been documented but presents less clear correlates to family factors. However, no factor has been more clearly documented as a principal basis of drug use than peer pressure. It is, of course, an insufficient explanation for continued participation in a behavior as seriously problematic as drug abuse. Family influences may be the mediating factors in determining why a youth resists, succumbs to, or identifies with "deviant" peer pressures. The availability of parent models is a key variable. Although many adolescents attribute drug use to their desire to protest against their parents, school, or society generally, the symbolic protest function of drug abuse does not appear to be a powerful explanatory concept. A final family characteristic frequently cited as present in the drug abuser's family is an ineffectual father, but this concept could divert attention from the family system as did older concepts. The system of relationships between combinations of parents and children is more important than characteristics of individual parents.

The Hispanic concept of the family differs in significant ways from that of the model U.S. culture. Attitudes toward drug use, mental health, and mental illness also differ. Compared with other American families, Hispanic-American families emphasize authority relationships more strongly, emphasize concepts of personal dignity and respect, inculcate macho values in males, rear females to be submissive, and emphasize the extended family and the place of birth. The self-medicating function of drugs, not the sensation-seeking function, applies to Hispanics. The availability of parental models is important, but among Hispanic families in the United States several conditions serve to weaken the opportunities for adaptive modeling. In addition, the widely extended family has both positive and negative benefits. Cultural values may be more easily transmitted than the strengths to implement them. Rebellion plays a role for Puerto Rican drug users, but it constitutes rebellion against their inability to become part of the mainstream, rather than rebellion against mainstream values. Rebellion may also occur against families. The educational system may also serve as a focus of rebellion for the Hispanic.

CONCLUSIONS

Traditional preventive approaches such as education and exhortations against drug abuse must reach Hispanic cultures in their own language, in the places they gather, and in ways to which they can relate. Social policy that weakens the Hispanic family or forces a rift between Hispanics and their culture will increase their chances of drug abuse. A major problem involves U.S. immigration policies, particularly those regarding undocumented aliens. Looking to the family to help understand the origins of drug use, one will also find a potent source of treatment for drug abusers. Family therapy is proving effective for treating many problems, including drug abuse, in Hispanic families. Structural family therapy has been successfully used with the Puerto Rican poor. Principles relating to authority, hierarchy, and lineality should be used with Hispanics, regardless of the treatment approach. Future research on Hispanic family factors and drug abuse should focus on comparisons of different Hispanic cultures, the influence of the time spent in the United States, the relative effectiveness of different therapies, sex differences, and approaches to limited adolescent experimentation with drugs.

Cotroneo, M., and Krasner, B.R. Addiction, alienation and parenting. Nursing Clinics of North America, 11(3):517-525, 1976.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Families of addicts
AGE	Not applicable
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Clinical observation; case study
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	5

PURPOSE

The family has long been viewed as peripheral to the treatment process for the addicted person. Transactional concepts dominate the writings about the family of origin and the marital life of addicted persons. Moreover, the literature is descriptive and oriented toward pathology. The common views of families as helpless victims or as intransigent victimizers have eliminated meaningful involvement of families in treatment of addiction. Thus, treatment remains addict centered. However, family members have colluded in this process because the family is basically a conservative system that resists change and therefore resists therapy. Seeking help for a family member may be an escape for a family, just as the drug career is an escape for the addicted person.

Family therapists' clinical experience has shown that drug and alcohol abuse is invariably associated with disturbed patterns of family relationships. However, therapists have often oversimplified the family dynamics involved. To expose and explore the interconnectedness of addiction, alienation, and parenting, this paper investigates the relational components of grandparents, parents, mates, and children in shaping the lives of addicted persons.

METHODOLOGY

A decade of involvement by the author and others in various modalities for treating addiction forms the basis for the paper's observations and conclusions. This experience includes involvement in the earliest methadone maintenance and detoxification programs.

RESULTS

Therapists involved in early methadone maintenance and detoxification programs were convinced that methadone was essential for sustaining addicted persons. Few therapists recognized addicts' needs for natural relational resources or realized that addicts operated on the assumption that addiction was the only trustable "parent" available to them. A decade of experience now indicates that sophisticated therapeutic efforts that abandon primary relationships are inadequate to the task of helping addicts find ways to feed from their own roots and rootedness. Addiction seems to be fixed in a complex network of family dynamics that are generally ignored in the midst of pressing demands to attend to the addict's immediate needs. Symptomatology has monopolized treatment; what begins as family therapy often deteriorates into individual therapy in the presence of family members. The goal of therapy thus becomes management of addictive behavior rather than the healing of distorted relationships between family members.

Parenting is a nonnegotiable need for all persons, including addicts. Inadequate parenting constitutes unfinished family business that the addicted person replicates by holding the world accountable for what was not received from family members and by viewing the world as unfair. In a rootless society, helping agents can easily overlook the intrinsic value of parenting and of other family ties. Therapists must recognize that repairing addictive behavior is associated with investigating the balance of experienced trust, fairness, and unfairness in the social hierarchy of the addict's human world. Otherwise, the addict may use the therapist as a form of "parent." The therapist who can resist being transformed into a "parent" by the addict increases the possibility of building trust that is not rooted in competitive disloyalty to the addict's family of origin.

An intergenerational case study of the Barrett family illustrates the significance of feeling cheated out of rightfully deserved parenting in one's family of origin. Initially, one of the Barrett children was identified as a drug abuser. Both parents had spent periods in orphanages during their childhoods, although their mothers were living. The marriage was stormy. During therapy, the mother was able to face and rework the relationship with her mother. In contrast, the father, an alcoholic, lacked the will to continue family therapy. The children's acting-out behavior was both an affirmation of their filial devotion to parents who themselves were in need and a demand for help for their own deprivation. As long as their parents' legacy of abandonment was not rebalanced, the children had to circumscribe their own lives so as to remain loyal to their suffering parents. After four family therapy sessions, the Barrett's daughter was able to explore her concern for the family and eventually abandon the use of barbiturates.

CONCLUSIONS

In family therapy related to drug addiction, the implications of each person's position in a relational system must be faced. Experiences of injustice and fear of future abandonment must be brought to the surface among family members to repair the injured order of the addict's existence. The therapist should not hesitate to initiate conjoint intergenerational family therapy, even in the midst of drug-induced crises. Therapists also need to focus on the processes by which separation from the family is effectively attained. If the family is a source of hurt, disappointment, and relational deprivation, the sense of injustice experienced in a family cannot be rebalanced by therapeutic concern limited to the addicted person and the process of addiction. Evidence indicates that in the long run it is more productive to face unresolved stagnating relational issues in the family than to focus solely on the addicted member.

Densen-Gerber, J., and Rohrs, C.C. Drug addicted parents and child abuse. Contemporary Drug Problems, 2(4):683-696, 1973.

DRUG	Heroin; methadone
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Addict mothers
AGE	Not applicable
SEX	Female
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Cross-sectional
METHODOLOGY	Theoretical/critical review
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	13

PURPOSE

The study outlines the cycle of problems created by the failure of authorities to attend to the needs and development of the infants of drug addicts. It is argued that physicians and social service agencies have ignored the dimensions of the problem constellation. Only the Odyssey House program described here has attempted to provide treatment to pregnant addicts and to the mother and child as a single entity.

SUMMARY

The 1972 report of the New York State Assembly Select Committee on Child Abuse documented the toll of drug abuse on the youngest group of victims: the fetus without prenatal care; the premature, low-birth-weight newborn in withdrawal; the helpless neonate sent home with an irresponsible, inadequate, hostile parent; and the infant and preschooler neglected by both parents and social agencies. Such youngsters are destined to become the problem individuals of the next generation.

Despite reports of medical literature about the great inroads being made in the field of newborn addiction, the data apply only to maternal and obstetrical complications. The emphasis is clearly on the mothers' welfare. While methadone programs for pregnant addicts reduce mothers' risk, 80 percent of the babies born to these mothers suffer methadone withdrawal. Yet, almost all the infants are released to the care of the addicted mothers. Hospitals frequently sign out mothers and infants without even detecting the addiction problem, yet criticize the Department of Social Services (in the case of New York City) for not being more efficient when children die of abuse or neglect. At best, medical and social care is fragmented and insufficient; it is merely after-the-fact crisis intervention rather than a rational conceptualization of means and ends.

Numerous statistics indicate the urgency of establishing procedures for safeguarding the right of children to be born drug free and to be raised in a nurturing environment. In 1970, 2,000 addicts in Newark, New Jersey, had produced 4,500 children under age 5. Out of every 40 births in New York City, 1 is an addicted child, and in Harlem Hospital, the number is 1 out of 19. In recent years, the number of addicted children born to white mothers has risen precipitously.

Children constantly exposed to parents' drug use display a persistent general inhibition of function as a primary adaptive response even after removal from the environment. Most are withdrawn, irritable, and unresponsive to child care. Although addicted parents are incapable of acting in the best interests of their children or of meeting children's needs at the denial of their own, no legal framework has yet been formulated to deal with the threats to these children.

The goal of mental health professionals must be to provide meaningful intervention and treatment so that such children do not remain unprotected. Because contraception and liberalized abortion programs have proved unworkable for addicts, pregnant addicted women must either be freed of drug dependence and trained in child care or have their children taken away at birth.

The female addict has special problems. Although she desires children she is ambivalent toward them; they are her love objects, yet she is incapable of sustained commitment to them. However the addiction in itself is not the only problem. Harlow concludes on the basis of experiments with monkeys that maternal behavior is not instinctive but learned by each generation as it experiences the nurturing process itself. If not learned during infancy, mothering cannot be learned later. Clearly, nonnurturing behavior could produce a disastrous cycle in subsequent generations.

Odyssey House has developed a special Services to Women program to combat such effects by helping the patient overcome her addiction in a residential therapeutic community and by changing her relationship to her child from a threatening to an enriching one. The program's service/observation course seeks to transmit mothering attitudes and behavior. The teaching staff is composed primarily of professionals with expertise in child care or of successful mothers. Through group and individual counseling observations can be made and changes instituted in keeping with program goals. Success or failure of the program will provide valuable information from which physicians and social service agencies can reevaluate present concepts. To date little conclusive information on treating the mother-child unit has emerged. Techniques will probably become apparent only after long-term experience.

CONCLUSIONS

Children have the right to be considered equal human beings and to be protected from irresponsible parental behavior. Pregnant addicts who refuse help and addict parents who reject intervention must be taken off the streets and placed under mandatory treatment until they deliver drug-free children. They must either relinquish their claims to the children or demonstrate the ability to care for them responsibly. Adequate facilities to care for such families must be developed. Finally, addiction must be designated as a prima facie criterion of unfitness as a parent.

Duncan, D.F. Family stress and the initiation of adolescent drug abuse: A retrospective study. Corrective and Social Psychiatry and Journal of Applied Behavior Therapy Methods, 24:111-114, 1978.

DRUG	Not specified
SAMPLE SIZE	31
SAMPLE TYPE	Applicants for halfway house treatment
AGE	Adolescents (mean: 17.5)
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Survey--correlational (retrospective)
DATA COLLECTION INSTRUMENT	Interviews; Coddington's Life Event Record
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	16

PURPOSE

Much research relates traditional family variables, such as family size, as well as disruption of family life, to adolescent drug abuse. Such findings are consistent with the theoretical model that proposes that drug abuse may serve as a mechanism through which the adolescent copes with a stressful family and social environment. If such a formulation is valid, it follows that drug abuse would be initiated following a period of disruptive events in the family. This hypothesis is tested in a retrospective study of drug-dependent adolescents.

METHODOLOGY

Data derive from interviews with applicants for admission to a halfway house for drug abusers. Of the 38 applicants interviewed over a 6-month period, 4 are unusable and 3 indicate only casual drug use and are thus excluded. A total of 17 subjects are male and 14 are female, with ages from 14 to 21 years. Their history of drug abuse covers an average of 2.4 years with the onset of abuse at the average age of 14.6. The drug dependence of all subjects is self-confessed and agency verified.

In the course of the interviews, subjects are asked to relate how they came to use drugs and whether certain stressful events had occurred in the year preceding their first illicit drug use. Family stress events are 15 items taken from Coddington's life event record: increase in number of arguments with parents and between parents, marital separation or divorce of parents, remarriage of a parent, change in financial status, mother beginning work, change in father's occupation causing his absence, loss of job by a parent, hospitalization of a parent or of a sibling, death of a parent or of a sibling, addition of a third adult to the family, and imprisonment of a parent. The significance of events is measured by chi-square analysis.

RESULTS

Subjects report an average of 3.5 stressful events in their families during the year before their first incidence of drug abuse. Only 2 of the 15 events (i.e., death of a parent and hospitalization of a sibling) did not occur significantly more often in the subjects' families than would be expected in the normal population. The most frequently reported event (22 cases) is an increase in arguments between the subjects and their parents. A total of 18 subjects report changes in the family's financial status, 14 of them to the family's disadvantage. Frequent financial changes are mother beginning work (9 cases), change in father's occupation (7 cases), and loss of a parent's job (6 cases). A stressful family environment is indicated by 13 cases of increased arguments between parents, 10 separations or divorces, and 4 remarriages. For eight of the families, hospitalization of a parent with a severe illness is reported, and two subjects indicate that siblings died.

CONCLUSIONS

Findings support the hypothesis that drug-dependent adolescents may initiate drug abuse after a period of family stress. Drug dependence results from adolescents' use of drugs to cope with the excessive stress. However, reduction in the anxiety or depression from stress through drugs negatively reinforces drug use. Ultimately, drug use only adds to family stress, producing further anxiety and depression and perpetuating abuse. Once set into operation, this cycle can maintain drug dependence indefinitely.

Eldred, C.A., and Brown, B.S. Heroin addict clients' description of their families of origin. The International Journal of the Addictions, 9(2):315-320, 1974.

DRUG	Heroin
SAMPLE SIZE	40
SAMPLE TYPE	20 addicts in treatment; 20 nonaddict patients
AGE	Mean: 24
SEX	Male
ETHNICITY	Black
GEOGRAPHICAL AREA	Washington, D.C.
METHODOLOGY	Survey--correlational, comparative
DATA COLLECTION INSTRUMENT	Adjective Check List
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	15

PURPOSE

According to previously reported findings, the families of male heroin addicts are headed by dominant mothers and weak fathers. Consequences of this family situation may include a negative self-concept in addicts because of their mothers' identification of them with their fathers, difficulties for addicts in achieving independence from their mothers, the addicts' selection of women similar to their mothers as mates, and perpetuation of the addicts' addiction by their wives and mothers. Most of these studies, however, are based on clinical impressions and are without adequate controls. Therefore, this study seeks to assess whether addicts' perceptions of their families differ from those of nonaddicts and explores the self-conceptions that develop from the family experiences of addicts.

METHODOLOGY

The addict sample is 20 clients from a treatment center of the District of Columbia Narcotics Treatment Administration. The control group consists of 20 ambulatory patients at Freedmens Hospital in Washington, D.C. Both groups are black, male, and come from low socioeconomic backgrounds. Mean age of the addict group is 24.25 years and of the control group 24.80 years.

The study instrument is the Adjective Check List (ACL), a 300-item self-administered inventory. Each subject is asked to check adjectives that best describe himself, his mother, and his father. Ten of the 24 ACL scales were determined to be relevant to this study. Seven of these are based on Murray's need-press system: achievement, dominance, nurturance, aggression, succorance, abasement, and deference. Also included were empirically developed scales for personal adjustment and self-control, as well as a scale for the number of favorable adjectives checked by the subjects. Differences between addict-clients and controls in their descriptions of their mothers, their fathers, and themselves are assessed through profile analysis using 3 2-factor univariate analyses of variance; the 2 factors are group membership and the 10 Adjective Check List scales.

RESULTS

Only the profiles of the addict-client's and the control's fathers differ significantly from each other, as revealed by a significant interaction between group membership and ACL scale. Addict-clients describe their fathers as significantly lower on the number of favorable adjectives checked, personal adjustment, dominance, and nurturance scales and higher on the succorance scale than do controls.

CONCLUSIONS

Overall, fathers of addict-clients are described in less favorable terms by their sons than the fathers of controls. Addict-clients' fathers are viewed as less well-adjusted, less able to get along with others, less likely to assume leadership roles, and less likely to extend material or emotional benefits to others, while requiring more sympathy, affection, and emotional support than fathers in general. These findings are consistent with the literature. However, the absence of difference between addicts' and nonaddicts' attitudes toward their mothers and of addicts' and nonaddicts' self-concepts casts doubt on the roles ascribed in the literature to addicts' mothers and to individual psychopathology. However, the study findings are limited by the small sample size, the exclusion of subjects' unconscious levels of awareness, and the demographic characteristics of the population sampled. Valid generalizations will be possible only after further research.

Eldred, C.A., and Washington, M.N. Interpersonal relationships in heroin use by men and women and their role in treatment outcome. The International Journal of the Addictions, 11(1):117-130, 1976.

DRUG	Heroin
SAMPLE SIZE	158
SAMPLE TYPE	Heroin users in treatment
AGE	Young adults (mean: 24.96, females; 24.94, males)
SEX	Both
ETHNICITY	Black; white
GEOGRAPHICAL AREA	Washington, D.C.
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Structured interviews; treatment program intake data
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	10

PURPOSE

Research and clinical reports have focused on patterns of the spread of addiction, on sex differences in the social milieu surrounding drug use, and on the interpersonal and family dynamics conducive to drug use or supportive of rehabilitation. This study attempts to incorporate these various approaches into a multifaceted examination of the importance of social or interpersonal factors in heroin use and drug rehabilitation.

METHODOLOGY

Data derive from interviews with 79 female clients and 79 male clients at the time of their intake to the District of Columbia Narcotics Treatment Administration (NTA), a city agency providing methadone maintenance, detoxification, counseling, and urine surveillance to Washington's heroin addict-clients. The female group includes significantly more white clients, significantly more clients between the ages of 20 and 29 years, and fewer teenagers than the male group.

The research instrument is a structured interview schedule. Its questions concern the social setting of the first and usual use of heroin, the living situation at selected points in the drug

history and presence in the household of other heroin users, the use of drugs by spouse or "friend," perceptions of the feelings of significant others about the drug problem, awareness of the role of others in the subjects' own addiction, efforts of others to encourage or discourage entry into treatment, and addicts' own efforts to influence others to avoid drugs. The interview schedule is administered immediately after intake interviews. Responses are grouped into categories, and those used in the data analysis represent consensus judgments by at least three of four judges. Intake counselors and normal NTA channels supply additional information.

RESULTS

Social Circumstances

There are significant differences in the way men and women use and acquire drugs. Males are usually introduced to drugs by someone of the same sex, while most females are introduced to drugs by a member of the opposite sex. A fairly large minority of women start to use drugs under the influence of another woman, but men rarely try or use drugs with women. Females are more likely than males to acquire drugs from someone else, often free, rather than buying them directly.

Living Situation

At the onset of drug use, women are more likely to be living alone or with their children than men, who are usually living with parents or relatives. Also, men are more likely to fall into the "never married" category than females. These differences are probably attributable to the large number of male clients still in their teens in the sample and to the slightly higher mean age at which drug use began for women in the sample (20.67 versus 19.61 for males). Overall, the incidence of relationships with members of the opposite sex is the same for both groups. Furthermore, females are more likely than males to have lived with a current or previous heroin user while first attempting to withdraw from heroin use or during present or previous involvement with the NTA program. Women are also more likely than men to have spouses who are current or previous heroin users.

Interpersonal Influences

Three-fourths of the combined group report that a spouse or friend of the opposite sex has urged them to give up drugs; half have been urged by other friends to give up drugs, and half have suggested that friends enter drug treatment. Only 16 percent had been dissuaded by others from entering treatment. Both sexes mention friends, spouses, and relatives as being the most unhappy about their drug use. However, female clients are more likely to mention their children as the most unhappy group. Family of origin or in-laws are considered by subjects to be the most helpful and same-sexed friends and other users as the least helpful in detoxification efforts.

A total of 49 clients belong to a supportive milieu group (i.e., live in a situation free of heroin users and supportive of treatment), while 67 clients belong to a nonsupportive milieu group (i.e., live with previous or current heroin users and have been discouraged from entering treatment). However, no relationship can be demonstrated between supportive or nonsupportive group membership and treatment progress. Only encouragement by opposite-sexed partners that clients enter treatment positively influences treatment length.

CONCLUSIONS

The social milieu surrounding heroin use varies as a function of sex. The tendency of both males and females to be introduced to drugs by males may have a probabilistic basis in the greater number of male heroin addicts in the population at large or may be the result of the power structure or status hierarchy implicit in male-female relationships. The significance of interpersonal influence variables for treatment outcome is rather ambiguous and requires further detailed exploration. However, clients undergoing treatment should be encouraged to give some thought to the role that other people play in their drug use and to understand that interpersonal influence, as a normal part of life, does not represent weakness on their part. With

sharpened perceptions of their social environment, they might learn to manipulate the social variables in their lives to provide maximum support for rehabilitation efforts.

Freedman, T.G., and Finnegan, L.P. Triads and the drug-dependent mother. Social Work, 21(5):402-404, 1976.

DRUG	Heroin
SAMPLE SIZE	Not specified
SAMPLE TYPE	Pregnant addicts
AGE	Young adult
SEX	Females
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Philadelphia, Pennsylvania
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	3

PURPOSE

A family therapy program for pregnant addicts has been developed by the Family Center of the Philadelphia General Hospital. According to the approach of this and similar programs, drug-dependent women's use of narcotics is tied to their inability to resolve generational conflicts and to the stress of our culture, as well as to deficiencies of the particular individuals. Intervention focuses on the pregnant addict's intergenerational conflicts with her family of origin, her children, the father of the child, and the addict's siblings. This study describes two therapeutic concepts that may be helpful in using the family therapy modality in the treatment of drug-dependent women: the triangularity of family relationships and the individual development process.

METHODOLOGY

Study findings are based on observations of the Family Center's population of pregnant, heroin-dependent women in their middle and late twenties.

RESULTS

Triadic family relationships are common in any family system, but it is the dysfunctional alignments in the drug-dependent population that warrant investigation. A triad may include, for example, an addict and her partner and her mother or grandmother. Various alignments may occur within the triadic system; the two women can be aligned against the male, or the addict and her partner can be aligned against the mother, and so on. Difficulties within the various triadic combinations arise on several levels, but the creation of a system with unclear boundaries separating generations is a common occurrence. The resulting dysfunction may render families incapable of reaching decisions until generational boundaries are restored. Dysfunction often focuses on the pregnant drug-dependent woman, who becomes the scapegoat for all family problems. The family is dependent on the drug-abusing woman to be "sick," and changes must be made in the underlying family structure to alter the pattern.

Many drug-dependent women become stuck in the developmental process at a point short of becoming independent young adults. Such women have typically not separated from parental figures and are thus caught in an intergenerational conflict between remaining a daughter and moving into the wife/mother role. They frequently have difficulty in dealing with authority, suggesting that many such clients are still functioning as adolescents. Their overwhelming feelings of anger and aggression cannot be constructively channeled, since changing the environment is beyond the immediate capacities of the women. Drugs may numb the anger and temporarily resolve conflicts by protecting the women from the necessity of choosing a new role. Pregnancy, however, reawakens the need to resolve role conflicts. Although many drug-dependent women believe that a newborn will change their lives immediately and fulfill all their needs, their exaggerated expectations only sustain dysfunction. The reality of the baby's dependence is seen as demanding, the baby's crying is taken as rejection, and the baby's powerlessness seems to the mother to be her own powerlessness.

CONCLUSIONS

Although generational dysfunction cannot be isolated as the only difficulty of drug-dependent women, this problem is a striking one that should be seen in combination with a multitude of environmental and psychological problems. Only intervention can prevent such dysfunction from appearing in successive generations. Finding solutions to the generational and developmental problems among drug-dependent women means working with the family system as a whole. Interventions that are directed at the essential conflict may force the client into such symptomatic behaviors as further drug abuse. Therefore, the worker and the family have to map out a step-by-step plan so that all of those involved in the larger family system and in the critical triad can begin to work toward resolving the problems. Mapping must include tasks, goals, and boundaries. This approach saves the worker from the impossible task of replacing the family's parenting figures, helps avoid the problem of family members sabotaging the work of the therapist, and relieves the worker of total responsibility for the outcome of planned interventions.

Friedman, P.H. Family system and ecological approach to youthful drug-abuse. Family Therapy, 1(1):63-78, 1974.

DRUG	Not specified
SAMPLE SIZE	Over 30
SAMPLE TYPE	Drug abusers; families of abusers
AGE	Adolescents and young adults (median: about 17)
SEX	Both
ETHNICITY	White
GEOGRAPHICAL AREA	Philadelphia, Pennsylvania
METHODOLOGY	Clinical observation; case study
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	November 1970-July 1971
NO. OF REFERENCES	35

PURPOSE

Previous studies on youthful drug abusers have focused on the individual dynamics of drug abuse. They have assessed individual drug abusers, usually paid volunteers, outside the context of the family by means of psychiatric interviews, projective tests, and Minnesota Multiphasic Personality Inventory profiles. In contrast, the present research is based on the author's observations of over 30 families. It aims to apply the systems or contextual approach to the analysis of youthful drug abuse. This approach, which is sometimes called "family systems theory" and has more recently been called the "expanded ecological approach," is based on communication and cybernetic theory, general systems theory, ecological psychology, and extensive observation of families in the clinical context. In contrast with the individual psychodynamic approach, the family systems approach perceives behavioral events, such as drug abuse, to be intertwined with the family and social environment. The drug abuser is seen as a reactor to events in the surrounding environment and as an actor on the environment.

METHODOLOGY

The author served as a volunteer consultant at a walk-in, self-help, hotline service and street clinic (HELP) in center city Philadelphia, Pennsylvania. The author observed over 30 families of drug-abusing youths at this clinic, as well as a few families in treatment at the Family Psychiatry Division of the Eastern Pennsylvania Psychiatric Institute. About half the families were referred to the author after a phone call or walk-in contact initiated by the teenager; other referrals were initiated by one or both parents. In most cases both parents, the siblings, and occasionally grandparents living in the home attended the family sessions. Most families were seen twice and then referred elsewhere, although about 10 families were seen in family therapy from 5 to 15 times.

RESULTS

The families generally came from white working class and middle class populations. The numbers of male and female drug abusers were approximately equal. Median age was about 17 years; all the youths were living at home or had run away within the last few days before the family interview.

Observations showed that drug abuse has both demonstrable advantages and disadvantages and positive and negative effects. It may serve as a temporary source of relief or burden of responsibility for other family members. Nearly all the drug abuse families were characterized by a marked lack of emotional closeness between the drug abusers and the parent of the same sex. The threat posed by the drug abuse also served as a temporary cohesive force between the parents, who united to rid themselves of the deviant intrusion but seldom agreed on other matters. Interviews often indicated a startling lack of communication, affection, sexual relations, or joint decisionmaking among the parents. They revealed that the child's drug abuse sometimes masked such problems as a parent's excessive drug use. Drug abuse thus indicated malfunctioning of the nuclear family system.

Drug abuse can serve an important function for the drug abuser's siblings. In most families, one or more siblings had difficulties in personal relationships or learning. Youthful drug abuse also could serve as a cohesive force between parents and grandparents, particularly between fathers and grandmothers. Observations also indicated that family ties are often disrupted by the dysfunctional relationship between occupational and family systems; in some drug abusers' families, the breadwinner was caught in a conflict of loyalty between the job and the family. School systems could also enhance or undermine family cohesion as well as individual growth. Harassed teachers can create more turmoil for troubled teenagers who may become further isolated from the school.

A case study of one family demonstrates and clarifies the functional and dysfunctional effects of drug abuse on various levels of the family system. It also indicates areas for consideration within the ecological system in which the family interacts. In this family, drug abuse served as a signal of covert disturbances in various levels of the family system. Family therapy sessions focused on exposing the various alliances, loyalties, and conflicts between the children, parents, and grandparents and on fostering creative problem solving and conflict resolution through negotiation. Numerous positive changes occurred in the family during therapy.

CONCLUSIONS

Drug abuse may be only one of many dysfunctional symptoms and relationships between family members. It serves a positive function in many ways and may be a transient symptom or disturbance. The likelihood of drug abuse by a teenager or young adult depends on many factors within the extended family and the ecological environment of the family members. Value conflicts between family members, accessibility of drugs, and peer group values are important considerations. In particular, occupational and school systems help to undermine positive family relationships. Overall, when social systems "go crazy," drug abuse will likely be one alternative for release in present day society.

A major attack on drug abuse would probably require a change in the values and functioning of occupational, educational, military, religious, legal, and political systems, so that they support and enhance family growth and human relationships rather than undermine or destroy them. A

more limited set of interventions should focus on helping family members realign their attitudes and alliances to make the family a growth-enhancing relationship system. However, helping the drug user may create dysfunction in other family members. Without changes in system factors, symptoms may just shift from one person or subsystem to another.

Ganger, R., and Shugart, G. The heroin addict's pseudoassertive behavior and family dynamics. Social Casework, 47:643-649, 1966.

DRUG	Heroin
SAMPLE SIZE	184
SAMPLE TYPE	104 addicts; 54 mothers of addicts; 11 fathers of addicts; 15 siblings of addicts
AGE	Not specified
SEX	Male
ETHNICITY	Not specified
GEOGRAPHICAL AREA	New York City
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Interviews; observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	8

PURPOSE

The observations in this report focus on the relationship of drug addiction to anxiety about sexuality and the expression of aggression. Previous literature maintains that individuals turn to opiates to subdue aggressive drives and hostilities (Wikler and Rasor; Nyswander). Similarly, drugs are believed to be a means used by adolescent boys to inhibit aggressive and sexual impulses (Zimmering). In contrast, the authors contend that addiction serves a disinhibiting function, especially in the addict's relationship to his family. Drugs frequently provide an excuse for direct expression of longstanding hostility and a means of opposing longstanding family prohibitions.

METHODOLOGY

The observations are based on individual interviews with 104 male heroin addicts in the Narcotic Addiction Program of Metropolitan Hospital (New York), 54 mothers of addicts, 11 fathers of addicts, and 15 siblings of addicts, over a 17-month period. Two groups of six mothers met weekly for six sessions, another group of mothers and addicts met weekly for six sessions, and a third group of mothers and addicts met weekly for 12 sessions. One family met weekly for 35

sessions and another for 4 sessions. Further information was obtained about 25 fathers from their wives and addicted sons and about 15 siblings from their mothers and addicted siblings.

RESULTS

The Mother-Son Relationship

As a rule, addicts have been overprotected as children and stifled when self-assertiveness evoked disapproval from their mothers. All areas of the boys' lives that might lead to autonomy, including friendships and excellence in schoolwork, have been invaded or prohibited by the mother. Mothers expect their sons to accept their rules without question and characteristically describe their sons as having been "good" before addiction. For them "good" means obedient and respectful within the home; truancy and acting out outside the home are not regarded as problems as long as the sons remain obedient at home.

Behavioral Changes and Other Effects From Addiction

Change in addicts' behavior after addiction are characterized by an apparently new ability to be overtly assertive in areas of previous inhibition. Many addicts become involved in criminal activities to support their drug habits. Addicts frequently become violent toward their mothers under the influence of heroin but blame their behavior on the drug rather than on their own aggressive feelings. Resistance is offered to earlier prohibitions; addicts eat sporadically, reject neatness, and are frequently absent from their homes. Many addicts no longer experience sexual problems such as premature ejaculation; heroin may diminish the anxiety associated with sexuality more than it inhibits sexual functioning per se. Paradoxically, addicts with underutilized work capacities often succeed at hustling, as it is a present-oriented activity that permits the addict to assert all his native intelligence and gain self-esteem while avoiding actual accomplishment in the eyes of the world. Many addicts feel that they can heighten their creative expression under the influence of drugs and in some cases are actually able to complete projects without inhibition and to express themselves more effectively than before addiction.

Family Conflicts and Perpetuation of Addiction

Drug addiction masks a complex of longstanding family problems. Family members often express feelings of frustration, anger, and rivalry toward each other indirectly through conflicts about addiction. The son's addiction enables the mother to intensify her tie to him and to avoid problems in her own marital relationship, increasing both the son's anger at excessive supervision and the father's rage toward his son. The symptom of addiction is perpetuated by all family members. The detoxified patient is greeted at home with renewed family prohibitions and extreme supervision born of mistrust. As the addict's frustration and anxiety mounts he reverts to drugs. Mothers may consciously or unconsciously supply money for drugs or perpetuate the addict's guilt about assertiveness by relating it to addiction.

CONCLUSIONS

Heroin addiction is a pseudosolution to basic emotional problems. Legalizing addiction under medical control by providing a heroin substitute will not alter the underlying emotional problems, which would appear in other symptomatic forms. Addiction is specifically a "familiogenic" disease; any cure must be undertaken within the context of the family unit. The success of treatment programs such as Synanon and Daytop Lodge, which provide a substitute family structure for reeducation, supports this conclusion and emphasizes the need for exploration of family treatment potential.

Kaufman, E. Family structures of narcotic addicts. The International Journal of the Addictions, 15(8), in press.

DRUG	Heroin
SAMPLE SIZE	78 addicts; 75 families
SAMPLE TYPE	Addicts in treatment; families of addicts
AGE	Young adults (mean: 25)
SEX	Both
ETHNICITY	Cross-cultural
GEOGRAPHICAL AREA	Manhattan, New York City; Los Angeles, California
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Videotapes; recordings; observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	18

PURPOSE

Much of the previous confusion about the family structure of addicts has arisen because studies were performed on addicts from one social class or ethnic group and generalized to all addicts. For that reason, the present study uses an ethnically diverse population to generalize about family structures.

METHODOLOGY

Data on family structure were obtained from 61 families of former heroin-dependent individuals housed in Su Casa, a residential treatment setting in the Lower East Side of Manhattan, and with 14 families of heroin addicts at the Awakening Family, a highly structured therapeutic community in Los Angeles County, California. Because 3 sibling pairs were in residence, a total of 78 patients participated. The ethno-racial breakdown of the group was 23 percent Hispanic, 19 percent Italian, 18 percent white Anglo-Saxon Protestant, 13 percent Jewish, 10 percent black, 9 percent Irish, 1 percent Greek, and 6 percent mixed. Jewish and Italian families were especially willing participants in therapy, while black families were reluctant to take part. A total of 62 patients were male and 16 female; the average age of patients was 25 years. A total of 8

families consisted of a mate only; 67 of the families contained at least 1 member of the family of origin; and 12 mates of residents whose family of origin also attended were part of the group, for a total of 20 mates.

The basic patterns of familial interaction were analyzed using the concepts of Minuchin, with parent-child relationships designated as enmeshed (a heightened sense of belonging requiring loss of autonomy), clear, or disengaged (characterized by a lack of feeling of family loyalty or belonging). Most families were observed for 6 months. All sessions were recorded and later analyzed to confirm initial impressions. Several months' sessions were recorded on videotape and presented to several experienced family therapists who reviewed the structural patterns with the therapists.

RESULTS

Structural Patterns

A total of 88 percent of the mother-child and 40 percent of the father-child relationships were enmeshed. Twenty-four fathers were disengaged (43 percent) but only two mothers.

Deaths of one mother and seven fathers as well as many divorces were linked to the onset of addiction. Mothers tended to be enmeshed with children in all ethnic groups. A total of 6 of 10 Jewish and 7 of 13 Italian father-child pairs were enmeshed, while Puerto Rican, black, and white Protestant fathers were disengaged or absent. The black families had especially strong, involved mothers and absent or passive fathers, and the Greek family encompassed three totally enmeshed generations.

Enmeshment or Disengagement Patterns

The most obvious pattern observed was that of a male addict enmeshed with his mother, thereby separating her from her spouse, who retaliated with brutality to the addict and/or disengagement from the family. Enmeshment involving the father was also common. In addition, the relationship between mothers and daughters tended to be extremely hostile, competitive, and at times chaotic. Half the mother-daughter relationships were also severely enmeshed. In the majority of Italian and Jewish families the entire family was enmeshed. Frequently both parents collaborated with addicts to keep them infantalized under the guise of protecting them from danger. A pattern of father-son brutality was common in enmeshed as well as disengaged relationships. Brutality by enmeshed fathers pushed sons into strong coalitions with mothers against fathers. Overt incest was reported in only one father-daughter pair but was suspected or experienced covertly in many parent-child and sibling pairs. Frequently, dysfunctional family systems could not be understood until members of the extended family (grandparents, aunts, uncles, and cousins) were included.

Communication Patterns

Generally, the family either denied the individual's addiction or blamed all intrafamilial problems on the addict. Guilt was frequently used by addicts to manipulate or coerce the family into supporting their drug habit or by parents to curb individuation. Most of the fathers who were present had worked hard to become supervisors and had set high performance standards for their sons that were not met. Physical expressions of love and affection within the family were either absent or used to deny and obliterate individuation or conflict. Family lives were marred by repressed anger about interpersonal conflicts and drug use, by negative communication, and by a lack of consistent limit setting by parents. All joy had disappeared from the families, as their lives were totally taken up with the sufferings and entanglements of having an addict child. However, in many cases, the joylessness preceded the addiction.

CONCLUSIONS

The basic structural pattern in the families observed is consistent with patterns previously found in families of drug abusers and of other pathologic entities: mother and son are symbiotically tied to each other prior to addiction and the father is excluded, becoming disengaged or brutal.

Several other observations have not been sufficiently developed in the literature. First, family patterns of narcotic addicts vary in different ethnic groups. The father may be enmeshed in some ethnic groups (e.g., Italian and Jewish) and disengaged in others (e.g., white Protestant and black). Larger samples must be studied to delineate these patterns. Additionally, siblings are of crucial importance through their own addiction, in their role as a parental child, or as a success with which the addict cannot complete. Third, addict-spouse pairs frequently duplicate roles that they have developed in their families of origin. Overall, the literature supports the general findings of the study, particularly the symbiotic relationship between mothers and sons and the role of drug use in maintaining interactional family equilibrium. Identification and alteration of maladaptive structures in families of addicts are considered to be the only means of preventing readdiction.

Kirschenbaum, M.; Leonoff, G.; and Maliano, A. Characteristic patterns in drug abuse families. Family Therapy, 1(1):43-62, 1974.

DRUG	Multidrug
SAMPLE SIZE	10
SAMPLE TYPE	Families with a drug-using member
AGE	Adolescents; young adults; mature adults (users: 14-39; mean, 19)
SEX	Users: 8 males; 2 females
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Interviews; observations; videotapes; Satir's Unstructured Clinical Interview; Watzlawick's Structured Family Interview
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	86

PURPOSE

Although much literature focuses on the close correlation between emotional maladjustment and drug use, few data on which to base generalizations about the patterns of interaction typical of families with a drug-using member are available. Keniston (1966) suggested that pressures toward academic performance and psychological numbing have increased the use of drugs among American youths. Willis (1965) found that drug users could be grouped into four categories including psychoneurotic individuals taking drugs to relieve anxiety or other problems and psychopathic individuals taking drugs as a result of aggressiveness, hostility, or other problems. In the one publication concerning the family and drug use, Ganger and Shugart (1966) found that heroin addicts were characterized by a strong symbiotic relationship with their mothers, hostility from their fathers, and a family in which drug use enabled longstanding anger and rage to come to the surface. Most studies of family interactions have involved a controlled situation in which the family performed a decisionmaking task. Studies have focused on family decision-making, communication patterns, feelings and attitudes, or other specific variables. The present study tried to assess the entire interactional pattern by using new methods. Clinical interviews and observations were used to examine family interactions in 10 families with a drug-using member.

METHODOLOGY

The identified patients included eight males and two females with a mean age of 19 years and an age range of 14 to 39 years. Drugs used included narcotics, psychedelics, amphetamines, and barbiturates. All families were biologically intact and had professional, managerial, skilled labor, or high-ranking military vocations. Satir's Unstructured Clinical Interview was used to elicit family interactional processes because of its open, flexible format. Watzlawick's Structured Family Interview was also used because of its ability to produce family interaction with high diagnostic value in a short space of time. Both adult and adolescent observers were chosen to assess the interaction. Adult observers were students of psychology and mental health occupations with varying levels of professional experience. The adolescent observers were untrained youths who were paid to spend 16 hours viewing tapes and completing a questionnaire form. The interviews totaled 3 hours per family and were conducted in a room with two one-way mirrors, a microphone, videotape camera, recorder, and screen.

RESULTS

Drug use appeared to express both the deadening of painful feelings produced by the family's unhealthy psychological situation and the need to gain nurturance and validation not available through other means. Numerous definable family interaction patterns characterized the families of drug users. Parents had good intentions, but their interactions were suffused with anger, rage, conflict, and other behaviors, thus causing the drug users to be maintained in their existing roles. Another pattern was the father's assumption of the traditionally defined male role of the American middle class. Fathers functioned in an authoritarian framework; provided the family's material support; were involved in stereotyped masculine activities; and maintained an appearance of control, independence, and emotional maturity. Parents did not support their children's uniqueness and tended to alienate their children through critical and moralistic statements. The drug users also had paradoxical relationships with their parent of the same sex; the relationships included both negative feelings and an intimate connection. These families' communications were also almost entirely intellectual and rational; sharing of intimate feelings was absent. What feelings were expressed were largely judgmental and defensive in nature; there was an almost total absence of nurturance or validation of the older children. Moreover, family members were emotionally isolated from one another; for example, everyone in one family abruptly left for separate rooms of the home whenever conflicts arose. Family interactional processes were also characterized by an absence of a tone of enjoyment, humor, or fun; depression, reluctance, and strain were the dominant tones. There was also a consistent coalition of the parents against the drug user. Another characteristic pattern was the fathers' assumption of the traditional male roles in appea ance but not in fact. Moreover, the triangle of mother, father, and user was never an integrated unit. Typically the same-sexed parent as the user would withdraw if the child and other parent seemed distant or disrupt the relationship if the two seemed to be getting close to each other. This would catch the parent of the opposite sex to the drug user in a double bind between the child and the spouse. Finally, parents of drug users characteristically had marital problems, especially in their sexual relationships.

CONCLUSIONS

Drug abuse is consequent to the user's feeling of being emotionally trapped and unable to break through defenses in order to make contact with inner experiences or other people. The societal situation that Keniston described is represented within the family, and the family's disconnected relationships produce a loneliness, depression, and pursuit of experience through drugs. The sensual stimulation of drugs represents an attempt to give temporary meaning and significance to life and to satisfy wishes for intimacy, fusion, and deep emotional involvement. The lack of intimacy in the home supports Blum's statement that drug use serves as a means to reduce psychic pain. In the research families, a pseudointimacy was observed, which failed to satisfy the deeper needs of the developing children. The psychological absence of the father and the mother's controlling role in the family supports Cummings's finding that drug users experience a gap both between generations and between themselves and their peers. Drugs are used as a substitute means of relating to peers.

Future research should focus on more specific and controlled investigations and should use control groups. The present methodology permitted wide exploration and produced an overwhelming volume of observations. Nevertheless, studying the entire family interactional process is the best way to determine behaviors and attitudes relating to family dynamics.

Madanes, C.; Dukes, J.; and Harbin, H. Family ties of heroin addicts. Archives of General Psychiatry, 37:889-894, 1980.

DRUG	Heroin
SAMPLE SIZE	36
SAMPLE TYPE	18 addicts, 9 schizophrenics, 9 college students, and their families
AGE	Young adults; mature adults
SEX	Males and their parents
ETHNICITY	Black
GEOGRAPHICAL AREA	Baltimore, Maryland, and Washington, D.C.
METHODOLOGY	Survey--comparative
DATA COLLECTION INSTRUMENT	Family Hierarchy Test
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	21

PURPOSE

Contrary to the conventional assumption that addicts are basically peer-oriented sociopaths, an increasing body of evidence indicates that they are enmeshed in dependent relationships with their families of origin or parental surrogates. The majority of heroin addicts maintain close family ties. Such ties may or may not be related to the origins of the addiction, but they do seem to be related to the maintenance of an addictive life. Thus, treatment that deals with both the drug use and the social matrix that helps maintain it is required.

This study investigates the hypothesis that heroin addicts are enmeshed with their parents or parental surrogates in alliances across generational lines and in reversals of the hierarchical organization of their families that, clinically, appear to perpetuate the addictive behavior. Families of black, male heroin addicts of low socioeconomic class were compared with families of schizophrenics and high-achieving normal controls.

METHODOLOGY

The study sample consisted of 18 heroin addicts, 9 schizophrenics, and 9 university students, along with their families. The students were considered to be high achievers in that they came from the same socioeconomic background as the heroin addicts. The heroin addicts came from the Methadone Maintenance Treatment Program at the University of Maryland in Baltimore. Access to the sample of schizophrenics was made possible by the Institute of Psychiatry and Human Behavior at the University of Maryland Hospital and the Department of Psychiatry at Howard University Hospital. High achievers were obtained through their enrollment in the Medical School, graduate schools of Social Work and Nursing, and the Psychology Department at the University of Maryland.

Three tests were given: the Proverb Test, the Family Rorschach Test, and the Family Hierarchy Test. This study reports only on results of the Family Hierarchy Test. In this test, family members chose representations of their hierarchical relations to show closeness and distance between family members. Family members were asked to describe their families as they thought they actually were, rather than as they would like them to be. In analyzing the results, hierarchical reversals were defined as presentations in which one parental person was placed below the other parental person, a parental person was placed below or at the same level as the index person, the sibling, or both; and other combinations. Representations produced by each member, by the two parental persons together, and by the family as a whole were counted. The unit of measurement of closeness and distance was labeled "attachment." A scoring system for measuring hierarchical reversals and cross-generational attachments was devised.

RESULTS

There were significant differences between the three groups. Addict families had the highest number of scores for heirarchical reversals and cross-generational attachments; families of high achievers the lowest; and families of schizophrenic families were in the middle. No single diagram was characteristically chosen by any group.

Hierarchical reversals, which are common to addict families, are generally produced by one parental person in the hierarchy being placed on the same level as the offspring. There is a struggle for leadership between parental persons in addict families, as well as a number of cross-generational and same-generation attachments. Siblings are more detached from the family than are the other family members. The struggle for power in the family is similar in schizophrenic families to that of addict families, but unlike the addict families, there are not a large number of cross-generational or same-generation attachments.

The families of high achievers had few hierarchical reversals. There were no extreme attachments across generations or within the same generation, and the parental persons are able to retain their positions of leadership even though the high achievers have higher educational levels and are more successful than the parental persons.

Use of one-way analysis of variance showed that the differences in family composition, as indicated by the much higher proportion of two-parent families in the high achiever group, did not significantly affect these results.

CONCLUSIONS

The representation of families of addicts is in agreement with clinicians' views that these families have only one parental person in a position of leadership. Members of addict families are involved in cross-generational alliances; in addition, hierarchical reversals and cross-generational attachments cannot be attributed to the lack of a parental figure or to a broken home since these occur just as often in the two-parent families of addicts. In contrast, results for high achievers indicate that some of the strengths of the low-socioeconomic black family reside in a traditional hierarchical organization and no extreme attachments across or within generations exist.

A certain family organization will not necessarily lead to a specific problem in the offspring--it is the addict who is involved with the family in a way that helps to maintain the addiction. Thus, therapists must reorganize the family hierarchy so that both parental persons are in a superior position to the addict. Parental persons must be encouraged to take joint responsibility

for changing the addict's behavior in relation to drugs. As the family hierarchy changes, the parental persons will come closer together and the addict will begin to disengage from them. At this point, the therapist must take care that the parental persons do not bring the addict back into their relationship as a problem that helps to hold them together. The therapeutic task is to influence the family so that it does not maintain the addiction but will collaborate in helping the addict to overcome it.

Mason, P. The mother of the addict. Psychiatric Quarterly Supplement, 32(Pt. 2):189-199, 1958.

DRUG	Not specified
SAMPLE SIZE	65
SAMPLE TYPE	Addicts in treatment
AGE	Not specified
SEX	52 males; 13 females
ETHNICITY	Not specified
GEOGRAPHICAL AREA	New York City
METHODOLOGY	Clinical observation; exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Observations; interviews
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	14

PURPOSE

A particular pattern has recurred in the family constellation of drug addicts: a dominant mother and a distant or absent father. For this reason the author seeks to define the nature of the relationship between addicts and their mothers from the addicts' infancy on and to characterize addicts' mothers.

METHODOLOGY

Data are derived from published case studies and the author's own clinical observations of addicts at Riverside Hospital in New York City. Data on early childhood experiences and attitudes of addicts are based on a random sample of 65 of the author's patients.

RESULTS

Mothers of addicts are described as controlling, excessively indulgent, and seductive. Mothers of addicts in treatment are difficult to deal with, as they tend to distort information, ignore therapists' attempts to discuss treatment, and cover up for the addict. Such mothers are frequently so possessive that they refuse to grant their children independence and interfere with hospitalization, arousing patients' fears on some pretext in the hope that they will leave. In many cases mothers supply money for addicts' drugs, claiming that the money is for something else, or even smuggle drugs into the treatment institution. While mothers tend to view marriage as a panacea, they become hostile when their sons actually consider marriage and will often set out to destroy these relationships. When the marriage flounders, the addict sons return to mother. The patterns are consistent in comfortable as well as poor economic settings.

Examination of child-mother relationships indicates that the addicts as infants had rarely been breast fed for more than 3 months and that weaning had frequently been abrupt because of the mothers' illness, return to work, or reluctance to continue breast feeding. Patients' rejection of breast feeding their own children apparently reflects the reluctant, ungracious treatment that they received from their mothers.

The vast majority of drug patients prefer their mother to their father, but in a fairly large number of cases the preferred mother does not return the affection.

Attempts to influence patients in their home environments through treatment of their mothers have failed. Mothers generally refuse referral, and hospital parent-staff organizations have had little success. Mothers become anxious as soon as their personal problems are revealed, and guilt over their hostility tends to drive them away from the groups. Although treatment efforts have been uneconomical, time consuming, and disappointing, even half-hearted, short-lived cooperation makes the treatment process slightly more favorable.

CONCLUSIONS

The mothers of drug addicts tend to be controlling, overpowering, overprotective, guilt-ridden, unhappy women with hostile and aggressive feelings toward their children. At the same time, the mothers are unable to separate from their children or to grant them independence. Such mothers may identify their children with one of their own parents toward whom they felt ambivalence. Because of their own problems, the mothers stimulate aggressive and sexual drives in their children and then proceed to deny and to disapprove of them. There is a marked disparity between what such women say and what they do, but they are apparently unaware of the damaging effects such duplicity may have. The wavering back and forth between promise and fulfillment on the one hand and denial and punishment on the other has a definite place in the formation of a personality conditioned to accept pain and failure as an integral part of the promise of love.

Mayer, J., and Black, R. Child abuse and neglect in families with an alcohol or opiate addicted parent. Child Abuse and Neglect, 1:85-98, 1977.

DRUG	Opiates; alcohol
SAMPLE SIZE	78
SAMPLE TYPE	Opiate-addicted parents; alcoholic parents
AGE	Opiate addicts: adults (mean: 26); alcoholics: adults (mean: 41)
SEX	Both
ETHNICITY	Cross-cultural
GEOGRAPHICAL AREA	Boston, Massachusetts
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Interviews; MMPI; Survey on Bringing Up Children; Schedule of Recent Experience
DATE(S) CONDUCTED	April-August 1976
NO. OF REFERENCES	35

PURPOSE

Only a few studies of families in which child abuse or neglect has occurred have tried to assess the extent to which alcoholism or drug addiction is involved. The results of these studies vary and are difficult to interpret due to methodological limitations. Nevertheless, factors associated with child abuse and neglect are present in the personalities, social backgrounds, and living conditions of drug addicts and alcoholics. It is also clear that not all addicted or alcoholic parents seriously abuse or neglect their children.

The present study examines the connection between the occurrence of child abuse and neglect and drug and alcohol addiction. Specific goals were to compare the frequency and types of child abuse and neglect associated with alcoholism and opiate addiction, examine the relationship between stages in the cycle of substance abuse and child care or abuse, and determine the presence in addict families of social and situational factors associated with child abuse and neglect.

METHODOLOGY

This paper reports the results of interviews with 78 parents, 54 of whom were addicted to opiates and 24 of whom were addicted to alcohol. Subjects were interviewed between April and August 1976. The subjects were those initially interviewed from a projected ultimate sample of 100 alcoholics and 100 opiate addicts caring for children under age 18. The subjects were patients of the Washingtonian Center for Addictions, a private, voluntary, multimodality treatment center for alcoholism and drug addiction in Boston, Massachusetts. Data were gathered on demographic factors; history of drug and alcohol abuse; childhood history; care, abuse, and neglect of children; and the relationship between stages in the cycle of alcohol or opiate abuse and child care, abuse, or neglect. Abuse was determined by parental reports of such occurrences as intentional serious injuries or loss of control during punishment. Data were also gathered via the Minnesota Multiphasic Personality Inventory, the Survey on Bringing Up Children, and the Schedule of Recent Experience. All participation was voluntary.

RESULTS

Most opiate addicts were female, while most alcoholics were male. The median age for opiate addicts was 26, and for alcoholics, 41. One-third of the opiate addicts and three-quarters of the alcoholics were married; 9 percent of the opiate addicts and 38 percent of the alcoholics were employed. The 78 subjects had among them 168 children for whom they were natural parents. They were caring for 111 children during the study period. A total of 18 percent of the children were under age 2, 25 percent were ages 2 to 6, 32 percent were 6 to 12, and 24 percent were 12 to 18. Use of opiates occurred during 24 percent of the 99 pregnancies reported by the opiate addicts. Five children were born addicted.

Certain or probable child abuse occurred in 10 families; 9 were cases of physical abuse and 1 was a case of sexual abuse. Nine of these families had a drug-addicted parent; one was the family of an alcoholic. No deaths attributed to abuse were reported. In addition, seven of the child abuse families were single parent families; nine were on welfare. Abusers included six mothers, two fathers, one stepfather, and one boyfriend. Five of the abusers who were study subjects had been abused as children.

Results of the Survey on Bringing Up Children indicated that 63.3 percent of the subjects were at risk of abuse or neglect. Of the eight families in which the parent completing the survey may have used physical abuse, three were identified as at risk, four were identified as not at risk, and one had not yet been classified. If use of physical punishment and loss of control during punishment were used as indicators of a risk for child abuse and neglect, 30 percent of the subjects would be potential abusers.

CONCLUSIONS

Results indicate a significant potential for child abuse, the presence of child abuse in some families, and the absence of child abuse in many families of alcoholics and drug addicts. Although the incidence of abuse in the addicted population appears to be lower than expected on the basis of other studies, the potential for abuse may manifest itself instead in child neglect. In addition, the families' characteristics support previous research showing that these families experience stressful living situations, including unemployment, broken families, and psychological and legal problems. Many of these families' parents also came from broken homes. Results also indicated that opiate addicts can and do control their opiate use during pregnancy and that substantial interruptions in use are more typical than continuous use. Although the small number of cases prevents conclusions about the significance of family characteristics, the data indicate that, in addition to drug or alcohol abuse, none of the factors such as poverty, family disruption, abuse of the parent as a child, and psychological problems can be eliminated as possible significant factors in the occurrence of abuse in this population.

Mead, D.E., and Campbell, S.S. Decision-making and interaction by families with and without a drug-abusing child. Family Process, 11(4):487-498, 1972.

DRUG	Not specified
SAMPLE SIZE	40
SAMPLE TYPE	20 families with an abuser; 20 families without an abuser
AGE	Adolescents (14 to 19); adults
SEX	Both
ETHNICITY	White
GEOGRAPHICAL AREA	Provo, Utah
METHODOLOGY	Survey--comparative
DATA COLLECTION INSTRUMENT	Questionnaires; observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	7

PURPOSE

This study replicated an earlier study by Ferreira and Winter of family interaction and decision-making, except that the present study considered families with and without a drug-abusing child. The 11 hypotheses tested concerned the amount of spontaneous agreement in both families, the time required to make a decision, and choice fulfillment.

METHODOLOGY

A total of 20 families with a drug-abusing child were compared with 20 families without a drug-abusing child. The families were white triads of father, mother, and child. In all families the child was between the ages of 14 and 19, and both parents were living in the home. Normal families were drawn by random selection from a population of families fitting the above criteria. A total of 28 letters and calls were made to secure a sample of 20 normal subjects. The drug-abusing sample was nominated by members of a local group organized to rehabilitate drug-using youths. A total of 61 letters and phone calls were needed to achieve a sample of 20 drug users. The subjects were at no time identified according to the variable of drug use. Chi-square analyses of demographic factors indicated no significant differences between the two groups.

All 40 families were tested in the family counseling facilities at Brigham Young University in Provo, Utah. Each person was asked, by questionnaire, to pretend that 7 situations were real and to indicate 3 favorite and 3 least favored preferences among 10 possible choices for each situation. The items concerned choosing a car color, a dinner from a menu, a sporting event, a room to remodel, a movie to attend, a family household chore, and a family activity. Family members completed the questionnaire in separate rooms. Family members were then brought together to choose group favorites and least favorites. The experimenter left the room but timed and recorded the interaction. Family members completed the socioeconomic questionnaire following the interaction task.

RESULTS

Normal families had significantly more spontaneous agreement than did the abnormal families. When dyad scores were compared, all normal dyads had a higher mean score than the drug user dyad mean scores, but only the mother-child dyad score differences were significant. The children's ages did not correlate positively with the spontaneous agreement scores associated with the father-child dyad or the mother-child dyad. Surprisingly, the age of the child correlated negatively with the mother-child spontaneous agreement scores.

Children tended to have greater spontaneous agreement with the parent of the same sex than with the parent of the opposite sex. The hypothesis of symbiotic mother-child relationships in families of drug users could not be supported in terms of the spontaneous agreement variable. The mean decision time did not differ significantly between normal and abnormal families. In addition, the drug family choice fulfillment score was significantly lower than the normal family choice fulfillment score. No significant correlation was found between spontaneous agreement and decision time for the total sample, although the normal families had a negative correlation between spontaneous agreement and decision time. Although not significant, the abnormal families' spontaneous agreement scores correlated positively with their decision time scores. Spontaneous agreement and choice fulfillment were found to correlate positively for the whole sample and for the separate groups. No significant correlation between decision time and choice fulfillment was found. The percentage of "chaotic" responses did not differ significantly between the two groups.

CONCLUSIONS

Results supported the work of Ferreira and Winter in that spontaneous agreement differentiated families with drug-using children from normal families, just as it differentiates other abnormal family patterns such as maladjustment, delinquency, and schizophrenia. Data indicated that normal families agree spontaneously more often than drug families. Dyads in normal families, especially the mother-child dyad, also showed more spontaneous agreement than dyads in drug families. However, data failed to replicate the earlier report of a positive correlation between the age of the child and spontaneous agreement with the child. All male children agreed more with their fathers, and all female children agreed more with their mothers, although data do not show that drug-using families have more agreement between mother and child.

Results also suggested that for normal families, decisions take longer when there is little spontaneous agreement, but for delinquent and drug-using families, when little agreement exists, decisions are quickly reached and time is spent discussing areas in which family members were previously in agreement. However, the abnormal families are inefficient in their decisionmaking. Drug-abusing families appear to avoid revealing that they disagree on such unimportant issues as the decisions presented in the experimental situation. Data supported earlier findings that spontaneous agreement is a rather stable variable in families and can differentiate normal from abnormal families. Also, the behaviors of families of drug-using children are similar in many ways to behaviors of families diagnosed as maladjusted, schizophrenic, and delinquent. Scores of drug-using families appeared most similar to those of delinquent families. Finally, decisions in drug-using families more often favor fathers than chance would dictate. This result contrasts with findings regarding schizophrenic families in which mothers have more influence than fathers.

Osterweis, M.; Bush, P.J.; and Zuckerman, A.E. Family context as a predictor of individual medicine use. Social Science and Medicine, 13A:287-291, 1979.

DRUG	Prescription and nonprescription medicines
SAMPLE SIZE	2,703
SAMPLE TYPE	Family members
AGE	Not specified
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Baltimore, Maryland
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Questionnaires
DATE(S) CONDUCTED	June 1, 1968-May 31, 1969
NO. OF REFERENCES	21

PURPOSE

The family unit is increasingly recognized as a key determinant of individuals' health and illness behaviors. Medicine taking is the most common preventive- and illness-related behavior. Past empirical research on medicine use has focused on determining the sociodemographic and morbidity characteristics associated with the use of medicine by individuals. Although several studies have included such family variables as income and family size, none has considered the family context as a whole as an influence on medicine use or has analyzed family patterns of medicine use. Like other health and illness behaviors, however, medicine taking behavior is probably patterned and acquired in childhood as part of the socialization process. Although the family is not the only socializing agent, it is the primary mediator between the individual and the larger social system. The goal of this study was to demonstrate the effect of the family context on individual's drug use. Hierarchical and stepwise regression models were used to evaluate the family context and individual variables to predict medicine use.

METHODOLOGY

Study data were derived from the Baltimore Household Survey of the World Health Organization/ International Collaborative Study of Medical Care Utilization. A family subset of 2,703 persons in 794 families ranging in size from 2 to 11 persons completed the questionnaires. Independent variables measured at the family level included family size, family income, percentage of females and percentage of children in the family, average family morbidity, and average use by other family members of nonprescribed and prescribed medicine. Variables measured at the individual level included age, sex, race, and morbidity. A morbidity index was formed by combining responses to several questions. Medicines such as pain relievers, cough medicines, vitamins, sleeping pills, and tranquilizers or sedatives were of concern.

Hierarchical and stepwise multiple regression techniques were used to test the hypothesis that family context is a better predictor of individual medicine use than are individual characteristics. For the hierarchical regression, the variables were entered in two groups and an F-test was performed to determine whether differences were significant. The stepwise regression with the "forward inclusion" option was then used to determine whether all the family context variables were more powerful than the individual variables or whether the order was mixed. In both regression models, the individual was the unit of analysis.

RESULTS

The hierarchical regressions showed that the set of family context variables was a better predictor of individual medicine use than was the set of individual characteristics. For example, other family members' medicine use behaviors were strong predictors of individuals' medicine use. However, the relationship was inverse; an individual was more likely to be using nonprescribed drugs if others in the family were using prescribed drugs and vice versa. The relative importance of the independent family variables was dependent upon whether prescribed or nonprescribed medicine use was predicted. In the stepwise regressions, some family context variables, notably others' medicine use, were more powerful predictors than were individual variables. The model was a better predictor of prescribed medicine use than of nonprescribed medicine use. Some variables, such as family size, which had been shown in previous studies to be significantly related to medicine use, were not important in the presence of other variables. Results also showed that as the proportion of women in a family increased, individuals in those families tended to take fewer prescribed medicines.

CONCLUSIONS

Results suggest that the importance of the health and illness behaviors of family members should not be overlooked when analyzing data on individuals' use of health services. Given that the family context was a strong predictor of individual behavior, it is urged that the family be the focus of attention in attempts to modify health and illness behaviors.

Penk, W.; Robinowitz, R.; Kidd, R.; and Nisle, A. Perceived family environments among ethnic groups of compulsive heroin users. Addictive Behaviors, 4(3):297-309, 1979.

DRUG	Heroin
SAMPLE SIZE	275
SAMPLE TYPE	215 addicts; 23 polydrug users; 37 nonusers
AGE	Young adults (mean: 26.17)
SEX	Male
ETHNICITY	White; black; Mexican-American
GEOGRAPHICAL AREA	Texas
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	MMPI; Family Environment Scale; Raven Progressive Matrices; questionnaire
DATE(S) CONDUCTED	1976-1977
NO. OF REFERENCES	32

PURPOSE

Current research on personal and social characteristics associated with heroin addiction has increased the realization that many different personality characteristics and adjustment levels are associated with compulsive heroin use. A related study (Penk et al., 1978b) suggested that family difficulties are a major source of problems for heroin addicts. However, the research on family experiences of addicts lacks an appreciation of the psychological understanding by the addict about events in his family. Thus, this study was designed to test and generate hypotheses about families of addicts, based on addicts' ratings of their past families in which they were children and their present family in which they are fathers. It was expected that compulsive heroin users would describe their families in dimensions differing from normative samples, that black and white heroin users would register the effects of inadequate modeling of social and role skills, and that black heroin users would evidence less deviation and variability among dimensions of personality and family characteristics when compared with white heroin users. No differential predictions were made between ratings of past and present family characteristics.

METHODOLOGY

Subjects were male compulsive heroin users voluntarily seeking treatment in a drug dependence treatment program of a Veterans Administration general medical and surgical hospital. Subjects were selected from consecutive admissions between July 1, 1976, and August 31, 1977. Three samples were also selected for comparison purposes. These included 23 white polydrug users, 37 veterans awaiting reconstructive knee surgery, and 25 Mexican-American addicts seeking treatment.

The Family Environment Scale (FES) was administered as part of a psychological assessement battery that included the Minnesota Multiphasic Personality Inventory (MMPI), Raven Progressive Matrices, and a drug history questionnaire. The FES measured dimensions of interpersonal relationships, directions and extent of personal growth encouraged, and the family's basic organizational structure. It was administered usually once but twice if a subject indicated he was married or headed a houshold. A total of 65 white and 125 black heroin users rated their childhood families; 39 white and 63 black heroin users also rated their present families. Findings are discussed for the smaller sample completing both past and present FES since results are equivalent for both samples.

Both univariate and multivariate analyses were performed for MMPI and FES scores. Blacks and whites were compared on MMPI clinical and content scales and on the FES scales. It was predicted that both addict groups would score lower on those FES scales registering inadequate instrumental role skill modeling and that ethnic differences would be apparent; white heroin users would evidence less family cohesion, greater family conflict, and poorer family organization and control than blacks.

RESULTS

Findings supported the three hypotheses. Drug users deviated from normative samples in measures of both personality and family social climate. As a group, heroin users showed personality maladjustments, with elevations in four MMPI scales: psychopathic deviate, depression, schizophrenia, and mania. White heroin users scored higher than black heroin users on MMPI clinical scales and on the social maladjustment and depression scales; blacks scored significantly higher on the mania scale and were aligned with feminine interests. Results replicated personality differences found earlier for compulsive heroin users differing in ethnicity.

In critical ratio comparisons with FES normative scores, black heroin users rated their past family environments as signficantly higher in achievement orientation, moral-religious emphasis, and organization and significantly lower in expressiveness, conflict, intellectual-cultural orientation, and active recreational orienation. Similarly, white heroin users rated their past family environments as being significantly higher in achievement orientation and significantly lower in expressiveness, intellectual-cultural, and recreational orientations; the childhood family was also lower in family cohesion.

Black heroin users rated their present family environments significantly higher than the normative sample in achievement orientation, moral-religious emphasis, and organization and significantly lower in conflict, intellectual-cultural orientation, and active recreational orientation. White heroin users differed significantly from the normative sample in higher expressiveness and lower conflict, independence, intellectual-cultural orientation, and active recreational orientation.

Five of ten past-present FES comparisons differed significantly for white heroin users but not for black addicts, indicating that greater dissatisfaction may be present in the social climates of white heroin users' family environments. Additional comparisons showed white polydrug users scoring higher than white heroin users in moral-religious emphasis and lower in independence. The white nondrug-using control group scored significantly higher on cohesion, moral-religious emphasis, and organization and significantly lower on conflict. Comparisons with Mexican-American heroin users showed that ethnic differences uniquely influence FES scores and generalize across FES scores.

CONCLUSIONS

Findings met predictions from earlier research and generated some testable hypotheses. First, heroin users regard both their past and present family environments in ways appreciably different from both the normal standardization sample and the comparison samples. Second, heroin users' past families place less emphasis on political, social, intellectual, and recreational activities and thus produce poor modeling of instrumental role and social skills. A testable hypothesis is that heightened achievement expectations in the absence of role skill modeling may be associated with compulsive heroin use. Third, ethnic differences in both personality and past and present family social climate measures cast doubts on the concept of an addiction-prone personality. Ethnic differences also suggest that the function of heroin differs for whites and for blacks: for whites it may provide a vehicle for rebelliousness and defiance, while for blacks it may be related to control of anger and aggression.

Findings matched several theoretical models, including the McLelland "power conflict" model, which hypothesizes that compulsive substance abuse is more likely in persons high in personal power needs but characterized by impulsivity and poor role modeling. Findings also fit Ausubel's speculation that heroin addiction is a motivational deficiency among inadequate personalities who are irresponsible, passive, and lacking in self-discipline. However, the results disagreed with studies showing that drug users lack moral or religious emphasis, although the study instruments did not identify the practice of such beliefs. Overall, the study supported the need for developing interactive multiple models to understand drug use. Although the study did not identify a family climate that produces compulsive heroin use, it did identify addicts' psychological stance toward one class of environmental cues associated with compulsive heroin use.

Reilly, D.M. Family factors in the etiology and treatment of youthful drug abuse. Family Therapy, 2(2):149-171, 1976.

DRUG	Multidrug
SAMPLE SIZE	Not specified
SAMPLE TYPE	Abusers in treatment and their families
AGE	Adolescents, young adults (12 to 25); mature adults
SEX	Not specified
ETHNICITY	White
GEOGRAPHICAL AREA	Long Island, New York
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	15

PURPOSE

Conjoint family therapy as a treatment modality for youthful drug abusers and their families is both a relatively new and a comparatively underused technique. Although many therapists intellectually accept the idea of intrafamilial pathogenesis, they do not apply the idea in practice. However, as drug abuse is above all a symptom of family dysfunction, family therapy must be considered especially suitable as a treatment mode. The present study seeks to further family therapy for drug abuse by characterizing surface interactions and underlying conflicts prevailing in the families of drug abusers and by describing the phases of the treatment process for such cases.

METHODOLOGY

Study observations have been made in the course of clinical work at the Southeast Nassau Guidance Center's Youthful Drug Abuse Program in Long Island, New York. The patient population consists of drug abusers between 12 and 25 years of age and their families, who have voluntarily sought outpatient psychotherapeutic treatment. Participants tend to be white and from middle

or lower middle class, intact nuclear families. Drugs most often abused are marijuana, hashish, and barbiturates, as well as alcohol. Hallucinogens, stimulants, and opiates are less common.

RESULTS

Surface Interactions

Many families of drug abusers seem to communicate primarily negative messages to each other. Their home lives are shallow, lifeless, and affectless, and negative habits such as nagging, complaining, and causing trouble to get attention are firmly entrenched. Such families appear to suffer from an affect-block related to families' intense ambivalence concerning intimacy. Parents in many of these families are incapable of setting consistent limits on their children's behavior. Drug abusers are unconsciously motivated to advertise their drug use as a means of invoking parental attention and provoking external limits on their behavior. Despite abusers' unconscious attempts to get caught, parents engage in unconscious denial and avoidance. Parents often ignore or fail to limit their children's drug abuse because they themselves gain vicarious gratification from it. In addition, families of drug abusers not only fear open expression of positive feelings but feel threatened by expressions of rage and anger. Repressed anger surfaces indirectly through displacement to persons other than parents, through passive aggressive behavior, or through intropunitive behavior. Family members frequently defend themselves against unpleasant feelings, such as alienation, rejection, guilt, and depression, by self-medication with substances ranging from tranquilizers to alcohol. In essence, chemical relief has become a family tradition.

Underlying Family Conflicts

Families of drug abusers frequently consist of individuals who have been unable to come to terms with the loss of a love-object because of suppressed grief. The incomplete mourning is projected outward onto the family, creating the lifeless atmosphere characteristic of these families. Parents who have not adequately mourned the loss of their own parents cannot tolerate separation from their children. The conflicts surrounding loss and replacement as well as attachment and separation move children into the drug-abusing role. As long as the child's drug abuse maintains the existing family homeostasis and protects against loss or recognition of loss, the family system will have a powerful unconscious commitment to preserve the symptom.

Conjoint Family Therapy

Therapy for young drug abusers should include all family members and should be limited to 15 sessions. The time limit harnesses the sense of crisis surrounding addiction and recreates some of the separation-individuation conflicts. Treatment begins with an intake interview, which familiarizes therapists with the family and helps the family realize the family orientation of the problem. After discussion of family likes, dislikes, and desired changes, specific goals and means of achieving them are defined. The cooperation involved in goalsetting is part of the therapy process. Family members are encouraged to talk to each other rather than to the therapist. This initial phase of treatment focuses particularly on patterns of surface interaction and their recognition. Blaming, scapegoating, anger, and guilt are often intense as the families begin to understand the family's relationship to drug use. Special efforts are made to confront family members with the intropunitive, self-defeating, and self-destructive aspects of their behaviors. Attention is also devoted to understanding verbal and nonverbal communication patterns and means for their improvement.

The middle phase continues to focus on the absence of positive interaction in the family and the overabundance of negative social behavior. The family is helped to understand how members reinforce deviant behavior and is then challenged to change this pattern by rewarding good behavior. Throughout this phase parents are encouraged to discuss their families of origin in great detail, with the goal of helping them recognize repetitions of their parents' relationship patterns in their own families.

In the final phase, parents withdraw their projections back into themselves and are able to mourn. Once the parents' attachments to their parental introjects are loosened via mourning, they can allow their own children to separate and individuate. The cathartic experience of

belated mourning drains away most of the displaced anger directed against the drug abusers. Family life becomes more pleasant, and there is less need to seek escape through chemical substances. In the final sessions both the treatment course and the families' gains are reviewed. The therapist expresses confidence in the family's ability to function independently, helps family members express their ambivalence about separation, and encourages them to view the therapist as a "good" object.

CONCLUSIONS

Conjoint family therapy with drug abusers and their families attempts to deal with surface interactions prevailing in such families and underlying conflicts relating to loss, impaired mourning, intimacy, separation anxiety, and inappropriate role allocation. The three phases of treatment improve family relationships, modify communication patterns, and help individuals understand each other. After therapy, the use of drugs is usually discontinued or diminished. The treatment allows families to work through unresolved grief and to gain considerable mastery over pathogenic family situations in a relatively short time. However, further research is needed on families from other socioeconomic backgrounds with different surface characteristics and dynamics and on the interaction of familial factors with other factors conducive to drug abuse.

Rosenbaum, M. Difficulties in taking care of business: Women addicts as mothers. American Journal of Drug and Alcohol Abuse, 6(4):431-446, 1979.

DRUG	Heroin
SAMPLE SIZE	100
SAMPLE TYPE	Addicts
AGE	Adults (mean: 28)
SEX	Female
ETHNICITY	Cross-cultural
GEOGRAPHICAL AREA	San Francisco; New York City
METHODOLOGY	Ethnographic/participant observation
DATA COLLECTION INSTRUMENT	Taped interviews; field observation
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	22

PURPOSE

One of the major differences between men and women addicts is their respective responsibilities. While for men addicts "business" involves heroin-related work, addicted women with children define their main responsibility as their children and experience a conflict of interest between their "work" (heroin) and their mothering roles. Although an extensive body of medical literature is available on the physiological aspects of addict mothering, there is little sociological or social-psychological information about the mothering process. For this reason, this study examines the feelings and conflicts of women addicts through pregnancy and birth, motherhood under addiction, incapacities in mothering, and disappearing options after long-term addiction.

METHODOLOGY

The study sample consisted of 100 addicted women, 95 from San Francisco, California, and 5 from New York City. Of the total sample, 70 were mothers. The women were active, uninstitutionalized heroin users procured through posting notices in drug using areas, prisons, and treatment facilities, as well as through neighborhood networks. The group was 43 percent white and 38

percent black; also included were 14 Latinos, 1 Asian, 1 Native American, and 3 Filipinos. The ages of the women ranged from 20 to 53, with a mean of 28.

The depth interview/life history method was used as the primary data collection tool. Interviews, conducted on a voluntary basis for remuneration, were taped, lasted 2 to 3 hours, and touched on all aspects of women's lives and drug careers. Demographic statistics were collected, and project personnel did field work in San Francisco, visiting women in their homes and accompanying them on their rounds. The perspective of symbolic interactionism and the method of grounded theory guided both data collection and analysis.

RESULTS

Fertility, Pregnancy, and Birth

Changes in heroin quality and availability as well as in addiction patterns may affect addicted women's fertility. Although addicts may occasionally miss a menstrual period, this cannot be counted on for birth control. Often pregnancy is not detected until other signs are present, sometimes as late as the seventh month. A strong ethic among women in the heroin world is that it is not acceptable to remain addicted while pregnant. The women in the sample express their contempt for women who do so. Those who do continue using heroin justify their use with the rationales that heroin will have already done its damage to the fetus by the time the pregnancy is discovered (too late for a simple abortion) or that withdrawal later in pregnancy is more dangerous than continuing use and giving birth to an addicted baby.

Addicts' newborns are often premature, with low birth weights, and in some cases withdrawal symptoms. Mothers are often treated with disdain by hospital staffs and physicians because of their addiction and their failure to seek normal prenatal care. Frequently, the normal mother-child bonding process is interrupted because the baby must be detoxified. These factors, together with the mother's guilt, lack of family support, and sense of failure, may spiral her further into drug use.

Mothering While Addicted

The mother who can maintain a heroin habit and take care of her children is afforded respect in the heroin world. Women are best able to cope when their child care responsibilities force them to control their drug use. Combining using and mothering is a source of pride to women addicts, and a few are able to establish a routine incorporating their children's needs with their own. But the world of heroin is unstable, and a woman without money for her habit may be unable to care for children, especially when she is withdrawing from drugs because she can't obtain any. Addicted mothers may be forced to perform illegal street work for money, leaving very small children unattended. Furthermore, the psychoactive effects of heroin can render the mother functionally absent; in the euphoric state she cannot carry out routine mothering tasks.

Women addicts often lose their children and experience guilt, failure, and shame. The loss of the children can be voluntary or involuntary, and children can be placed temporarily in homes of relatives, foster homes, or even juvenile institutions. As addicts tend to view their children and motherhood as their singular claim to worthiness, their greatest responsibility, and the essence of their responsibility, removal of their children can be devastating and lead to uncontrolled heroin use.

Realization of Dwindling Options

Women addicts often begin their careers in drugs with relatively reduced options. They are poor and belong to racial minorities. Their educational and occupational opportunities are limited. Motherhood is one of the desirable options in terms of social worth, yet it is often seen as a "given" until threatened. The motherhood role may be threatened by the mothers' abusive behavior, prolonged separations from their children due to drug behavior and prison terms, or the mothers' fear of rejection by children who disapprove of their lifestyle. Other women fear that their children will accept them as role models and become addicts themselves.

CONCLUSIONS

Although in the early stages of addiction, men and women fare similarly, women with children have a decided disadvantage in later maintenance stages, because heroin-related business cannot be their central concern. Because children and mothering are central to the female addicts' feminine identity, loss of their children arouses intense feelings of guilt and failure. Their very womanhood is threatened. At this point in the women's career, they realize that their motherhood options are being funneled, and that the sacrifice for heroin is getting close to their own person, identity, and sense of self. In this state, they can gear themselves to abstinence from heroin. While the option of a viable family life remains, women addicts are in an optimal frame of mind for abandoning their addiction careers.

Rosenbaum, M., and Richman, J. Family dynamics and drug overdoses. Life-Threatening Behavior, 2(1):19-25, 1972.

DRUG	Multidrug; medicines
SAMPLE SIZE	40
SAMPLE TYPE	Attempted suicides and their families
AGE	Not specified
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	New York City
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Interviews; questionnaires
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	5

PURPOSE

Since self-poisoning is the most common method of attempted suicide, information that aids in understanding the phenomenon might help to control and prevent it. This paper examines the family context and pressures within which an overdose occurs, rather than the individual components. The study is limited to those family dynamics that might be relevant to drug overdoses as the method of choice, and to the situational contexts within which these acts occur.

METHODOLOGY

Study subjects were selected from the authors' case files. The first 40 patients who had attempted suicide by taking an overdose of some drug or medicine constituted the sample. Most of these subjects had completed an extensive questionnaire that covered many aspects of their social and personal functioning, as well as an account of the events leading up to the suicidal act. The authors had also conducted individual interviews with the subjects. In 18 cases, relatives completed a parallel questionnaire, followed by a family interview with both patients and relatives. For the present study, data on how the drugs were obtained and the nature of the family interactions were used. The authors also examined the presence of such oral components

as an undue preoccupation with food (e.g., dieting compulsive overeating, anorexia, and feelings of deprivation), a drinking problem, and an excessive reliance upon pills and medication.

RESULTS

The most prominent characteristic of the study sample was a general pattern of family conflicts and family involvement in the pressures that led to the act. For example, 89 percent of the suicide attempts occurred in the home, or in family members' presence, or immediately following a quarrel with a relative. In addition, the suicidal person was often in a deeply disturbed relationship with a significant other. Moreover, both physicians and family members were vital sources of the drugs used for the suicidal behavior. A total of 45 percent of the drugs were obtained from a doctor's prescription; 40 percent from relatives; and 15 percent from contacts, friends, or drugstores with no prescriptions. The overdose sometimes concisely and dramatically expressed a person's conflict and ambivalence over medical treatment. In many cases, expediency seemed the most significant reason for the use of the drugs and the sources of supply.

Nevertheless, the interaction between the suicidal person and the family in many cases specifically led to drugs as the method of choice. Family factors included fearful expectation yet covert encouragement of the person's suicide attempt by drug overdose and an imitation of or identification with another suicidal family member. Other features included a high level of oral preoccupation and oral fixation, a high level of trauma in the family's life history, and direct participation by other family members in the suicidal act. The amount of orality in both the suicidal person and the entire family was quite impressive.

CONCLUSIONS

Findings confirmed Tabachnick's description of the person who takes an overdose and of the pathological relationship with a significant other. Tabachnick described a pattern of personality traits that were characteristic of orally fixated, dependent, and masochistic persons. He also emphasized the interpersonal aspects that are illustrated by this study's finding of pathological dyadic relationships embedded in a pattern of disturbed family relationships.

Results indicated that each individual suicide attempt could be understood only through an intensive investigation. Detailed case histories are more valuable than statistical surveys for understanding the suicidal act. Findings also suggested that two major determinants of an overdose are easy availability of drugs, especially from a doctor's prescription, and the nature of the interpersonal and family interactions. Therapists should routinely ask where, why, and how the drugs were obtained because this information can be useful for diagnostic, therapeutic, and management purposes.

Schneider, R.J.; Kojak, G., Jr.; and Ressdorf, H. Father-distance and drug abuse in young men. Journal of Nervous and Mental Disease, 165(4):269-274, 1977.

DRUG	Multidrug
SAMPLE SIZE	76
SAMPLE TYPE	Soldier/nonaddicts Soldier/psychiatric patients Soldier addicts
AGE	Not specified
SEX	Male
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Bangkok, Thailand (U.S. Army base)
METHODOLOGY	Survey--correlational, comparative
DATA COLLECTION INSTRUMENT	Questionnaire (Father-distance scale)
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	37

PURPOSE

Previous studies have described heroin addicts as close to their mothers and distant from their fathers, but no objective data have substantiated or quantified this father-distance (i.e., lack of admiration, respect, and closeness of individuals for their fathers). This study, therefore, tests the hypothesis that illicit drug abusers have a greater father-distance than either control groups or mixed psychiatric outpatient groups, and that the disorder of behavior reflected in drug use is consequently different from that of other emotional problems.

METHODOLOGY

The samples were three groups of males serving in the U.S. Army in Thailand. The first group consisted of 23 individuals for whom there was no evidence indicating current use of illicit drugs (excluding marijuana because its use was so pervasive in this population) or chronic alcohol abuse. The psychiatric group included 25 individuals who reported to the Social Work Service at the U.S. Army Hospital, Bangkok, with a psychiatric difficulty, excluding drug use, serious enough to interfere with job performance and to warrant further consultation. The drug use group encompassed 28 individuals who had been using an illicit drug besides marijuana at least

6 days per month for 4 months (23 subjects) or who were physically dependent on alcohol (5 subjects).

The 16-item questionnaire had an agree-disagree format. All questions were selected from a previous study showing significantly different responses from drug users and nonusers. Most of the questions related directly to the individuals' relationships with their fathers and could identify absent, distant, negative, or conflict-ridden relationships. Other questions probed various aspects of home life and parents, indicating possible family conflicts or disintegration.

The father-distance score calculated for each subject was the total number of items scored as father-distant. Sheffe tests were used to determine the location and direction of the differences.

RESULTS

Analysis of variance of scores indicated that the means of the three groups were significantly different. The mean father-distance score of the drug use group was significantly higher than the nondrug-using group and the outpatient group, but the means of the nonusing and outpatient groups were not significantly different. Average father-distance scores were highest for the drug users. Only one nonuser had a score above 10 on the father-distance scale; eight drug users had such scores. The average father-distance score of the five alcohol-dependent men in the drug user group was almost identical to scores of other drug users.

CONCLUSIONS

Drug users consider their relationship to their fathers as more difficult and distant than nonusers and mixed psychiatric outpatients. Alcohol and drug abuse are thus perhaps best regarded as a disorder of behavior associated with a disturbed father-son relationship. Research has established that identification with the father is crucial to the development of proper social development in children. Disturbances of such identification processes could account for the relative lack of social skills observed among heroin-dependent servicemen in Thailand. Under these conditions, one can assume that treatment that tries to make use of social skills or self-control will fail. The most appropriate treatment approach for drug and alcohol abuser is comprehensive in living situation and time, residential for a significant period, highly structured, supportive, nurturing, and authoritarian. Fathering factors such as guidance, encouragement, personal involvement, provision for reward and punishment, and models for identification would be the important components. Not all drug abusers will fit this pattern, but father-distance should be considered in evaluating young drug or alcohol abusers. Expansion of the father-distance scale, coupled with further validation and factor analysis, as well as examination of the role of the sex of the therapists and the problems of female abusers, are recommended.

Schwartzman, J. The addict, abstinence, and the family. American Journal of Psychiatry, 132(2):154-157, 1975.

DRUG	Heroin; barbiturates
SAMPLE SIZE	21
SAMPLE TYPE	Families of addicts; addicts in treatment
AGE	Adults (addicts, 16 to 36)
SEX	Addicts: males
ETHNICITY	Mostly white
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	22

PURPOSE

Drug addicts usually have an extremely difficult time ending their drug use and remaining abstinent. This problem can be partly explained by examining the meaning of the drug for the addict in a social context, rather than by viewing drugs simply as pharmacological agents. The idea that addiction is a social phenomenon within the addict's family suggests a relationship between the family's functioning and its inability to tolerate abstinence. This paper describes characteristics of addict family contexts and interactions to suggest how such families function to reinforce addiction.

METHODOLOGY

The study population included 21 families, each of which contained at least 1 male heroin or barbiturate addict. Addicts were seen at an inpatient drug unit, an outpatient methadone clinic, and an outpatient mental health clinic. Families were seen in from 1 to 22 psychotherapy sessions. Information was also collected from informal interviews held with these addicts and others. Subjects were mainly from white working class families. The addicts ranged in age from 16 to 36, with an average age of about 23.

RESULTS

Most of the addicts' families had the same general characteristics as those described in the literature. These included an overprotecting, controlling, and indulgent mother, who used the addict to gratify her emotional needs and who infantilized the addict. However, contrary to the literature negating the influence of the context of drug use or the characteristics of the user, evidence has shown that the social context of the addict, particularly the addict's family, is an important factor in the inability to stop using drugs. For example, all families in this study felt powerless to stop the drug use since they assumed that the addict was incapable of resisting drugs if exposed to them. Thus, if the addict was abstinent, other family members would communicate in various ways the belief that was a temporary condition.

Parental Roles

The mother's role as the protector of the addict was reinforced by the father's demand that the addict stop using drugs and get a job or leave home. The mother blamed her overprotectiveness on the father's hostility; the father blamed the mother for preventing their son from growing up. Because fathers were either ineffectual or remote, their attempts to control the addict's behavior were always undercut by the mother. Conflict between the addict and his father was reinforced by the father's secondary position in the mother's affections and his lack of authority in the household. The father's financial support was his one source of gratification and also provided an excuse to remove himself from family conflict. Overall, the addict was viewed by all family members as inadequate and in need of help.

Parental Conflicts

The marital dyad was characterized by emotional distance and a lack of interaction, except for those periods when the addict seemed to need the most help. Problems in the parents' relationship were acted out through disagreements about the addict's drug use and lack of employment. As a result of the familial conflict focused on their behavior, addicts saw themselves as powerless as well as responsible for the problems between the parents. Parental disagreement over how to stop the drug use caused even more tension within the parental dyad. The close relationship between the addict and the mother was reinforced by the belief that the addict was unable to control drug use and therefore needed help. The belief that heroin reduces sexual interest may have been necessary to reduce incestuous fears of the addict.

CONCLUSIONS

The addicts studied had inadequately separated from their families because of certain aspects of their parents' relationships. Attitudes and behavior of mothers in particular caused the addicts to remain unprepared for adult responsibility. The addict's relationship with the mother exacerbated the distance between the addict and the father. At the same time, the addicts maintained at least some relationship between the parents by their continued drug use. Addicts were caught in a paradox; they were taught that to be a man one must work, but they were also covertly encouraged to remain home unemployed as long as they continued to use drugs. While the family tried to convince the addict not to remain on drugs, all family members viewed the addict as incapable of resisting drugs. Moreover, social interactions outside the family, mainly with drug users, reinforced the drug use. The addicts' concern with drugs eliminated almost all other stimuli; the drug subculture norms and way of life, reinforced by family behavior and attitudes, resulted in the maintenance of the addiction.

Stanton, M.D. The addict as savior: Heroin, death, and the family. Family Process, 16(2):191-197, 1977.

DRUG	Heroin
SAMPLE SIZE	Not specified
SAMPLE TYPE	Addicts in treatment; families of addicts
AGE	Young adults (20 to 35)
SEX	Males
ETHNICITY	White; black
GEOGRAPHICAL AREA	Philadelphia, Pennsylvania
METHODOLOGY	Case studies; clinical observation
DATA COLLECTION INSTRUMENT	Videotaped therapy sessions; observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	22

PURPOSE

Research has established that the mortality rate among drug addicts far exceeds that for comparable groups within the North American population and that this high incidence is to a great extent the result of a suicidal phenomenon. Addiction has been described as chronic suicide, an alternative to suicide, or as a means by which addicts tell their families how close to death the families have brought them. This study seeks to place the death and addiction relationship within a familial, interpersonal systems context; to describe some of the processes that attend the relationship; and to discuss its function for the family.

METHODOLOGY

Two clinical examples involving an Italian and a black family with sons addicted to heroin are presented with material taken directly from videotaped therapy sessions. The author's overall conceptualizations are based on his observations of drug addicts' families over a 6-year period, especially as director of a research project investigating the family characteristics and family treatment of male heroin addicts in the 20- to 35-year-old range.

RESULTS

According to the model portrayed in literature and the clinical examples, sick family members help to keep the family together by allowing them to unite over the subjects' incapacitation. If the addict improves and begins to individuate, the parents may begin to fight or separate. By becoming readdicted the addict allows them to reunite. In this sense, the addict is a loyal family member who rescues the family by playing the role of savior and martyr.

Death issues are a part of the hidden agenda of the family. Such issues may take the form of a death wish toward the addict, usually expressed openly by the mother. Such mothers feel capable of expressing their "love" for their addicted children only standing over their graves. These mothers would rather lose their children to death than to friends, relatives, or others. Furthermore, the close addict-mother relationship robs the father of his power as a spouse and parent, increasing his hatred. Siblings may resent the addict's favored position and also feel guilty about their own success at the addict's expense. Moreover, the addict often cooperates with the family, usually out of loyalty and the feeling of owing them a great debt, so that the process is both systematic and reciprocal. Previous research has noted a tendency for these families to deal with deaths of other family members in a participatory way through substitution of the addict for a deceased member. After the death of one sibling through a drug overdose, other siblings may in some cases seek to draw attention to themselves with addictive episodes, frequently following in the first sibling's footsteps.

CONCLUSIONS

Addict families vary only in the clarity with which they demonstrate the family death wish and the extreme to which it is pushed. In some families the mother may even enjoy planning the funeral because death is viewed with honor, a monument to the devotion of the deceased member. Symbolically, the real or fantasized death of the addict makes him or her a receptacle of the family's pain, suffering, and even baser instincts. Addicts thus function in the same manner as the ancient Greek scapegoat who was sacrificed as a means of purification, absorbing community impurities and then perishing with their evil burdens. However, unlike the Greek scapegoats, addicts are willing participants. The phenomenon has an almost religious flavor; as Christ died for our sins, the addicts wear the mantle of both a savior and a martyr who will take the families' worth with them when they leave.

Stanton, M.D., and Coleman, S.B. The participatory aspects of indirect self-destructive behavior: The addict family as a model. In: Farberow, N., ed. The Many Faces of Suicide. New York: McGraw-Hill, 1980. Pp. 187-203.

DRUG	Heroin
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Families of addicts
AGE	Not specified
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Literature review and clinical observation
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	56

PURPOSE

A theoretical framework in which to view family relationships and interactions is helpful in understanding the concept of indirect self-destructive behavior (ISDB) within the family systems context. Family theory, developed over the last 20 to 25 years, views the family as a functional system rather than as a collection of persons. The family is also characterized by homeostasis (a sense of balance and stability), the tendency to identify one member as the patient or scapegoat, family boundaries, intergenerational coalitions, family member role selection, and a family life cycle. The authors explain the process whereby ISDB can be adaptive, functional, noble, sacrificial, and understandable when viewed within its interpersonal context. The focus is on drug addiction, primarily heroin addiction, but its approach can be applied to other forms of ISDB.

SUMMARY

The symptomatic member in a family can, in many ways, be viewed as a sacrificial person, who gives up reputation and well-being in the service of the family. The symptomatic member may also protect other family members by drawing attention to the symptoms and away from family problems.

Families with drug addicts are characterized by one parent, usually of the opposite sex to the addict, who has an overinvolved, indulgent, and overpermissive relationship with the drug abuser; by another parent who competes with the abuser and is negative, inconsistent, uninvolved, or absent; by the absence of one parent from the home; and by a high incidence of parental drug abuse or alcoholism, especially among fathers. In addition, male addicts' marriage relationships appear to reenact their relationships with their opposite sex parent.

A commonly described dilemma for the addict family is that of separation. An early study on the developmental role of symbiosis or separation individuation among addicts found that addicts' mothers had greater symbiotic needs than mothers of schizophrenics and normal adolescents. The parental system in such families fails to release the addict to become an individuated, autonomous person who can cultivate close outside relationships. Issues surrounding death are an important facet of the means by which the addictive process is both generated and maintained. Whether symbolic or real, death appears to be an integral part of the functioning of these families. High death rates among drug addicts, addiction as a suicidal phenomenon, and high incidence of early loss of one or both parents are all observed death themes of addicts and their families.

The significant etiological aspect of ISDB is that the addict family's inability to allow individuation of the drug-using member derives from unresolved and premature deaths experienced by one or both parents. The parents have not resolved the death; they still mourn it and have not outgrown the loss. The parents select the addict as a "revenant" of the decedents, who are usually grandparents or a grandparent, and they have a paramount need to keep the addicted member close. When such parents remain in a mourning process, the child's entry into adolescence will reawaken the original loss experience. Rather than surrender the drug user to outsiders, the family chooses the more preferable route of death, which is almost the only allowable separation. The addict is used for reenactment of previously experienced deaths of significant others; the addiction becomes analogous to a slow dying process. The addiction is a compromise on the part of the addict; it allows a partial surrender to the wishes of others and is a way of partially fulfilling the death wish without actually dying.

In the linear model of addiction just described, in which addiction is seen as part of a death-related continuum, a causal chain of events occurs, beginning with premature loss by parent of grandparent and culminating in drug use by offspring. However, this model does not account for the complex set of feedback mechanisms involved in the drug-taking process and the repetitive cycles that evolve. A nonlinear model recognized that each person's behavior influences and is influenced by each other person's behavior. This kind of model, described by Minuchin and others, is a way of conceptualizing what is currently happening within the interpersonal system.

This model has been used with some success in dictating modes of intervention in the family addictive process. The intervention strategy involves identification of the sequence and therapeutic intrusion at crucial points to alter and redirect the sequence without intervention. The death of the addict only momentarily halts the sequence; the family repetitively preserves its mourning process. One clinical technique for dealing with the unresolved issues of death involves revisiting, in a therapy session, the deathbed scene and altering its reenactment. Restructuring and the entry to new transactional sequences can have a beneficial effect.

CONCLUSIONS

Many types of ISDB other than drug addiction also have participatory features and involve significant others. Such phenomena as role selection, intergenerational coalitions, acts of martyrdom, and repetitive homeostatic patterns may apply to them as well. The interpersonal/familial systems approach might also be useful in the study of physical disease and its psychosomatic components, especially in view of the work of Lewis and others on psychological health in family systems. Other forms of ISDB merit exploration from an interpersonal systems and family homeostatic viewpoint; among these are hemodialysis, traffic accidents, and gambling.

The kinds of models used for describing and predicting ISDB have usually been too limited in that they rest on concepts of personality, type, or trait that are static and do not account for cross-generational variables, the impact of interpersonal systems, and the patterns involved in ongoing behavior. The field should develop models that are more dynamic, time based, and responsive to interactional patterns and sequences.

Torda, C. Comments on the character structure and psychodynamic processes of heroin addicts. Perceptual and Motor Skills, 27:143-146, 1968.

DRUG	Heroin
SAMPLE SIZE	60
SAMPLE TYPE	30 addicts in treatment; 30 nonaddicts
AGE	Young adults (18 to 33)
SEX	Male
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Survey--comparative, correlational
DATA COLLECTION INSTRUMENT	Biological Personality Assessment Test
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	8

PURPOSE

The study interprets the emotional structure of heroin addicts and their childhood relationships to their mothers on the basis of the Biological Personality Assessment Test. Motivations for drug use by heroin addicts are then compared to those of chronic alcoholics and LSD users.

METHODOLOGY

The sample consisted of 30 heroin addicts and 30 matched abstinent patients. The 60 patients were males of low income with various religious backgrounds ranging in age from 18 to 33 years. A total of 4 from each group were diagnosed as psychotic, 11 of each group as psychoneurotic, and 15 of each group as exhibiting passive-aggressive psychoneurotic disorders.

The Biological Personality Assessment Test was filled out by the patient and by available family members. The test's 300 questions relate to the parents and the patient during his early infancy and to the methods of infant care used. Main areas of investigation were sleep, feeding, bowel and bladder functions, bathing, sensory stimulation, play, interpersonal relationships, learning, motility, moods, emotional reactions, and distractibility. Three independent judges scored test performance.

RESULTS

Heroin addicts were products of families in which the mother was dominant and the father, who was often absent, was either weak or uninterested in the family, and particularly the addict. Since he was the easiest to raise, the future heroin addict became his mother's favored child even though she had no genuine love for him and was unaware of his needs. To placate other family members, the addict's mother developed the habit of feeding him before he was hungry. As a result, the future addict never understood the necessity of developing skills or giving up his automatic passivity. The passivity-creating infant-raising practices of the mother were continuously reinforced by rewarding only passive submission and by punishing activity and self-expression. Full dependence on others for need-fulfillment left the patient with feelings of helplessness, worthlessness, and frustration. Attempts to avoid frustration eventually led him to deny having needs, and the sensation of lack of needs aroused the illusion of need fulfillment and strength. Similarly, the illusion of being sexually unique and fulfilled prevented any awareness of his underdeveloped social skills. Maternal indoctrination against externalizing hostility resulted in increasing self-hatred and hopeless feelings with each frustration. Never having reached his mother led to social ineptness and superficial peer relationships. The only area in which he could escape from multifaceted pain remained intellectualizing and fantasizing.

The heroin addict, the alcoholic, and the LSD user have resorted to drugs that induce different reactions. Heroin addicts are loners who have never experienced genuine love, dread past memories, and crave reinforcement of their inhibitions. Heroin use provides temporary relief from frustration and hostility by creating the illusion of self-sufficiency and the satiated feeling of preoral existence. In contrast, alcohol intake is motivated by the unconscious desire to recreate feelings of happiness experienced in the inhibition-free atmosphere of the oral-sucking phase, a momentary togetherness with the mother. By comparison, LSD users have experienced genuine love and have had mothers who enjoyed fulfilling their needs. Hallucinogens produce an anxiety-free and emotionally intensive atmosphere of togetherness in which past memories are disguised as creativity. LSD users will undergo severe frustrations to fulfill their compulsive yearnings for experiences and growth.

CONCLUSIONS

Recognition of these basic patterns in the familial relationships of heroin addicts and awareness of differences in heroin, alcohol, and LSD users may shorten the initially difficult period of psychotherapy for addicts. Perceptions of detrimental effects produced by certain child-rearing practices may further the prevention of drug addiction and reduce drug consumption.

Vaillant, G.E. Parent-child cultural disparity and drug addiction. Journal of Nervous and Mental Disease, 142(6):534-539, 1966.

DRUG	Narcotics
SAMPLE SIZE	488
SAMPLE TYPE	Addicts in treatment (inpatient)
AGE	Young adults
SEX	Male
ETHNICITY	Non-Puerto Rican blacks; Puerto Ricans; Non-Puerto Rican whites
GEOGRAPHICAL AREA	New York, New York
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Hospital records; census data
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	8

PURPOSE

Several studies have revealed a close association between minority group membership and postwar urban narcotic addiction. It is not known, however, whether this association results from the devalued identity associated with minority group status, from social conditions in urban slums, or from social stress associated with recent urban immigration. Although all these factors may be involved in narcotic addiction, the present study hypothesizes that the highest risk of addiction in New York City occurs not among urban immigrants but among first-generation adults with membership in an established minority group. It compares the personal and parental backgrounds (nativity) of New York addicts with those of nonaddict New York residents of similar age, sex, and ethnic origin.

METHODOLOGY

The study group included all addict patients discharged from the U.S. Public Health Service Hospital at Lexington, Kentucky, between April 1 and December 31, 1961. They were male, born between 1931 and 1940, and residents of New York City when admitted to the hospital. Total study population was 488. The sample included 171 non-Puerto Rican black addicts, who were

grouped according to whether they were born in New York, the southern United States, elsewhere in the United States, or abroad. They were also grouped according to their parents' birthplaces. Also included were 130 Puerto Rican patients, who were grouped according to birthplace, and 187 non-Puerto Rican white patients, who were grouped according to both their own birthplaces and those of their parents. First-generation residents of New York were defined as those who were native born and had at least one foreign-born parent.

The relative distribution of New York City males of the same age in these groups was obtained from 1960 U.S. census data. Since census data did not provide information on the expected number of first-generation New York residents, data from 1930 and 1940 were used to develop the assumption that about 21 percent of the parent-aged white adults living in New York City from 1930 to 1940 were foreign born. Equal birth rates for native and foreign-born families were also assumed in order to compare the nativity of the non-Puerto Rican white parents with that of the parents of the census group. Available data indicated that the majority of black young adults born in New York had parents born either in the South or abroad.

RESULTS

For all three ethnic groups, the rate of addiction among the first-generation New York City residents was three times that of the immigrants. In contrast, relatively few black immigrants from the South or from outside the United States were admitted to the hospital for drug addiction. Although the absolute number of Puerto Rican immigrants admitted was greater than the absolute number of first-generation New York Puerto Ricans, the relative proportion of the latter was significantly greater.

The likelihood of hospitalization was also strongly correlated with minority group membership. The rate of addiction was about 20 times as high among the New York Puerto Rican and black populations as among the rest of the New York population.

Findings apply with certainty only to those New York addicts who came to the hospital as prisoners or as voluntary admissions. The assumption that the hospital's admissions are fairly representative of lower class and lower middle class urban narcotic addicts in general has not yet been proven.

CONCLUSIONS

Findings suggest that it is the parents of addicts, rather than the addicts themselves, who are migrants. A recent study of U.S. addicts as a whole supports this contention. Data on urban addict admissions to the hospital also support the hypothesis that within a given ethnic urban group, addiction may diminish as the percentage of first-generation members diminishes, although exceptions exist.

Results also indicate that the social roots of addiction are different from those of schizophrenia and that addiction cannot be attributed solely to poverty, association, and prejudice. Immigrant naivete also does not appear to account for the study's findings. Results also suggest other possible hypotheses, which should be tested. (For example, the immigrant mother may be exceptionally dependent on her children, separated as she is from her own family ties.) The author suggests that hypotheses might be tested in middle class suburban communities with "immigrants" to both the suburbs and the middle class. Overall, both minority status and parental cultural mobility are positively correlated with the incidence of drug addiction among individuals from lower socioeconomic groups.

Vaillant, G.E. A 12-year follow-up of New York narcotic addicts. III. Some social and psychiatric characteristics. Archives of General Psychiatry, 15:599-609, 1966.

DRUG	Narcotics
SAMPLE SIZE	100
SAMPLE TYPE	Addicts in treatment (inpatient)
AGE	Adults
SEX	Male
ETHNICITY	White; black; Latin American
GEOGRAPHICAL AREA	New York, New York
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Questionnaires; hospital records; official records
DATE(S) CONDUCTED	1952-1964
NO. OF REFERENCES	43

PURPOSE

Four recent books on urban narcotic addiction have reviewed most of the known data about addiction and have demonstrated how little is known about the natural history of addicted individuals. This study used data from a 12-year followup of 100 New York City addicts to illustrate the characteristics that may differentiate addiction from other psychiatric syndromes. Longitudinal data were used to conceptualize the addict simultaneously as a delinquent and as a psychologically disturbed individual.

METHODOLOGY

The study sample included 50 black and 50 white adult males from New York City who were admitted to the U.S. Public Health Service Hospital in Lexington, Kentucky, between August 1, 1952, and January 31, 1953. The study sample was unselected, except for the exclusion of Chinese patients, four patients with extremely incomplete records, and all men over age 50. Thirty (25 white and 5 black) subjects were of Latin American background, usually Puerto Rican. The average study subject first used illegal drugs at age 19, was first addicted at 23, and was first admitted to Lexington at 25. For most, heroin was the drug of choice.

The average patient who survived was followed until age 37; 94 percent were followed for at least 10 years after their Lexington stay. Although 90 percent relapsed after discharge from Lexington, by 1964 more than 30 percent of the sample had achieved sustained abstinences of 3 years or more.

For 90 percent of the patients, a social worker completed a 55-item questionnaire when the patient was admitted to Lexington. Information included routine demographic data and information about family addiction history, early delinquency history, arrest record, military and occupational history, and drug experience. Charts from the stay at Lexington covered mental status and, in most cases, an estimate of the addict's intelligence. Medical system reviews were obtained on all patients. Data concerning criminal history and routine demographic data were usually confirmed from several official sources. Data on childhood delinquency, deprivation, and family psychopathology represented minimal values.

RESULTS

The three groups (white, black, Latin American) were similar in terms of family histories of crime, delinquency, addiction, and alcoholism. There were also no differences in the incidence of broken homes, "maternal overprotection," ages through which addicts lived with female relatives, psychosomatic illness, psychosis, and schizoid personality. The education and general intelligence of the three groups were roughly similar, as was the likelihood that the parents of the given ethnic group had been born into a culture different from that of the addict.

As a group, the blacks were more frequently apprehended for delinquency; 66 percent of the blacks and 46 percent of the whites were known to be delinquent before using drugs. The incidence of psychological disability appeared to be slightly higher among the white and Latin groups, although these differences were not statistically significant. The finding that 24 percent of whites and only 2 percent of the blacks died within 12 years of their Lexington admission appeared to be an artifact of the small sample, since another study of New York addicts showed identical death rates for the two groups.

The parental factor that correlated most strongly with addiction was parent-child cultural disparity, in that a majority of the addicts were first-generation New Yorkers. The addict's sustained dependent role in the family constellation was a second demonstrable familial influence. Almost three-quarters of the sample lived with their mothers at age 22; 47 percent lived with a female relative after age 30. The predominance of addicts as the youngest children in the family was statistically significant beyond the .01 level. Fifty-two of the 100 addicts came from homes broken by death or by permanent separation before age 16; 28 percent of the homes were disrupted before the addict reached age 6. A total of 70 percent of the sample had either married or achieved fairly stable common law relationships; 48 percent had children. Although the addicts were both delinquent and economically deprived, an unexpected finding was that they were slightly above average in intelligence, as were the Lexington addicts in general. At some time during their lives, 96 percent of the sample had engaged in illegal activity. However, they committed fewer felonies and received fewer long sentences over time.

Evidence also indicated that urban addicts may be regarded as both delinquent and mentally ill. The long-term followup indicated that the urban addict rarely becomes psychotic but does suffer from severe character disorder. This disorder is characterized by hypomanic defenses, well-defended depression, and a strongly antisocial but not schizoid orientation. Addicts also had extremely poor work histories before addiction. In most cases the addiction abolished employment altogether; no addicts were able to work as well while addicted as when abstinent. When abstinence was associated with parole, nearly all of the addicts involved were gainfully employed. Almost one in five had some kind of psychosomatic illness, such as an ulcer, asthma, or eczema. Although their death rate was about three times what would be expected in a control population, death was almost always due to misuse of narcotics or alcohol. The relapse into drug use was related to many factors besides the pharmacological hold that narcotics exert.

CONCLUSIONS

Results suggest that narcotics addicts have been deprived by sociological forces, by physical loss of parents, and by having been born into a culture different from the one in which their parents were reared. Delinquency often precedes drug use, and inadequate school and

occupational performance occurs despite adequate intellectual ability. Use of drugs does not seem to conceal a latent psychotic condition or to compensate for intellectual or physical inadequacy. Moreover, ethnic differences do not seem to lead to different drug use patterns. Results also indicate that addicts' character disorders are complicated by latent depression, which rarely becomes manifest even when drugs are removed. Furthermore, there is less difference between the urban heroin addict and the chronically delinquent nonaddict than is commonly appreciated. Findings suggest that an understanding of the roots of urban addiction may be found through studies of the dynamics of repetitive delinquent behavior in general.

Wellisch, D.K.; Gay, G.R.; and McEntee, R. The easy rider syndrome: A pattern of hetero- and homosexual relationships in a heroin addict population. Family Process, 9(4):425-430, 1970.

DRUG	Heroin
SAMPLE SIZE	Approximately 1,000
SAMPLE TYPE	Addicts in treatment (outpatient)
AGE	Not specified
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	San Francisco, California
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Interviews; MMPI
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	7

PURPOSE

Staff members of the Drug Detoxification Section of the Haight-Ashbury Free Medical Clinic in San Francisco, California, have observed a recurrent interpersonal pattern in addict couples who are married, unmarried, and homosexual. This pattern was labeled the "easy rider syndrome" to denote a socioiogical dyad in which one partner, usually the male or male figure, is supported and cared for by the other and so becomes an "easy rider" throughout the relationship and through life in general. This article discusses this syndrome in terms of its familial antecedents, current dynamics, and treatment implications.

METHODOLOGY

Staff members noticed the pattern during the course of interviewing nearly 1,000 cases of heroin withdrawal since October 1969. As many as 60 patients were interviewed per afternoon. Data were collected through the interviews and the use of the Minnesota Multiphasic Personality Inventory (MMPI). Addicts were interviewed in an outpatient setting.

RESULTS

The dynamic structure of the easy rider lifestyle usually evolves after 1 year of heavy heroin usage. The male partner characteristically lives off the returns of prostitution generated by the female partner.

MMPI profile patterns show that both potential candidates for the easy rider syndrome have high psychopathic deviate scales. In addition, the female "supporters" have high mania scales and the male easy riders have high depression scores. The female partner typically adopts the role of all-provident pseudomother figure for her male partner. The female partner's childhood family is characterized by an inept and/or alcoholic father and by a silent and manipulative mother. The daughter uses the dynamics of this family situation as the source for her own role playing in the easy rider syndrome. In place of her own father, she substitutes a passive-aggressive, inwardly raging young male of her own age. The male partner of the syndrome is ostensibly just along for the joy ride but inwardly feels such guilt that he is often driven to commit crimes or make foolish errors that land him in jail. This is the punishment that expiates his subconscious guilt. He classically describes his mother as overprotective and highly dependent, which is analogous to his addict mate. These male figures' fathers are described as usually having been absent from the home and as passive-aggressive, emotionally distant figures.

The addict couple is best handled as a unit rather than singly. Instead of being amenable to social therapy or psychotherapy, both members overtly or covertly undercut their partner's progress or growth. Therapy sessions are often two-way dialogs but are almost never three-way dialogs. The female always monopolized the conversation with the therapist, as the male almost visibly sinks into his chair. When dealing with anxiety-provoking subjects, the female adopts the defense of sexual seductiveness or of shifting attention to the quiet male. If the female does not monopolize the conversation, both addicts may talk at once, each negating the other's voice. This behavior demonstrates both partners' covert hostility toward one another and their insatiable needs for nurturance from the therapist. Their competition for the therapist's interest must be handled directly and regulated.

As the heroin withdrawal symptoms are resolved, the male partner may start to model himself after the therapist and assume some control over the female partner as he gains insight into the emotional sabotage that has been taking place. Therapy must also resolve the boredom involved in withdrawing from heroin and from the lifestyle involved in getting it. In his "clean" state, the male may be highly anxious and agitated. This state is the crucial point in the couple's rehabilitation, for if the male's reactivated high energy level can be redirected, positive results can be achieved. The female may test this change, but the therapist's modeling and intervention can help the male maintain his sense of control. The female can gradually settle into a more dependent role. Reinstitution of normal sexual drives and activity helps stabilize the relationship.

A major problem can occur if one partner is drug free and appears to want to help the partner kick the habit but draws psychological strength from an unconscious manipulation directed at keeping the partner addicted and dependent. The most serious reality involved in ending heroin use is the possibility of separation and/or divorce. The couple's bonds may have been predicated on heroin use and may not be able to stand the strain of problems previously obscured by heroin. Addicts with longer term habits are more likely to be separated or divorced than are those with short-term habits.

CONCLUSIONS

The easy rider syndrome is a pathosociological entity that must be altered and restructured if the couple is to remain together. Elimination of overt heroin dependence is only the first step in the overall process of rehabilitation. The syndrome can serve as a realistic therapeutic model for other community health workers involved with treatment of heroin addiction. If the problems that lead any couple to heroin are not dealt with, the easy rider or his partner will be pushed back into the familiar heroin lifestyle.

Wilson, G.S.; McCreary, R.; Kean, J.; and Baxter, J.C. The development of preschool children of heroin-addicted mothers: A controlled study. Pediatrics, 63(1):135-141, 1979.

DRUG	Heroin
SAMPLE SIZE	77
SAMPLE TYPE	Children of addict and normal mothers
AGE	Children (range: about 3-6 years)
SEX	Both
ETHNICITY	Latino; black; Anglo-American
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Survey--comparative, correlational
DATA COLLECTION INSTRUMENT	Interviews; Parental Attitude Research Inventory; psychometric, perceptual, behavioral measures; physical examinations; hospital records
DATE(S) CONDUCTED	January-May 1974
NO. OF REFERENCES	20

PURPOSE

This study investigates the growth, development, and behavior of heroin-exposed children in the preschool period. Comparison groups are used to test the influence of variables such as family environment, socioeconomic status, and perinatal complications on children's behavior and performance.

METHODOLOGY

The research sample consisted of 77 children, born from 1968 to 1970, 40 boys and 37 girls, ranging in age from about 3 years old to about 6 years. Of the participants 30 had Latin American surnames, 30 were black, and 17 were Anglo-American. Subjects included 22 children exposed to heroin during their mothers' pregnancy; 20 children of mothers involved in the drug subculture but who had not used drugs during pregnancy (a drug environment comparison group); 15 children exhibiting fetal distress, intrauterine growth retardation, and dysmaturity at birth (a high-risk comparison group); and 20 children born after uneventful pregnancies and deliveries (a socioeconomic comparison group). The four groups did not differ significantly in mean age, race, sex, or socioeconomic status.

Data on medical status and family background came from hospital records, a complete physical examination, and a structured social interview conducted at the home of each child. Parental attitudes were measured with the Parental Attitude Research Inventory. Tests administered included the Illinois Test of Psycholinguistic Abilities; the Columbia Mental Maturity Scale; the McCarthy Scales of Children's Abilities; the Minnesota Child Development Inventory; and a perceptual battery to assess visual, auditory, and tactile perception adapted from the model of Deutsch and Schumer. Three subtests of the Child Behavior Rating Scales were completed by the parent or parent substitute to rate the child's physical, social, and individual adjustment. A pediatrician rated the children for alertness, cooperation, attention, activity level, and intensity based on the physical examination. Based on a videotaped free play period and a structured doll play period, a psychologist rated the children for attention, activity level, cooperation, independence, and confidence. Ultrasonic equipment gave a further measurement of movement during free play, and a device recorded the motion of the rocking chair. Speech was evaluated by a speech pathologist. Data were analyzed by a two-step multiple regression procedure.

RESULTS

Although the overall performance of subjects in the heroin-exposed group fell within the normal range, this group consistently ranked lower than the comparison groups on physical, intellectual, perceptual, and behavioral measures. The heroin-exposed group differed most strikingly from the normal comparison group, with the drug-environment group and the high-risk group taking intermediate positions. Group differences cannot be attributed to educational level or occupation of parents; to single-parent families; to physical condition of the home; to parental attitudes; or to variations of age, sex, ethnic group, socioeconomic status, or participation in school readiness programs. The one factor that does differentiate the heroin-exposed group from the comparison groups is the amount of contact between child and biological mother: drug-exposed children had considerably less contact with their natural mothers. This limited contact could, however, have either positive or negative effects. Furthermore, the unstable child-parent relationship cannot be held responsible for the subnormal length and head circumference observed in the heroin-exposed group. The poor growth of this group suggests that narcotic exposure during pregnancy may affect mechanisms that control human growth.

Overall intellectual function of the heroin-exposed group does not differ from comparison groups as measured by the Columbia Maturity Scale, but significant deficits are evident on other tests. The heroin-exposed group scored significantly lower than the comparison groups on subtests measuring the organization process and organizational skills, yet all groups performed about the same on verbal or motor scales and on tests of receptive or expressive processes. A consistent pattern of low functioning by the heroin-exposed target group occurred in all modalities of the perceptual batteries, indicating a problem common to the general process of perception rather than to a specific sensory deficit. While none of the subjects had significant neuromotor abnormalities, the heroin-exposed group performed poorly on tests of rapid alternating motion of the hand, apparently as the result of poor attention and persistence rather than lack of motor coordination. Behaviorally, the problems of the heroin-exposed group were related to impulsiveness, aggressiveness, and peer relations. These behavioral problems may also be manifestations of impaired attention and organizational abilities.

CONCLUSIONS

Functional deficits in heroin-exposed children appear to be related to maternal heroin use during pregnancy rather than to extraneous factors. The functional deficits differentiating heroin-exposed children from comparison groups are not of sufficient magnitude to impair cognitive development. But because of differences in behavioral, perceptual, and organizational abilities, drug-exposed children must be considered more vulnerable to suboptimal social and environmental conditions. Additional investigation is needed to determine whether heroin-exposed children will perform adequately in an educational setting or whether special education will be needed.

ADOLESCENTS AND ADOLESCENT/PARENT RELATIONSHIPS

Although conflict between the family and adolescents is one of the oldest, most predictable and, in Western society, probably least avoidable of developmental conflicts, the sharp and specific focus upon this conflict in the context of adolescent drug use is a recent development. As interest and concern regarding adolescent drug use has grown, so has the research seeking to explain this behavior. As can be seen in the literature presented in this section, much of this research has been focused on the interplay between the adolescent and his or her family.

Attardo, N. Psychodynamic factors in the mother-child relationship in adolescent drug addiction: A comparison of mothers of schizophrenics and mothers of normal adolescent sons. Psychotherapy and Psychosomatics, 13(4):249-255, 1965.

DRUG	Not specified
SAMPLE SIZE	129
SAMPLE TYPE	Mothers of addicted, schizophrenic, and normal sons
AGE	Sons, 16 to 25 years; adults
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Survey--comparative, correlational
DATA COLLECTION INSTRUMENT	"S" scale
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	14

PURPOSE

The study investigates the symbiotic aspects in the mother-child relationships of drug-addicted adolescent sons and compares them with mothers of schizophrenics and mothers of normal adolescent sons. Clinical observation suggests that a mother-child symbiosis interferes with addict children's drives toward the establishment of their separateness and identity. The hypotheses tested were that certain psychodynamic factors in the mother-addict son relationship are peculiar to that group, and that the mother-child symbiosis would differentiate between the three groups of mothers, with greater similarities between mothers of schizophrenics and addicts than between mothers of those groups and normal mothers.

METHODOLOGY

Three groups of mothers were compared: 28 mothers of drug-addicted sons, 41 mothers of schizophrenics, and 60 mothers of normal sons. The sons were 16 to 25 years old. Data were obtained in a series of interviews. Variables considered were socioeconomic status, religious affiliation, marital status, age and education of mother, and age of son. The instrument of measurement was a 103-item "S" scale devised by the author, and developed in terms of

psychoanalytic psychology as conceptualized by Mahler's work on symbiosis. Items were modeled after the scales of Shoben (1949) and Mark (1953). Items in the scale's four parts covered mother-child relations in the major phases of children's psychosexual development from birth through adolescence, as well as mothers' intrapsychic processes and feelings about themselves, their husbands, their children, and their perceptions of themselves in relation to the world. The major dynamic components of symbiosis, such as ambivalence, clinging, narcissism, masochism, and mothers' fear of object relationships were also measured. Five psychoanalytically oriented judges who were familiar with addiction agreed that the items measured the essential dimensionality of symbiosis. The 103-item scale was administered to the 3 groups of mothers and then trimmed to a final scale of 38 items. Scores were analyzed by means of two-way analysis of variance based on condition versus religion. Where the F-test showed significant relationship differences, the Duncan Multiple Range Test was used to identify specific group differences that were significant.

RESULTS

As predicted, the mother of the addict is clearly different from the mother of the normal son. However, contrary to expectation, the mother of the addict is also significantly different from the mother of the schizophrenic, while mothers of schizophrenics and normal individuals show similarities. All three groups exhibit the same degree of symbiosis for the child's early developmental stage (birth to 5 years). However, in the second stage (age 5 to age 10) the mothers of normal sons and of schizophrenics are able to loosen their symbiotic ties to their children, but the mothers of addicts are not able to do so. In the third stage (age 11 to 16) the differences between the three groups are more pronounced, with addicts' mothers becoming more fixated in their symbiotic ties to their children. In this stage, the mother of the schizophrenic also shows more symbiosis than the normal group but not so much as the addict group. Since the symbiotic relationship normally decreases as the child grows older, the indications are that the mothers of addicts and, to a lesser extent, the mothers of schizophrenics seem to be fixated at the earlier phase of the mother-child symbiosis. The symbiotic interaction in these cases persists up to the onset of the sons' symptomatology in late adolescence. The addict-group mothers have higher mean scores for symbiotic needs than either of the other two groups. While the schizophrenic group has somewhat higher scores than the normal group, the difference is not statistically significant. The slight difference between the mother of a schizophrenic and the mother of a normal son may be due to a response on the part of the mother of the schizophrenic to a child who cannot respond adequately to her because of genetic factors.

CONCLUSIONS

Mother-child symbiosis is a clearcut differentiating factor in adolescent narcotic addiction and may be a major predisposing factor to this form of pathology. If symbiosis represents a powerful dynamic in adolescent addiction, then the mother must be included in psychotherapy for the addicted son. Further research is required on the exact nature of the connection between mother-child relationships and drug addiction, as well as on the significance of similarities between mothers of schizophrenic individuals and mothers of normal individuals.

Baer, D.J., and Corrado, J.J. Heroin addict relationships with parents during childhood and early adolescent years. The Journal of Genetic Psychology, 124(1):99-103, 1974.

DRUG	Heroin
SAMPLE SIZE	200
SAMPLE TYPE	Addicts in treatment; nonusers
AGE	Adolescents; young adults (16-29)
SEX	Both
ETHNICITY	White; nonwhite
GEOGRAPHICAL AREA	Massachusetts
METHODOLOGY	Survey--comparative, correlational
DATA COLLECTION INSTRUMENT	Biographical Inventory
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	10

PURPOSE

Although the rise of the drug subculture is part of the general youth movement, faulty parent-child relationships and poor self-image are also frequent correlates of subsequent drug problems. Any long-range solution must consider the underlying causes and influences that lead to eventual drug abuse. Biographical inventory studies demonstrate that past experience foreshadows future behavior. This study used a Biographical Inventory to examine the kinds of relationships that heroin addicts had with their parents during their childhood and early adolescence. These life history data were compared with responses of nonusers of heroin to provide an estimate of the important early influences that may lead to addiction.

METHODOLOGY

The 100 addicts in the sample were participants in rehabilitation programs conducted by 10 nonprofit organizations located throughout Massachusetts. Their ages ranged from 16 to 29 years; 82 were white; 68 were male and 32 female. A comparison group of 100 nonusers was selected from the same geographical regions to match the addicts in age, race, sex, and educational level. Although some of the nonusers of heroin had used marijuana, only individuals without hard drug

experience were eligible for the study. The subjects completed a Biographical Inventory consisting of 56 questions on life history. A total of 19 multiple-choice items pertained to parental relationships, and 37 additional items concerned previous drug use and background data. Contingency tables were formed to compare the addict group and the nonuser group. Chi-square tests of independence were used.

RESULTS

Of the 19 statements concerning parental relationships, 15 were statistically significant. The addicts were less likely to report having had a happy childhood but were more likely to wish to relive part of their childhood or teen years than nonusers. Physical punishment during childhood was more prevalent for the addict group. It was also more common for the mothers to be employed when addicts were children. Significantly more addicts had freedom in the evening as teenagers, but fewer were encouraged to bring their friends home. Fewer parents of addicts expressed interest in their children's school performance; addicts tended less than nonusers to describe their fathers as "pals" and their mothers as consistent and well-intentioned individuals. Addicts were more likely to report lack of parental concern regarding sexual conduct and career guidance, and religion was less often an important part of their family life. Nonusers were more likely to come from intact homes in which parental influence was a significant positive factor.

CONCLUSIONS

Although many factors during the initial phases of drug use undoubtedly contribute to subsequent addiction, the present results suggest that earlier life histories of individuals may also be important predisposing influences. Results also showed that the Biographical Inventory approach is a promising technique for obtaining this type of autobiographical data from heroin addicts. The majority of addicts experienced an unhappy childhood that included harsh physical punishment and a general pattern of parental neglect and rejection. However, the finding that a significant number of addicts did not report an inadequate home environment suggests that emphasis on an ideographic approach would provide a more relevant biographical inventory. Although all influences that lead to addiction cannot be controlled, results imply that parents should promote several factors in their child's development as some insurance against drug abuse. Such factors should include inculcation of religious or ethical values; consistent treatment and appropriate punishment; discouragement of permissive sexual conduct, with emphasis on impulse control and delayed gratification; and the maintenance of an open relationship to reduce feelings of isolation.

Bratter, T.E. Wealthy families and their drug abusing adolescents. Journal of Family Counseling, 3(1):62-76, 1975.

DRUG	Multidrug
SAMPLE SIZE	4
SAMPLE TYPE	Adolescent abusers and their parents
AGE	3 adolescents; 1 young adult; mature adults
SEX	Both sexes
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Case study
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	.13

PURPOSE

Many affluent suburban families of adolescent drug abusers give an illusion of being cohesive and harmonious but in reality exhibit massive avoidance and denial that their intrafamily relationships are sterile and fraught with hostility and disrelatedness. Family members have many leisure time diversions and generally only convene for the evening meal, which is usually an unpleasant experience. Family members relate to each other as commodities, with unending power struggles over use of a family car, gaining more independence, and other matters. Wealthy parents are often demanding because they are used to receiving preferential services that can be purchased. Psychotherapists need to understand how these manipulations can interfere with the working alliance between the therapist and the adolescent. This article presents four clinical case examples that illustrate some of the negative manipulations the affluent use to undermine the psychotherapeutic process. Therapeutic interventions the author used to counteract the parents' pathology are also described.

SUMMARY

During the initial phase of therapy, when the goal is to control and curtail adolescents' self-destructive and illegal behavior, the wealthy parents remain cooperative and supportive of the therapist. However, they may also encourage the therapist to take responsibility for the youth's custody and control or ask the therapist to spy on the adolescent and report back to them. After treatment progresses beyond this initial phase, the affluent may attempt either subtle sabotage or blatant obstruction of the therapeutic relationship.

Kenny Todd, age 17, had been involved in numerous accidents, which had totally destroyed three cars. His stepfather responded by purchasing new cars to replace the destroyed ones. At the first therapy session, Kenny mentioned that his favorite activity was to ingest drugs and see how fast he could drive. Mr. Todd resented Kenny and was insensitive to the possibility that the boy might hurt himself. Mrs. Todd seductively overprotected Kenny. The therapist forced Kenny to give him his driver's license as a condition of continuing therapy. This strategy failed when Kenny's stepfather secured a duplicate license for him. The therapist wrote Kenny a dramatic letter of reprimand for continuing to drive, and the group decided to expel Kenny. Mr. Todd continued to sabotage the therapeutic relationship. As a result, a therapeutic community, using self-help principles, was chosen for Kenny. He thrived for 8 months but left when the parents moved away. This case illustrated how the family appeared to be committed to the destruction of one of its members so that any intervention by the psychotherapist would not be effective.

The case of the Gold family showed how the pursuit of affluence prevented the parents from paying any attention to their 16-year-old daughter, Pattie. The father, a stockbroker, worked long hours, and the mother's life revolved around the country club and her card-playing group. Having failed to gain parental recognition by excelling in school, Pattie turned to drugs. The drug materials she deliberately left in obvious places were discarded without any comment. Her efforts to discuss her problems with her parents also failed. To dramatize the urgency of her need for parental attention, Pattie, at the therapist's suggestion, withdrew her savings of $900 from the bank and gave it to her father with the request that he sell her an hour of his time. The father listened for about 45 minutes and then excused himself to call a client. Pattie moved out that night. The therapist later learned that she had completed college and was happily married. In this case, the therapist served several vital functions. Pattie learned that at least one adult could care about her, that she was a worthwhile person, that her parents would not change, and that she had to extricate herself from her pathological family.

The Evans family was characterized by an inability to set limits for its son. The father was a successful businessman and trustee of an Ivy League college. Mrs. Evans, a graduate of a prestigious women's college, was frustrated by her lack of a profession but had recently started working part-time. Sammy, age 22, had few friends, failed fifth grade, and later became addicted to heroin. He had been seen and discharged by three senior psychiatrists before Mr. Evans contacted the therapist in desperation. At the first session, Sammy gave the impression of being a self-indulgent, unmotivated, spoiled brat who, when asked a question, would become abusive. The therapist set and maintained strict limits for Sammy. For example, whenever Sammy became abusive, the therapist sent a letter of reprimand to Sammy and a copy to his parents. Despite the therapist's attempts to persuade the parents to set firm limits, such as threatening Sammy with expulsion from the home when he became abusive, the parents were unable to set convincing limits. The family situation deteriorated, and the therapist eventually resigned from the case when the family, against his advice, arranged private methadone treatment for Sammy. However, the therapist offered to keep communication open. At age 22, Sammy became drug free and was accepted by a college. In this case, the parents frequently deviated from meticulously arranged therapeutic plans and acquiesced to Sammy's infantile demands; nevertheless, the therapist remained task-oriented.

The case of the Reynolds family showed how a mother's desire for revenge against her first husband, who had deserted her, produced both a destructive relationship with her drug-abusing son and attempts to interfere with the therapy. This case illustrated that working with an obstreperous family member, who wishes to see the adolescent destroy himself or herself, poses many problems for the psychotherapist. To avoid confronting her own pathology, Mrs. Reynolds maintained a vested interest in having her son continue to have problems. The therapist had difficulty functioning in a helping role regarding the family members' individual problems.

CONCLUSIONS

It is therapeutically imperative to involve parents in the treatment of their drug-abusing adolescents. The psychotherapist must recognize that parents are legal guardians. Unless there is communication between the parents and the psychotherapist, and between the adolescent and the parents, the wealthy will devote their formidable energies to sabotaging the fragile therapeutic alliance. Countertherapeutic inducements that lure the adolescent away from treatment must be discussed nonjudgmentally, and alternatives must be explored objectively. The psychotherapist must avoid overreacting and becoming part of the pathological family. A few families present too much pathology and/or too little motivation to help the adolescent. In these situations, alternative living situations must be explored. College is one possibility; the therapeutic community, which could be a vital part of every adolescent's socialization, is another viable alternative. Overall the therapeutic payoff for working with affluent families is that they have the social, political, educational, and economic resources to help their adolescents once they stop punishing themselves and begin to realize their potential.

Brook, J.S.; Lukoff, I.F.; and Whiteman, M. Peer, family, and personality domains as related to adolescents' drug behavior. Psychological Reports, 41(3):1095-1102, 1977.

DRUG	Marijuana
SAMPLE SIZE	403
SAMPLE TYPE	General population
AGE	Adolescents (13 to 17)
SEX	Both
ETHNICITY	American black; white; British West Indian black
GEOGRAPHICAL AREA	Brooklyn, New York City
METHODOLOGY	Statistical analysis
DATA COLLECTION INSTRUMENT	Interviews; questionnaires
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	28

PURPOSE

The study examines interrelationships among family, peer, and personality domains as they relate to adolescents' drug behavior, particularly adolescents' marijuana use. To this end, three separate models--interdependent, mediational, and independent--are applied. According to the interdependent model, personality, peer, and family factors simultaneously cause adolescents' drug behavior, while in the mediational model one domain is prepotent to the others, mediating the relations of the remaining domains and drug use. In the independent model, each domain has a separate significant relationship to drug use. To test these models, personality, family, and peer factors that are known to affect adolescents' drug habits were used, such as nonconformity or parental drug use.

METHODOLOGY

The sample consisted of 138 (77 male, 61 female) British West Indian black adolescents, 141 (65 male, 76 female) American black adolescents, and 124 (60 male, 64 female) white adolescents. The two groups of blacks were differentiated because they differ in family structure, occupational mobility, and social class standing. Adolescents were sampled from three contiguous census

tracts in Brooklyn, New York; one is predominantly black, one is predominantly white, and one contains many West Indians. Houses and blocks were randomly selected within these areas, and mothers of the adolescents were screened in their homes to determine ethnicity, social class, and presence of a child between 13 and 17 years. The sample design was used to ensure equal numbers of black, white, and West Indian adolescents comparable in terms of socioeconomic background.

A preliminary study of 50 adolescents established an interview schedule in which items were grouped into scales that measure the three domains. The scales for the personality domain are the Marlowe-Crowne scale (Crowne and Marlowe, 1964; 5 items), the Internal-External Locus of Control scale (adapted from Rotter, 1966; 9 items), and the Attitude Toward Deviance scale (adapted from Jessor, Graves, Hanson, and Jessor, 1968; 10 items). The peer domain scales are the Friend Expectation scale (adapted from Jessor et al., 1968; 3 items), Closeness to Peers scale (3 items), the Parents vs. Peers scale (3 items), and the Peer Drug Use scale (a yes or no item). Family domain scales are the Involvement in Deviance by Relatives scale (2 items) and the Family Drug Use scale (a yes or no item). Adolescents' own drug use is classified as marijuana only, marijuana plus other illicit drugs, or other drugs alone; 85 percent of the adolescent drug users were experimenters rather than heavy users. A total of 98 percent of the subjects contacted agreed to participate; they were interviewed for a period of approximately 1 hour in their own homes and then answered the questionnaire.

RESULTS

A total of 19 percent of the adolescents reported having used marijuana; most reported only marijuana use. Sex and ethnicity were found to be unrelated to drug use. With respect to age, 10 percent of the 13- to 15-year-olds and 30 percent of the 16- to 17-year-olds reported drug use.

Correlations of personality factors to drug use indicated that adolescent drug use is related positively to lower conformity scores, to an internal locus of control orientation, and to tolerance of deviance. In the peer domain, adolescent drug users were more subject to peer than parental influence, expected satisfaction of emotional and recognition needs from peers, were close to peers, and were involved in the peer drug subculture. In the family domain, adolescents' drug use was associated with relatives' deviant behavior and drug abuse. The three highest correlations overall were in the areas of attitude toward deviance, peer drug use, and family drug use.

Each domain with control on the remaining two domains was analyzed with the multiple regression formula of Cohen (1968) to determine which model best fits the data. Although multiple correlations showed a reduction under control conditions, all three domains were independently related to adolescent drug abuse. Regression analyses of individual variables indicated that the majority of the scales (Internal-External scale, Attitude Toward Deviance, Orientation to Parents vs. Peers, Closeness to Peers, Peer and Family Drug Use) remained statistically significant even when other variables in the other domains were controlled, while Marlowe-Crowne, Friend Expectation, and Involvement in Deviance by Relatives scores lost significance with control on remaining domains.

CONCLUSIONS

Each of the three domains seems to be independently related to adolescents' marijuana use; the relationship of factors in one domain to drug use cannot be considered manifestations of factors in other domains. Moreover, specific variables (e.g., family drug use) within each of the domains are connected to adolescent drug use despite control on the other two domains. While the domains are not totally independent, control of interactive and mediational possibilities supports a residual independent effect. Further, the use of multiple regression techniques with control on domains allows the researcher to answer questions in terms of theoretically related sets of variables, and the use of hypothetical models is a viable method for testing conceptions about possible relations between individual dispositions and aspects of the environment. Finally, the independent model implies that simultaneous intervention in all domains is necessary for maximum control; a diagnostic emphasis on one of the domains would not be complete without considering the independent action of the other two domains.

Gantman, C.A. Family interaction patterns among families with normal, disturbed, and drug-abusing adolescents. Journal of Youth and Adolescence, 7(4):429-440, 1978.

DRUG	Multidrug
SAMPLE SIZE	30
SAMPLE TYPE	10 normal families; 10 families of abusers; 10 families of emotionally disturbed adolescents
AGE	Adolescents (range: 14 to 18); adults
SEX	Both
ETHNICITY	White
GEOGRAPHICAL AREA	Philadelphia, Pennsylvania
METHODOLOGY	Survey--comparative
DATA COLLECTION INSTRUMENT	Structured Family Interview
DATE(S) CONDUCTED	November 1975-February 1976
NO. OF REFERENCES	28

PURPOSE

This study is designed to determine whether family interaction patterns differ significantly among families of normal, disturbed, and drug-abusing adolescents. It is hypothesized that the interaction styles of families with a drug-abusing adolescent will not diverge significantly from those of families with an emotionally disturbed adolescent and that families with normal adolescents will differ significantly in interaction style from both of the other groups.

METHODOLOGY

The sample consisted of 30 intact white upper and middle class families from a suburban Philadelphia county in Pennsylvania. Offspring were between the ages of 14 and 18. Of the 30 families, 10 were controls (NOR), with adolescents free of drug abuse symptoms or signs of psychopathology. The 10 families with a drug-abusing adolescent (DA) were drawn from families with an adolescent applying for treatment at the local outpatient drug and alcohol clinic. The adolescents were mostly polydrug users whose substance abuse interfered with the adolescents' performance of their everyday responsibilities. However, these adolescents were not physiologically addicted or administering drugs through injections. The 10 families with an emotionally

disturbed adolescent (ED) had applied for treatment related to their emotionally disturbed adolescents. The adolescents' emotional disturbances were defined as any psychopathology excluding mental retardation, organic brain syndrome, or psychosis. Preliminary statistical analysis showed no significant differences among the families with regard to socioeconomic status; ages of father, mother, and adolescent; number of children in the family; and adolescents' birth order position. Distribution of adolescents' sex in each of the three groups and differences between families of male and female adolescents also proved insignificant.

In a 1-hour interview the family was asked to work together on four assigned verbal tasks. The tasks of the Structured Family Interview (Watzlawick 1966) included identifying family problems, deciding on an activity that all would enjoy, and other tasks. Observers rated and recorded the verbal behavior of each family. Observations were assessed for quality of interaction, ability to reach a decision, scapegoating, number of double-bind messages, and frequency of each member's communications.

RESULTS

Statistical analysis showed no significant differences between DA and ED families with respect to referral source, duration of adolescents' problems, parents knowledge and perceptions of problem causes, difficulty with the adolescents' siblings, adolescents' presenting problem, and behaviors by which the problem was manifested.

According to task analysis, there was significantly more scapegoating of the adolescents by both mothers and fathers' and the total family of the DA and ED groups than for the NOR families. No significant difference was found between DA and ED families. NOR families were significantly more accurate in their perceptions of each other than the DA and ED groups, although the time required for decisionmaking was, contrary to expectations, the same for all three groups. Furthermore, NOR families did not produce fewer double-bind communications. than the other groups. However, in explaining concepts, NOR parents consulted adolescents significantly more often than DA and ED parents. NOR families produced significantly more positive communications than DA and ED groups, but all three groups of families gave the same number of suggestions and opinions. Analysis of quality of interaction indicated significant differences in the amount of freedom of expression between the NOR and the DA/ED groups but no significant differences between the DA and ED groups. The same pattern applied for amount of cooperation and amount of participation by each member. However, differences between NOR families and DA or ED families were not so pronounced as expected for the measures assessing clarity of communications and democracy of the leader.

CONCLUSIONS

Families with a drug-abusing adolescent are not significantly different from families with an emotionally disturbed adolescent on the variables assessed. However, significant differences exist between normal families and DA and ED family groups. The study emphasizes that adolescent drug abuse should be considered a family affair, as the emotional symptoms of the DA and ED adolescents are manifested on the family level. The power and potential of the family are underscored by the finding that families with a normal adolescent interact in patterns clearly distinguishable from families with a drug-abusing or emotionally disturbed adolescent. The conclusions suggest the need for family involvement in the treatment of adolescent psychopathology and the clinical importance of understanding what constitutes normal family interaction.

Gerard, D.L., and Kornetsky, C. A social and psychiatric study of adolescent opiate addicts. Psychiatric Quarterly, 28:113-125, 1954.

DRUG	Opiates
SAMPLE SIZE	32
SAMPLE TYPE	Addicts in treatment
AGE	Adolescents (mean: 19 years, 7 months)
SEX	Male
ETHNICITY	Black; Puerto Rican; white
GEOGRAPHICAL AREA	New York and Chicago
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Interviews; observations; clinical statistics; psychological tests
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	0

PURPOSE

The striking increase in the incidence of opiate drug use among adolescents in urban areas stimulated a research project at the National Institute of Mental Health. The results of the first phase of the project, reported here, describe the social, familial, and psychiatric characteristics of male adolescent opiate addicts. The possible adaptive functions of drug addiction in adolescents are also discussed.

METHODOLOGY

The sample consisted of 32 volunteer or Federal male probationer patients under 21 years old admitted to the U.S. Public Health Service Hospital in Lexington, Kentucky. Most subjects were blacks or Puerto Ricans from low status neighborhoods of New York and Chicago. (There were 27 blacks and 5 patients of Puerto Rican descent.) With regard to the variables of age, duration of drug use, ethnic background, socioeconomic status, and stability of the parental home, this sample resembled a larger sample of male adolescent addicts admitted to the Lexington Hospital in the preceding 6 months. Thus, the sample subjects appeared to be representative for that particular hospital, and the authors' clinical experiences suggest that the sample is

representative for young drug addicts in general. Information about the subjects was collected from observations during treatment; diagnostic and therapeutic interviews; projective material obtained in the Thematic Apperception test and Rorschach; and social agency reports from the patient's home community. The Wechsler-Bellevue, Draw-a-Man, and Bender-Gestalt tests were also used.

RESULTS

Contrary to the common conception that adolescents usually do not obtain drugs concentrated enough to become addicted, the subjects were deeply involved in opiate drug use and exhibited definite withdrawal symptoms. Patients were usually from economically comfortable middle class families; there was no essential relationship between drug addiction and membership in particular socioeconomic groups, and family structures of patients were variable. Mothers could be characterized as excessively controlling and strict (40 percent), overindulgent and nondisciplining (48 percent), or seductive (24 percent). Fathers played an insignificant role in patients' lives through separation, divorce, or disinterest (60 percent), or were actively punitive and moralistic (30 percent), and/or were paranoid and controlling to both the mother and patient (20 percent). Parental relationships were generally poor, with a domineering father pitted against mother and children (30 percent) or a weak father held in contempt by his family (70 percent). Manifest instability of the home and foster care or institutional experience of patients were rare. In 41 percent of the homes, the mother and father sustained a conventional relationship until the time of the patient's hospitalization; in 41 percent of the homes, there was a death, divorce, or separation before the patient was 10 years old (mean age of patient--7 years); and in 25 percent of the homes there was a death, separation, or divorce after the patient was 10 years old (mean age of patient--12½ years). Family lives did, however, appear to be conducive to serious adjustment difficulties.

Despite special efforts, subjects were cooperative only as long as the interviews centered on techniques for obtaining drugs, junkie slang, and patients' experiences with police corruption. Patients resisted discussions of themselves and their relationships, denied emotional problems, and were hostile or indifferent toward therapy. Patients rationalized their difficulties by citing commonly known superficial causes (i.e., broken homes) and displayed evasion, suspicion, and hostility at the authors' attempts to undercut the rationalizations.

Mental disturbances of juveniles were classified as overt schizophrenia with flattened affect, thinking disorders, delusions, and withdrawn social behavior (six patients); and incipient schizophrenia involving extreme anxiety related to inadequacy feelings, paranoia, thinking disturbances, nonperformance, confusion under stress, and avoidance of participatory situations (eight patients). Other patients displayed delinquency-dominated character disorders manifested as pseudopsychopathic delinquency in which delinquents denied their basic passivity by establishing macho criminal roles (eight patients); or oral characters with demands for nurturance, low frustration tolerance, and petty delinquent behavior intended to punish significant figures (six patients). Four of the patients exhibited inadequate personalities, impoverished thinking and emotional expression, and a paucity of interests and goals.

The boys as a group suffered from dysphoria marked by depression, low self-esteem and feelings of guilt, inadequacy, pessimism, and futility; from disturbances of sexual identification such as fear of homosexuality or homosexual rape, homosexual affairs and prostitution, shame toward heterosexual perversion, and feminine mannerisms; and from disturbances in interpersonal relationships. Patients refused involvement with male or female peers, considered adult males weak and viewed adult females as castrating figures to be avoided, manipulated, or abused. The characteristics were extreme and obvious handicaps in their functioning in any setting.

Drug addiction had an adaptive function for the subjects. The problems of living as an addict enabled them to deny underlying problems. They could avoid awareness of sources of discomfort, act out hostile feelings, with drug effects as a handy rationalization for their actions, and find support in the drug culture's distorted perception of interpersonal relationships. Opiate drug use also helped reduce overt psychiatric symptomatology, control the anxiety and strain that patients experienced in interpersonal situations, and provided patients with a comfortable sense of detachment during highs.

CONCLUSIONS

The patients' drug use was not only a manifestation of their difficulties in living but a successful and malignant way of coping with these difficulties. As a result, the young addicts proved difficult to treat. They misinterpreted acts of kindness; could not adjust to institutional life; did not participate in educational or vocational rehabilitation programs, despite their own awareness of their needs; and conformed overtly while behaving hostilely in a subtle fashion. The authors concluded from the experience that successful treatment programs for adolescent addicts require a psychiatric facility prepared to undertake long-range treatment of emotional disturbances linked to delinquency.

Kandel, D.B. Inter- and intragenerational influences on adolescent marijuana use. Journal of Social Issues, 30(2):107-135, 1974.

DRUG	Marijuana
SAMPLE SIZE	13,780
SAMPLE TYPE	High school students and their parents
AGE	Adolescents; adults
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	New York State
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Questionnaires
DATE(S) CONDUCTED	Fall 1971; spring 1972
NO. OF REFERENCES	86

PURPOSE

Social interpretations of drug behavior by young people have tended to see peer influences as critical and marijuana use by friends as one of the most important variables in explaining adolescent drug use. This view presumes discontinuity between the generations and alienation of adolescents from adults. In contrast, a recent interpretation has linked adolescent drug use to parental consumption of psychoactive drugs such as tranquilizers. This theory stresses continuity between the generations rather than youthful rebellion. As the extent of parental versus peer influence has not been adequately assessed, the present study examines the relative similarity in drug use patterns across and within generations as well as generational interactional factors that affect the level of interpersonal influences. For adolescent drug behavior, the focus is on marijuana; for parents, the use of psychotropic drugs and recreational drugs such as alcohol is considered.

METHODOLOGY

The study sample consisted of 8,206 public high school students and 5,574 of their parents from New York State. The survey was conducted in the fall of 1971 and the spring of 1972. The

two-stage sampling procedure involved the selection of a stratified sample of high schools and a sample of students clustered by homerooms and stratified to represent the different grades within each school. Structured self-administered questionnaires were given in a classroom situation to a random sample of homerooms in 13 schools and to the entire student body in 5 schools. In the five schools data were collected from the students' best schoolfriends. Several weeks after the survey of the 18 schools, questionnaires were sent to one of the student's parents. Identification and linkage of records between waves and between parents and adolescents, and adolescents and best schoolfriends within each wave was accomplished through the use of self-generated identification code numbers. With these codes it was possible to match 49 percent of the students to their parents and 38 percent of the students in the five schools to their best schoolfriends. In these five schools, 23 percent of those surveyed could be matched to parents as well as best schoolfriends.

The adolescents' questionnaires included a wide variety of items about the use of legal and illegal drugs, as well as personal characteristics and behaviors (i.e., extent of student marijuana use, parental psychotropic drug use, and parents' smoking and drinking habits). Parents' questionnaires paralleled those of children. Any respondent who gave a positive response to either of the use questions was considered a user.

RESULTS

Adolescent Marijuana Use and Parental Psychotropic Drug Use

A total of 29 percent of the students reported having used marijuana at least once, with the proportion of marijuana users increasing progressively from the freshman (16 percent) to the senior year (41 percent). Data confirmed the previously reported association between adolescents' drug use and perceived parental use of psychotropic drugs. Marijuana use was higher among youngsters whose parents used tranquilizers than among those whose parents did not. Furthermore, adolescent marijuana use was directly related to the perceived degree of parental drug involvement as measured by extent of use, number of drugs used, and use by one or both parents. Associations based on adolescents' perceptions of parental behavior were twice as high as associations based on parental reports.

Adolescent Marijuana Use and Parental Use of Tobacco and Alcohol

Self-reported parental alcohol use had the most significant association with adolescent marijuana use. The proportion of adolescent users increased from 16 percent for children of nondrinking fathers to 38 percent for children of drinking fathers. The lowest rates of adolescent marijuana use were observed in families in which parents neither smoked nor drank.

Marijuana Use and Peer Influence

There was an extremely strong correlation between adolescents' own marijuana use and their perception of their friends' use of marijuana. For adolescents who reported that none of their close friends were users, only 2 percent had used marijuana, as compared with 92 percent when all friends used drugs. Whether on the basis of perceptions or of actual self-reports, the association between drug use of adolescents and friends was much larger than between parents and adolescents.

Relative Influence of Parents and Peers

In cases where parents' and peers' drug behavior diverged, adolescents reported greater similarity to peer than parent patterns. A total of 56 percent of the adolescents used marijuana when peers used marijuana and parents did not use psychoactive drugs, but only 17 percent used marijuana when parents had used one or more drugs but best friends were not users of marijuana. The highest rate of adolescent marijuana use (67 percent) appeared when both parents and friends were users, suggesting a synergistic effect.

Marijuana Use and Involvement With Peers

Adolescent marijuana use was under the control of peers and took place almost completely in response to peer pressures. Marijuana use appeared to be the single most important behavior that friends shared in common. Furthermore, drug use was directly related to the frequency of contacts with peers and to an orientation of peers away from parents. Adolescents who used marijuana moved in peer groups in which drug use was approved and formed an important part of everyday life. For drug users, information about drugs was channeled through contemporaries and not through adults.

Peer Influence and Interpersonal Generational Factors

The closer the intragenerational relationships, the stronger were the influences of peers; the closer the intergenerational relationships with parents, the weaker the influence of peers. When friends used marijuana, 55 percent of the adolescents used marijuana themselves among those who were close to their mothers, but 72 percent did so among those not close to their mothers. When the friend did not use marijuana, 12 percent and 21 percent, respectively, were users.

CONCLUSIONS

The data indicate that estimates of parental influence on adolescent use of illegal drugs, based on the child's perception of parental behavior, greatly exaggerate the importance of parents. Parental self-reports of certain types of drug behaviors have some relationship to adolescent marijuana use, but the effect is small, especially when compared to the influence of peers. These findings on the relative influence of parents and peers fit a cultural deviance model of behavior and include the theory of differential association developed by Sutherland to explain delinquent behavior. Paradoxically, parents may forbid the use of illegal drugs by children but influence that use by their own drug habits. On the issue of generational continuity versus discontinuity, adolescent drug use does not necesarily carry with it rejection of parents and family, although peer influences may predominate in adolescence. Empirical data suggest that the use of marijuana and other mood-changing drugs for recreational purposes will remain a characteristic type of behavior for the stage in the life cycle represented by adolescence and youth. It also appears likely that the present cohorts will continue using marijuana as they progress through the life cycle, much as their parents use alcohol.

Kandel, D.B.; Treiman, D.; Faust, R.; and Single, E. Adolescent involvement in legal and illegal drug use: A multiple classification analysis. Social Forces, 55(2):438-458, 1976.

DRUG	Multidrug
SAMPLE SIZE	1,112
SAMPLE TYPE	High school students and their parents
AGE	Adolescents; adults
SEX	Both
ETHNICITY	Cross-cultural
GEOGRAPHICAL AREA	New York State
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Questionnaires
DATE(S) CONDUCTED	Fall 1971; spring 1972
NO. OF REFERENCES	35

PURPOSE

Despite numerous studies of illicit drug use, definitive understanding of adolescent drug involvement has not yet been achieved. Many studies tend to focus exclusively on one class of variables and thus fail to distinguish the relative importance of the various factors that affect drug use. This study seeks to establish the contribution of various background, personal, and interpersonal factors to adolescent involvement with different types of illicit and licit drugs. Three aspects of illicit drug behavior in adolescents are considered: the probability of using marijuana, the frequency of marijuana use, and the probability of use of other illicit drugs. A theory of stages of drug use and a tentative model for the processes related to involvement in the stages are developed.

METHODOLOGY

Data are based on a subsample of adolescent-parent-best schoolfriend triads from a two-wave panel survey carried out in the fall of 1971 and spring of 1972 at 18 schools. A two-stage stratified random sample of adolescents representative of public secondary school students in New York State was obtained. Structured questionnaires were administered in a classroom situation

to the entire student body in five schools; 2 to 3 weeks later questionnaires were mailed to students' parents. Self-generated identification code numbers allowed matching of an adolescent with best schoolfriend and parent, and 1,110 triads could be matched in this manner.

Adolescents were asked how many times they had used hard liquor, marijuana, hashish, LSD, other psychedelics, methedrine, other amphetamines, barbiturates, tranquilizers, cocaine, heroin, other opiates, and inhalants. Parents were questioned about their use of psychotropic drugs and alcohol. All respondents were asked about cigarette use. Of the 16 independent variables considered in relation to adolescent drug use, 5 concerned background characteristics of the adolescent, 8 related to personal attributes, and 3 pertained to interpersonal influences. Separate dummy variable multiple regression analyses were conducted to obtain net effects for each of the 16 variables on probable marijuana use, frequency of use, and probability of other illicit drug use; for each of the 16 variables plus adolescent hard liquor and cigarette use on the same 3 measures; and for each of the 16 variables on the probability of adolescent use of hard liquor.

RESULTS

Probability and Frequency of Marijuana Use

The single most important factor associated with marijuana use is the pattern of drug use by the best schoolfriend, even when all other factors are controlled. Psychoactive drug use by parents has little bearing on adolescent drug use, but under controlled circumstances hard liquor use of parents is the fourth most influential factor. Political attitudes and level of participation in peer activities are the variables next in importance after friend's use. Church attendance and closeness to parents are negatively associated with marijuana use, although modestly. Marijuana use is clearly the result of attitudinal and interpersonal processes. The importance of peers and lifestyle variables supports the contention that there is an adolescent subculture that revolves around the use of marijuana.

The same factors that determine the probability of use also determine the frequency of use. Two exceptions are political attitudes and parental use of alcohol, which appear to influence the frequency of marijuana use less than the probability of use, indicating that these factors may relate to experimentation rather than to regular use of marijuana.

Use of Illicit Drugs Other Than Marijuana

While peer drug use still shows the strongest effect of any variable on the use of other illicit drugs, other variables show almost as strong an effect. Relative to their importance for marijuana use, closeness to parents and personal characteristics such as depression and school performance increase in importance for the use of other illicit drugs, while peer influence decreases. Effects of political and church attendance variables, as well as parents' use of psychoactive drugs are not readily interpretable. These findings suggest important differences in the meaning and processes of involvement with marijuana as compared with other illicit drugs. Thus, marijuana use is mostly a peer group phenomenon, while progression to other more serious illicit drugs appears to express personal dissatisfaction and maladjustment, as the importance of depression, poor school performance, and alienation from parents indicates.

Effects of Tobacco and Hard Liquor on Drug Use

For each category of adolescent illicit drug use, the best friend's pattern of illicit drug use is still the most important factor, but use of hard liquor and cigarettes rank second and third in importance with respect to the probability of marijuana use and third and fourth with respect to frequency of marijuana use. Hard liquor clearly has a stronger effect than smoking on the probability that an adolescent who has tried marijuana will use other illicit drugs. With the addition of smoking and hard liquor in the regression, the adjusted effect of level of peer activity on the probability of marijuana use is reduced in importance, while the effect of parental liquor use persists and is relatively strong. Thus, adolescent use of marijuana and of other illicit drugs is part of a progressive process of drug consumption that starts with legal rather than illegal substances.

Correlates of Liquor Use

In contrast to illicit drug use, the single most important factor of liquor use is peer activity, followed by best friend's use of hard liquor, parental use, and sex. Parental use of psychoactive drugs also has a positive association with adolescent alcohol use.

CONCLUSIONS

Illicit drug use is part of a process of drug behavior in which three phases can be delineated: (1) use of a legal substance, (2) use of marijuana, and (3) use of other illicit drugs besides marijuana. These phases are probably culturally determined and are not obligatory developmental stages. However, a developmental model can account for adolescent drug use. In the entrance stage, adolescents who enjoy high levels of activity with their peers start to participate in the kind of drug usage accepted by adults, perhaps applying drinking patterns learned from their parents. In the course of their social participation, these youths enter the second phase of the process, coming to associate with marijuana-using youths and using marijuana themselves. They tend to have an antiestablishment political orientation and negative feelings toward church, school, and family. In the third phase, only those who experience high levels of personal dissatisfaction and depression, as well as strong feelings of alienation from parents, go on to use still more serious drugs. While drug use by peers is the most important factor for initiation into marijuana use, progression to more serious drugs depends increasingly on intrapersonal factors and not as strongly on values and activities characterizing the peer group.

The nature of the model is tentative, and definitive causal ordering must wait until further analysis of data. The authors suggest that the model has broad behavioral implications; the acquisition of a social behavior involves well-defined stages involving different processes at each stage. Although situational and interpersonal factors may be most important for initiation into a behavior, the factors that affect increased involvement may be intrapersonal.

Prendergast, T.J., Jr. Family characteristics associated with marijuana use among adolescents. The International Journal of the Addictions, 9(6):827-839, 1974.

DRUG	Marijuana
SAMPLE SIZE	Not specified
SAMPLE TYPE	Marijuana users
AGE	Adolescents
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Child's Report of Parent Behavior Index
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	21

PURPOSE

The study was conducted to determine whether marijuana use by adolescents was related to certain characteristics of the adolescent's family. Three categories of mechanisms were considered as possible influences on the adolescent's behavior: modeling, parental attitude toward marijuana use, and the general parent-child relationship. To assess the importance of factors already known to be associated with drug use, selective demographic information, as well as information on parental educational achievement, was collected.

METHODOLOGY

A detailed description of the population sampled, reasons for nonparticipation, results of other variables, and statistical methods of analysis were presented in an earlier paper by the author.

A two-part survey questionnaire was administered. The first part recorded information about respondents' own drug use, their perceptions of over-the-counter and prescription drug use by each of their parents, and the attitude of their parents toward their possible or actual drug use. The responses were analyzed as indices with values from 1 ("never" and "strongly approve") to

5 ("almost daily" and "strongly disapprove"). Standard demographic variables, including age, race, sex, grade, and maximum level of educational achievement of each of the parents, were also obtained. Part two of the questionnaire consisted of a modified version of Schaefer's "Child's Report of Parent Behavior Index" (CR-PBI). The following scales of the behavior index were included: Rejection, Control, Enforcement, Positive Involvement, Control Through Guilt, Inconsistent Discipline, Nonenforcement, Acceptance of Individuation, Control Through Withdrawal of Relations, Control Through Instilling Persistent Anxiety, Hostile Detachment, and Extreme Autonomy.

Three major parent-child relationship factors could be derived from the 12 CR-PBI scales. These were "Acceptance-Rejection," "Firm Control-Lax Control," and "Psychological Control." The last of these was further designated "Control Involving Psychological Tension" or "Psychological Tension" because the scales influencing this factor assessed the use of psychological child control techniques that result in parent-child tension. The three factor scores for each parent were used in the data analysis.

RESULTS

Factors Relating to Parents' Behavior and Attitudes

The increasing perception of control by the child in the mother-child relationship was significantly correlated with decreasing marijuana use. The acceptance-rejection of the psychological tension factors did not affect respondents' marijuana use. In contrast, respondents' increasing perception of the use of the psychological tension mechanism in control by the father was associated with increasing marijuana use by respondents. Neither fathers' acceptance-rejection factor nor the firm control-lax control factors were significantly correlated with respondents' marijuana use index. Results show the correlation between each scale of the mother- or father-child relationship and the dependent variable, marijuana use frequency. Neither the use of over-the-counter drugs by parents nor the use of prescription drugs by the mother, was related to marijuana use, but the use of prescription drugs by the father did have a significant effect on respondents' drug use. Marijuana use was significantly and positively correlated to attitudes of the father and mother toward the child's marijuana use, even though most parents agreed in strongly disapproving of such behavior. An increase in marijuana use by respondents was thus associated with less disapproval by parents.

Demographic Variables

Marijuana use did not appear to be correlated to age or sex factors, but a clear relationship was apparent between race and marijuana use, with white students using more of this drug than others. Furthermore, adolescents reporting greater use of marijuana also reported higher levels of education attained by their parents. Race and educational achievement levels of mothers and fathers were also closely associated.

Multiple Correlations

After controlling for fathers' education level, the partial correlations of race and of psychological control by fathers were no longer significant, but the partial correlation with the mothers' firm-lax control factor became more impressive. Significant correlations also persisted with fathers' and mothers' attitudes toward marijuana use and fathers' use of prescription drugs. The fathers' level of educational achievement and the firm control-lax control factor from the mother-child relationship explained 30 percent of the variance in respondents' marijuana use index scores.

A statistical model for predicting marijuana use provided the maximum reduction of variance attainable with all of the data available, utilizing a minimum number of independent variables, each of which contributed significantly to the overall reduction in variance of the dependent variable.

CONCLUSIONS

Parental attitudes toward possible or actual marijuana use are significantly associated with frequency of marijuana use by their adolescent children. The correlation between fathers' use of prescription drugs and respondents' use of marijuana tends to support the current concern in some medical circles that illicit drug use by children is modeled on adult behavior and attitudes. The factors from the parent-child relationship that are significantly correlated with drug use support the contention that the parent may be one of the problems of adolescence, but the network of correlations between race, parental education, and the psychological control factor make it impossible to select the variable of primary importance. Higher marijuana use by adolescents under lax maternal control suggests that firm control either is an effective barrier to acquisition of illicit drugs or is an important part of a supportive relationship with the mother that facilitates resolution of adolescent conflicts. No entirely satisfactory explanation for the relationships between drug use and socioeconomic status or race is available. Finally, the statistical model for drug use is valuable because it makes possible separation of otherwise unselected students into subgroups with a likelihood of regular drug use varying from as little as 8 percent to as much as 83 percent. Further research is needed to understand the influence of parents on their offspring's illicit drug use and to establish whether children's perceptions of their parents are altered after they become drug users.

Marijuana use is more likely to occur among young people, the "best" statistical model suggests, when the father is well-educated, the parents do not strongly disapprove of use of marijuana, the father uses prescription drugs, and the child perceives the relationship with the mother as one with relatively lax control. These results suggest that the concept of multiple causes of adolescent drug use is accurate.

Rathus, S.A.; Fichner-Rathus, L.; and Siegel, L.J. Behavioral and familial correlates of episodic heroin abuse among suburban adolescents. The International Journal of the Addictions, 12(5):625-632, 1977.

DRUG	Heroin
SAMPLE SIZE	296
SAMPLE TYPE	High school students
AGE	Adolescents
SEX	Male
ETHNICITY	88 percent white; about 12 percent black
GEOGRAPHICAL AREA	Northeastern New Jersey
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Questionnaires
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	22

PURPOSE

Most research on heroin abuse and addiction has focused on black urban males with impaired family structures. In the past two decades, however, heroin abuse had spread increasingly to the predominantly white, middle class suburbs, where material insecurity and limited opportunity are unlikely causes of drug abuse. For that reason, the present study seeks to correlate heroin abuse of suburban adolescents to their family structures, the incidence of other socially proscribed behaviors, and their attitudes toward their parents and themselves.

METHODOLOGY

The study sample included 296 male students recruited from 10 senior high schools in northeastern New Jersey. Names were selected at random from lists of heterogeneous classes to avoid any systematic biasing of the selection procedure. Eighty-eight percent were white and most of the remainder black; 61 percent were Protestant and the rest Catholic.

A scale assessing frequency of antisocial behaviors was constructed, based on the work of Gold (1970) and Hindelang (1971), with respondents self-reporting the degree to which they had

engaged in proscribed behaviors within the past year. A total of 29 such behaviors were measured in anonymous self-reports. Heroin use was not included as it was the criterion employed to separate respondents into abuser and nonabuser groups. Frequencies were coded from 0 to 9, with the upper limit designed to prevent misleading positive skewing of the data as a result of excessive individual claims. Semantic differential (SD) scales (Osgood et al. 1957) were used to assess respondents' attitudes toward their parents and themselves. With this method the psychological meanings of concepts were indicated by rating them along 7-point scales whose poles were opposite in meaning. Order of presentation and polarity of the SD scales were randomized.

RESULTS

A total of 20 respondents, or 6.8 percent of the sample, reported using heroin at least once within the last year, taking it a mean of 2.7 times, with a standard deviation of 1.9. Abuse for this group thus appears to be largely episodic. Demographic variables for abusers and nonabusers showed no significant differences in age, race, religion, size of family, sex of siblings, or order of birth. Homes of each group were largely intact and 95 percent of both groups lived with at least one parent. In addition, heroin abusers engaged in proscribed activities more frequently than nonabusers. Among the activities cited were use of other illicit drugs (virtually absent among nonusers of heroin), crimes of physical aggression, crimes against property, and reckless behavior such as running red lights. Although there was no significant difference in the frequency of alcohol intake between heroin abusers and nonabusers, heroin abusers reported becoming intoxicated more frequently than nonabusers. Heroin abusers appeared sensitive to the euphoria-inducing properties of the substances. Seven of the 10 scales used to measure attitudes toward parents indicated significant differences between the groups. Fathers of heroin abusers were viewed by their sons as significantly less nice, honest, strong, and kind. The greatest difference was on the strong-weak continuum, with fathers of heroin abusers seen as slightly weak and those of nonabusers seen as rather strong. The only differences between the groups in self-concept were that abusers viewed themselves as less strong than nonabusers, suggesting a deficit in coping ability from generation to generation. Similarly, heroin abusers found their mothers to be less fair, honest, and valuable than did nonabusers. The distant, inconsistent mother-son relationship of abusers may be associated with tendencies toward depression and dependency. Deficient coping ability, depression, and dependency may make abusers more susceptible to the transient euphoria of drugs.

CONCLUSIONS

Suburban, middle class, predominantly white adolescent heroin abusers hold significantly less positive attitudes toward parents and their own strengths than nonabusers. These attitudes are associated with characteristics of the antisocial personality. Heroin abuse in the suburbs does not appear to be a circumscribed instance of experimentation. Instead, the impaired family relationships of the middle class suburban heroin abuser resemble those of urban, lower class, minority group addicts, even though the family groups of this particular sample are superficially intact.

Schulz, D.A., and Wilson, R.A. Some traditional family variables and their correlations with drug use among high school students. Journal of Marriage and the Family, 35:628-631, 1973.

DRUG	Multidrug
SAMPLE SIZE	31,882
SAMPLE TYPE	High school students
AGE	Adolescents
SEX	Both
ETHNICITY	Black; white
GEOGRAPHICAL AREA	Delaware
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Questionnaires
DATE(S) CONDUCTED	Fall 1970 and spring 1971
NO. OF REFERENCES	19

PURPOSE

Studies on the causes of delinquency have often relied upon several family variables, including the mother's employment, broken home, family size, and birth order. Although these studies have not shown strong relationships between these variables and delinquency, sociologists continue to use family variables, perhaps because intuition dictates that they must be important. To test the effectiveness of traditional family variables as predictors of drug use, this study examines the relationships between the use of drugs and three variables: principal wage earner, family size, and birth order.

METHODOLOGY

A representative probability sample, based on urban-rural census classifications, was drawn from junior and senior high school students in Delaware during the fall of 1970 and the spring of 1971. The sample size was 31,882. This sample represented the entire student body from 49 schools and about 50 percent of the population of all Delaware schools in the 7th through 12th grades. Data were collected via self-administered questionnaires. Several validity checks were used to

determine if the data on drug use were accurate. Questionnaires were discarded if they failed to pass these checks.

RESULTS

Of every 100 students 8 were currently using at least 1 of the illegal drugs listed in the survey; another 8 percent had used 1 or more drugs in the past. Within individual schools, the proportion of drug users ranged from 5 percent to 40 percent. Rural schools were generally lower in drug use than urban schools. Less than 5 percent of the students refused to provide information on their drug habits.

Examination of the association between principal wage earner and drug use showed that 16.3 percent of the students whose father was the main wage earner used drugs, compared to 17.9 percent for those answering "mother," and 25 percent of those answering "other." The pattern was accentuated when drugs other than marijuana were examined. However, the relationship did not hold for blacks; students in black families in which the mother was the principal wage earner were least likely to use drugs (9.8 percent). The variable "principal wage earner" explained only a minute portion of the total variance in drug use.

Results also showed that 14.5 percent of only children were drug users, compared to 14.6 percent of firstborn; 17.1 percent of middleborn, and 18.2 percent of lastborn. Family size was even less strongly associated with drug use, although only children were the least likely to use drugs (13.6 percent). The highest percentages of drug users were found in families with seven or eight children (17.9 percent and 19.4 percent, respectively).

To assess the relative predictive power of the family structure variables, family variables were inserted into two stepwise regressions. Results showed that family variables accounted for less than 1 percent of the total variance in drug use. Other variables such as race, future plans, and school grades accounted for much more of the variance in drug use. The strongest single predictor of drug use was having friends who were drug users. This variable accounted for over three-quarters of the explained variance.

CONCLUSIONS

Results demonstrate weak but persistent relationships between several family variables and drug use. However, these demographic structural variables, which have traditionally been associated with delinquency and drug use, are not strong predictors. Results suggest that the peer group may provide the most important socializing influence affecting the teenager's decision to experiment with drugs. Furthermore, drug use may be more a type of fad than an act of deviance related to fundamental values and norms.

Smart, R.G., and Fejer, D. Drug use among adolescents and their parents: Closing the generation gap in mood modification. Journal of Abnormal Psychology, 79:153-160, 1972.

DRUG	Multidrug
SAMPLE SIZE	8,865
SAMPLE TYPE	Junior high and high school students
AGE	Adolescents
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Toronto, Canada
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Questionnaire
DATE(S) CONDUCTED	1970
NO. OF REFERENCES	13

PURPOSE

Many studies have examined the characteristics of adolescent users of illicit drugs, although few have focused on the parents of drug users or have examined parental use of such psychoactive drugs as tranquilizers, barbiturates, and stimulants. Some researchers have argued that the psychopharmacological revolution of the 1950s created a tendency among both adults and adolescents to value mood modification for its own sake. Thus, drug taking, as a form of mood modification, could be a phenomenon learned within the family environment.

This study reports data from a large survey in Toronto, Canada, that studied the relationship between parental and adolescent drug use as reported by students. The investigators hypothesized that both illicit and licit drug use will be more frequent in families where parents are reported to be users of psychoactive drugs (tranquilizers, barbiturates, and stimulants), and that the heavier the reported use of psychoactives by the parents, the more likely adolescent use of licit and illicit drugs. The study also attempted to ascertain whether there was a pattern of parental drug use associated with student drug use and whether the sex of the parent and student was significant.

METHODOLOGY

Data were derived from a survey of junior high and high school students in Toronto in 1970. The survey included 20 percent of the urban and suburban high school districts, with about 120 students in each of 5 grades. Total sample size was 8,865. Students were asked about their use of the following drugs during the 6 months prior to the survey: alcohol, tobacco, marijuana, glue, solvents, barbiturates, opiates, speed, stimulants, LSD, tranquilizers, and other hallucinogens. Questions were also asked about their parents' use of alcohol, tobacco, tranquilizers, stimulants, and barbiturates, and about demographic and social information.

RESULTS

Tobacco and alcohol were the drugs most commonly used by the students. Almost one-third of the students had smoked tobacco in the last 6 months and the majority drank alcoholic beverages. About 14.5 percent had smoked marijuana, 7.2 percent had used LSD, 4.1 percent had used glue, 7.2 percent had used solvents, and 7.6 percent had used tranquilizers. About one-third of the marijuana and LSD users had taken the drug seven or more times (the maximum category); just over one-third could be considered experimenters. Use of all drugs except tranquilizers was more common among males than females.

Students frequently reported that their mothers used tranquilizers (18.1 percent) and that their fathers used alcohol (63.7 percent) and tobacco (58.4 percent). Students tended to report use by only the mother most frequently; neither males nor females reported use by only their fathers. Cross-tabulations showed that in every case there was a statistically significant relationship between reported parental and student drug use. Also, for every drug for which parents were reported to be frequent users, their children were more likely to be as well. Parents who were reported to be nonusers were also more likely to have children who were nonusers, and the proportion of students using a psychoactive drug was highest when they reported that their parents were daily users of the same drug. The relationship between student use of tranquilizers and parental use of tranquilizers, barbiturates, and stimulants was closer than that found for marijuana.

CONCLUSIONS

Results indicated an apparent positive association between reported drug use of parents and that of their children. This relationship held for parental use of psychoactive drugs, tranquilizers, barbiturates, stimulants, alcohol, and tobacco, on the one hand, and for adolescent use of psychoactive and illicit hallucinogens on the other. The pattern of more prevalent adult female psychoactive drug use as compared to male use has been found in other studies as well. Results also show that the relationship between child and parental drug use was close, regardless of the sex of the child. Although the survey method was not ideal, reported parental drug use was similar to that found in surveys based on adults' own estimates of their drug use. A survey elsewhere in Ontario 2 months earlier produced results similar to the present one; the findings of these two studies provide some evidence that students are modeling their drug use after that of their parents. Thus, the whole family rather than just the individual should be considered in the treatment of drug abusers, and target populations for drug education should be entire families rather than students. Further research using self-reports from parents, examining factors mediating the association between parents' and children's drug use, and considering families in which parents are heavy drug users is needed.

Streit, F.; Halsted, D.L.; and Pascale, P.J. Differences among youthful users and nonusers of drugs based on their perceptions of parental behavior. The International Journal of the Addictions, 9(5):749-755, 1974.

DRUG	Marijuana; LSD; barbiturates; amphetamines
SAMPLE SIZE	1,050
SAMPLE TYPE	Students (grades 7-12)
AGE	Adolescents
SEX	Both
ETHNICITY	White; black
GEOGRAPHICAL AREA	Mid-Atlantic region of United States
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Questionnaires
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	12

PURPOSE

Interactions within the family are recognized as important influences on the child's psychological development. Empirical research has focused both on objectively described parental behaviors and on the child's perception of parents. Based on research on children's perceptions, Schaefer developed a 10-item scale for each of 26 dimensions comprising 8 concepts: autonomy, autonomy with love, love, love with control, control, control with hostility, hostility, and hostility with autonomy.

A recent study by Streit and Oliver indicated a strong relationship between a negative perception of family and drug abuse. The present study compares drug users' and nonusers' perceptions of their parents and compares males with females as well, using an adaptation of Schaefer's scales.

METHODOLOGY

The study instrument was completed by 1,050 students in grades 7 through 12 in 3 mid-Atlantic school districts. The districts included a suburban middle class and upper class community with

religious and ethnic diversity, a lower class and upper-lower class urban community with a 30 percent black population, and a suburban-rural community with limited racial, social, or religious heterogeneity.

Subjects could indicate whether statements describing possible parental behaviors applied to both parents, mother only, father only, or neither parent. In addition, a lie scale was included to verify the accuracy of responses regarding use or nonuse of drugs. Questions concerning facts about drug use were developed at meetings with former heavy users and abusers of the drugs studied. Answers were not accepted if the child reported extensive use of a specific drug but could not correctly answer the factual question.

The four drugs studied were marijuana, LSD, barbiturates, and amphetamines. For marijuana and LSD, a drug user was defined as a person who used the drug 7 or more times; for barbiturates and amphetamines, 11 or more times used was the indicator.

One-way analysis of variance was used to compare male users to male nonusers and female users to female nonusers. Comparisons were made for each of Schaefer's dimensions for each drug. Scheffe post hoc procedures were used to find the significant contrast whenever a significance level of less than 0.05 was obtained.

RESULTS

Marijuana

Male users perceived significantly more hostility from both parents than did male nonusers, female users, and female nonusers. Both male and female users perceived significantly more hostility with autonomy from both parents and from fathers than did nonusers. Both male and female nonusers perceived significantly more love from both parents than did users.

LSD

Male users perceived significantly more hostility from both parents than did all other groups and significantly more autonomy from both parents than did female users. Female users perceived significantly more love with autonomy from their mothers than did the other groups, and both male and female users perceived significantly more hostility with autonomy from both parents than did nonusers. Nonusers of both sexes perceived significantly more love from both parents than did users.

Amphetamines

Both male and female users of amphetamines perceived significantly more hostility with autonomy from both parents and from fathers than did nonusers. Female users perceived significantly more love with autonomy from their mothers than did the other groups. Nonusers of both sexes perceived significantly more love from both parents than did users.

Barbiturates

Nonusers of barbiturates perceived significantly more love and more love with autonomy from their parents than did users. Users of both sexes perceived significantly more hostility and more hostility with autonomy from both parents than did nonusers. Male users perceived significantly more autonomy from their parents than did the other groups; female users perceived significantly more love with autonomy from their mothers than did the other groups.

CONCLUSIONS

Nonusers of both sexes showed a consistent perception of love from both parents. In contrast, users of all the drugs except amphetamines perceived hostility from both parents. Drug users also perceived their parents as granting autonomy with hostility. Results showed that indicators of potential drug abuse may be found within the child's perceptions rather than within demographic or sociological classifications. Further development of predictive models is needed.

Zimmering, P.; Toolan, J.; Safrin, R.; and Wortis, S.B. Heroin addiction in adolescent boys. Journal of Nervous and Mental Disease, 114:19-34, 1951.

DRUG	Heroin
SAMPLE SIZE	22
SAMPLE TYPE	Adolescents in treatment
AGE	Adolescents (14 to 17)
SEX	Male
ETHNICITY	Black; Puerto Rican descent; white
GEOGRAPHICAL AREA	New York City
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Observations; psychological tests; educational tests
DATE(S) CONDUCTED	1951
NO. OF REFERENCES	19

PURPOSE

Although heroin addiction among adolescents had previously been rare, after 1951 hospital admissions of juvenile addicts, especially from the Harlem area of New York City, began rising rapidly. The present study seeks to identify social and psychological characteristics of the young drug users and to recommend measures for management of the problem.

METHODOLOGY

The sample consisted of 22 boys admitted consecutively for heroin addiction to the Boys' Ward of Bellevue Hospital (New York) during January and February 1951. They ranged in age from 14 to 17 years; all but one of the boys were black or of Puerto Rican descent, and all were from Harlem. Most were referred by the Children's Court, although some were sent by social agencies or their parents. The period of addiction was 1 to 18 months, with an average of 5 to 6 months. The boys remained for 3 to 5 weeks on the ward, where they received complete medical and psychiatric evaluation.

RESULTS

Social Factors and the Development of Addiction

Heroin use was reportedly high in the addicts' neighborhoods and circles of friends. The young addicts whose family lives were examined (12) all lived with one or both of their natural parents, and their family constellations closely resembled those of a control group with one possibly significant exception: Two members of a nonaddicted control group did not have a sustained relationship with a mother figure.

The boys were commonly introduced to the drug by a pusher or by other boys; they took drugs out of curiosity and due to peer pressure and rapidly progressed from sniffing to subcutaneous use to intravenous injection. The addicts usually took the drugs alone or occasionally in small groups of other boys. Drug use provided euphoria, heightened self-confidence, loss of all drives, narrowing of interests, and fantasies bordering on hallucinations. Negative effects were vomiting and nausea during initial use and depression after the high had worn off. Many of the boys began stealing to support the habit.

Characteristics of the Adolescent Group

The addict group was nonaggressive, soft-spoken, and articulate. The boys did not display rebellious tendencies or engage in power struggles. They are not typical gang boys. They had many casual friends but few intimate ones.

The family configuration of the boys was characterized by a dominant mother and a father who was absent or distant. Three of 12 addicted boys expressed open hostility, fear, and rebellion toward the father; another boy neglected to mention his father when enumerating the members of the family. All the boys had close, empathetic relationships with their mothers, to the point where they identified with their mothers rather than their fathers. The relative importance of the mother was greatly overweighted by the group. Many of the boys stated that they were the favorite of the mother, and none of the mothers seen at the ward took a punitive attitude toward their son's addiction. A significant number of the patients planned to go into domestic types of occupations--such as baking or tailoring. Only 1 boy of 12 in a control group described such a close, dependent-possessive relationship with the mother.

Test results indicated borderline to high average intelligence scores; disturbance in intellectual functioning, indicating underlying conflicts; immature and labile emotional reactions; anxiety and depression under pressure; weak ego development as apparent in overdependence on mothers; disturbed interpersonal relationships and inadequate social adjustment; and sexual maladjustment or homosexual tendencies.

Problem Management

The boys treated were not easily influenced by therapy, and their return to drug use after release to their natural environment was anticipated. The prognosis for adolescent addicts, however, is better than for adult addicts if remedial intervention is started early, but for the proper solution of the adolescent's problems active participation in the experiences of constructive living is necessary. Unfortunately, because of the characteristics of the developmental stage, a high incidence of serious crimes can be expected from adolescent drug addicts. Recommendations to reduce addiction include police action to eradicate illicit drug distribution, public education about characteristics of addiction in adolescents, preventive education of adolescents, expansion of existing psychiatric facilities for adolescents, and use of institutions as rehabilitation centers for boys with behavioral disorders. Treatment of adolescent addicts should involve placement away from home for up to 3 years.

CONCLUSIONS

Family configurations displayed by adolescent heroin addicts were characterized by a dominant mother and an absent or distant father. Personality characteristics included a nonaggressive type of social adaptation; a close, empathetic relationship with mothers; weak relationships with others; omnipotent strivings; and a tendency to regression. Addiction involves a dynamic

complex of determinants, including economic and social factors. The management of adolescent addicts is essentially a psychosocial and police problem.

FAMILY TREATMENT APPROACHES

As the theorized role of the family in the drug abuse of one or more of its members has been broadened to include the initiation, maintenance, cessation, and prevention of this activity, so also have the means of therapeutically intervening in it been broadened. The literature in this section, addressing such issues as multifamily therapy, structural family therapy, recidivism rates, treatment of special populations, and specific types of family treatment for specific types of drugs, not only reflects the breadth and growing strength of this field but also points out the most fruitful directions for the future.

Bartlett, D. The use of multiple family therapy groups with adolescent drug addicts. In: Sugar, M., ed. The Adolescent in Group and Family Therapy. New York: Brunner/Mazel, 1975. Pp. 262-282.

DRUG	Multidrug
SAMPLE SIZE	Not specified
SAMPLE TYPE	Addicts and their families; addict couples
AGE	Addicts: adolescents, young adults (15 to 21)
SEX	Both
ETHNICITY	Cross-cultural
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	9

PURPOSE

The lives of addicted adolescents from an urban ghetto are characterized by a turbulence that is integral to the chaotic family and neighborhood life into which the youth is born. This turmoil includes vague and inappropriate rules, confused modes of communication, shifts in the family power structure, and unpleasant street and school life. For the addict, societal and familial dysfunctions are dominant influences in fostering addiction and even in altering the "normal" intrapsychic development.

This paper reports on the use of multiple family therapy in two discrete settings that are contiguous and deal with the same population at different points in time. The settings are a detoxification program and a residential treatment program. In planning the treatment, a change in the family mode was considered essential to planning for rehabilitation. Other realities that had to be faced were large numbers of addicts, a meager staff, and too little time.

SUMMARY

The parents in the families were primarily Spanish-speaking immigrants and poor black and white ghetto dwellers. Many had been trapped in the slums for the past 15 or 20 years. Few families were intact. Patients in the short-term hospital detoxification program were primarily heroin addicts ranging in age from 15 to 21. Drug abuse or addiction dated from 1 to 8 years. Most were from the lowest socioeconomic classes. The program provided a 3-week stay; admission was voluntary.

Family therapy goals included educating the family about the program's goal and the need to plan for rehabilitation, examining family relationships to determine factors that could affect planning, helping families help one another, planning for rehabilitation, and helping the family find alternative ways to cope with conflicts that obstructed cooperation. Families were considered to be people with whom the patient lived and had emotional ties. The groups met for four to six sessions. Multiple family therapy and couples' groups were usually attended by four families, two therapists, and a participant observer. The first session usually included complaints about the program; questions about medications; and themes related to trust, blame, willpower, and disavowal of knowledge of the addiction. The families' interactions revealed lack of generation boundaries, loose concepts of time and behavior, and jockeying for position within the family. Disjunctive communication demonstrated the families' chaotic existences. Sessions also revealed such family roles as "pusher," scapegoat, and supplier. The second stage of multiple family therapy is characterized by the therapists' confrontations with what has been observed of the interactions, family structure, and denials. These may produce denials and accusations and family cohesion against the therapist. The last stage ideally culminates in a decision and a plan. The decisionmaking process is fraught with tensions and conflicts related to assertions of parental authority over the adolescent's preferences and the addict's power to maintain anxiety in the others. In one-third of the cases the plans remain nebulous. The therapists are usually left with the feeling of unfinished business and of having gained knowledge that could be helpful if further sessions were possible. The time limitations are especially difficult when the addict's ambiguity about future plans indicate the decision to remain on drugs.

Addicted couples' groups follow similar patterns, but their content centers around sexual problems, the demoralizing activity of one partner or the other, and resentments toward the partner's parents. Role structures developed by these couples were almost caricatures of the conventional nuclear family. Decisionmaking as couples is turbulent and explorations of the nature of the relationship are threatening to the couples' myths of closeness and intimacy. These couples present a challenging problem in treatment and counseling.

A report on a parent-couples group whose children were in a residential program showed how such groups can prepare parents for the youth's re-entry into the family. Phoenix House, a therapeutic community in New York City, invited seven parent-couples to visit with a family therapist once a week for 6 months. Results showed improvements in family functioning and communication, as well as avoidance of scapegoating when problems occurred. Unless both adolescents and parents are prepared for the reentry, the ex-addict can be pulled into former family roles by the suction of the family system; the current family organization can be disrupted by the returning member.

CONCLUSIONS

The groups described in the paper show that multiple family therapy is helpful in reversing a trend when the patient and the family are both in a crisis and at a point of decision. The modality's limitations are also apparent. For example, four to six sessions are insufficient. In addition, the parent-couples group's problems result from its lack of integration into the adolescents' resident program. Family therapies are not by themselves the answers to the problems of adolescents and/or drug addiction but are helpful in reducing some of the stresses in the lives of the families with an addicted member. Family therapies should be introduced at the earliest possible moment and considered essential rather than ancillary to the treatment of an addicted adolescent. Coping with such societal problems as lack of job opportunities for ghetto youths remains a problem.

Berger, M.M. Multifamily psychosocial group treatment with addicts and their families. Group Process, 5(1):31-45, 1973.

DRUG	Narcotics
SAMPLE SIZE	Not specified
SAMPLE TYPE	Addicts in treatment
AGE	Not specified
SEX	Female
ETHNICITY	Not specified
GEOGRAPHICAL AREA	New York
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	9

PURPOSE

The study describes the structure and course of the family therapy program at the therapeutic community residence for female narcotics addicts of the Quaker Committee on Social Rehabilitation, Inc., in New York. The multifamily groups were started to widen the network of constructive resources available to therapists and residents and to educate family members.

METHODOLOGY

Therapy sessions consist of once-a-month evening meetings attended by all residents and by an average of 10 to 18 relatives from 4 to 8 of their families. Relatives come to meetings on a voluntary basis. A psychiatric consultant experienced in group methods conducts the meetings. The executive director and the counseling supervisor also attend every meeting, while other staff members (e.g., psychologists, vocational education teachers, and volunteers) may participate voluntarily. Visitors are allowed to attend upon invitation.

RESULTS

Group Structure

A meeting is conducted in a style that incorporates the best features of Quaker meetings along with analytically oriented group psychotherapy. Nonauthoritarian leadership and open communication facilitate exposure of collusive attempts to undermine and bypass authority. The group is arranged in a large circle or in a circle within a circle. Sometimes a small family group sits within the large group. The group code stresses examination of past and present events, not provocation of guilt. The differences between practices of the residential community and of the families, which emerge during discussion, reinforce the residents' demands for their families to examine and to alter their rigid positions.

The work in multifamily meetings consists of interaction, discussion, identification, and examination of those conflicts, attitudes, covert alliances, and unconscious arrangements in families that have led to disruptive family patterns and possibly to drug use. Despite family variations, common problems exist in the areas of dependency, inadequate impulse control, poor frustration tolerance, and lack of respect for inner and outer authorities. The community, therefore, attempts to increase addict's ability to examine themselves and to consider the rights of others.

Group Meeting

Difficulties in getting started, which are common, can be overcome with a statement about addicts' desire to escape from feelings of pain to joy, followed by an invitation to comment. In the course of the ensuing discussion, the impact of the relationship between parent and child on the child's self-image usually becomes apparent. Patterns of nonverbal behavior, repetitive self-defeating attitudes, and roles played by addicts and their families can also be explored. At times the focus is shifted to learning ways of feeling elated without drugs by becoming aware of what is occurring in nature and life.

Typical regulating patterns that may be revealed in the course of sessions include placation, provoking guilt, preaching, changing the subject to something irrelevant, withdrawal of family members into silence and resignation, denial, psychosomatic responses, discounting remarks of other family members, and realistic acceptance of conflicts.

Crisis creating is a common pattern in addicts and their families. Describing the significance of this behavior is of great significance for therapy. Addicts and their families should be made to understand that although crises serve to unite families, other ways of communicating and relating can also bring about truthful, confrontational communication and better relationships.

Written evaluation of the family therapy program by residents and parents indicates that therapy sessions are beneficial to both groups. Parents and children learn to talk to each other directly for the first time and come to understand each other's feelings and positions.

CONCLUSIONS

In multifamily group therapy, parents learn about their child's inability to live with frustration, to postpone impulse gratification, to accept structured behavior and to trust authorities. Family members have the opportunity to rebuild respect for their addict relatives, to understand the inner pressures that lead to drug abuse, and to become actively involved in rehabilitation of their relatives. For patients, the multifamily group approach serves to reinforce the impact of insights gained in regular group therapy sessions, to provide a sense of belonging, and to experience the similarities of daily living in the lives of others. New paths of communication are made available to both sides. The author's experiences with the program confirm the value of incorporating multifamily psychosocial group therapy meetings into the regularly scheduled total program of a drug addiction treatment center.

Bratter, T.E. The methadone addict and his disintegrating family: A psychotherapeutic failure. The Counseling Psychologist, 5(3):110-125, 1975.

DRUG	Heroin; methadone
SAMPLE SIZE	1
SAMPLE TYPE	Addict in treatment
AGE	22
SEX	Male
ETHNICITY	Italian
GEOGRAPHICAL AREA	New York, N.Y.
METHODOLOGY	Case study
DATA COLLECTION INSTRUMENT	Observations; recordings and written records of therapy sessions
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	33

PURPOSE

The study outlines the goals and methods of family therapy for addicted adolescents. The nature of pathological family relationships of addicts and problems of treatment are illustrated by the case of a methadone addict that ended in failure.

METHODOLOGY

The author's observations are based on his experiences with 75 clients of the City Island Methadone Clinic in New York. Most of the clients are Italian, hold blue-collar positions, and are aged 20 to 35. Additionally, most clients have failed in school, lack satisfactory peer relationships, and are branded by themselves and others as losers. The clinic employs a Confrontation-Reality Therapy approach that enables addicts to penetrate their defenses and to see their own assets and liabilities. The clinic stresses positive alternatives to drug abuse and addiction (e.g., employment, education), advocacy services for motivated clients, and minimal use of methadone.

The 22-year-old Italian man whose case is detailed had been a multidrug user and heroin addict since his junior year of high school. While receiving treatment, the subject and his parents attended group family therapy sessions, which were taped.

RESULTS

Objectives of Family Therapy for Addicts

Psychotherapy seeks to offer addicted individuals healthy replacements for their pathogenic families. To achieve this goal, the psychotherapist must create a parent-child relationship that not only defines but also enforces limits. The therapist becomes a meaningful parent surrogate to the addict and an idealized role model for addicts' parents. Change in potential suicidal behavior requires prolonged controlled intervention that can be effective when the psychotherapist believes that the addict is out of control. The psychotherapist must be prepared to become totally involved with the addicted person. Refusing to be intimidated, continuing to confront self-destructive behavior, and providing rational answers to angry accusations enable the psychotherapist to establish a working alliance with the addict. Confrontation and crisis precipitation can help the addicted person acknowledge the problem, become motivated to find solutions, and recognize that drug abstinence is more meaningful than drug dependence. Overall, the goal of therapy is to assist addicts in assuming responsibility for themselves.

Family Dysfunction and Failed Treatment

The family under study was typical of many families whose pathology abets drug abuse. The addict was externally carefree and proud of his "junkie" image, but underneath the facade he felt lonely and inadequate, feared failure, and was terrified of women. Drugs were his escape from painful feelings. His father was a child of the Depression who had succeeded modestly through hard work. He deprived himself of everything to provide for his family and refused to impose any limits on his son. The addict's mother was a dutiful wife and mother trapped in her household routine without happiness and glory, stoically accepting her son's addiction. A stifling symbiotic relationship existed from which the son could not extricate himself. The addict had no identity and asserted himself by ordering his parents around. They, in turn, complied with his every wish, protecting him from the consequences of his own behavior and even supplying money for drugs to prevent his involvement in crime. The prognosis for the family was pessimistic from the beginning because they refused to accept residential treatment of the addicted son as the best alternative. Methadone only acted as a pacifier that perpetuated an infantile homeostasis and dependency.

In the course of group therapy, the therapist focused on the problems of other participants as a means of involving the parents and son in the group process; letters summarizing the sessions were sent to the family. Despite group attempts to establish a unified "team" against the son's impulsive self-destructive behavior, and to confront the son with his own actions, the parents remained unable to articulate or to enforce behavioral limits. The son continued to engage in illicit drug activities, even forging a prescription on the clinic's prescription slips. Sensing failure, the therapist attempted to force the parents to have the son placed in a residential treatment facility, without avail. Shortly after the son's exclusion from the clinic's treatment program, he was convicted of selling drugs to minors and was incarcerated. He later died of a methadone overdose when out on a weekend pass in anticipation of release.

CONCLUSIONS

Certain family constellations are clearly too pathological and inconsistent to provide the limits that addicts require for motivation and recovery. In this case the therapist should have considered other treatment options, such as negotiating directly with the addict rather than delegating some responsibility to his ineffectual parents, or assigning other clinic participants the responsibility of helping the addict help himself.

Callan, D.; Garrison, J.; and Zerger, F. Working with the families and social networks of drug abusers. Journal of Psychedelic Drugs, 7(1):19-25, 1975.

DRUG	Not specified
SAMPLE SIZE	Not specified
SAMPLE TYPE	Drug abusers
AGE	Adolescents; young adults
SEX	Both
ETHNICITY	Mostly white
GEOGRAPHICAL AREA	Boston, Massachusetts
METHODOLOGY	Clinical observation; case study
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	11

PURPOSE

In the effort to find effective methods for dealing with drug abuse and drug addiction, the concept of the therapeutic community has received much attention. Now that the usefulness of these communities has been fairly well established, efforts are focusing on increasing their effectiveness. This paper outlines the Network Sessions technique, which the authors have found effective in enhancing the capacity of one therapeutic community (Project Cope) to create a climate of change within the community and in increasing the chances that changes made will continue when the resident returns to the real world. The technique is based on the use of the energy and resources in the residents' natural families and social networks to aid their treatment in the community.

SUMMARY

The Project Cope Residential Facility is a 24-hour residential rehabilitation facility located in Lynn, Massachusetts. It provides drug-dependent individuals from an area north of Boston with an intense therapeutic environment. Its philosophy is that drug addiction is a destructive way for an individual to deal with personal problems and with the outside world. Treatment centers

around the issue of control: control of drug dependency, control over one's life, and finding ways of interacting without a distorted sense of control. The program also tries to avoid assuring residents that successful completion of the program will guarantee control over their lives in the outside world. The goals of the therapeutic process are to help residents become drug free, to help residents form an idea of what they want to do and be, to give residents the experience of drug-free living, and to give them the chance to reenter society with the tools necessary to deal with life's problems. Rehabilitation usually lasts 9 to 12 months and includes four phases. Residents include up to 15 males and females who are from 15 to 30 years old.

Concern for residents' problems during reentry into the real world resulted in the use of social network techniques to create an ever-expanding social system for the ex-addicts. The vehicle for involving the resident's social environment in the program is the Network Session, which brings together significant members of the resident's family and social environment for a multipurpose conference. A main purpose of the Network Session is to involve the resident's family and social network in diagnosing the problem and planning treatment. This process creates an alliance between the staff and the network to help the resident at the time of reentry. Information gathering is also an important function of the Network Session.

Sessions may take place at several different stages of a resident's program involvement, including the time of entry, following a period of no change, just prior to reentry into the outside community, or when outside incidents begin to affect in-house behavior. Participants may include nuclear family members, extended family members, friends, acquaintances, the parole officer, employer, teacher, and clergyman. The typical session includes 20 to 25 people. Certain network members, such as residents' drug-addicted friends, may be deliberately excluded from a Network Session. Skill in convening participants is a major component in the network technique. In contacting network members, the staff member never refers to the session as "therapy" but calls it a discussion group in which participants will share ideas and try to help with the problem. The elements of a typical Network Session include convening, introductions, a statement of the meeting's purpose, a determination of whether to proceed without absent members, listing of complaints from the network, and narrowing of the list of complaints and reversing them to statements of goals or expectations of competent behavior. Other elements include assessing the network's potential as a support system and encouraging network members to reconstruct a positive identity and establish positive expectations for the resident. Further elements include traditional counseling techniques; a summary to highlight each session; and a debriefing conference among the convenor, in-house staff, and senior residents. The case of Lola, a 16-year-old polydrug user, illustrates how network members (i.e., family members) used the therapeutic community approach to vent their anger and ultimately view Lola as a valued family member.

CONCLUSIONS

The authors' 12 months of experience with Network Sessions have indicated that family members are quite receptive to the idea and have found that the sessions satisfy their curiosity about the staff and program of the therapeutic community. The focus on the resident's and network's strengths and resourcefulness contrasts with the sometimes alienating approach used by traditional psychotherapists trained to find and expand on psychopathology. Some residents have posed strong objections to convening their networks; staff members have also noted that residents' anxiety levels increase as the time of the sessions nears. Experience has shown that the most effective convenor is someone who is a relative outsider to both the therapeutic community and the resident's out-of-house social network. Experience also suggests that contact before and after the sessions must be controlled or residents may use the Network Session as a chance for unearned contact with friends and family. In addition, if a session is not guided carefully, it may explode emotionally. Moreover, outside peers may bring contraband to the resident.

In general, involving a resident's social network in the planning and treatment process in a therapeutic community seems to enhance the treatment environment's potential. The technique appears to be particularly suitable to those programs preparing residents to leave the treatment system and live independently in the community. Network Sessions promote dialog and problem-solving, create productive links between people, improve negative relationships, alter expectations, and provide a chance for community education.

Campos, R.L. Family therapy and the Chicano drug abuser. In: National Institute on Drug Abuse. Drug Abuse From the Family Perspective, Ellis, B.G., ed. DHHS Pub. No. (ADM) 80-910. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1980. Pp. 49-56.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Addicts and their families
AGE	Not applicable
SEX	Male
ETHNICITY	Mexican-American
GEOGRAPHICAL AREA	New Mexico
METHODOLOGY	Ethnographic/participant observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	9

PURPOSE

The study addresses the issues of family therapy with families of Mexican-American drug abusers. The author focuses on the unique needs of the Mexican-American family because literature on family therapy approaches for this particular group are practically nonexistent. Also, evaluative comments on drug treatment programs are needed because such programs have become a federally funded growth industry without proper assessment of the myriad treatment approaches.

METHODOLOGY

The author's remarks are based on 12 to 15 years of experience in the field of drug abuse treatment. The author has modified his family therapy training to fit the needs of monolingual and bilingual Spanish-speaking families.

RESULTS

Characteristics of the New Mexico Spanish Family

The traditions of the Chicano family have long been at odds with Anglo-American culture. Central to the Chicano family is the powerful authority of the father, who is expected to be strong, forceful, and aloof, at once a good provider and a disciplinarian. His authority cannot be questioned. In contrast, the mother is permissive, a source of love and reassurance. The Spanish family is patrilineal, brothers are ranked by age, girls are under the control of their mother, and brothers are bound to protect the welfare and honor of their sisters. From the family the individual derives support and personal identity. Family honor and respect of one's fellows are a preoccupation of adult male behavior. As the individual is either inferior or superior to all other family members, he seeks friendship on an equal footing outside the family. Such friendships tend to be deep and longlasting, with the obligation of reciprocal help. Within this system, a "mi hijito" (my little son) syndrome may develop. In such cases, a mother's overprotective love for her son in childhood may become a destructive bonding relationship in the son's adult years, so that the mother refuses to acknowledge his failings. The syndrome appears to be the response of the mother to the traditional, powerful father.

The typical Mexican-American family coming into therapy includes a dominant father; an infantalizing, guilt-provoking mother; a daughter who is caught up in the role of a Mexican-American woman; and a son who abuses drugs, goes to school only when so inclined, and considers therapy a bore. The immediate family is supplemented with an important support system consisting of godparents, coparents, grandparents, cousins, aunts, uncles, and a neighborhood patron. Chances are high that the drug abuser is supplied drugs by an old neighborhood friend with a parallel support system.

Family Therapy Strategies

The goal of therapists is to encourage family members to shift to more productive roles. To achieve this goal, therapists must be flexible enough to meet family needs and should be Hispanic or at least sensitive to Hispanic culture. Moreover, they must be able to handle the family's gradual inclusion of them in the family support system. Therapy sessions away from the office are recommended. During the first crucial meeting with the family, therapists must develop a rapport with family members; establish clear, structured goals; and set a time limit for achievement of the goals. The initial session also sets the stage for further intervention. During further sessions the mother-son interactions are revealed, and the father's position of power and the sanctity of the family are acknowledged and reinforced. The family is invited to join the treatment team, thus sharing responsibility for the problem. Therapists, building on the folk healer concept, move in and out of the family, gradually becoming acceptable to the system.

Further sessions should be consistent with the ground rules of the first session. Other members of the extended family may be included only with permission from immediate family members. Therapists must understand that traditional courtesy extended to them during sessions in the family's home is not manipulation. Conducting sessions in Spanish may prove to be an advantage because switching languages may reveal a whole new facet of the problem and assist therapists' intervention efforts.

CONCLUSIONS

Problems of Chicano drug abusers are linked to the complex, specific family network typical of their cultural group. Family therapy by a specialist sensitive to Chicano culture is therefore the treatment of choice for Mexican-American drug abusers.

Cannon, S.R. Social Functioning Patterns in Families of Offspring Receiving Treatment for Drug Abuse. Roslyn Heights, N.Y.: Libra, 1976. 104 pp.

DRUG	Not specified
SAMPLE SIZE	42
SAMPLE TYPE	26 families of abusers; 16 nondrug families
AGE	Users (14 to 22, mean: about 17); mature adults
SEX	Both
ETHNICITY	White
GEOGRAPHICAL AREA	Phoenix, Arizona
METHODOLOGY	Survey--comparative, correlational
DATA COLLECTION INSTRUMENT	Heimler Scale of Social Functioning; Nine-item family questionnaire
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	92

PURPOSE

Psychosocial functioning involves a complex interrelationship between the individual, the family, and society. Drug abuse may be seen as both a problem and a symptom of dysfunction at all three levels. The present study is designed to explore the ways in which the family system contributes to adolescent drug abuse. To this end, the social functioning patterns of individuals within the family and the relationship between the family and the community are examined. The findings are intended to aid in defining goals for family education, to provide guidelines for family treatment, and to assist in establishment of social policy and programs.

METHODOLOGY

The sample consisted of 26 families, with 1 offspring in treatment for drug abuse, who were referred by programs of the Community Organization for Drug Abuse Control in Phoenix, Arizona. Subjects interviewed included 18 complete parent-child triads, 3 pairs of fathers and mothers, and 5 offspring only. The families were white and belonged to the upper-middle and middle classes. A matched control group contained 16 families in which no member was abusing drugs. Both drug families and nondrug families were volunteers.

Data were collected with the Heimler Scale of Social Functioning and a nine-item family questionnaire adapted from the Structured Family Interview. Data were organized to show individual social functioning patterns; individual patterns were compared across families; patterns of family members were compared within families; and family patterns were compared to other family patterns.

RESULTS

Profile of Drug Abuse Families

Parents of drug abusers were hard-working individuals who had been children during the Depression but had managed to earn both material goods and status during their lifetimes. Their friendships and marriages were generally satisfactory, and they wanted the best for their children, providing material goods, direction, and affection. They hoped to help their children avoid obstacles but had not developed enough autonomy in their own childhoods to be able to develop it in their children. The parents often handled their own frustrations with denial and rigidity, although some resorted to somatization, depression, blaming, and overactivity. Most drug-involved children were allowed to express their feelings through means other than denial. Children encountered problems in adolescence when they received double signals from inside and outside the family; they were expected to do more for themselves but were viewed as too weak to do so. They responded by doing more for themselves but seeking escape from family obstacles and looking for direction and affection among their drug-using peers. In contrast, nondrug-involved families showed more shared authority and cohesion, as well as better communication than abuse families. Nondrug offspring expressed less frustration than abusers.

Treatment

Treatment programs must provide therapeutic alternatives for family patterns, either through a residential environment or by changing family patterns. In either case, the family should be involved in treatment of the drug abuser so that escape patterns are not reinforced. Residential settings can replicate the firmness characteristic of nondrug families and can promote responsibility through participation in managing the program, education and/or work requirements, reduction of means for escaping from frustration, and emphasis on the here and now. Autonomy in interpersonal relations could be furthered through group participation and a variety of interpersonal experiences.

Family groups are the ideal means of including families in treatment because the therapist can intervene in family interactional patterns with the entire family present, and families have the opportunity to view their situation objectively and learn new patterns. Treatment would involve exploration of alternative means of coping and decisionmaking, as well as improvement of communication. Special emphasis should be placed on each family member's taking responsibility for his or her own behavior but not assuming responsibilities for other family members. Individual support is required for parents with a high frustration level.

Prevention

All families need assistance in developing more functional interaction patterns. Dysfunctional family patterns can be identified and changed through family life education, well-family clinics, or direct intervention of professionals such as doctors and ministers. Schools, churches, and community organizations can provide activities for young people as an outlet for their creative energies and a means of practicing decisionmaking. Drug education programs can alert both parents and children to symptoms, dangers, and myths of drug abuse. Reduction of drug availability decreases the attractiveness of this form of escape, and development of less dangerous alternative means of escape and constructive coping patterns can diminish risks of drug abuse.

Research

The symbolic interaction approach proves useful in studying the family. The research instruments are a standardized means of comparing reported perceptions among family members, and the variation of responses between subgroups demonstrates the need for including all subgroups

to avoid distortion. Measuring individual perceptions through the use of these instruments is effective in ascertaining family interaction patterns but not necessarily more useful than direct observation of the family unit, except for gathering information on social variables such as employment and finances. The present study should be replicated on a larger, more wide-ranging population. Studies of siblings, single-parent families, progress of drug abusers whose parents are or are not involved in treatment, and family patterns before and after problems such as drug abuse are proposed.

CONCLUSIONS

Findings suggest that drug sample offspring are allowed to find escape rather than to cope with their frustrations. In contrast, nondrug offspring are encouraged to deny their frustrations and make the best of existing circumstances. Peer reference groups do influence adolescent drug abuse but only when the influence is compatible with family patterns. Structural residential treatment and concomitant family group therapy to modify family interactional patterns are recommended. Community education programs and organizational activities are needed to inform families and provide creative outlets for abusers. More extensive research on family interactional patterns is needed.

Catanzaro, R.J.; Pisani, V.D.; Fox, R.; and Kennedy, E.R. Familization therapy: An alternative to traditional mental health care. Diseases of the Nervous System, 34:212-218, 1973.

DRUG	Alcohol; drugs (general)
SAMPLE SIZE	Not specified
SAMPLE TYPE	Alcohol and drug users in treatment
AGE	Not specified
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	West Palm Beach, Florida
METHODOLOGY	Literature review; program statistics
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	37

PURPOSE

During the last several years familization therapy, an alternative method to traditional psychotherapy approaches, has been developed for treating marginally functional patients and their families. The theoretical basis for this treatment method was developed by Fox, Catanzaro, and Pisani. The authors' clinical observations of persons with emotional disorders, especially alcohol and drug problems, provided the impetus for developing this treatment approach. The malfunctioning of the patient's family unit had repeatedly shown itself to be a major contributing factor to emotional illness. This chronic malfunctioning family unit hindered the progressive personality development of all family members. Instead of being a well family with a sick person, the situation was characterized as a poorly functioning family unit with one or more casualties as a result. The group was often functioning too well for traditional psychiatric hospitalization but not well enough for outpatient therapy to be effective.

The central goal of familization therapy is to help a person become a responsible and caring member of a family. A parallel improvement in the individual's mental health and the family's mental health characteristically occurs at the same time as improvement in the individual's ability to relate to the family. This paper describes the development and basic treatment concepts of familization therapy and briefly discusses the treatment's use and results.

SUMMARY

The techniques of familization therapy were developed at the Palm Beach Institute, a unique inpatient facility located in Florida. The institute consists of a cluster of large, formerly private homes modified into an intensive psychotherapy facility. Familization therapy was built on the concept of problem habits, which are compulsive, learned behavior patterns that reduce short-term anxiety under stress but have a long-term destructive effect on the individual and others. Learning alternative ways to handle specific stresses can modify the habit's repetitious occurrence. Total abstention from the habit is also essential. This approach was initially applied to alcohol and was then expanded to include other problem habits. Familization therapy is currently used for persons from essentially all diagnostic groups except persons with severe psychosis or brain damage.

A review of recent medical literature shows that the topics most pertinent to familization therapy are the therapeutic community, halfway houses, combined alcohol and drug treatment programs, and family therapy. Familization therapy differs in important ways from those approaches. The case history of a 46-year-old woman who had been unsuccessfully treated using other approaches for 10 years prior to the successful use of familization therapy illustrates the method's benefits.

Core treatment concepts of familization therapy include therapeutic family living with people from a wide age range, admission of key natural family members as full-fledged copatients, and unified therapy, plus specialized therapy for alcohol, drug, sexual, and other problems. Other core treatment concepts include the family residential center, the phase system to promote treatment progress, and a renewal treatment contract. Additional treatment concepts include immediate reassurance and description of familization therapy when the patient is admitted, the use of professionals and counselors who are recovered alcoholics and drug addicts as the treatment team, and daily use of individual therapy and a wide variety of group psychotherapy techniques. Other concepts include flexible alternative treatment plans and the use of an independent facility with a wide latitude to develop new treatment concepts.

The therapeutic family is a unit of about 30 patients that approximates a large extended family group ranging in age from young teenagers to great-grandparents. Both sexes are included. The ratio of two adults to one teenager appears to be the most effective. A supportive, caring atmosphere is created, and new areas of interpersonal understanding begin developing. Toward the end of inpatient therapy the patient's family is routinely admitted for several weeks as a copatient. Family members have their own therapist and attend all therapy activities as did the primary patient. Therapy emphasizes helping patients understand their problem habits and what emotional problems led to development of these habits. Each morning the entire therapeutic family meets for a large group session. Special groups are also provided. Provision of a homelike community atmosphere reinforces socially acceptable behavior and the feeling of being a member of a community. An evaluation and treatment phase lasts for several weeks, after which is an intensive therapy phase, for which patients are screened and voted on by patients in that phase. Renewable treatment contracts usually run about 4 weeks each. Of the first 300 patients admitted to the institute and treated by familization therapy, the major diagnosis was alcohol problems for 122 cases, followed by drug problems for 61 cases. Average treatment stay is about 2 months.

CONCLUSIONS

Familization therapy as developed at the institute constitutes a very promising alternative to other types of traditional mental health care. It fills the broad gap between outpatient psychotherapy, day care, and hospitalization in a traditional psychiatric setting. Familization therapy also has great versatility. A small number of transiently psychotic patients can be treated along with patients dependent on alcohol and drugs and those with neurotic, sexual, character, and family crisis problems. Familization therapy also appears to reduce the trauma and stigma of traditional psychiatric hospitalization. Its cost is also lower than most psychiatric hospitalization. To determine the validity of these initial results, a 2-year followup study is planned.

Coleman, S.B. Cross-cultural approaches to addict families. Journal of Drug Education, 9(4): 293-299, 1979.

DRUG	Multidrug
SAMPLE SIZE	2,012
SAMPLE TYPE	Drug treatment programs
AGE	Not applicable
SEX	Clients: both
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Questionnaires; interviews
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	6

PURPOSE

To adapt family therapy techniques to families from varying ethnic or minority backgrounds, both family and environmental systems theories must be integrated into an ecological approach. Ecological treatment incorporates the family's sociocultural norms and values into methods of intervention that can help to reduce treatment failure. Since resistance to all forms of therapy is prevalent in drug abuse situations, ecological family therapy would appear to be essential. A recent national survey indicates that the use of family therapy is increasing, although racial and ethnic minorities are less likely to receive family therapy than are white populations. Site visits made in connection with the survey point to numerous and unique methods of working with families from diverse cultures. This paper uses a systems framework to provide an overview of the way different minorities approach families with drug-abusing members and the various treatment strategies used.

METHODOLOGY

The study is based on the national survey of 2,012 agencies with drug-abusing clients in which either family or marital therapy was a therapeutic approach. In addition to data acquired from mail questionnaires, 36 site visits were made to a wide range of treatment facilities.

RESULTS

Agency interviews resulted in the identification of a number of unique methods currently used to work with families from some of the diverse cultures discussed below.

Christians

A Christian population of recovering heroin addicts is secluded in a remote treatment community where the gospel of God and Christ prevails. The Bible is the reference point for all program guidelines, including the approach to families. There are some attempts to counsel family members, although the center believes that the only acceptable means of resolving family problems are those consistent with formal, fundamentalist biblical standards.

Gays

A gay community takes a strong departure from any serious effort to preserve the connection with families of origin, based on the rationale that gay people rarely return to their families and have no need to resolve family alienation. Family therapy techniques are adapted to the specific needs of this minority group population; therapy with homosexual couples, counseling for gays who are raising families, and a type of network therapy are used.

Mormons

A Mormon agency studied is an outpatient facility treating adolescents from a rural area, most of whom live at home. Drug abuse is largely limited to marijuana and occasional abuse of amphetamines or hallucinogens. Families are resistant to becoming involved in therapy; drug counselors often develop secondary sources or agents in the school system to communicate with parents.

Asian-Americans

The Asian-American treatment population is an older, heroin-using population. Most are either married or living with their families of origin. Families provide a protective shelter by concealing problems within the security of the home environment. Thus, agency therapists prefer to work separately but concurrently with the client and the family.

Women's Center

A program for recovering female heroin addicts and their children provides a day care center for the children as well as childrearing guidance for the mothers. The focus is exclusively on women, although husbands are often attending other treatment programs.

Chicanos

In a program for Chicanos, little therapy is actually practiced. Instead, staff therapists try to become integrated into the community where the extended Chicano family is seen as "the patient." A real community network is in action here, with therapists serving as a resource for giving practical family training.

Blacks

An inner city ghetto program for a primarily black population makes family treatment mandatory. Therapy groups are often composed of 45 people representing many different families. The program's goal is to build strong, viable family units.

Native Americans

In the Navajo Nation, for example, alcohol is still the primary abused drug. Because a slow process of cultural change is occurring, drug workers are most concerned about the damage being incurred to the basic family structure. Navajo parents are extremely resistant to outside intervention and refuse to come to an agency for therapy. Thus, workers follow local customs in their efforts to initiate treatment inside the Navajo hogan.

CONCLUSIONS

Three general treatment approaches have emerged. Families are seen as discrete subgroups, amorphous units, or holistic entities. The most frequent method involves work with subsets, as demonstrated in the gay community where homosexual couples, former heterosexual spouses, and children are treated in separate therapeutic modalities; families of origin are similarly put into independent therapy groups. Christians, Asian-Americans, and clients at the women's center are seen as subsystems rather than as whole family units. In contrast, the Mormon and Chicano families are apt to be contacted in an unstructured manner; a major effort is made to involve the extended family and the community network. Only the black inner city agency works exclusively with entire families.

The agencies' rationales for these different methods are considered to be functions of the sociocultural systems of families. Despite these differences, all the treatment approaches place a high value on the family. In addition to family work, other problems associated with drug abuse include intrafamilial communication difficulties and a high percentage of alcoholism among parents. Loss and separation issues and problems and conflicts regarding discipline of children are also common issues in all these families. Data suggest that the similarities in the patterns associated with families of drug abusers transcend idiosyncratic ethnic roots. This reinforces the belief that family therapy is a viable and adaptive treatment approach worthy of further investigation.

Coleman, S.B. Siblings in session. In: Kaufman, E., and Kaufmann, P., eds. Family Therapy of Drug and Alcohol Abuse. New York: Gardner, 1979. Pp. 131-143.

DRUG	Not applicable
SAMPLE SIZE	18
SAMPLE TYPE	Siblings of addicts in treatment
AGE	Adolescents
SEX	Both
ETHNICITY	White
GEOGRAPHICAL AREA	Philadelphia, Pennsylvania
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	8

PURPOSE

The study describes an exploratory attempt to apply group therapy techniques to siblings of addicts as a complement to therapy with their families. The typical dyadic relationships of addicts' families (e.g., the mother-addicted son attachment) tends to leave younger siblings to fend for themselves. Such siblings are aware of covert family transactions and usually form coalitions among themselves; they tend to be loyal to their families and to identify strongly with each other. Networks of younger siblings from neighboring families develop. If one member of the peer groups takes or rejects drugs, other group members are likely to follow. The therapeutic group for siblings is thus viewed as a measure to prevent inheritance of addiction.

METHODOLOGY

Over a 2-year period 18 youngsters attended the sibling therapy group. The group consisted of three pairs of brothers, one pair of sisters, two pairs of brother/sister dyads, and six individual female siblings. The siblings were members of middle-class white families with at least one adolescent drug abuser being treated in a therapeutic community.

Sessions were held once a week for 60 to 75 minutes. During the sessions, participants were encouraged to express feelings within the group, to use group processes as a means of reflecting interpersonal reactions, and to consider the group a trusting milieu for resolving stresses about family, peers, and school. Group confidentiality was respected. In addition to the sibling therapy sessions, periodic group meetings were held with parents to exchange information regarding the youngsters' behavior at home and in school.

RESULTS

Despite initial enthusiasm of parents and siblings, the first months of the group sessions proved difficult because the siblings were anxious and expressed their tension by becoming physically abusive with each other. The excess energy of the group was channeled into outdoor recreational activities, sculpting, and making collages. The first spontaneous discussion developed as the result of a sculpting project. Structured methods of expressing hostility met with some success, but spontaneous means of facilitating group communication always seemed more useful than preplanned activities. Group drawings and poetry provided an immediate vehicle for expression when members were uncomfortable with each other. After one particularly disruptive member left, the group began to function smoothly. It became cohesive, and no more violence occurred.

Death was a recurring theme in the group discussions. Most of the group had experienced unusual losses through death, and group members came to rely on each other for suppport during mourning over new losses. Sexual functioning and behavior were also important concerns. Serious problems developed after 18 months when smoking and drinking became central issues because a number of participants expressed the desire to smoke in sessions and bragged of their drinking experiences. At the same time, truancies, school suspensions, and behavioral difficulties requiring disciplinary action increased.

The subgroup at the root of the problem consisted of youngsters from the same street. Special multifamily therapy sessions for the families involved brought the group's activities under control. Factors causing the misbehavior were lack of parental attention to the children's activities and a lack of neighborhood controls, as well as an indiscreet affair of the mother of two siblings. The problems were resolved by introducing consistent rules enforced by all neighborhood parents. The sibling group disbanded 3 months after cessation of multifamily therapy because they had successfully come to grips with their basic difficulties. A year after the termination of the group most of the youngsters were drug free and doing well both at home and in school.

CONCLUSIONS

Younger siblings of addicts are not well integrated with their families and tend to be ignored in the face of major family conflicts. Sibling group therapy rescues younger brothers and sisters from "exile" and becomes a vehicle for anxiety release. At the same time, parents can learn through multiple famly therapy sessions to be more efficient in their executive functions by using their neighborhood family network as a resource.

Coleman, S.B., and Davis, D.I. Family therapy and drug abuse: A national survey. Family Process, 17(1):21-29, 1978.

DRUG	General
SAMPLE SIZE	2,012
SAMPLE TYPE	Drug treatment agencies
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	United States; Virgin Islands; Puerto Rico
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Facility Information Form; Family Therapy Questionnaire; Therapist Information Fact Sheet; Progress Index for Family Therapy Programs; interviews
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	17

PURPOSE

Growing numbers are addressing the issue of the family's role in supporting a family member's use of drugs. However, use of family therapy in rehabilitating drug abusers is a relatively new treatment approach. Because the rate of recovery from drug addiction is low, despite increasing numbers of drug treatment centers, clinicians who treat substance abusers are increasingly including families in the treatment process. The scattered positive results concerning family therapy are too preliminary to allow for systematic evaluation, although the rationale for using such therapy is both logical and impressive. This survey was designed to establish a data bank on the current status of family therapy in drug treatment agencies throughout the United States. It aimed to learn what was happening to families with a member being treated for drug abuse and to identify the characteristics of the therapists working with these families.

METHODOLOGY

In the study's first phase, a brief questionnaire, the Facility Information Form, was sent to 3,126 existing agencies in the United States, Puerto Rico, and the Virgin Islands. The questionnaire included multiple-choice and short-answer questions on the agency's geographical location,

type of facility, types of family services offered, perceived importance of family therapy in the treatment of drug abusers, interest in providing family services, and requirements for implementing such services.

In phase II, data were gathered on the treatment population and concerned demography, technological characteristics of family therapy, program ecology, research and evaluation, and prevention and education. Subjects were 1,372 agencies chosen from those agencies giving affirmative responses to the first instrument. The agencies studied provided family therapy to recovering drug abusers. Data were gathered via the Family Therapy Questionnaire, a 10-page questionnaire containing 260 items. In addition, a brief Therapist Information Fact Sheet, completed by family therapists on the agencies' staffs, gathered information on therapists' personal demography, caseload characteristics, education, training, and clinical orientation. A 23-item index, the Progress Index for Family Therapy Programs, was also designed to assess agencies' relative sophistication and experience with family therapy.

The survey's third phase consisted of site visits to 36 drug treatment agencies providing family therapy. Data were collected via structured interviews with family therapists, administrators, agency directors, students, and clients, when possible. A brief evaluation form was used to rate each agency following the visit.

RESULTS

Results showed that 93 percent of the 2,012 responding to the first questionnaire provided some type of family therapy. Three-quarters of these agencies included addicts with their entire families in therapy. Marital or couple therapy ranked second to treatment of the whole family. These findings were consistent for all regions and modalities, except for community mental health centers, where individual therapy was the most frequent treatment cited. Positive attitudes toward family therapy prevailed.

The survey's second phase produced complete responses from 500 agencies. Results showed that the most typical drug agency providing family therapy was a therapeutic community that had treated drug addiction for just over 4 years. Most staff professionals used family therapy. Middle to upper income, married, white, Protestant clients were slightly more likely to be included in family therapy programs than were lower class, black, separated, or Catholic clients. Heroin was the drug most frequently abused, followed by alcohol and marijuana. The identified patient was usually included in family therapy. Most sessions were held once or twice a week for several weeks to a year. Acting-out and other addictive behavior, such as alcoholism, were the primary problems treated. About half the agencies offered family therapy training. An unexpected finding was that family therapists were extremely well educated. Behavioral and learning theories had maximum influence on the therapists. Over half the therapists were males; over half were married. The agencies' overall levels of sophistication were not high; methadone maintenance programs had the least sophisticated family therapy treatment.

The personal interviews with staff supported the findings from the questionnaire data. Program directors viewed family therapy as extremely important. Few differences were found between the functions of the administrators and those of the program directors. Further, family therapists were uniformly convinced of this therapy's value in the drug user's recovery process. The few clients who were interviewed were positive about the personal effects of family therapy and viewed it as a major determinant in changing their addictive patterns.

CONCLUSIONS

The study's most significant finding was that drug treatment agencies and their staffs were willing to contribute to a project that was solely interested in family therapy with drug abusers. This result suggests that working with the families of drug abusers is becoming a relevant treatment approach. Results also indicate that low opiate groups receive more family therapy by more adequately trained therapists than do high opiate groups. Findings indicated that there is a demand for family therapy but that improved and expanded training of family therapists is needed.

Coleman, S.B., and Kaplan, J.D. A profile of family therapists in the drug-abuse field. The American Journal of Drug and Alcohol Abuse, 5(2):171-178, 1978.

DRUG	Multidrug
SAMPLE SIZE	1,117
SAMPLE TYPE	Family therapists
AGE	Not specified
SEX	Both
ETHNICITY	Black; white
GEOGRAPHICAL AREA	Cross-sectional
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Therapist Information Fact Sheet
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	2

PURPOSE

The family therapy approach to the treatment of drug abuse is gaining widespread attention. To assess the status of the approach, the National Institute on Drug Abuse appropriated funds for a national survey conducted by the Department of Psychiatry's Center for Family Research at George Washington University Medical Center. The three-part survey demonstrated that family therapy plays a much larger role in drug treatment agencies than previously suspected. This study uses data from the survey to describe characteristics of the therapists responsible for providing services to families of recovering drug abusers.

METHODOLOGY

The first phase of the survey employed a brief questionnaire, the Facility Information Form, which requested information on agencies' facilities, locations, services, and family therapy programs. Of 3,335 forms sent out, 2,000 were completed and returned. The second phase gathered more detailed information using a 10-page Family Therapy Questionnaire relating to the treatment population, family therapy, research, and prevention. A second questionnaire, the Therapist Information Fact Sheet, solicited information about therapists' personal backgrounds,

caseload characteristics, education, training, and clinical orientation. Data for this phase were collected from a sample population of 500 agencies and their 1,117 family therapists. The final phase consisted of site visits to a national sample of 36 drug treatment agencies that offered family therapy to recovering drug abusers. Structured interviews were conducted with staff members, and an evaluation form was completed by the project director and an accompanying task force member.

The information for the present study was taken from the responses of the sample population of 1,117 family therapists from a wide variety of treatment centers. In addition to the descriptive statistics, all data were subjected to a one-way analysis of variance to assess differences among types of treatment facilities, types of drugs used by the treatment population, and geographical regions.

RESULTS

Therapists were predominantly male (57.5 percent) and white (86.6 percent). Black therapists were more likely than white therapists to be working with heroin abusers at methadone maintenance clinics. In addition, more than 56 percent of the therapists were married, 17 percent had been married, and 5 percent were cohabitating. Only 9.4 percent of the therapists were former addicts; most of them were working in methadone maintenance clinics. Moreover, 60 percent of the therapists had graduate degrees at the master's or doctoral level; nearly 85 percent were college graduates.

Highly educated staff tended to work in traditional settings, while less educated therapists worked in therapeutic communities or methadone maintenance clinics. A total of 35 percent of the therapists were still in school, particularly those who were former addicts. In addition, 63.6 percent of the population studied reported having some specific family therapy training. Therapists had had a mean of 3 years experience in family therapy, with an average of 2 years in their present position.

In most instances family therapy was not the therapist's predominant therapeutic focus. The average monthly caseload of nonfamily cases was 20.3 (17.8 therapy hours weekly) compared to 8.4 family therapy cases (6-7 therapy hours weekly). Family caseloads were highest for polydrug populations and lowest for heroin addicts. Overall, only 4.5 percent of the therapists worked exclusively with families.

When asked to rank professional theories and theoreticians, therapists placed behavioral and learning theories first (41.6 percent), especially in the central and southern regions, small group theory second (41 percent), systems theory third (39.2 percent), and existential theory last. Polydrug clinics, community mental health centers, and outpatient clinics favored systems theory more than did heroin treatment programs. Therapists from the eastern and central areas were more likely to have a systems orientation than those from the West and South.

Virginia Satir was the most influential professional, especially for therapists working with polydrug populations, for community health centers, and for outpatient clinics in the South and West. Jay Haley followed Satir in popularity throughout all regions and drug populations. Murray Bowen was ranked lowest except in the East. Preferred techniques of family therapy were family tasks and role playing, with psychodrama and sculpting used least. Motivations for involvement in family therapy ranged from personal experiences and early exposure to family therapy to intellectual appreciation of the rationale behind family therapy and practical needs as perceived in actual experiences.

CONCLUSIONS

Although nonfamily therapies still take precedence over family therapy, these results show that family therapists are generally well educated and sophisticated in their rationale for providing family therapy. When this information is considered in conjunction with therapists' reported high educational levels, a new and more accurate perception of the professional who works with the families of drug abusers should emerge.

Coleman, S.B., and Stanton, M.D. An index for measuring agency involvement in family therapy. Family Process, 17(4):479-483, 1978.

DRUG	Multidrug
SAMPLE SIZE	1,617
SAMPLE TYPE	Drug treatment agencies and therapists
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Cross-sectional
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Progress Index for Family Therapy Programs
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	3

PURPOSE

Family approaches to psychotherapy have increased in popularity and breadth during recent years. Despite the growth of such therapy and training in it, there is much variability both in the extent of family therapy involvement by various agencies and in the sophistication of their programs. This paper presents an instrument for assessing the level of such involvement attained by a given program or programs. The instrument, called the Progress Instrument for Family Therapy Programs, is designed to determine the relative level of sophistication of family therapy treatment and training within an agency. Information provided by this instrument for assessing family therapy involvement in 500 drug treatment agencies is also reported on.

METHODOLOGY

The index evolved from a nationwide survey of 2,012 agencies providing some kind of treatment for drug programs. More extensive data were collected from a subset of 500 of the facilities that actually engaged in family therapy, including 1,117 of their therapists. While most of the 500 agencies primarily treated drug abuse, some dealt with other problems as well; for instance, 76 were community mental health centers. Items for the index were chosen by researchers and

professionals serving as advisers to the survey. This task force reviewed the various instruments used in the larger study and chose the most relevant items for inclusion. Each item was given a weighted score based on a consensus of task force members as to its relative value. All decisions to determine appropriate item weights were subjects to considerable discussion. Although the assigned weights were arbitrary, it was felt that certain items were better indicators of family therapy involvement and should be given more credit. One item's weighting was changed following use of the index. The final product of the development process was a 23-item index. The instrument's questions concerned the location of therapy, whether therapy was mandatory, the therapist's role, and the amount of training in family therapy of agency therapists. Other subject areas included therapists' experience levels, agency funding for family therapy training, and family therapy research activities.

RESULTS

An item analysis of the questions selected for the index revealed a reliability coefficient of 0.67, which indicated that the scale was composed of internally consistent items. Results of the analyses of the index scores for the entire sample of 500 agencies that treated families showed that the group's mean score was 18.5. The maximum possible score was 58. Results suggest that few drug treatment agencies have yet achieved a high level of sophistication with regard to family therapy. About one-third of the sample used live families in supervisory sessions. Only 24 percent of the sample used videotape equipment, which is generally found in advanced programs. Only 27 percent of the agencies had family therapy training budgets; only 4 percent were performing family therapy research. Over one-third of the agencies employed therapists with rather minimal family therapy training.

Examination of the 40 programs that received the highest overall scores showed that 18 were agencies that treated both drug abuse populations and other psychiatric populations. Of the 500 agencies, 40 required family therapy for all their clients; their range of total index scores was 15 to 52.7. Programs requiring family therapy were most often outpatient clinics or therapeutic communities. Structured interviews with agencies' staff showed no obvious differences between those requiring family therapy and those for which such therapy was optional. Neither the characteristics of the program nor the client demography proved to be significant predictors of a family therapy requirement.

CONCLUSIONS

The Progress Index for Family Therapy Programs provides a method for comparing levels of family therapy involvement among agencies such as those sampled. It gives a rough quantitative indication of what provision of family therapy entails. However, the instrument does not provide direct evidence of the actual effectiveness of the treatment given by a particular program; rather, the level of effectiveness is inferred from the reported levels of training and experience. The instrument's questions also apply to areas other than drug abuse. Thus, the instrument could be used to assess family therapy programs in mental health clinics and other settings or to determine an agency's progress in family therapy program development. It could also be used by a single agency to obtain a base rate of its own progress in expanding family therapy over a period of time. Overall, the index can help in discriminating between beginning and mature treatment programs. Further research and use of the instrument are recommended.

Davis, D.I. Family therapy for the drug user: Conceptual and practical considerations. Drug Forum, 6(3):197-199, 1977-78.

DRUG	Multidrug
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Families of abusers
AGE	Not specified.
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	0

PURPOSE

Results of a recent survey suggest that a large majority of programs offering drug treatment are using some form of family therapy. Staff of drug treatment programs not offering this approach express the desire for appropriate training in family therapy; staff of programs that have used family therapy favor continuing this approach. This article presents evidence supporting the view that family therapy is often the treatment of choice for abuse of both alcohol and other drugs. It also briefly presents the basic principles and strategies of family therapy.

METHODOLOGY

Interactions among members of substance abusers' families were observed in a clinical research setting. Principles and strategies of family therapy were developed from the work of the author and others.

RESULTS

Clinical observation seems to support the hypothesis that drug-using behavior serves a central function in the regulation of daily interactions between the drug user and significant others. For example, one young adult moved out of the home of an abstinent drug-dependent parent but returned immediately when the parent again used a drug. However, the functions of drug abuse are not necessarily the cause of the drug abuse pattern. Nevertheless, they become the source of powerful resistance on the part of significant others to any successful change in the drug-taking behavior of the substance abuser. This resistance is not malicious but is an automatic response that occurs most strongly when no new alternative to the former drug use is in sight. For example, if a drug-using parent is treated alone, it is common for that parent to start using drugs again or for some other severe symptomatic behavior to appear in another family member. If, on the other hand, treatment focuses on all family members' coping techniques and interrelationships, the decrease in drug-using behavior would soon become more acceptable to the family.

Several principles and strategies of family therapy have been found to be particularly useful with drug abusers. For example, the earlier the family is exposed to therapy the more likely family members are to cooperate with a family approach and the more likely the abuser is to stay in treatment. Furthermore, substance abusers and their families are among the most difficult of all psychotherapy patients to get to treatment. Repeated phone calls may be necessary but are worth the effort. Even if the abusers are not living with their parents, restoration or establishment of a traditional parent-child hierarchy around the issue of the irresponsible behavior that accompanies substance abuse is an important step. Without it, the abuser's further individuation from parents aborts and abuse is more likely to resume. Drug or alcohol abuse must be explicitly identified as the problem upon which all agree to focus. This identification often permits a shift in focus from the identified abuser to problems of others and then to interactions within the whole family. Encouraging change in the parents while focusing on the child is easier if the therapist relabels the family's concern about the abuser as positive and introduces tasks that show caring so that blaming ends and there is greater incentive to accept new limits.

CONCLUSIONS

If these essential family treatment considerations are applied with skill, they make family therapy particularly well suited to the treatment of many substance abusers. It is essential that control of therapy sessions be firmly established by the therapist, who is the sole authority through whom all drug-giving decisions are cleared. Results of the initial controlled studies of outcome of family therapy with drug abusers are highly encouraging. Results suggest that structural family therapy is vastly superior for treatment of heroin abuse in young adults to methadone maintenance clinic treatment alone. Results also show that family therapy often results in the abusers' abandonment of methadone and heroin, as well as their marked gains in social and work functioning. Continued research should support the growing use of family therapy for substance abusers and should confirm the initial positive impressions of family therapy.

Dell Orto, A.E. The role and resources of the family during the drug rehabilitation process. Journal of Psychedelic Drugs, 6(4):435-445, 1974.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Literature review; theoretical/critical review
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	37

PURPOSE

The paper outlines the effects on the family of crises, such as those arising from drug abuse, and describes therapeutic approaches applicable to families of drug abusers. Such families have become more reliant on external support systems to facilitate alteration of drug abusers' dysfunctional behavior as well as on internal modifications to meet crises. The helping professions must continue to meet the often difficult challenge of assisting these families to insure their survival.

SUMMARY

The Impact of Addiction

Families face similar financial and interactional adjustments whether coping with disability, alcoholism, or drug addiction. In all cases, the family is viewed as a necessary component in the process of rehabilitation. Through therapy for alcoholism, family members learn to understand the addiction and their responsibility in bringing on the condition. Meeks and Kelly emphasize the importance of a number of factors for intervention with families of recovering alcoholics. The family must understand the reasons for treatment of the entire family and should be

encouraged not to maintain a facade of harmony to mask family conflicts. The intrusive role of alcohol should be put into perspective and not negated. Games in treatment that obscure conflicts should be related to similar games at home; individual behaviors that reinforce family problems must be explored. The therapist and family should recognize changes wrought by shifts in family equilibrium and periodically assess these shifts. Family members should be helped to accept compromise and to apply problemsolving approaches. These principles can also be applied to the family of the drug abuser. Through awareness and implementation of these principles, the family can solve future problems by assuming responsibility for its own actions and monitoring its own dysfunctional behavior.

The intensity of the family's reaction to the condition of drug abuse can be related to the resources of the family. Because drug dependence may consume the drug abuser and create a sense of loss, failure, and helplessness, control of the situation forces the families to face the task of self-examination, self-exploration, and even self-incrimination as they attempt to define their own roles as causal factors. In general, family therapy with the drug-abusing person should avoid dwelling on failures and should emphasize what can be done now, as well as the impact of new behaviors on the future. Working with abusers' families is especially difficult because helping professionals frequently encounter a myriad of dysfunctional behaviors within the family that may be the result of the drug abuse situation or the cause of it. The therapist's task is frequently compounded by the limited ability of the family to function as a cohesive integrated unit while working toward mutual goals. The reestablishment of a functional, dissonance-free state within the family may require initial efforts on a basic level, such as attempting to open channels of communication.

Therapeutic Approaches to the Drug Abuser's Family

The family is a significant factor in changing a person's behavior. Before families can solve their problems, however, they frequently need family therapy to help them overcome their feelings of ineffectiveness. Various approaches to treatment may be used. Multifamily therapy promotes group interaction as a means of crystallizing critical problem areas masked by individual behaviors and of teaching basic coping behaviors. The family system approach requires that the therapist come to understand the drug abuser in the context of the family system. Once the abuser's interpersonal world is understood, treatment should be designed to reduce substance abuse, to build relationships, and to encourage community involvement of the family. Special efforts must be made to help spouses cope with the sense of role failure and loss during crisis periods. This may become a particular problem if the drug-free abuser disavows all decisions taken under the influence of drugs and denies responsibility for the family.

Home placement for the drug-abusing person is advisable when the family is unable to accept the demands being made on it and when removal from destructive environmental influences would benefit abusers. Residential drug treatment programs for adolescents and adults allow the drug-abusing person to demonstrate a willingness to change. This, in turn, may rekindle the hope of the family that the drug-dependent individual can and will carry through on earlier promises to rehabilitate. Family group therapy is vital at this point to temper the family's expectations with reality and to prepare them for the challenges ahead. Family support groups permit families to continue as contributors to the financial and material needs of the family member under treatment. The support groups and the family therapy groups provide an opportunity for a wide range of families to get to know each other, to work together, to learn from others' experience in solving problems, and to clarify the family position for the client. The family program in therapeutic communities is automatically extended to residents who have been disowned or have no families. In the typical residential program, a team of two professional and two paraprofessional therapists colead with multiple family group. One professional works with families and residents, the other works with just family members and the family as a group, and the two paraprofessionals work closely with residents. Together they explore selected issues that emerge.

CONCLUSIONS

The philosophy of family involvement during drug rehabilitation favors building on the family's assets rather than focusing on its limitations. Most drug abusers' families have serious problems that they do not know how to solve. When introduced to a model for assistance and to families with similar problems, abusers' families are reassured and revitalized. It is essential that such

programs emphasize accomplishment of present tasks for attainment of future goals instead of rehashing the pathological past. Therapeutic living arrangements are an opportunity to resolve family crises, to reintegrate the family unit, and to prepare the individual for self-sufficiency. The family is a potent force, both in the achievement of rehabilitation and in the elimination of obstacles to recovery. Drug-dependent individuals must not be detoxified and released only to discover that their families do not want them. When drug rehabilitation integrates the drug abuser, the family, and support services, a sense of community awareness and responsibility is created.

Fram, D.H., and Hoffman, H.A. Family therapy in the treatment of the heroin addict. 5th National Conference on Methadone Treatment, 1973 Proceedings, 1:610-615, 1973.

DRUG	Heroin
SAMPLE SIZE	Not specified
SAMPLE TYPE	Addicts in treatment and their families
AGE	Not specified
SEX	Both
ETHNICITY	Mostly white
GEOGRAPHICAL AREA	Washington, D.C.
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	2

PURPOSE

Examinations of drug addiction have often neglected the family and viewed the addict as a person alone, abandoned by the family, and long devoid of meaningful family contacts. Family treatment has, however, been useful in treating many kinds of psychiatric disorders and seems to be a useful approach to explore in developing a treatment program for narcotic users. This paper describes the authors' treatment program and presents case histories illustrating the characteristics of the families of addicts and the treatments used.

SUMMARY

The treatment program is a fee-for-service outpatient and inpatient facility that is part of a large private mental health center, the Psychiatric Institute of Washington, D.C. The treatment program includes group therapy, family therapy, and rehabilitation counseling. Families are largely white and middle class. Patients are an unrepresentative sample of the addict population. Although this sample might be expected to be healthier than the average, the family relationships of most of these patients are disturbed.

A number of family patterns have emerged. Typically, the families are in crisis. There have usually been protracted struggles with the deviant member, resulting in chronic turmoil and lack of meaningful relationships. Basic to the families' interaction is the issue of trust, as expressed both in lack of trust and in inappropriate maintenance of trust. Parents often act as police; such families become relatively stable as family members adapt to their "cops and robbers" roles. One such family unit involved an adolescent girl who had been doing poorly in school and had become involved in the drug scene. In treatment, the parents were freed of their policing responsibility, which was assumed by the program. The family members were then able to explore the background of their mutual difficulty in allowing the patient to mature and then became capable of relating with each other more appropriately. Inappropriate trust is illustrated by the case of two parents who focused much energy on their son's drug taking and long hair but were unable to face the more painful issue of their son's housebreaking activities. When the parents were able to acknowledge their feelings about their son's criminal activity and realize that trust would develop rather than being given automatically, their son was able to learn from the experience and further develop his conscience.

An excessively indulgent famly is reflected in the example of a parent who gave his son $45 a day so that he would not have to steal to obtain drugs. Another father cared for the addicted children and sabotaged whatever efforts they made to gain independence from him.

This middle class population also contains neglecting parents, who give too little gratification and seem not to care or be able to care for the addict. One adolescent male, who became involved in a criminal gang and addicted to heroin, had parents who made no attempt to become involved in his treatment or even to inquire about him. Treatment revealed that for much of his childhood his mother had been a severely depressed alcoholic and unable to relate to him. In other families, the addict was necessary for the maintenance of the family integrity; the addict's deviant behavior is the focus around which the parents' marriage stays together. In one such family, the parents, who were not living together, agreed to provide a home for their runaway and drug-abusing son. A pathological pattern was established, wherein the parents argued about how to handle the son while he used more and more drugs. Therapy revealed to the son his role in holding the parents together; when he stopped using narcotics and made plans for an independent life the parents recognized that they must make plans for themselves and decided to separate.

Another significant aspect of families of drug abusers is the number of parents who have considerable psychopathology, often expressed by alcoholism but also by severe neurotic or psychotic symptomatology. For example, one patient was presented for treatment, not because he was in a crisis, but because his mother was suffering from a severe anxiety neurosis, made more severe by the discovery of his addiction. In another family, both the father and the son had severe interpersonal difficulties and marked low self-esteem. Therapy revealed the extent of the son's identification with the father and enabled him to give up immediate gratification to avoid becoming like his father.

Another sort of family constellation is the couple in which one or both members is addicted. The nonaddictive partner may have a need for a devalued individual for a partner and reinforces the addictive behavior. In one such couple, the husband was helpful and supportive to the wife when she was despondent but became more dissatisfied as the wife stabilized and was discharged to outpatient care. Therefore, the husband's needs tended to maintain the patient's addictive behavior. Marriages of addicts are fraught with conflict--two persons who are incapable of trusting or being trusted are thrust into a relationship that by definition calls for trust. When issues are discussed openly, the marriage becomes extremely unstable.

CONCLUSIONS

In addition to having psychotherapeutic effects, family involvement often serves to educate parents about drugs and the drug world. Because the authors' program is only 18 months old, the relationship between family involvement and success in therapy remains unproven. However, clinical impressions indicate that significant changes have been effected in families involved in treatment. Preliminary results of the program indicate that families of addicts have patterns of disturbance that extend beyond mere reactions to the presence of the addict. Nevertheless, drug addiction is a multicausal phenomenon; it cannot be concluded that there are "addictogenic families." Regardless of the family's etiological role in drug abuse, understanding and helping addicts and their families is a worthwhile therapeutic endeavor.

Funk, M.J. Recidivism rate following a volunteer communication program for families with juvenile drug offenders. The Journal of Voluntary Action Research, 3(1):26-30, 1974.

DRUG	Not specified
SAMPLE SIZE	62
SAMPLE TYPE	Delinquents
AGE	Adolescents (mean: 16)
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Utah
METHODOLOGY	Experimental study
DATA COLLECTION INSTRUMENT	Court records
DATE(S) CONDUCTED	1972
NO. OF REFERENCES	2

PURPOSE

The reasons for drug abuse among adolescents are multifaceted, but chronic drug involvement appears to relate to family problems. In Utah, a family therapy program was founded to provide information about drugs and adolescent behavior to parents, to reduce family anxiety, and to stimulate family communication. Evaluations in 1970 and 1971 showed an improvement in family attitudes as a result of the program. In 1972, the program began using trained volunteers to lead small discussion groups. The present study reevaluates the success of the drug program in terms of recidivism rates and assesses the effectiveness of using nonprofessional volunteers as group leaders.

METHODOLOGY

The sample consisted of 62 teenagers who completed the 3-session series of the drug school program. A total of 47 of the subjects were male and 14 female. Subjects' mean age was 16. All of the subjects had been referred by the Utah Second District Court and were ordered to attend a program series during one of the months between January 1972 and August 1972.

The program involved three separate sessions at which attendance by the juvenile and the parents was mandatory. Sessions lasted 1-3/4 hours, and were held one evening a week. The first half hour was devoted to didactic presentations and the remainder of the time to small group discussions. Presentations by psychologists and a psychiatric social worker focused on general information about drug use and teenagers' behavior under the effects of drugs, psychological and social factors influencing drug use, and communication techniques. Volunteer-led discussion groups consisted of 10 teen-parent members, with no 2 members of the same family in any one group. At the third session, families were left intact for the last hour of discussion.

Recidivism data were obtained from juvenile court records. Three types of recidivism rates were tabulated for each subject for both the 9-month period prior to participation in the program and for a subsequent period of 9 months following completion of intervention. Data covered the total count of all offenses, an adjusted rate that excluded misdemeanor categories, and offenses involving drugs only. The three types of recidivism data were analyzed using t-tests. Offense severity was tabulated for before and after intervention.

RESULTS

The total number of offenses decreased 72.6 percent (124 versus 34) from the preintervention to the postintervention period. For total adjusted offenses, the mean number of offenses per juvenile dropped from 1.52 to 0.35. The number of drug offenses dropped by 86.8 percent, from 68 to 9. The greatest reduction in offense frequency occurred in middle range offenses (e.g., disturbing the peace, possession of alcohol, mischief or vandalism, and other behavior endangering welfare). All crimes in the most serious category were drug-related offenses. Additionally, comparing data on first offenders and multioffenders revealed a significant difference in decrease rates for the two groups: 90 versus 70 percent, respectively, for adjusted offenses, and 97 versus 81 percent, respectively, for drug offenses. The results are significantly different from those of the 1971 program evaluation, which showed a total offense decrease of only 45.3 percent and an adjusted rate decrease of only 46.5 percent.

CONCLUSIONS

The results of this study are consistent with the findings of earlier evaluations and suggest that volunteer group discussion leaders with appropriate training are at least as effective as paid professionals in dealing with juvenile drug offenders and lowering their recidivism rates. In addition, the data on recidivism rates for first offenders and multioffenders indicate that the arrest and court hearing per se may be an intervening factor in deterring arrests, but chronic offenders would appear less easily influenced than first offenders by the drug school programs and/or the arrest or court hearing. Finally, it appears that interventions involving efforts to improve and extend communication between family members may be an effective deterrent to adolescent drug offenses.

Haley, J. The process of therapy: A heroin problem. In: Haley, J. Leaving Home: The Therapy of Disturbed Young People. New York: McGraw-Hill, 1980. Pp. 194-220.

DRUG	Heroin; methadone
SAMPLE SIZE	1
SAMPLE TYPE	Family with addict member
AGE	Young adult (age: 25); mature adults
SEX	Addict: male
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Case study
DATA COLLECTION INSTRUMENT	Interviews; observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	0

PURPOSE

Three possible ways to begin therapy with the family of a problem young person are to have the parents deal with the young person jointly, to have the parents take turns being in charge, or to put the parent who is more peripheral to the youth's problem in charge of the youth. This last mode precipitates a reaction from the more involved parent, which brings out the marital issues. This paper describes a case in which the intervention placed the father in charge of the addicted son at the first stage of therapy, thereby beginning to disengage the mother from the son. The problem son had been a heroin addict for 5 years and had recently begun a methadone program. The case report is based on the film script of the therapy and includes verbatim conversation as well as a commentary.

SUMMARY

Initially, the therapist encouarged the son to express his despair about his parents' relationship and lack of understanding of his battle with addiction to help bridge the gulf between the addict and his parents. The therapist also had to take charge and organize action to permit change to take place. The goal of therapy was to draw a generational line at which the parents would hold

together in relation to the son to prevent either one from joining the son against the other. The father was first put into the middle of the intense relationship between the mother and the son, as the first step in the ultimate joining of the mother and the father. If the therapist had to object to what the parents were doing in order to change their behavior, he had to avoid implying that something was wrong with the parents' character. The mother was directed to communicate to the son only through the father, to encourage the father and son to talk together and to prevent the mother from becoming overly involved again. The therapist actively prevented the mother from interfering with this communication. By the end of the first interview, the therapeutic plan was set. The plan called for the father to deal directly with the son and the mother to deal with the father about the son's problems. The therapist had to be prepared to deal with the predictable increase in marital tension and the son's relapse to save the parents. The therapist's goal was to keep the family's focus on the problem it wished to solve: the addiction.

During the week, the young man improved until the parents fought, but for the first time the father became actively involved in stopping the youth from taking heroin. During the second week, the youth was detoxified and placed on a drug that would cause him to reject heroin, but this experiment was done without considering the therapy and it went badly. The therapist then attempted to shift the focus of therapy to the parents' marriage to bring about the second stage of therapy. He persuaded the parents that they would eventually have to give up their son and face the problems plaguing their marriage. Further interviews focused on the youth's job, school, and disengagement from the parents. As the parents and the son faced the issue of separation, it became more real to them and their improvement continued. Nevertheless, as the time of separation approached, the parents predictably developed conflicts with each other. The therapist met with the father and son to deal with the father's intense reaction to the son's leaving home. The therapy lasted for a few months, at the end of which the son moved out. Soon after the son left home, the parents separated. However, the son soon returned, and the parents were reunited. A few years later, the parents were still together and the young man was living at home. He had a responsible managerial job and had not used heroin for 2 years. After 4 years, the son was still off heroin and had moved to another State; the parents were still living together.

CONCLUSIONS

Family therapy was initially recognized as the best approach for schizophrenics; it has since been recognized as valuable for narcotics addicts only after research showed how closely most addicts were involved with their families. Once it was recognized that heroin addicts are enmeshed in their families, it became apparent that the therapeutic approach should systematically involve those families.

Hendricks, W.J. Use of multifamily counseling groups in treatment of male narcotic addicts. International Journal of Group Psychotherapy, 21(1):84-90, 1971.

DRUG	Narcotics
SAMPLE SIZE	85
SAMPLE TYPE	Addicts in treatment
AGE	Not specified
SEX	Male
ETHNICITY	White; Mexican-American; black
GEOGRAPHICAL AREA	California
METHODOLOGY	Survey--correlational
DATA COLLECTION INSTRUMENT	Program/clinical statistics
DATE(S) CONDUCTED	1967 and 1968
NO. OF REFERENCES	0

PURPOSE

The multifamily counseling group is one of the treatment methods used for residents of the California Rehabilitation Center, a Department of Corrections facility for the treatment and control of male narcotic addicts. An addict may enter the program voluntarily or may be committed following a misdemeanor or felony conviction, the proceedings of which have been suspended. An initial period of 6 months of inpatient treatment is required by law. Treatment involves vocational training, academic instruction, work assignments, recreation, physical conditioning, medical care, and intensive group treatment. Individuals may be released to outpatient status when the inpatient treatment process has progressed to a point at which it is believed that the individual should be given the chance to adjust in the community. After 3 drug-free years in outpatient status, the individual may be considered by the Narcotic Addict Evaluation Authority for discharge from his commitment.

This study's goal was to examine the outpatient performance of male residents who, as part of their inpatient programing at the center, attended eight or more multifamily counseling groups.

METHODOLOGY

A sample group of 85 individuals was chosen randomly (every third case) from the rosters of those attending 8 or more consecutive multifamily counseling sessions in 1967 and 1968. The rosters represented membership in 11 different multifamily counseling groups. The names and numbers of the individuals in the random sample were processed by the center's research section to determine the individual's status at the end of a 1-year followup period. Membership in each of the 11 multifamily counseling groups was limited to no more than 8 residents and their family members. Participation in multifamily counseling was voluntary. Legal wives constituted 61 percent of family members attending; parents, 16 percent; common law wives, 14 percent; fiancees, 6 percent; siblings, 2 percent; and other family members, 1 percent.

The sample group was 57 percent white, 36 percent Mexican American, and 7 percent black. Each of the 11 multifamily counseling groups was conducted by 2 staff members who functioned as cofacilitators or coleaders. The main treatment approaches used varied from group to group. Methods varied from supporting groups to those in which role playing and psychodrama were used significantly, to those that were conducted as psychoanalytically oriented group psychotherapy. Residents and family members participated for an average of 5.5 months; groups usually met for 1½ hours each week. A description of one group session illustrates the ways in which the groups functioned.

RESULTS

Of the 85 individuals in the study, 35 remained in outpatient status at the time of the 1-year followup. This 41 percent success rate compared favorably with the 1-year followup rate of 21 percent for all male outpatients released in 1967. Since most of the study sample were released to the Los Angeles metropolitan area, the 41 percent success rate also compared favorably with the 18 percent rate found in a previous study for those released in the Los Angeles area. Statistical comparisons of the sample to the total inpatient population, currently 1,900, showed that the sample was essentially similar to the total population. Indices used for comparison included the number of arrests, the existence of an arrest-free period of 5 or more years, number of jail commitments, existence of a family criminal record, alcohol involvement, work record, and prior living arrangements. The absence of black individuals in the success group probably resulted from the small number of blacks (six) in the total sample. Results also showed that 40 sample members had been returned to inpatient status at the of the 1-year followup, for a violation rate of 47 percent. Eight individuals had left supervision; one was discharged from his commitment; and one committed suicide.

CONCLUSIONS

Findings showed that those who experienced multifamily counseling made a more acceptable adjustment in outpatient status that did male outpatients not receiving this treatment. The selective factors involved in both residents and family members volunteering to participate in multifamily counseling groups and their probable higher motivation to overcome the addiction process probably influenced the results.

Hertzman, M.; Balsley, E.; Davis, D.I.; and Richmond, R. Alcohol and other drug-abuse by psychiatric inpatients: Treatment pursuant to a family contract. Contemporary Drug Problems, 8(1):73-81, 1979.

DRUG	Alcohol; multidrug
SAMPLE SIZE	2
SAMPLE TYPE	Psychiatric residents
AGE	43 and 33
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Washington, D.C.
METHODOLOGY	Case studies
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	6

PURPOSE

Treatment of psychiatric patients with drug problems has tended to be limited by attitudes of therapists. They emphasize the psychological understanding of individuals' drug problems and cite lack of motivation as the cause for treatment failure, even though the first causes of addiction are poorly understood and drug abusers may not be able to self-motivate. The study describes and evaluates the family alcohol drug contract system used at the Inpatient Psychiatry Service of George Washington University Medical Center, which has tried to adapt traditional psychotherapeutic approaches to deal with alcohol/addict treatment in new ways.

METHODOLOGY

George Washington University Medical Center's Inpatient Psychiatry Center treats a variety of psychiatric patients with severe problems. Each patient works with a primary therapist, but individual treatment plans are developed by a multidisciplinary team. Special attention was focused on problems of drug and alcohol abuse when both a survey and laboratory data revealed that dysfunctional alcohol and drug abuse was quite widespread in the psychiatric ward and even appeared to be normal behavior. Furthermore, those treating the substance users were unaware

of the use. With identified substance abusers, however, the staff had experienced difficulties in treatment. A series of negative experiences led to a search for alternative treatment methods, from which the family contract treatment technique evolved.

The family treatment technique is illustrated with two case studies; the first, a 43-year-old alcoholic executive, whose drinking problems proved to be related to the drinking and behavioral problems of his wife; and the second, a 33-year-old upper-middle class woman whose persistent alcohol, Lomotil, and Valium abuse was connected to her unhappy marriage.

RESULTS

A contract system has evolved in response to the search for a different approach to treating alcohol and drug abusers. The contracts are explicit statements of what the hospital will provide to the patient and the family of the patient and the ways in which the patient and family members are expected to participate in the treatment process. The contracts are signed before admission or as soon as the alcohol/drug problem is discovered. Contract provisions stipulate that the program will provide a range of therapeutic services and individually tailored treatment, and that the patient will actively participate in family evaluation and therapy, while following restrictions to encourage abstinence from alcohol and drugs. Noncompliance is considered breach of contract.

The advantage of such contracts is that they bind the whole family in treatment, which, as the examples show, is often the only way to get at the root of the problem. Participation in Alcoholics Anonymous and its allied organizations Al-Anon and Alateen is part of the contract process for family and patients. Patients can thus realistically continue treatment in the community as soon as they are ready to leave the hospital.

This approach proves problematic when there is no identifiable family member who is available or willing to participate in therapy; the program must then decide whether or not to treat patients on their own terms. There is also some question about whether such contracts are actually legally binding. Finally, the contractual therapeutic process has been criticized because such an approach is ostensibly one-sided and offers the patient no alternative. However, other programs are available, and patients have the right to leave this particular program if they do not like the conditions in the facility.

CONCLUSIONS

The use of family alcohol and drug contracts makes it possible for a psychiatric program to work with a group of patients who are often excluded from treatment. However, the relative efficacy of alcohol and drug contracts in comparison to other techniques or devices must be demonstrated by further research.

Hirsch, R., and Imhof, J.E. A family therapy approach to the treatment of drug abuse and addiction. Journal of Psychedelic Drugs, 7(2):181-185, 1975.

DRUG	Not specified
SAMPLE SIZE	47
SAMPLE TYPE	Families of addicts
AGE	Not specified
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Long Island, New York
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	24

PURPOSE

A number of studies have concluded that family disturbances are a major influencing factor in the life of the drug addict. Researchers have recognized that isolated concern with individual dynamics, diagnosis, and genetics has not been therapeutically effective in many psychological illnesses, including drug abuse and addiction. In this study, experiences of the North Shore University Hospital's Drug Treatment and Education Center (New York) with a family-oriented evaluation and treatment method for drug addicts are presented, and relevant characteristics of interaction patterns in addicts' families are outlined. The Drug Treatment and Education Center was founded in 1971 to evaluate and refer individuals with drug problems. Since then the program has expanded, adding a rehabilitation unit for short- and long-term individual therapy. A family session has been included as part of the intake evaluation process, which precedes treatment determination. The addict is thus assessed in terms of the total environment.

METHODOLOGY

Observations were based on the initial evaluation of 47 families of drug addicts as they presented themselves to the Drug Treatment and Education Center. Although part-families were seen in

addition to various family combinations, evaluation was limited to the total family during the intake process. Significant family members were told that their presence was mandatory.

RESULTS

The initial individual or family referral to the clinic centered consistently around a disruptive crisis in the family interactional balance. Crises included an arrest of the drug-using member; school problems; outbreaks of physical violence between family members; and in a few cases, an acute psychotic, depressive, or suicidal episode. The families studied generally had a multigenerational history of excessive alcohol use as a coping device and the use of psychotropic drugs to facilitate a decrease in parental anxiety. Future addicts had long been exposed to the use of chemicals in their families, and many parents actually furnished money to their addicted children for drugs.

In the families studied the addict member had the role assignment of parent. Sick members were consistently protective of parents and siblings, absolving them of any responsibility in the genesis of addiction. In the interest of balance the family reinforced that position; in one case, for example, the user's symptoms were retained as a means of denying the parents' chaotic marriage. To preserve family homeostasis the drug users could not relinquish their symptoms; leaving parents at home alone would be disloyal, but symptomatic improvement would amount to treason.

Study families were also characterized by high expectation levels of parents for children, probably as a result of the parents' own needs for self-esteem. Repeated parental messages stressing the children's worthlessness seemed to be a projected image of their own childhood years. The addicts always fell short with both parents and peers, and drugs were used to relieve a faltering self-esteem system and depression. Because of underlying feelings of worthlessness addicts were initially almost mute; with hanging heads they anticipated rejection by family and therapist. This image was invariably questioned by the whole family after the initial session because other conflictual areas and dynamics were dramatically exposed.

In one case studied, a successful father bolstered his self-esteem by making parasites out of people to lessen his guilt for his undeserved success. His daughter soon assumed the role of his protector against the criticism of her mother. The daughter's addictive symptoms served as an antidepressant for her father, allowing him to be the good guy-rescuer. Not until group therapy did the longstanding marital conflict and the mother-daughter rivalry surface. In this, as in most cases, the family was tremendously relieved to be able to deal with longstanding problems by relating to each other openly. Even one family session helped such families evolve new ways of looking at themselves and others.

Initial family sessions set the tone for further intervention. The therapist emphasizes that families can make themselves into a viable unit by improving their powerful interactional processes. According to this approach, entrenched role assignments can be changed by understanding how messages are transmitted and received by family members. The family system can be modified by translating constructive assertiveness into action. Family therapy is painful but can eliminate reruns of the same old problems; families and therapists need only identify the significance of symptoms or messages transmitted by family members.

CONCLUSIONS

The approach of family therapy shows promising results, especially when addicts' depressive symptoms are also treated with tricyclic antidepressants during methadone treatment. Further research on the family process as related to the evolution and treatment of addiction is needed.

Huberty, D.J. Treating the adolescent drug abuser: A family affair. Contemporary Drug Problems, 4(2):179-194, 1975.

DRUG	Multidrug
SAMPLE SIZE	Not specified
SAMPLE TYPE	Adolescent abusers and their families
AGE	Adolescents; mature adults
SEX	Not specified
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Literature review; clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	14

PURPOSE

Drug abusers' activities result in the full or partial neglect of other personal goals, interests, and beliefs, as well as the neglect of social and family responsibilities. Drug taking becomes primary, and goal-directed behavior becomes secondary in the abuser's life. This behavior contrasts with the occasional recreational forms of drug use, which may be considered normal behavior for experimenting adolescents. However, just as any form of alcohol consumption is pathological for the alcoholic, any form of drug intake is pathological for the drug abuser and has serious implications for the abuser and the abuser's family. This article focuses on adolescents who are at the stage of pathological drug taking with accompanying self-destructive behavior. It discusses treatment of the adolescent as a matter for the entire family.

SUMMARY

The adolescent's family is the family of origin and includes parents and siblings. A psychoanalytic framework of personality development would include the family of origin as the main ingredient in personality development. Much material on narcotic addiction documents the family's unhealthy involvement in the addict's life. Various studies have characterized addict's families

as having open hostility, divorce, desertion, an immature mother, and an emotionally absent father. This type of family inadequately prepares youths for healthy emancipation, for it fails to instill in addicts the motivation for building their own family groups. The family picture is similar in most cases of delinquency but seems to be even more marked in regard to addiction. As the basic socializing unit, the family is the basis for good or poor emotional health.

Adolescence is a crucial state. The conflict of loyalties to family and to peer plus the normality of experimentation account in large part for the epidemic of drug usage over the last 5 or 10 years. Since the 13- to 17-year-old drug abuser usually returns to the family of origin even after treatment in a residential center, it is imperative to bring the family into treatment to prevent its maintaining the drug abuse behavior as part of the interactional system of family stability.

All families are guided by a rational desire for stability; drug abuse and the behavior that accompanies it may become part of the family's equilibrium. Without family treatment, the family will usually sabotage the efforts of the treatment staff. Moreover, effective treatment of the drug abuser must deal with the cause and not just the symptoms of abuse. The family is characterized by circularity of causality, which means that the drug abuser and the family members share similar or even identical problems. Once the counselor has identified specific problems in the adolescent drug abuser, the counselor may safely assume that a similar problem or complement of that problem exists within the family unit, particularly with the parents.

Specific mutual interaction problem areas may exist, although their specific nature may vary from family to family. One problem area is ignorance of the effects of specific drugs and of the process of becoming dependent on mood-altering chemicals. Both adolescents and parents do not realize the potential contribution of drug abuse to behavioral and other problems. Thus, treatment must include factual, academic information on the effects of drugs, the process of chemical dependency, and the process of rehabilitation. Quite separate from intellectual ignorance is emotional denial of chemical dependency. A nearly universal characteristic of denial is compartmentalizing, especially of the fact that alcohol is a mood-altering chemical and is also a potential drug problem. Family members often encourage the abuser to change drugs rather than to stop using them. Once they understand chemical dependency, drug abusers are often ready to accept the possibility that alcohol is also a problem.

Another shared problem is failure to accept responsibility. Drug abusers tend to project most of the blame onto their parents without accepting ultimate responsibility for their own behavior. Parents also project blame onto their children without examining their own role in the relationship. Because parents and drug abusers often find external explanations for the identified problems, counseling must help individual family members to accept their own problems, thus permitting drug abusers to experience the consequences of their actions. Still another problem area is the repression of anger and hostility and avoidance of all strong emotional expression, including expressions of love. The simultaneous existence of hostility and love is one example of ambivalence found in both drug abusers and their families. Ambivalence should be viewed as normal vacillation in the testing of new relationships as the family unit undergoes change.

Dishonesty in the parent-child relationship is also a problem area. Families have adapted to their adolescents' dishonesty by relating to them in a dishonest fashion. Drug abuse by parents is also a major role model for adolescent drug taking. A high proportion of adolescent drug abusers come from families with a history of identifiable alcoholism or some other form of substance abuse. The possibility of active parental alcoholism must be openly confronted during treatment.

CONCLUSIONS

Treatment can explore these interlocking problem areas and work toward helping patients and their families understand them. Learning to understand the mutuality of these problems and to accept one another as individuals is the heart of the treatment effort. This knowledge can lead to adolescents' emancipation and growth toward independence, which can then permit their healthy return to the family as adults. During treatment, family communication patterns are identified, clarified, and faced. Each family has rules to govern its stability. Since most family rules are implicit rather than explicit, one goal of family therapy is to make implicit rules more explicit so they can be dealt with more directly. Counselors must also deal with family members' resistance to change and must consider treatment a family affair.

Huberty, C.E., and Huberty, D.J. Treating the parents of adolescent drug abusers. Contemporary Drug Problems, 5:573-592, 1976.

DRUG	Multidrug
SAMPLE SIZE	Not specified
SAMPLE TYPE	Parents of adolescent abusers
AGE	Mature adults
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	15

PURPOSE

Although much literature on family dynamics and family treatment for the chemically dependent individual considers specific drugs, more recent literature deals with the broader concept of chemical dependency in general. Family dynamics, family pathology, and family treatment have essential similarities as they relate to the various addictions. Treatment programs usually encourage the spouse and children of the drug abuser to seek help primarily for their own sake and only secondarily, if at all, for the ultimate help of the chemical abuser. The emphasis is on a "positive selfishness" aimed at the family's own emotional health and well-being.

This paper describes the theory and treatment involved in a parents' survival group for the parents of the adolescent chemical abuser. Treatment is designed mainly for the parents and for the rehabilitation of the marital relationship, which is a unique relationship separate from the other family roles that the couple performs as father and mother. This relationship tends to be ignored whenever there are serious problems with a child.

SUMMARY

As a unit, the family is guided by a rational desire for ongoing stability. As the drug abuse becomes more serious, the family puts increasing amounts of energy into coping with the situation. The pressure on the family is for constant emergency living as the drug abuse progresses. The drug abuser and the parents develop a unique kind of interactional pathology in that drug abuse may fulfill unhealthy marital needs. The drug abuser may become a wedge that splits the parental structure and the marriage relationship. The conflict does have the potential, however, of becoming a constructive crisis in the marriage. Unfortunately, parents tend to deny such a conflict and try to maintain the facade of a good marriage. Because their sole emotional contact with one another is one of conflict, they develop a strong psychological investment in maintaining that conflict. Because the family roles become firmly entrenched and highly resistant to change, treatment for chemical dependency often requires moving the "patient" from the family unit to an inpatient treatment facility where new behavioral patterns may be learned away from the reinforcing domain of family expectations, sanctions, and equilibrium.

Based on this awareness of the effects of drug abuse on family dynamics and the marital relationship, a parents' survival group was formed to help restore the marriage relationship. This group was separate from any family therapy that included the drug-abusing adolescent. The group was designed as an education/therapy group in which parents' initial reason for attending was to help their child. Parents soon discovered, however, that their main goal was survival of the marriage relationship. Goals of the sessions were to provide a positive and enjoyable professional therapeutic experience and to start building marital communication and the mutual support needed for the marriage to survive and improve. These goals were accomplished through didactic presentations of information on chemical dependency and family dynamics, an interview demonstration of a family constellation, and a number of techniques of confrontation and support. The didactic material was used to present background information and to help define the group setting as being a conscious combination of education and therapy. Three primary lectures covered the disease concept of chemical dependency, the effects of chemical dependency on the emotions, and the five phases of a marriage (romance, disillusionment, despair, growth, and maturing love). These didactic presentations were emotionally safe and helped parents understand what had become a disorganized chaotic issue of chemical dependency, family crisis, and near disaster for the marital relationship. In addition, the demonstration interview on family constellations helped parents understand each person's role within the family and the influence of parental values on the family. Confrontations had the goal of helping parents face their systems of denial, their ambivalence and resulting inconsistency toward their children, and their own drug abuse. The most important support technique used was encouragement. Other support techniques included conscious teaching of communication; "permission-giving," which allows parents to express their feelings freely; and such homework assignments as making an appointment to have private time alone together. Use of two therapists who are married to each other provided a model of a couple who have had and continue to have solvable problems. The groups also provided marriage evaluation and referrals of couples or the entire family for more intensive therapy.

CONCLUSIONS

The parents' survival group, using a therapist-couple and focusing on the marriage relationship, seems able to restore the priority of the marriage relationship in relation to concern over the drug abuser. The group provides a parental support system that many couples have used separately from the group meetings. It also provides many couples with a recreational night out where they can share with other parents the pain and growth from this family crisis. By sharing their hurt, couples gain the chance to share the joy and hope of growing back together as a couple and helping their child to progress.

Kaufman, E., and Kaufmann, P. Multiple family therapy with drug abusers. In: Kaufman, E., and Kaufmann, P., eds. Family Therapy of Drug and Alcohol Abuse. New York: Gardner, 1979. Pp. 81-93.

DRUG	Not specified
SAMPLE SIZE	Over 40
SAMPLE TYPE	Addicts and their families
AGE	Not specified
SEX	Not specified
ETHNICITY	Cross-cultural
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	13

PURPOSE

Multiple family therapy is a technique that is particularly useful for drug abusers and their families. The structure of multiple family therapy groups and treatment techniques are described and illustrated.

METHODOLOGY

The typical multiple family therapy group examined consisted of 10 families and 3 therapists, for a total of over 40 individuals. Several of the families received intensive attention and the other participants sought to identify with their problems.

RESULTS

Group Composition and Environment

Residential therapeutic communities lend themselves best to multiple family therapy. Identified patients are already drug free, and participation of family members is considered vital. Groups may include all the families in the therapeutic community or several well-matched families; 40 to 50 individuals may be involved. Relatives, friends, and lovers are all included if they are important members of the addict's network and are drug free. Families should be interviewed and oriented before entering the group. A family map should be made and individual family counseling provided as needed. Within the group, families share experiences and offer help by acting as extended families to each other and to the residents outside the therapy sessions.

The group is seated in a large circle with cotherapists distributed at equal distances to provide observation of the total group. Families sit together, and their seating arrangements are carefully observed, as they usually follow structural patterns. Initially, group members introduce themselves and one group member describes the purpose of the group, stressing the need for open communication and for changing the family forces that have led to drug abuse. The first family receives attention for about an hour; the conflicts discussed with the first family set the tone for the entire group. Three or four families are treated every session, and almost all families participate orally. Informal contacts before and after group sessions are crucial to therapists' confirmation of insights gained during therapy.

The Therapeutic Team

The team consists of a primary therapist experienced in group and family therapy as well as several cotherapists involved in the treatment program. Cotherapists should work together as a unified team leaving room for individual differences. The therapist becomes the paternal/maternal figure for the whole group of families, at the same time acting as their child. Therapists must be involved yet objective. While being supportive, they must interrupt any destructive communications.

Family Dynamics and Techniques

Techniques used are those most familiar to the treatment system. Common bonds are built among the families through shared grief and isolation feelings arising from the crisis of addiction. An initial period of ventilation of anger and resentment may be necessary before strategies of change can begin. The role of the family in perpetuating drug abuse, patterns of mutual manipulation and coercion, and scapegoating tendencies must be identified. Parents must be given support to reduce their sense of guilt. The family therapy sessions help residents actualize insights about their families that they have gained in individual treatment. Frequently, the identified patient acts as the barometer of the functioning of the total family. Physical expression of emotions and shared activities are sometimes recommended to strengthen weak ties between family members. Therapists must focus on dysfunctional communications, delineate individual boundaries, make underlying meanings explicit, and assign tasks to family members to promote individuation. Specific techniques that may be effective are psychodramas, "empty chair" discussions (i.e., discussions of family members who are absent), and family sculpture. In the later phases of multiple family therapy, families are likely to express mourning responses and family secrets. At this stage, the family and patient can be separated for advanced treatment on an individual family level. Videotapes can also be used to confront family members with emotions that are denied.

CONCLUSIONS

While literature on the specific use of multiple family therapy with drug abusers is sparse, results of studies to date suggest that multiple family therapy more successfully reduces recidivism rates than does individual treatment. Most multiple family therapy participants tend to be enmeshed middle class Italian, Greek, Irish, or Jewish families. In many cases, the treatment goal may be restoration of family homeostasis, while in others the goal might be to establish distance between family members. On the whole, multiple family therapy is viewed as a technique that reduces the incidence of premature dropouts from treatment, acts as a preventive measure

for other family members, builds a subculture to serve as an extended family, and supports family changes conducive to drug-free living.

Klimenko, A. Multifamily therapy in the rehabilitation of drug addicts. Perspectives in Psychiatric Care, 6(5):220-223, 1968.

DRUG	Not specified
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Drug addicts; families of drug addicts
AGE	Not specified
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	New York
METHODOLOGY	Not applicable (descriptive study)
DATA COLLECTION INSTRUMENT	Not applicable
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	10

PURPOSE

The Samaritan Halfway Society in New York provides a program of multifamily therapy for drug addicts and members of their families. The society, a voluntary agency dedicated to the rehabilitation of drug addicts, holds joint family-addict sessions conducted by two cotherapists. Among its other services are individual counseling; all-addict group therapy; psychological testing; medical consultation; and liaison work with courts, prisons, hospitals, and other agencies. All of the services are free and are used by both white-collar and blue-collar clients. This article presents a description of the society's multifamily approach to drug abuse therapy.

SUMMARY

The inclusion of family members of drug addicts in a group therapy program is unusual, if not unique. Most references in the literature on multifamily therapy pertain to therapeutic efforts on behalf of disturbed children of schizophrenic persons. It is believed that supporting the family as a total unit is an important element of the society's program in that previous research has reported that successful efforts to break the drug habit are directly related to family cohesiveness. Moreover, the "hangups" with relatives and friends observed in the multifamily

therapy group may indicate that drug-addicted persons are intensely involved with the significant people in their lives. This observation is in direct opposition to Brill's view that the addicts he worked with seem unable to maintain sustained relationships.

The multifamily therapy program welcomes not only the relatives of the drug-addicted person being treated but also their girlfriends, roommates, and friends. No limits are set on the number of family members who may attend the sessions. The size of the group ranges from as few as 7 people to as many as 30. Moreover, attendance of families is entirely voluntary, although efforts are made to encourage attendance. Meetings are held on a weekday evening so that working family members can attend. This is done to avoid limiting the group to drug addicts and nonworking relatives, such as mothers, since the addict may have serious difficulties with other relatives as well.

The two cotherapists who conduct each session are a formally trained psychiatric nurse and a nonformally trained ex-addict. The therapists also differ with respect to sex, race, age, and life experiences, although they share an aggressive attitude toward the treatment of drug addiction, enjoy people, and derive great personal satisfaction from responding to them.

The major theoretical framework for the program's approach was outlined by Laqueur, who developed the scientific basis and techniques for multifamily therapy with hospitalized mental patients. Laqueur's objectives are to improve communication between all family members and to help them gain a better understanding of the reasons for their disturbing behavior toward each other. The program has adopted these objectives, but has tailored its approach to the special features of the families of drug addicts, because statistical comparisons have shown that these families exhibit significantly less cohesion or "togetherness" behavior than average families. Families of drug addicts have serious problems controlling behavior potentially dangerous to family functioning, such as nagging and prolonged isolation. Moreover, the cotherapists have observed that anomie is typical of the addicted member but not of the rest of the family.

The sessions are held once a week and last 1½ hours. A large room is used, with comfortable chairs preset into a circle. Group members are allowed to sit wherever they wish, can leave the room to visit the vending machines at any time, and generally can discuss whatever topics appear relevant to them. Whatever the topic, the message conveyed is that the families as functional, productive units are disorganized, and that recognition of this fact can be the first step toward reorganization. Thus, technical discussions about drugs or addiction are discouraged, and attempts are made to refocus the conversation on relationships between family members. The emphasis on the idea that drug addiction is only one symptom of disturbed family functioning has apparently been successful, since some families attend despite the absence of their addict member.

Group members are encouraged to speak openly and explicitly and to discuss known, observable data using any vocabulary they choose. Acting out harmful impulses is not permitted, but group members are free to verbalize their hostile feelings. A major effort is directed toward promoting communication within a family, and each member of the family is asked to assume his or her share of the responsibility for family dysfunction. The families are helped to see their similarities and differences and to learn by identification or analogy. The more troubled families are encouraged to use the healthier families as models in adapting to other ways of relating.

The cotherapists serve as role models in that these families need to witness two or more people with differing personalities discuss and collaboratively work together. This process is helpful to the therapists themselves as are their postsession discussions in which observations are shared and interventions challenged.

CONCLUSIONS

The work done in the multifamily program has generated ample evidence from which to generalize that family disturbances are a major influencing factor in the life of a drug addict. Thus, improving family mental health can be a major approach in treating drug addiction. Moreover, contrary to therapists' expectations that families would be difficult to treat and that work with them would interfere with the counseling of individual drug addicts, the therapists found the families to be cooperative and willing to take action to change their life patterns. Therefore, by focusing on the family and family problems, the Samaritan Halfway Society is exploring a vitally important factor in drug addiction and its treatment.

Noone, R.J., and Reddig, R.L. Case studies in the family treatment of drug abuse. Family Process, 15(3):325-332, 1976.

DRUG	Multidrug
SAMPLE SIZE	323
SAMPLE TYPE	Addicts in treatment and their families
AGE	Adults (mean: 24.4)
SEX	Not specified
ETHNICITY	White
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Case studies; clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	5

PURPOSE

Although drug abusers are rarely portrayed as loyal family members, the present study seeks to show that the deviant, asocial, and alienating behavior of the addict is in congruence with the family's unique internal organization, perception of reality, and emotional balance of the family's social operations. The authors have found that a majority of drug abusers maintain close family ties and a majority of their families are willing to participate in treatment.

METHODOLOGY

The author's observations are based on work with 323 clients of a community mental health center. Clients varied in age from 14 to 83 (average 24.4). They were predominantly white and from the low and middle classes. Drugs abused were opiates, 36.8 percent; barbiturates, 18 percent; stimulants, 12.5 percent; and polydrugs, 32.6 percent. Of the total client population, 62.5 percent lived with their families, 10 percent had lived with their families within the past year, and 17 percent lived with spouses. Three case studies illustrate the different variations of family problems and of treatment.

RESULTS

In general, the population of clients and their families have a difficult time moving beyond the stage in the life cycle when the young become independent of their parents. Often other siblings and grandparents in these families become involved in the emotional tug-of-war. Getting stuck in this developmental stage implies a protective maneuver on the part of the family to defend itself against further stress. When anxiety due to threatened separation and individuation becomes intolerable, the drug abusers frequently offer their "problem" to the family as a means of avoiding separation and shifts in the family's structure. Family and individual stress thus become concretized in the form of drugs.. Drugs enable abusers to remain both highly dependent and rebellious, thereby blurring the lines of separation and providing a scapegoat to blame for the stress. Moreover, the family and individual frequently engage in mock separations (e.g., overdoses) to strengthen loyalty bonds.

Three variations of these patterns are illustrated in case studies. In the first case, a 24-year-old youth's drug abuse is shown to be an intensified expression of loyalty to the family system, especially the mother. When the youth's initial drug abuse provoked rejection, he intensified his behavior to demand the attention he needed. Treatment did not bring about change until the addict was permitted to express his dependence to his family openly and to demonstrate his affection for both parents. The second case exemplifies multigenerational involvement of a number of drug abusers from the same family. Because drug-related problems held this family together, the issue of separation was avoided. Therapy focused on other types of problems to relieve anxiety and to enable family members to assess their situation realistically. In the third case, drug use by a 15-year-old boy served as a buffer for the family against the impending death of the mother from cancer and illness of the father. The son's delinquent behavior permitted other family members to focus on his problem rather than dealing directly with the underlying cause. Treatment involved placing the son's drug abuse in its proper context and evoking the family's expressions of anticipatory grief over impending losses.

CONCLUSIONS

Drug abuse is governed by primary family loyalties and is most effectively treated when these loyalties are taken fully into account. In most cases, the condition indicates a problem in the developmental cycle of the family and fears of family members about endangered stability. Family treatment of drug abuse requires that therapists affirm family loyalties and facilitate constructive expressions of these loyalties. Therapy may involve resolution of grief transmitted through several generations, resolution of separation anxiety, and clarification that personal autonomy does not exclude loyalty. The elements of loyalty in drug-abuse behavior often provide the context and the resources for beneficial change.

Polakow, R.L., and Doctor, R.M. Treatment of marijuana and barbiturate dependency by contingency contracting. Journal of Behavior Therapy and Experimental Psychiatry, 4:375-377, 1973.

DRUG	Marijuana and barbiturates
SAMPLE SIZE	2
SAMPLE TYPE	Married couple
AGE	21 and 23
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Case study
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	8

PURPOSE

The study illustrates the use of contingency contracting and behavioral rehearsal as a treatment of outpatients dependent upon marijuana and barbiturates. Treatment is based on a counterconditioning model in which low frequency behaviors incompatible with habitual drug behaviors are accelerated. The approach assumes that the drug user lacks the social and interpersonal skills necessary to develop sources of reinforcement outside those provided by drug usage.

METHODOLOGY

Study subjects were a 21-year-old man and his 23-year-old wife, both of whom were on a 3-year grant of probation for possession of marijuana. The husband had an extensive record for drug possession and sales; this was the wife's first offense. The wife had not been involved with drugs before meeting her husband, and her use pattern entailed only minimal use of barbiturates and occasional marijuana smoking. In contrast, the husband's behavior had deteriorated to the point at which he was using marijuana and barbiturates every night, could not hold down a job, and was allowing his drug use to destroy his marriage.

The subjects were seen weekly for 1-hour sessions over a 9-month period. The initial six contacts were used to ascertain the contingencies involved in their drug use, behavior potential for prosocial activities, and sources of possible reinforcement for nondrug activities. Behavioral analysis determined that the wife's efforts to reduce her husband's drug usage were actually reinforcing stimuli for this behavior. The husband had deficits in social and interpersonal skills and needed to strengthen social behaviors alternative to drug usage. The wife was to serve as a major source of reinforcement for nondrug activities.

At the seventh session, a contingency contract that specified one nondrug-related activity per week was drawn up between the therapist and the clients, the completion of which would result in a matching week off the total probationary grant. The wife contracted not to mention her husband's drug use and to react positively to his expressed desire not to use drugs and to his attempts to find employment. The husband agreed to start looking for a job on a 4-week contractual sequence. Job finding was reduced to small increments of easily manageable job procurement behaviors. The four phases included (1) looking through want ads; (2) looking through want ads, selecting possible jobs, and making contact with employers to gain further job information; (3) going through the same process to the point of setting up interviews; and (4) attending interviews. Reinforcement was contingent on performance of the behaviors in the specified stage. After the husband had found employment, probationary time off was granted both partners. The demand was increased to two nondrug activities a week at the 14th session, to three at the 20th session, to four at the 24th session, to five at the 26th session, and to seven at the 28th session. At each contracting session any problems deriving from nondrug activity were discussed and behavioral rehearsal was used to anticipate novel future activities planned.

During the 20th week the subjects began to participate in group training to develop social skills and to provide further reinforcement for nondrug activity. The group concentrated on rehearsing social and interpersonal situations and furnishing feedback on each group participant's performance. Both clients reported at group sessions that their marriage was improving. At the same time the therapist began to assist the husband and wife in forming their own contracts. This contract was to be maintained for 6 weeks during which the couple were urged to negotiate and contract for any behaviors that they desired in the other. At the end of this 6-week period they were dismissed from probation.

RESULTS

The couple had not had new violations for the 9-month contract period, and the husband maintained employment for the last 7 of the 9 months. Followup contacts at 3, 6, and 12 months after the contract period revealed that no drugs were being used, the husband was still employed, and no marital difficulties had occurred. Police and court records showed no further arrests or suspicions of involvement in drug activities.

CONCLUSIONS

The results of this study cannot be generalized to all drug dependencies or environmental settings, but they do suggest that a combination of behavioral techniques can be effective in the treatment of drug dependency in the natural environment. The methodology merits further study.

Schwartzman, J., and Bokos, P. Methadone maintenance: The addict's family recreated. International Journal of Family Therapy, 1(4):338-355, 1979.

DRUG	Methadone
SAMPLE SIZE	100
SAMPLE TYPE	Addicts in treatment and their families
AGE	Young adults; mature adults
SEX	Both
ETHNICITY	White; black; Latino
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	32

PURPOSE

Since its development in 1967, methadone maintenance has become widely used for the treatment of heroin addicts in U.S. drug rehabilitation centers. However, more recent research establishing the importance of lifestyle and social context rather than a biochemical deficit to explain addiction has placed the effectiveness of methadone treatment in question. The present study investigates both drug addicts' family relationships and the conflicts between professionals and paraprofessionals that negatively affect methadone treatment results.

METHODOLOGY

Study information derives from observations of 4 methadone outpatient clinics, which are part of a State drug treatment system, and from work with more than 100 families, each with an addicted member. Methadone clients were at least 18 years old, had experienced at least 2 years of opiate use, and had twice tried to detoxify unsuccessfully. The clients of three of the four clinics observed were about one-quarter Latinos, one-quarter inner-city blacks, one-quarter working-class whites, and one-quarter middle class whites; each clinic had about 110 clients. The fourth clinic had about 40 clients, almost all of them white and from either the working class or the

middle class. Two-thirds of the clients in all the clinics were male. The clinic staffs consisted of a director, an assistant director, and a medical director; 2 to 10 paraprofessionals, frequently ex-addicts, provided most of the therapeutic input with clients. Initially clients were required to pick up methadone doses daily and to give a weekly urine sample; after several months, they could pick up several days' dosage at one time. Some facilities also required weekly attendance at family, individual, or group therapy sessions.

RESULTS

Addicts' Families

A significant context for most addicts is their family. Addicts' natal families are often marked by longstanding dissonance between the parents, resulting in a covertly hostile relationship. One parent, usually the mother, is extremely protective of the addict, while the other, usually the father, is distant or hostile. Often the parents blame one another for the addict's problems and undercut one another's attempts at setting limits. Lack of control appears to be a core concern, manifested most pervasively by addicts' inability to control themselves and their parents' inability to constrain them. Whether abstinent or using drugs, addicts are treated as weak and incompetent. Addicts soon learn that they are most successful when out of control, and their depression over feeling responsible for their parents' problems increases drug use. Addicts' competence is limited to drug-related skills that allow them to remain involved in their family of origin while avoiding anxiety. Parents who set only pseudolimits underscore both the addicts' need for constraint and its impossibility. Furthermore, addicts remain overinvolved with their natal families and can separate only by means of drugs, which eventually results in increasingly serious drug-induced crises and in either addicts' rescue by their parents or incarceration.

Methadone clinics are often characterized by structural dissonances analogous to those addicts experience in their natal families. Perhaps the most troublesome grouping at all levels of the methadone treatment system is the triangle formed by the clients' family or overinvolved parent, the client, and staff members at the clinic. A difficult situation is created as the client stops using illegal drugs and becomes less of a problem for the family. The result is an attempt at self-correction in which the overinvolved parent tries to undercut treatment or constraints on the client.

The Methadone Maintenance System

There is wide variation among staff members and clinics concerning goals, particularly regarding methadone maintenance as contrasted with abstinence, and the degree to which maximum goals are encouraged and minimum goals tolerated. The process of treatment and the means of changing clients' behavior are also sources of dissonance. While paraprofessionally run clinics work to change clients through counselors' relationships with clients and seek only to keep clients off the street, professionally run clinics emphasize constraints as part of treatment and the need to increase clients' responsibility by requiring prompt payment of bills and attendance at therapy sessions. In clinics with both professionals and paraprofessionals, attempts are frequently made to set limits on some aspects of clients' behavior. In the clinic, as in the natal family, the situation validates for addicts their own lack of control and a perception of a social world without constraints. Clients often seek allies in paraprofessionals with whom professionals are in covert conflict. Responding to such clients' needs can be so draining that counselors become frustrated, exhausted, and even readdicted themselves, while professionals and experienced paraprofessionals alike withdraw behind bureaucratic procedures and other protective mechanisms. The dissonances in ideology, status of paraprofessionals, and beliefs about addiction create more inclusive analogs to addicts' families. The situation is maintained by the flow of clients and paraprofessionals among clinics, and treatment becomes a function of the social system rather than psychotherapeutic considerations.

CONCLUSIONS

A perverse triangle characterizes the families of many drug addicts. Addicts are caught between overprotective mothers who prevent their individuation and distant fathers. Within this family system, addicts are rewarded by being out of control and receive few needed constraints. The interaction patterns of addicts with their natal families are projected onto other situations,

particularly methadone treatment programs. The dissonances between paraprofessionals and professionals and between differing schools of thought on treatment invite drug abusers to behave in treatment as they do within their natal families. The "treatment" itself thus recreates contexts in which addicts validate basic negative premises about themselves and their social contexts. Despite recognition by some researchers that resolution of the perverse triangle in the family is by far the most effective therapy, methadone therapy is continued because of the basic premise that addiction is a disease treatable through a positive relationship with a counselor.

Schwartzman, J., and Kroll, L. Methadone maintenance and addict abstinence. The International Journal of the Addictions, 12(4):497-507, 1977.

DRUG	Heroin; methadone
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Addicts in treatment
AGE	Not applicable
SEX	Not applicable
ETHNICITY	Not applicable
GEOGRAPHICAL AREA	Not applicable
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not applicable
NO. OF REFERENCES	15

PURPOSE

The functioning of the families of heroin addicts makes it difficult for the addict to remain abstinent. Families of addicts are characterized by covert or overt conflict between the addict's parents; the addict's overinvolvement with one parent, usually the mother; and the addict's hostile or nonexistent relationship with the other parent. The family discourages the addict from functioning autonomously. Problems such as lack of self-control, inability to express hostility, and paradoxical definitions of responsibility must be faced if psychotherapy with addicts is to be successful.

This article describes a methadone clinic at which the authors were staff members. It focuses on the clinic's goals and structure, the relationship between treatment and the addict's pathology, and this relationship's effect on the clinic's functioning. The study illustrates how a methadone clinic functions in a fashion analogous to the functioning of the addict's family.

SUMMARY

The methadone clinic's minimal treatment goal is elimination of the addict's illicit drug use and substitution of methadone legally dispensed by the clinic. The optimal treatment goals are total drug abstinence, with the exception of the social use of alcohol and tobacco, and the elimination of all deviant behavior. The clinic has a therapeutic staff, a paraprofessional staff of ex-addicts, and a medical staff who by law must dispense the methadone. The client population consists of about 115 individuals who have had at least a 2-year history of drug abuse that includes opiates, hypnotics, stimulants, minor tranquilizers, and other mood-altering drugs, or who have had at least two unsuccessful attempts at detoxification. Clients are chosen through self-referral, transfers from other methadone clinics, and conditions of probation or parole.

The clinic must restructure the addicts' typical functioning, since the addicts are most successful in behaving in a manipulative and symptomatic fashion, indicating that they cannot control their behavior. The treatment process can be understood as the interaction between the client's typical mode of behavior and the staff's attempts to restructure this behavior, particularly in terms of therapy, methadone, and drug use. The clinic redefines the "out of control" drug use by specifying the exact dosage, time of medication, and context. Addicts are also encouraged to seek employment or vocational or educational training in place of drug-related activities. Success in these areas reinforces their ability to take responsibility for their behavior.

Treatment is not generally this simple, however, due to the addict's typical mode of interaction and to the relationships among staff members. Since no clear procedure exists for making treatment decisions when staff members disagree, perverse triangles may occur in which the addict, rather than the staff, controls the treatment. The addict can manipulate staff members, especially when two staff members are in covert conflict. For example, a common maneuver is for the addict to speak in private with one staff member about an unsatisfactory relationship with another staff member. The greatest potential for perverse triangles at the clinic results from drug subculture values that conflict with the clinic's formal structure. The overt disagreement focuses on the flexibility of treatment guidelines. Paraprofessionals argue in favor of individual discretion in bending the rules, while professionals try to enforce the rules rigidly. This process often produces increased methadone or illegal drug use by the client. Moreover, if the addict has a special relationship with one staff member, that staff member may defend the addict against another staff member. The paraprofessional's inability to refuse the addict's requests because of a special relationship parallels the overinvolved parent's inability to say no for fear of the addict's renewed drug use.

The problem of perverse triangles is most clearly shown in the dispensing of methadone. Decisions on how to deal with "high" clients or clients asking for special privileges such as being late result in conflict between the professional and nonprofessional staff. Another difficult situation occurs when one staff member pressures the addict to fulfill obligations, while the overinvolved staff member defends the addict's behavior.

CONCLUSIONS

Addicts manipulate their parents by forming a covert coalition with one parent against the other. This mode of functioning can be recreated at a methadone clinic if uncommunicated differences exist between staff members concerning the addict's treatment and tolerance of the addict's frustration. Such differences are inevitable if one staff member is overinvolved with the addict. In contrast, clear communication and joint decisionmaking concerning the addict's medication and commitment to the clinic can be successfully employed in the therapeutic process. The addict's inability to control drug use is acknowledged, transformed to another drug, structured in particular ways, coupled with other behaviors, and gradually eliminated. This process puts the addict's symptomatic behavior under the control of the addict and the clinic and encourages and reinforces responsible behavior. Further research is needed to determine if the functioning described here varies significantly from that of other symptomatic or nonsymptomatic individuals.

Silver, F.C.; Panepinto, W.C.; Arnon, D.; and Swaine, W.T. A family approach in treating the pregnant addict. In: Senay, E.; Shorty, V.; and Alksne, H.; eds. Developments in the Field of Drug Abuse. Cambridge, Mass.: Schenkman, 1975. Pp. 401-404.

DRUG	Heroin
SAMPLE SIZE	147
SAMPLE TYPE	Pregnant addicts
AGE	Early twenties to mid-twenties
SEX	Female
ETHNICITY	Black; Puerto Rican; white
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	1

PURPOSE

A comprehensive treatment program for pregnant addicts and their husbands is described. The program is designed to deal with the usual problems of addiction as well as to provide prenatal care and instruction in child care for female patients unable to care for their infants.

METHODOLOGY

The patients who came to the clinic were in their early twenties to mid-twenties, were 80 percent black and 20 percent Puerto Rican or white, and had been using drugs for 3 to 5 years. Half of the women were admitted to the program with their addicted spouses.

RESULTS

Goals

The initial goal was stability of the pregnant addict's life situation. The long-term goals were to help the woman become a consistent and loving parent, to help her give up the drug life, and to clarify her role as a mother and a woman. The clinic sought to create a family atmosphere, to maximize patient-staff contacts, and to provide role models for the patients. Daily observations of marital, parent-child, and social interactions allowed staff to intervene. Formalized group meetings and counseling sessions were also held. Progress in mothering preceded growth of self-esteem, but as mothers grew they began to feel more positive about themselves and to enjoy their children.

Prenatal Care

Upon admission, initial family sessions were scheduled with all members of the addict's household as a means of diagnosis and staff training. Child care classes were held by the program's nurse to assist new mothers in discipline, personal hygiene, and demonstrating feelings. The programs were provided to help patients, who generally had a low tolerance for frustration, adjust to a new lifestyle.

Treatment intervention during pregnancy was successful; 81 percent of the women remained in the program, and 63 percent of the population had at least 2 months of medical surveillance prior to delivery. Obstetrical complications such as preeclampsia were controlled, and medical diseases such as syphilis were treated. After delivery, 88 percent of the mothers cared for the children themselves, 96 percent of the women found acceptable housing, and 55 percent of the husbands took jobs as opposed to less than 10 percent at the time of admission.

Postnatal Care

Staff assisted mothers in caring for their children, in encouraging them in developmental skills, and in learning the importance of physical demonstrations of affection for children. Women were encouraged to enjoy their female roles. Although women addicts were generally dependent and without self-esteem, the program changed the pattern. The women brought their men into the program, thus taking leadership roles. They could also determine their methadone dosage and their detoxification course. Women were taught to plan their families to ease the burdens of child rearing and to take time for themselves. Many received peer support in the form of compliments on their caregiving abilities and of successful collaboration in fundraising activities for the recreation committee. Women also had access to remedial education and vocational training opportunities.

Medication

The clinic offered methadone in low dosages to patients who felt that they needed medication to succeed in treatment. During pregnancy the maximum dosage was 40 mg and lower dosages were encouraged; the maximum dosage was 60 mg for nonpregnant patients. Of 147 patients, 40 percent achieved and maintained a drug-free status, 6 percent were admitted drug free, 10 percent were in the process of detoxifying at the time of the study, and the remaining 44 percent were on medication. Three-quarters of the patients on medication received less than 40 mg.

CONCLUSIONS

The Family-Maternity Program has demonstrated that initial intervention with pregnant addicts can lead to successful prenatal care and safe deliveries. Significant strides can also be made in detoxification of patients with methadone. Continued supportive and educative treatment improved patients' psychosocial stability and feelings of self-esteem, especially in their maternal roles.

Stanton, M.D., and Todd, T.C. Engaging "resistant" families in treatment: II. Principles and techniques in recruitment. Family Process, Vol. 20, in press.

DRUG	Heroin
SAMPLE SIZE	92
SAMPLE TYPE	Addicts in treatment and their families
AGE	Adults
SEX	Male
ETHNICITY	Black; white
GEOGRAPHICAL AREA	Philadelphia, Pennsylvania
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations; videotaped therapy sessions
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	40

PURPOSE

Research has shown that nonbehavioral family therapy is generally superior or equal to other treatment modes. Specific applicabilities and limitations of the approach must now be explored. The present study describes the problem of getting people involved in family therapy and principles for getting resistant families into treatment. The difficulty of engaging addicts' families in treatment is considered by many to be the most urgent family treatment problem facing therapists.

METHODOLOGY

Observations underlying study results were based on a 6-year research program investigating the family characteristics and family therapy of heroin addicts, as well as experiences recruiting families in 6 other drug treatment programs and over 20 nondrug programs. Recruitment attempts were made with 92 families. The patients themselves were male, 55 percent black and 45 percent white, and aged 23 to 35 years; only 25 percent were married. They had been addicted to heroin for at least 2 years and were enrolled in outpatient drug treatment when initially placed on methadone. The socioeconomic composition of the group, as defined by

Hollingshead and Redlich's Two Factor Index of Social Position was Class II--2 percent, Class III--8 percent, Class IV--58 percent, and Class V--31 percent. All clients were in regular contact with their families, and none had had previous family therapy experience. Nine therapists worked on the project. The study project demanded that the addict, both parents or parent surrogates, and, whenever possible, siblings attend an initial evaluation session before being assigned to a treatment group. This session included videotaped family interaction tasks and family perception tests. Members were paid for participating. Contrary to expectations, families were not difficult to retain in treatment once they had been recruited, but recruitment itself was difficult.

RESULTS

Initial Contacts With the Parents

Most addicts are extremely reluctant to include family members in therapy for a variety of reasons, many of them relating to family protection. Consequently, the therapist, not the patient, should decide which family members should be included, otherwise only certain constellations show up (e.g., sister, mother and sister). Whenever possible, one or more family members should be encouraged to attend the initial or intake interview. It must be emphasized that patients will not bring in their families on their own. The patient's permission should, however, be sought before contacting the family. Sometimes subtle pressure can be used to induce patient cooperation.

Immediacy and Primacy of Contact

Experience indicates that the closer the family therapist's first patient contact is to the time of intake, the greater the chances are for recruiting the family. Furthermore, early entry of the family therapist into the chain of treaters encountered by the client also enhances family recruitment. The sooner the family is contacted, the more likely it is to be engaged.

Crisis Aspects and Contacting the Family

Viewing the family recruitment effort as crisis-inducing can help therapists in their engagement efforts. Therapists must convey a sense of calm. They must circumvent the patient and directly contact each family member, getting their explicit agreement to participate as soon as possible. This may involve many telephone calls and home visits.

Approaches to Parents and Family

The therapist should take special pains not to ally with the patient against parents. Fathers are the most difficult family members to recruit and must be involved through creative approaches, such as visiting the father at work, spending a congenial beer-drinking evening with the father, or stressing dangers to the addict who is deprived of the father in treatment. In their persuasive tactics, therapists should avoid confrontation and find an area for connection and leverage. Mothers are generally more willing to participate in therapy than fathers but may also be resistant. The most successful approaches reframe participation in therapy as positive and valued rather than painful. Wives are usually only resistant to participation when open antagonism exists between the wife and the patient's family of origin.

Therapist Leverage and Therapist Factors

When therapists find that their goals differ from those of the family, they should adopt the family's goals for the patient as the primary ones for treatment. The chances for successful family recruitment are increased if the therapist does the recruiting and remains the primary treater of the patient and the family.

An important recruitment variable is the extent to which therapists show interest in the family through their willingness to expend considerable effort in engaging them. The rate of success

is increased by providing incentives to therapists for each successfully recruited case. The program must be structured so that therapists cannot back down from recruiting whole families.

Recruitment Effectiveness

A total of 71 percent of the 92 families were recruited. Two-thirds of the failures occurred when the therapists could not get the permission of patients to contact their families. Black families were more difficult to recruit, and successful recruitment required a median of 5.4 direct contacts over a median of 20.5 days. The success rate was considerably higher than other reports in the literature with similar clients.

CONCLUSIONS

The massive resistance to therapy by many patients' families makes it necessary for therapists to develop new, sometimes outlandish approaches. Recruitment in itself becomes intervention. Problems related to recruitment can be reduced by such program procedures as mandatory family participation in treatment programs. Without such procedures, however, the principles presented can be applied to unmotivated families of patients with other types of disorders. Finally, emphasis must be placed on seeking out and engaging families of patients, which requires a reframing of the therapeutic enterprise in an active--or outreach--mode.

Stanton, M.D., and Todd, T.C. Structural family therapy with drug addicts. In: Kaufman, E., and Kaufmann, P., eds. Family Therapy of Drug and Alcohol Abuse. New York: Gardner, 1979. Pp. 55-69.

DRUG	Heroin; opiates
SAMPLE SIZE	Over 60
SAMPLE TYPE	Addicts in treatment and their families
AGE	Under 35
SEX	Mostly male addicts
ETHNICITY	Black; white
GEOGRAPHICAL AREA	Philadelphia, Pennsylvania
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	20

PURPOSE

Although the literature on family factors in drug addiction is growing, little has been written on actual methods for family treatment of addiction. Thus, family-oriented therapists have been left to their own resources to bring about changes in addict families. This paper's goal is to present some strategies and techniques of structural family therapy, based on the authors' experiences with a research program on the effectiveness of family therapy with drug addicts. Research and other studies show that most addicts are closely involved with their families of origin, indicating that family therapy is relevant.

METHODOLOGY

The therapeutic approaches described here are based on research involving more than 60 families seen in family treatment, as well as on less systematic experiences with drug-using families prior to the research project. Followup studies of 33 of the families have been conducted, and results are dramatically better than for a matched group of clients in a methadone/individual counseling program.

The family therapy model used in the project had two major influences. Many of the concepts derived from the work of Minuchin and colleagues at the Philadelphia Child Guidance Clinic. Their work showed that structural therapy is effective with a variety of problems and with different kinds of therapists. A second major source of ideas was Jay Haley, whose ideas were originally developed from work with families of schizophrenics.

Structural family therapy typically focuses on patterns of family interaction and communication within the session. Therapy attempts to influence these patterns directly and actively. Tasks or "homework" are assigned to consolidate changes made during the sessions. Past history and insight are deemphasized; the main emphasis is on changing current interaction. The therapist usually attempts to set boundaries and restructure the family, often by reinforcing generational boundaries between parents and offspring.

Most of the authors' work has been done with patients enrolled for methadone treatment. Most were male, under age 35, and addicted to opiates for at least 2 years; half were black and half were white. All had weekly contact with one parent or parent substitute. In 71 percent of the cases, the family was successfully brought into treatment.

RESULTS

Families showed patterns described in earlier literature, including a close, dependent mother-son relationship paired with a distant, excluded father. Families usually lack constructive pressure for change, and addict's actions helped maintain family stability. The usual treatment length is 10 to 12 sessions. The basic approach used was based on Haley's assumption that if the family organization does not change, the young person will continue to fail. Therapy should occur in five stages: placing one therapist in charge rather than having a team approach, interviewing the family and placing the parents in charge of solving the young person's problems, dealing with the instability resulting from the addict's becoming normal, providing an intense involvement and a rapid disengagement, and conducting regular followups to insure that positive change continues.

The initial contact with the addict and the family may demand considerable time and effort by the therapist. The therapist must take a nonblaming stance and not use the confrontative techniques that may be useful in group therapy with drug abusers. Early sessions typically focus on setting common goals for treatment. The therapist's main goal is to form an alliance with both parents, so they can take an effective stance toward the addict. The therapist must encourage the parents to work together. As change starts to occur and the addict curtails drug taking, crisis can be expected. This usually happens 3 or 4 weeks into treatment and often revolves around the marital relationship, with talk about or steps toward separation or divorce. Such turmoil puts pressure on the youth to resume drug taking to reunite the family. Therefore, the therapist must devote much energy and time to resolving this crisis. Responsibility for the drug taking should rest with the family; the therapist should help the family either to accept it or to effectively disengage from the addict so that the addict must accept responsibility for the addiction. A recently explored technique is to have the family take charge of the detoxification process in the home, to reinforce this concept of responsibility. During the therapy's final phase, treatment may evolve toward other issues, such as employment and education, if freedom from drug taking has been maintained for a month or more. Another subject that may emerge is the parents' marriage. Termination difficulties will generally not arise if adequate change has occurred and been maintained long enough for the family to feel a sense of real accomplishment. Otherwise the family will be fearful and may generate crises or other problems to keep the therapist involved.

Administrative support and flexibility is essential to treatment. The therapist must also have control over all aspects of treatment. Further, requiring the family to come in at or immediately after intake saves much of the effort of recruiting families. In addition, results of weekly urinanalysis tests have been helpful in family treatment by giving tangible indication of progress and preventing the therapist or family members from avoiding the major issue. Dealing with the parent-addict triad must take precedence over other aspects of therapy. Other interpersonal systems such as friends, vocational counselors, employers, school authorities, and legal authorities may also need to be involved in family treatment. In cases where only one parent, usually the mother, is available, the therapist may have to temporarily fill a parental role toward the addict or assume a spouselike role toward the parent. Alternative structures and supports for the parent must then be developed. The little work that has been done with families of female

addicts indicates that these families' dynamics are similar in many ways to those for males, as are the therapeutic strategies.

CONCLUSIONS

Recent studies have illustrated how intensively involved addicts are with their families of origin. Family therapy that seeks to change the family organization is a favorable treatment approach. Moreover, certain qualities and behaviors in therapists appear to contribute to successful treatment. Most important of these is the ability to be active rather than passive or reflective. In addition, the therapist must be supportive, concerned, accessible, enthusiastic, and flexible. Therapists should handle no more than three or four such cases at a time because these families can be demanding and emotionally draining.

Stanton, M.D.; Todd, T.C.; and Associates. The Family Therapy of Drug Abuse and Addiction. New York: Guilford Press, in press.

DRUG	General
SAMPLE SIZE	Not applicable
SAMPLE TYPE	Not applicable
AGE	12 to 35
SEX	Both, emphasis on males
ETHNICITY	White; black (lower to upper-middle income)
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Literature review; theoretical/critical review; clinical cases
DATA COLLECTION INSTRUMENT	Videotapes; observations
DATE(S) CONDUCTED	1970-1980
NO. OF REFERENCES	200

PURPOSE

While there is an increasing body of literature on the nature and importance of family factors in drug abuse and addiction, there has not been a great deal written on the actual methods used for family treatment of such cases. The purpose of this volume is to fill that gap by presenting a comprehensive review and analysis of the strategies, techniques, and research associated with this mode of therapy. The book attempts to present a cohesive treatment approach, developed conjointly by a sizable group of colleagues, that is applicable to the majority of drug abuse problems of people under age 35.

SUMMARY

Eighteen chapters, divided into three sections and preceded by a foreword written by Salvador Minuchin and an introduction, are presented in this volume. Each of the three sections concerns a different aspect of the family therapy of drug abuse--pretherapy aspects, strategies and techniques of treatment, and other dimensions of therapy. The chapters in each section are a mixture of 14 original and 4 revised/reprinted articles by leading practitioners and researchers in this field. Summaries of each of these sections follow below.

Pretherapy Aspects

This section begins with an exposition by Stanton and his colleagues of the conceptual model upon which this volume is based. Essentially, this model proposes that drug addiction be thought of as part of a cyclical process involving three or more individuals, commonly the drug abuser and two parents or parent surrogates. These people form an intimate, interdependent, interpersonal system. At times the equilibrium of this interpersonal system is threatened, such as when discord between the parents is amplified to the point of impending separation. When this happens, abusers become activated, their behavior changes, and they create situations that dramatically focus attention upon themselves. This behavior can take a number of forms. For example, they may lose their temper, come home high, commit a serious crime, or overdose on drugs. Whatever its form, however, this action allows the parents to shift focus from their marital conflict to a parental overinvolvement with the child. In effect, the movement is from an unstable dyadic interaction (e.g., parents alone) to a more stable triadic interaction (parents and addict). By focusing on the problems of the abuser, no matter how severe or life threatening, the parents choose a course that is apparently safer than dealing with long-standing marital conflicts. Consequently--after the marital crisis has been successfully avoided--the abuser shifts to a less provocative stance and begins to behave more competently. This is a new step in the sequence. As the abuser demonstrates increased competence, indicating the ability to function independently of the family--for example, by improving in school, getting a job, getting married, enrolling in a drug treatment program, or detoxifying--the parents are left to deal with their still unresolved conflicts. At this point in the cycle, marital tensions increase and the threat of separation arises. The abuser then behaves in an attention-getting or self-destructive way, and the dysfunctional triadic cycle is again completed. This general pattern, and its variations, has important implications for treatment.

Following this theme-setting chapter, other discussions in this section include the importance of establishing a viable programmatic and research context for therapy; techniques for establishing a positive initial contact and getting the abuser to involve his or her family in the ensuing therapy; principles for engaging resistant families in treatment; and methods for initial assessment of the crisis that precipitated the family's entry into therapy.

Strategies and Techniques of Treatment

This section addresses both broad and specific issues in treating the addict and the family. An overview of the therapy approach, by Stanton and Todd, focuses on the techniques of structural/strategic family therapy and extends them to drug abusers' families. This is followed by a presentation of a clinical model for the family therapy of drug addiction by Jay Haley and a discussion of crisis induction, resolution, and the addiction cycle by Mowatt, Heard, and others. Other topics considered in this section include the role that the death theme plays in addict families, therapeutic techniques in special circumstances such as in families with a drugpusher, alcoholic parents, elderly parents, or an adolescent abuser, and a presentation of views by therapists' supervisors of the special requirements of family therapy with drug abusers. Extensive case studies are included. Stanton and Todd provide some final comments on strategies and techniques with drug-abusing families.

Other Dimensions of Therapy

A brief final section presents discussions of two topics not dealt with earlier, the absolutely essential need for program support and flexibility when working with the families of addicts and the methods and importance of careful therapy outcome studies. Particular emphasis is accorded the latter topic since Stanton and his associates have conducted extensive outcome studies with their own clients and are closely attuned to the pitfalls and ultimate need for this research. Posttreatment outcome data, comparing four therapy conditions, are presented. The final chapter points to directions for the future of family therapy with drug abusers.

CONCLUSIONS

Each of the chapters in this volume presents a set of principles and conclusions relevant to the topic discussed. The book's five major conclusions are as follows: (1) most drug abusers either live with or are in regular contact with the people that raised them; (2) families are extremely

important both in maintaining the drug problem or addiction and in helping to eliminate it; (3) families of drug abusers present the therapist with a set of special circumstances and problems; (4) there are correct and incorrect ways for treating such families which dictate the success or failure of the therapy; (5) application of this treatment model can lead to a therapy that is very effective, especially in relation to the usual outcomes obtained with this patient population.

Stanton, M.D.; Todd, T.C.; Steier, F.; Van Deusen, J.M.; Marder, L.R.; Rosoff, R.J.; Seaman, S.F.; and Skibinski, E. Family Characteristics and Family Therapy of Heroin Addicts: Final Report, 1974-1978. National Institute on Drug Abuse Grant No. R01 DA01119. Philadelphia, Pa.: Philadelphia Child Guidance Center, Oct. 1979.

DRUG	Heroin
SAMPLE SIZE	143
SAMPLE TYPE	118 addicts in treatment; 25 nonaddicts
AGE	Young adults; mature adults (mean: 25.5)
SEX	Male
ETHNICITY	Black; white
GEOGRAPHICAL AREA	Philadelphia, Pennsylvania
METHODOLOGY	Survey--comparative, correlational
DATA COLLECTION INSTRUMENT	Videotapes; audiotapes; family perception tests; questionnaires
DATE(S) CONDUCTED	1974-1978
NO. OF REFERENCES	64

PURPOSE

In recent years the importance of the family in the genesis, maintenance, and alleviation of drug problems has received increasing attention. To define the nature of the relationship between drug abusers and family variables more precisely than has been done until now, the study examines how heroin addicts differ from nonaddicts in their interactional patterns and perceptions and whether inclusion of the addicts' families in the treatment process can significantly affect treatment results.

METHODOLOGY

The experimental sample consisted of 118 subjects from the male patient population of the Philadelphia VA Hospital Drug Dependence Treatment Center (Pennsylvania). Subjects were under age 36, had been addicted to heroin for at least 2 years, had already attempted to detoxify, had no history of psychosis, and were in regular contact with their families. They were 52 percent black and 48 percent white. Of the latter group, 40 percent were of Italian descent and 25 percent of Irish descent. The mean age was 25.5, and 31 percent were married. All had been away from home to serve in the military, and 59 percent still lived with their parents.

The patients' general prognosis was poor. In addition, a control group contained 25 nonaddict veterans and families that closely approximated the addict families in demographic and historical variables.

Test subjects and families were divided into four groups: families paid to undergo therapy (21), families not paid (25), families paid for treatment in which they viewed noncontroversial anthropology movies about foreign cultures (19), and addicts treated alone without family intervention (53). The treatment period from intake to termination lasted 4½ to 5 months, with all families attending 10 therapy sessions. The structural family therapy approach used for the paid and unpaid family therapy groups sought to alter family interaction within sessions by restructuring the family and altering dysfunctional cycles. The family movie treatment group served as a control for the effects of reimbursement and attending weekly sessions together. Since most of these families did not usually get together for family activities, in this respect the movie program was a family intervention. The nonfamily group underwent the standard Center treatment. Family members were not recruited at all for this group, which provides a baseline estimate of standard methadone program treatment outcomes.

Data for the two family therapy groups were obtained through videotapes of family interactions during four tasks--planning a menu (decisionmaking), discussing a recent argument, and talking about their likes and dislikes for each other (conflict resolution), and relating to a picture of a family seated around a birthday cake. Raters scored videotapes statement by statement, taking into consideration as many as 24 dimensions of structure, process, and content (for example, likes and dislikes, clarity, continuity, focus, and intensity). Data were then organized, refined, and analyzed statistically, using two-tailed t-tests and Mann-Whitney U tests. Further data derived from recordings of tasks were analyzed according to six dependent measures. Finally, information was gathered with the Animal Concepts Picture Series and the Family Situations Picture Series, instruments developed to measure family perceptions.

RESULTS

Paid family therapy was somewhat superior to unpaid family therapy and clearly superior to both movie and nonfamily treatments. While payment did apparently improve attendence, the therapy itself was the decisive factor. A much higher rate of posttreatment deaths was observed among addicts who did not engage in family therapy than among those who did (10 percent versus 2 percent).

Differences Between Interaction Patterns of Heroin Addict and Normal Families

Videotapes produced the most useful data on distinct interaction patterns. According to the videotapes, addict families, compared to normal families, showed rigid, stereotyped interaction characterized by open conflict. Roles within the family were those described in the literature for male addicts; the mother was usually dominant and/or central, while the father was peripheral. The primary interaction was between mother and addict. The addicts' statements were likely to be irrelevant, and the families tended to stray from the assigned tasks. However, results did not always hold up across interaction tasks or across all measures, and further analysis was deemed necessary.

Effects of Therapy on Family Interaction Patterns

As a result of therapy, families became more cooperative and less conflictual. Although family members continued to interrupt each other, these attempts were less successful following therapy, suggesting reduced intrusiveness. Moreover, fathers became more involved and mothers became less dominant, although the latter remained central. Addicts showed increased disagreement, contrary to the general family tendency toward agreement after therapy. Both fathers and addicts exhibited an increase in relevant task suggestions.

Links of Successful Therapy to Changes in Family Interaction

The data reveal clear relationships between successful family therapy and changes in family interaction. The relationships were more apparent in tasks such as argument, which was freeflowing, involved conflict resolution, and was relatively unstructured, so that it revealed patterns outside the family's awareness. The effects of the therapy are statistically significant and have important theoretical implications. The Relational Continuity and Interpersonal Process Analysis measures have the best predictive power for therapy outcome.

Clinical Principles

Considerable success can be achieved in recruiting families for therapy by contacting family members personally, portraying involvement in family therapy as a means of helping the addict, avoiding blame, and maintaining therapeutic management of the case. The structural family therapy used successfully focuses on present patterns of family interaction and works to modify them rather than dwelling on past failures. In the case of addicts, concrete changes relating to drug use must be emphasized. When marital conflicts between parents surface, addicts must be prevented from attempting to rescue their parents. The therapist should insist that families resolve the crises that arise themselves.

CONCLUSIONS

A short-term structural family therapy approach for adult male heroin abusers is quite effective in reducing drug abuse. The kinds of improvements demonstrated in this study are rarely shown by any kind of treatment with any subset of heroin addicts, either in terms of outcome or cost efficiency.

Families of addicts tend to differ from those of controls in the dominant role of the mother and the peripheral role of the father. However, therapy modifies these roles sufficiently to bring about improvement in the addict. Further research must refine predictions as to which families can be successfully treated, what factors predict readdiction, and which pretherapy family patterns dictate different therapeutic goals.

Van Deusen, J.M.; Scott, S.M.; and Stanton, M.D. Engaging "resistant" families in treatment. I. Getting the drug addict to recruit his family members. The International Journal of the Addictions, 15(7):1069-1089, 1980.

DRUG	Heroin
SAMPLE SIZE	92
SAMPLE TYPE	Addicts in treatment
AGE	Young adults; mature adults (23 to 35)
SEX	Males
ETHNICITY	Black; white
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Clinical observations
DATA COLLECTION INSTRUMENT	Videotapes; family perception tests
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	22

PURPOSE

While researchers agree on the importance of family therapy for the families of addicts to assure the addicts' complete recovery, inducing families to participate is extremely difficult. Families generally abdicate responsibility for the addicts' problems and blame external systems. To aid other researchers in family recruitment, this study describes techniques used for inducing addicts to involve their families in therapy in a research project investigating family characteristics and family treatment of heroin addicts.

METHODOLOGY

Recruiting experience was based on work over a 7-year period with 92 male heroin addicts, half of them black and half white. Their ages ranged from 23 to 35. The research design called for an initial evaluation session that included at least the addict and both his parents, as well as spouses and siblings whenever possible. The initial evaluation sessions involved videotaped tasks and family perception tests. Approximately 80 percent of the addicts granted the therapist permission to contact their families, and 88 percent of the families contacted appeared for treatment. The total family recruitment rate was 71 percent.

RESULTS

The initial interview with the patient is crucial in determining whether he and the rest of the family can be recruited for treatment. The therapist must, therefore, be aware of the kind of resistance that the patient may offer to involvement of his family.

Setting the Appointment

The therapist should work as little as possible over the telephone and set the time for the interview not more than 2 or 3 days after the telephone contact to avoid cancellations. Directions to the clinic and the therapist's phone number should be supplied. The therapist should also encourage the patient to bring another family member or the whole family. The patient's response to the suggestion will alert the therapist to the extent of family involvement in the patient's drug problem.

Guidelines for the Interview

In the session the therapist must obtain stated or implicit indication from the patient that he wants to abandon his drug habit. This statement and its acknowledgment by the therapist form the basis for all future sessions. If the patient will not declare readiness to break his habit, the therapist should try to work toward that goal. In the remainder of the interview the therapist may focus on recruiting the family immediately or may deal with secondary issues, such as dosage increases and program privileges. Minimal resistance from the patient may either be a sign of genuine willingness to detoxify or a sign that the patient has no intention of complying with the plans agreed to.

Standard Interview Structure

A standard interview structure allows the therapist to begin the discussion with a topic that the patient expects to discuss. In the opening session, the therapist explores the patient's history of drug use and treatment. The therapist should be aware of addicts' tendency to spend hours setting up a situation to get what they want. Discussion moves from the area of drug problems to the patient's interests in future plans. Employment and educational status are key topics, with talk becoming less formal in this segment. As a result of these discussions, the patient should gain a better idea of what he will do when drug free and learn to believe that the therapist is interested in him as an individual.

Inquiries should be made about the patient's family of origin only when the therapist is ready to involve them in treatment. The therapist must elicit information about the composition of the family and the amount of contact among members. While the patient is talking about his family, the therapist should be mapping out its configuration and deciding which members should be included. For the time being, the family of origin should be separated from the family of procreation. Prior to suggesting that the family be brought in, the therapist must ascertain how much family members know about the drug problem. As the patient has a legal right to confidentiality, the therapist will have to work on this matter before going any further.

At this point the therapist should begin to discuss his or her own orientation. The general aim is to set up the situation so that the patient can admit to the value of getting his family's help. If the patient claims that parents are unwilling to help or are missing, the therapist should verify this information, possibly even by a telephone call during the session. If the patient is determined to "make it alone," the therapist should discuss this alternative with him. The therapist should manipulate the discussion by asking primary questions so that the patient agrees that his parents know about his problems. It may be necessary to review with the patient the salient points covered in the session. In certain situations the patient will not cooperate. If this is the case, the therapist can give the patient time to think things over, allow him to return when he is ready, or withhold minor privileges until the patient complies.

CONCLUSIONS

In conducting an initial interview with a drug-dependent individual, the therapist must demonstrate understanding of drug dependency in general and the patient's drug problem in particular. Furthermore, the therapist must show willingness to help the patient formulate and realize plans for a better future. Finally, the therapist must convey throughout the course of the interview the sense that he or she is competent in family therapy. The patient's unwillingness to involve his family in treatment will be minimized when these concerns have been dealt with in the initial session.

Webb, N.L.; Pratt, T.C.; Linn, M.W.; and Carmichael, J.S. Focus on the family as a factor in differential treatment outcome. The International Journal of the Addictions, 13(5):783-795, 1978.

DRUG	Alcohol; drugs (not specified)
SAMPLE SIZE	36
SAMPLE TYPE	Alcoholics and drug abusers in treatment (inpatient)
AGE	Adults
SEX	Male
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Miami, Florida
METHODOLOGY	Experimental study
DATA COLLECTION INSTRUMENT	Social Dysfunction Rating Scale; Hopkins Symptom Distress Checklist
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	18

PURPOSE

Several studies have focused on such prognostic indicators of treatment outcome as prior levels of adjustment, age, employment, and social history. Literature dealing with mental patients has shown that the type of living arrangement is a significant factor in treatment outcome. Most studies have dealt with residential settings after discharge. In contrast, the present study aims to determine if prehospital living arrangements result in differential responses to substance abuse treatment. Patients who lived with their parents, wives, nonrelatives, or alone were compared with respect to changes in social dysfunctioning and symptomatology as a result of inpatient treatment.

METHODOLOGY

Thirty-six adult males who completed the substance abuse inpatient treatment program at the Veterans Administration Hospital in Miami, Florida, were studied. Of these patients 19 were alcoholics and 17 were drug abusers; none was diagnosed as psychotic or organically ill. All were self-admitted to the unit after being screened by a counselor from the program; patients were admitted for about 4 to 6 weeks. Moreover, the program operated as a therapeutic commu-

nity, with the immediate goal of full participation of all members and the eventual goal of resocialization of individuals that they might function adequately in the community. Goal-oriented counseling provided corrective learning experiences for members. Patients were required to take part in recreational activities, regular community meetings, and work assignments.

Following intake, each patient was interviewed for about 1 hour by a research social worker who used a semistructured interview guide to rate each subject on a 21-item Social Dysfunction Rating Scale (SDRS). The scale was developed by Linn and others to assess and quantify objective observations of a person's interactions with the intrapersonal, interpersonal, and geographic environments, while also taking into account the person's satisfaction within these areas. The scale's reliability and validity were each assessed by two methods. In addition, the Hopkins Symptom Distress Checklist was administered to all subjects. This self-report instrument was designed to measure basic neurotic symptomatology with respect to somatization, obsessive-compulsive tendencies, interpersonal sensitivity, depression, and anxiety. Subjects were also interviewed, using the same instruments, within 3 days after discharge from patient care.

Data were analyzed in a factorial design using multivariate analysis of covariance related to changes over time on the outcome criteria. Multivariate analysis of covariance was also used to test for significant differences between the residential setting of groups at admission and discharge, so that absolute levels of functioning and symptomatology could be examined at those times.

RESULTS

Despite some attrition during the study period, results seemed representative of the entire population of program completers. The 17 drug abusers had a median age of 25 years and were mostly white and unmarried. Over three-fourths had finished high school and almost half had some college training. Before entering the hospital, 12 percent had lived with their wives, 53 percent with their parents, and 35 percent with nonrelatives or alone. The alcoholics had a median age of 45 and were mostly white and divorced. Their educational levels were similar to those of the drug abusers. Before entering the hospital 42 percent had lived with their wives, 5 percent with their parents, and 53 percent alone or with nonrelatives. Upon entrance into treatment, those living with nonrelatives or alone were slightly more dysfunctional and symptomatic than were those living with their wives or parents, but these initial differences were not statistically significant. All three groups became less dysfunctional and symptomatic after inpatient treatment, but the rates of improvement varied. The changes were statistically significant at a multivariate level. Those who had lived with nonrelatives or alone changed most; those coming from family settings, the least.

At a univariate level, the somatization factor significantly differentiated the groups. Those living with nonrelatives or alone and those living with wives prior to hospitalization became significantly less distressed about bodily dysfunction, although a slight increase in somatization was noted for the group coming from a parental home. Except for the somatization factor, all groups improved as a result of treatment. Drug patients became significantly less symptomatic and dysfunctional than alcohol patients, but these differences disappeared when age and the number of days hospitalized were held constant. Although living arrangement groups differed significantly at a multivariate level, there were no significant interactional effects related to community set and type of substance abuse.

CONCLUSIONS

The finding that rates of improvement were related to prehospital living arrangements supports the prognostic relevance of this variable. Study results also indicate that the type of residential setting is a useful indicator of receptivity to the actual rehabilitative process itself. The finding that those coming from parental homes changed less than those coming from conjugal settings supports prior research. The finding that those living alone or with nonrelatives changed the most was unexpected, because it is generally believed that persons living alone or without family do worse in treatment. The therapeutic community probably functioned as a surrogate family, providing shelter, security, and role affiliations. Differences in the need to break dependent ties and in motivation could also explain the differences in the observed changes. Results also indicate that coming from a more neutral environment is more advantageous for treatment effectiveness than is coming from an environment consisting of family members. This finding

supports the rationale for such treatment modalities as self-help programs and therapeutic communities in which familial involvement is not encouraged because it is perceived as harmful to the addict's growth. Findings suggest the need for assessment of the patient's family environment and use of community resources as a means of enhancing the patient's adjustment.

Wellisch, D., and Hays, J.R. Development of family therapy as a new treatment modality in a drug abuse program for adolescents. In: Schoolar, J., ed. Current Issues in Adolescent Psychiatry. New York: Brunner/Mazel, 1973. Pp. 221-232.

DRUG	Multidrug
SAMPLE SIZE	5
SAMPLE TYPE	5 abusers and their families
AGE	Adolescents
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Texas
METHODOLOGY	Clinical observation
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	7

PURPOSE

Staff of the drug abuse section at the Texas Research Institute of Mental Sciences has been heavily involved in exploring and integrating family therapy into the mainstream of its therapeutic program. This paper describes an initial exploratory effort at the Institute to enable the staff to consider the family, not only the individual, when viewing adolescent and postadolescent drug problems as they are presented for treatment. The design of this pilot program, including clinical material and trends observed, and staff issues encountered in the development of a family-conscious approach are presented.

METHODOLOGY

The family program is based on the hypothesis that drug abuse can be a symptom of a maladaptive family system, and that unless the system is altered, the patient's drug use will continue. It was established in 1972 and designed initially for eight adolescents between the ages of 13 and 17 who were treated through peer group and family group therapy. Of the original eight adolescents, only five agreed to active treatment with their families. All families contained a

parent who had been divorced. Issues of concern to these families centered on the patient's being "stoned" around the family group or running away from home for days or weeks.

RESULTS

The outreach house program proved to be an excellent therapeutic tool for dealing with families in conflict. Adolescents who choose to live at the outreach houses are able to talk about such potentially volatile subjects as parental behavior, pressures by the family to remain silent about family secrets, and even the state of the parents' marital relations without fear of reprisal immediately after the session ends.

One of the best diagnostic indicators of how difficult it is for an adolescent to stop using drugs was the longevity of the family's need to talk about the drug use, rather than about themselves or their patterns of interaction. Many families will agree on the verbal-intellectual level that they have a family problem, but they will consistently demonstrate a pattern of returning to the comfortable subject of the adolescent's drug use or running away when confronted by issues that concern themselves. This was rarely confined to parents but was also a recurrent pattern of nonsymptomatic siblings. Shifting focus away from the adolescent's drug use was often the initial intervention measure used to probe and develop the issues of "a family problem" in a meaningful fashion.

The issue of expressing loving feelings and physical nurturance seems to be critically important to both adolescents and their families. Because the parents in the group had deprived childhoods, they found it difficult to nurture or show affection to their children. Once they were made to see the effects of their behavior, the parents were able to give the gratifications adolescents required without the occurrence of drug abuse or violence.

Successful therapy radically altered family homeostasis and created severe dependency crises in two cases involving previously nonsymptomatic family members. In both cases attempts by adolescents to move away from parents led to pathological behavior by the parents to hold on to their more integrated children. Changes in the family equilibrium were most easily coped with through the modality of family therapy.

CONCLUSIONS

Developing family therapy as a treatment modality has forced the Institute to reconceptualize its staff as three basic units: outreach staff, inpatient staff, and outpatient central unit staff. The outreach staff have readily accepted family therapy as a modality and are easily able to schedule their work to suit parents. However, both the outpatient and inpatient staff have resisted conceptualizing problems on a system basis and using a family therapy approach to deal with such problems. The outpatient staff must crystallize their work with the family systems model, and the inpatient staff must redefine patient problems as originating from external social and family systems.

Wieland, W.F.; Yarnes, A.L.; and Bellows, B.L. Family mediation centers: A contribution to drug abuse prevention. In: Senay, E.; Shorty, V.; and Alksne, H., eds. Developments in the Field of Drug Abuse. Cambridge, Mass.: Schenkman, 1975. Pp. 681-685.

DRUG	Multidrug
SAMPLE SIZE	6 family mediation centers
SAMPLE TYPE	Family mediation centers
AGE	Adolescents and young adults (12 to 21)
SEX	Both
ETHNICITY	White; black
GEOGRAPHICAL AREA	Atlanta, Georgia
METHODOLOGY	Exploratory/descriptive survey
DATA COLLECTION INSTRUMENT	Questionnaire; agency records
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	0

PURPOSE

When the drug abuse epidemic reached metropolitan Atlanta, Georgia, it had the usual characteristics of a marked rise in heroin addiction and an influx of wandering, alienated youths. Georgia's response to the problem was the typical progression of increased law enforcement, development of crisis-oriented helping agencies, and finally, Federal and State funding of a comprehensive treatment program. This paper describes the evolution of the crisis-oriented centers into a network of centers oriented toward families. These "family mediation" centers contribute significantly both to drug abuse prevention and to the prevention of other psychological and social disorders.

METHODOLOGY

Data were collected from six of the eight family mediation centers in metropolitan Atlanta. Two sociology graduate students from Georgia State University visited each center and interviewed at least two staff members, using a questionnaire. Case records were also reviewed. The data base was impressionistic, although much of it was reasonably objective.

RESULTS

The centers concentrate most of their attention on youths and make special efforts to involve their parents. The first center opened in December 1969; the most recent, in October 1974. Staffing patterns range from a minimum of one full-time employee to a maximum of nine full-time staff. All centers employ part-time staff; all also rely heavily on services of trained and supervised volunteers. Funding sources included State and county governments, title XVI, and private donations. Obtaining secure funding is a source of anxiety for all of the centers.

Centers are open from 8 hours, 5 days a week, to 24 hours, 7 days a week. Most are open one to four evenings a week. Services include family mediation, telephone information and counseling, individual counseling, group therapy, referral to other agencies, speakers bureau, and training. One center also has a free medical clinic. Treatment generally consists of one to six sessions over a period of 1 to 8 weeks. Other clients are referred to longer term treatment centers or are seen for subsequent brief periods of therapy. Drug abuse exists in 40 percent to 90 percent of the cases, but is not required as a presenting problem. Other typical problems include runaways, family conflicts, school problems, and juvenile arrests. Drug abuse usually consists of sporadic polydrug abuse.

Clients are typically between ages 12 and 21 years. One or both parents are involved in counseling sessions whenever possible. At least 55 percent of the clients requesting service are females. Except for two centers operated in primarily black neighborhoods, the centers are almost exclusively white in both staff and clientele. Moreover, most clients are blue-collar workers or above and have no previous history of drug abuse treatment. Referral sources range from self-referral to juvenile courts. Most centers refer about 10 percent of their clients for additional treatment, mainly to drug-free programs or mental health facilities. The number of telephone contacts per year ranges from 700 to 16,000 per center, and counseling contacts range from 40 per month to 450 per month per center. Staff estimate that 65 percent to 95 percent of the clients achieve at least partial resolution of the presenting problems, while the rest are either unchanged or, in rare cases, worse. Objective followup data to verify these estimates are unavailable.

Based on the literature on crisis intervention and secondary prevention, several centers have evolved a highly sophisticated, inexpensive, and apparently effective model. Elements of this model include a supportive, community-based environment, an informal and homelike atmosphere, an enthusiastic staff, and counseling that is related to practical concerns. Other elements include strong linkages with other agencies such as schools and juvenile courts, a focus on the family system, and active involvement in education and training programs.

CONCLUSIONS

Family mediation centers are recommended as valuable for dealing with the problems of youths and young adults with respect to their conflicts with their families, their schools, and their communities. If they are as effective as they appear to be, additional funds should be allocated to continue and expand their functions. However, Federal funds cannot currently be used to support these centers, and potential cutbacks in Federal and State funding may eliminate them. Thus, only the most expensive and bureaucratic treatment centers, which are effective only in terms of tertiary prevention, will remain.

Wunderlich, R.A.; Lozes, J.; and Lewis, J. Recidivism rates of group therapy participants and other adolescents processed by a juvenile court. Psychotherapy: Theory, Research and Practice, 11(3):243-245, 1974.

DRUG	Not specified
SAMPLE SIZE	200
SAMPLE TYPE	100 adolescent drug offenders; 100 adolescent nondrug offenders
AGE	Adolescents
SEX	Both
ETHNICITY	Not specified
GEOGRAPHICAL AREA	Prince George's County, Maryland
METHODOLOGY	Exploratory/descriptive survey; survey--comparative (longitudinal)
DATA COLLECTION INSTRUMENT	Not specified
DATE(S) CONDUCTED	1970 to 1972
NO. OF REFERENCES	3

PURPOSE

Because there is little research into the differences between the court-referred juvenile drug offender and the nondrug-related juvenile offender, this paper compares the two groups of offenders on selected demographic variables: age, sex, and school problems. It also compares both groups on school attendance and recidivism rates.

METHODOLOGY

The experimental sample consisted of 100 randomly selected drug court cases referred by the juvenile court of suburban Prince George's County, Maryland, to a county program for adolescent drug abusers (GUIDE: Guidance, Understanding, and Information in Drug Evaluation). A control group of 100 was chosen from among the nondrug cases of the county's juvenile court referred to agencies other than GUIDE. In addition to comparison of descriptive statistics, school attendance and recidivism rates of both groups were examined for the calendar year following legal involvement of the nondrug juvenile offenders or 1 year following completion of the GUIDE program for drug-related offenders. For purposes of longitudinal examination, only juveniles with a court change in 1970 were included in the samples.

RESULTS

Sex and Age

Males in both groups outnumbered females by about 3 to 1 (GUIDE, 78 percent male and 22 percent female; nondrug cases, 72 percent male and 28 percent female). Subjects in the GUIDE sample ranged from 14 to 19 years old (mean 16.6), while nondrug adolescents were between 9 and 18 years old (mean 15). The age difference is attributed to the large number of subjects under 14 years in the nondrug sample and the number of subjects over 18 years (5 percent) in the GUIDE sample.

School Records and Problems

GUIDE program subjects completed 10.4 grades as opposed to 9.1 for the nondrug sample. A total of 14 percent of the GUIDE subjects and 25 percent of the controls were dropouts or had been expelled. Expulsions were considerably higher in the control group (10 percent) than in the GUIDE group (3 percent). Both groups' school problems occurred in the areas of suspension, poor grades, and drug usage, although nondrug subjects had more problems than GUIDE subjects in the areas of disciplinary problems, quitting school, and expulsion. GUIDE subjects had a greater incidence of problems than nondrug subjects only in truancy.

Arrest Records and Recidivism

As might be expected, drug charges predominated in the GUIDE group (75 percent versus 5 percent among controls) and felonies in the control group (62 percent versus 13 percent of the GUIDE subjects). The recidivism rate was three times higher for the nondrug sample than for GUIDE subjects. Moreover, rearrest records of GUIDE subjects were below those of nondrug offenders (13 versus 44 percent), and nondrug subjects were arrested on felony charges four times as often as GUIDE subjects.

CONCLUSIONS

GUIDE program subjects seem to exhibit a lower overall level of social maladjustment than the control group. Certain aspects of the GUIDE program probably contribute to the kind of effectiveness indicated by the statistics. Group therapy sessions focus on the individual and provide consistency of membership and continuity of treatment. Parents are involved in the group sessions, facilitating resolution of family disharmony reflected in adolescents' illegal behavior. About 85 percent of the parents attend the groups, although some attend initially because they are pressured to do so. Parental attendance conveys two messages to the young person: the family has some part in the problem, and the family is concerned. The staff's position is that family problems should be approached by as many family members as possible. Certain process variables useful in the program are the directive function of the therapist, the focus of sessions on the meaning of responsibility in everyday situations, and the step-by-step movement from reduction of parents' negative attitudes toward their children to analysis of parents' own feelings and marital relationships.

Ziegler-Driscoll, G. The similarities in families of drug dependents and alcoholics. In: Kaufman, E., and Kaufmann, P., eds. Family Therapy of Drug and Alcohol Abuse. New York: Gardner, 1979. Pp. 19-39.

DRUG	Multidrug; alcohol
SAMPLE SIZE	90
SAMPLE TYPE	Addicts and alcoholics in treatment
AGE	Not specified
SEX	Both
ETHNICITY	Black; white
GEOGRAPHICAL AREA	Eagleville, Pennsylvania
METHODOLOGY	Survey--comparative
DATA COLLECTION INSTRUMENT	Interviews
DATE(S) CONDUCTED	October 1974-December 1975 (6- to 8-month followup)
NO. OF REFERENCES	11

PURPOSE

Literature on families of alcoholics usually focuses on families of procreation, while works on drug addicts usually focus on families of origin. However, results from the Eagleville Family Study of 90 families did not substantiate this difference in the nuclear families of the 2 substance abuse groups. Barr has also proposed that families of alcoholics and families of drug dependents have many similarities in both identified family roles and family dynamics. This paper describes findings from the Eagleville Family Study that have corroborated these hypotheses and the changes that have occurred through family therapy, either conjoint family therapy or relatives' groups.

METHODOLOGY

Subjects were patients at the Eagleville Hospital and Rehabilitation Center in Eagleville, Pennsylvania. Residents were admitted into the family study as randomly as possible from October 1974 until December 1975. Most of the men and women in the final sample had completed the first stage of treatment, which was the in-hospital phase of 45 to 60 days. The 90 residents were 51 percent drug dependents, 49 percent alcoholics, 69 percent black, and 31 percent white. Over four-fifths of both the drug addicts and the alcoholics were men. Following an initial

audiotaped research interview, the families were randomized into one of three subgroups: conjoint family therapy, relatives' group, and a control group. Therapy continued for 10 to 20 weeks. A second research interview was scheduled 6 to 8 months following the close of therapy.

RESULTS

Findings indicated an approximately similar distribution of the families of origin and of procreation in the two substance abuse groups. Despite age differences, 59 percent of the drug addicts and 48 percent of the alcoholics entered the family study with only their parents or surrogates; another 9 percent and 14 percent, respectively, entered with members of both their families of origin and procreation. A second similarity between the two groups was the high rate of substance abuse, usually of alcohol, among the family members, especially fathers.

Families of Origin

The two groups of families differed in that two-parent families were more highly represented in the drug families, whereas single-parent families were more highly represented in the alcoholics' families. Despite the parental composition, there were common characteristics in these families. The first was a high level of reactivity to the substance abuse problem in conjunction with a relative lack of understanding about addiction and the nature of its role in the life of the addicted member. The second was an overly dependent relationship of the younger substance abuser, whether an alcoholic or addict, with the the parent figures. A third characteristic found in over three-fifths of the families of origin was either an absent or peripheral father figure. Another common syndrome was that of the parental child. Treatment steps included establishing rapport with each family member, decreasing the family's overreactivity, clarifying mutual expectations, and facilitating the individuation/separation process. The initial steps in both types of group sessions were similar. The structure of the parents' group advanced the process of individuation and separation. However, relatives' groups were hampered by lack of coordination and the inability to use role playing or restructuring tasks in the actual sessions due to the drug abuser's absense. A combination of the separate approaches did prove effective with one parents' group which met regularly throughout the study period. Findings on outcome failed to support the hypothesis that family therapy, in addition to regular inpatient treatment, would produce better outcomes than the usual treatment. More favorable outcomes occurred in families in which both parents were involved in the process, subjects were under 30 years old, and parents were younger. A case example illustrates these prognostic factors. Results of family therapy were not generally impressive, although some parents learned to shed guilt feelings and to become better parents.

Families of Procreation

These families represented the second large group in the study. One-third had partners who were also substance abusers. For subjects without a substance-abusing spouse, the marital status was generally poor. Only seven subjects had non-substance-abusing spouses and intact families. Goals in conjoint family therapy sessions were to reduce overreactivity, appropriately place responsibility for drinking or drug behavior on the addict or alcoholic, improve parenting skills, restructure the family, make peripheral addict fathers more central, and encourage work on the couples' intimate relationships. In three-generation households, realignment of the generational rôles was also necessary. Because few families of procreation have good prognostic characteristics, the unimpressive outcomes become more understandable. Better results have been noted in intact, two-parent families that have been treated following this study. However, in families of procreation that do improve, many changes occur whether or not the addict parent stops using drugs or alcohol. More appropriate interactions among the family members result.

Results also showed that in all the families except one, the children's behavior was an accurate barometer of the state of the parent substance abuser. With the parent's return to alcohol or drugs, the children displayed more antisocial behavior and performed poorly in school. A recent critical review of the offspring of alcoholics has also concluded that they are more likely to suffer from emotional disturbance, particularly antisocial behavior, compared to various control groups of children.

CONCLUSIONS

Results substantiate the hypothesis that the families of drug addicts and alcoholics are similar. Similarities were found in the distribution of family types, the high rate of alcoholism or problem drinking, and family dynamics. The treatment of the family is part of a total approach that offers a chance for the addicted member and the family to take a new step, together or apart, but with better understanding and less conflict. Treatment of families of procreation might be one approach to primary prevention. Further research is recommended.

Ziegler-Driscoll, G. Family treatment with parent addict families. In: Smith, D.E.; Anderson, S.M.; Buxton, M.; Gottlieb, N.; Harvey, W.; and Chung, T.; eds. A Multicultural View of Drug Abuse: Proceedings of the National Drug Abuse Conference, 1977. Cambridge, Mass.: Schenkman, 1978. Pp. 389-396.

DRUG	Multidrug; alcohol
SAMPLE SIZE	90 families
SAMPLE TYPE	Parent-addict and parent-alcoholic families
AGE	Not specified
SEX	Both
ETHNICITY	White; black
GEOGRAPHICAL AREA	Not specified
METHODOLOGY	Case studies
DATA COLLECTION INSTRUMENT	Observations
DATE(S) CONDUCTED	Not specified (1970s)
NO. OF REFERENCES	6

PURPOSE

This study, the extension of an earlier research effort, describes the characteristics of families with an alcoholic or addict parent--that is, families of procreation--and the problems they present for therapy. Two types of intervention, conjoint family therapy and spouses groups, are examined, and the results of a study on parent addict families are reviewed. Alcoholic parents are included with drug addicts to promote the hypothesis that any distinction between the groups seems more arbitrary than real.

SUMMARY

Family Characteristics

Ninety families participated in the Family Study, 51 percent with drugs and 49 percent with alcohol as the abused substance. The distribution of the families of origin and of procreation was approximately the same in the two substance groups; 37 percent and 36 percent were families of procreation in the drug and alcohol groups, respectively. Four (9 percent) and six (14 percent) of the subjects in these two groups brought parental figures into their family session. The

composition of the families of procreation groups is further subdivided into a subject and spouse group (11 drug subjects and 7 alcohol subjects) and a subject with family of origin group (8 subjects).

One-third of the subjects in the subject and spouse group (6 out of 18) are married to spouses who are also substance abusers, 4 of them active and 2 inactive. Families with an active spouse have experienced stormy relationships. Twelve subjects have spouses who are not abusers, but the marital status of five of these families is poor. Of this group of five only one family has continued in therapy after an initial session and progress has been poor. Of the seven families with intact relationships, only three have continued in therapy. They are characterized by the presence of children, intact family life, a spouse overreacting to substance abuse, a spouse with minimal understanding of addiction, a spouse attempting to control the subject, and parenting problems. The next subgroup, subject with family of origin, is made up of eight subjects, included because of their unique problems as parents of their own children as well as children of their parents. Only two families span three generations, and in these cases grandparents cared for addicts' children during addiction or treatment.

Therapy

The only spouse group organized has expired without the development of inner cohesion.

Conjoint family therapy has sought to reduce overreactivity by educating the spouse about addiction, by placing the responsibility for substance abuse on the alcoholic or addict to reduce spouse guilt, by improving parenting skills of both parents and restructuring family alliances, and by examining the couple's intimate relationship. In three-generational families, where the mother-subject is like a dependent child, generational realignment is necessary. This requires conjoint family therapy to increase the subject's adequacy as a parent, to shift grandparents from parenting of grandchildren to other acceptable activities, and to help grandparents and the subject develop mutual respect.

Preventive efforts are needed to aid children of addicts and alcoholics because these children have an increased risk of emotional disturbances and antisocial behavior as well as of substance abuse.

CONCLUSIONS

A large percentage of the families of procreation in the study possess characteristics predictive of an unfavorable outcome. However, admission of more intact, two-parent families to therapy would seem conducive to more positive results for intervention. Of 22 families treated from October 1974 to April 1976 (7 with a single parent and 15 with both parents, 12 white and 10 black), 15 (68 percent) improved with family therapy; 11 (73 percent) of the 15 families attended 5 or more sessions. There appears to be some correlation between degree of improvement and length of treatment. In improved families, parents have learned to assume parental roles, children's aggressive behavior has decreased, and subjects have come to relate to their own parents on an adult level.

Ziegler-Driscoll, G. Family research study at Eagleville Hospital and Rehabilitation Center. Family Process, 16(2):175-189, 1977.

DRUG	Not specified
SAMPLE SIZE	181
SAMPLE TYPE	97 alcoholics and their families; 84 drug abusers and their families
AGE	Abusers: (mean; 26); alcoholics (mean: 35)
SEX	86 percent male; 14 percent female
ETHNICITY	45 percent white; 55 percent black
GEOGRAPHICAL AREA	Philadelphia, Pennsylvania
METHODOLOGY	Clinical observation and survey--comparative
DATA COLLECTION INSTRUMENT	Observations; program/clinical statistics
DATE(S) CONDUCTED	Not specified
NO. OF REFERENCES	12

PURPOSE

Based on the philosophy that the likelihood of a favorable treatment outcome for substance abusers would be increased when members of their families were also engaged in treatment, the Combined Treatment Project and the Family Study Program were established at the Eagleville Hospital and Rehabilitation Center near Norristown, Pennsylvania. The project was also designed to test the philosophy that treatment in a mixed addiction unit is more effective than treatment in units composed entirely of drug addicts or alcoholics.

This paper describes the family study program and discusses an analysis of a sample of drug abusers, their families, and their course in family treatment. The Community School Program is also described as a demonstration of the potential for effective primary prevention. Areas of promise for future development are also reviewed, as they provide direction for further clinical and research work with the family and drug abuse.

SUMMARY

Eagleville Hospital and Rehabilitation Center is a private facility housing an abstinent, therapeutic community for the treatment of alcoholism and drug dependence. Two forms of family treatment are being tested: family therapy, in which the entire family, including the primary patient, is seen together, and outpatient relatives' groups. Most subject families are from the Philadelphia area; the two main groups include black Philadelphia families and primarily white working- or middle-class families of Montgomery County and adjacent areas. Training of the family therapists was conducted by staff of the Child Guidance Clinic of the Children's Hospital of Philadelphia. The sequence of contacts and interviews from admission to discharge included personal or telephone contacts, an open house, an orientation program, an initial research interview, conjoint family therapy, and a second research interview.

Staff resistance to the program and loss of patients and families from the program hindered both the clinical program and the research efforts surrounding it. Problems occurred at all phases of the program. These included refusal to enter the study, failure to stay in treatment, and many other problems. Analysis of a sample of 49 drug abusers and their families showed that the return to drug use following discharge was similar in both treated and nontreated groups. A total of 55 percent of the treated individuals and 54 percent of the nontreated individuals resumed drug use by the 1-month followup; the proportion increased to 68 percent for both groups by the second month. At the 4- to 6-month followup, however, 48 percent of the treated group were known to be abstinent, compared with only 25 percent of the untreated group. Further analysis indicated, however, that the most difficult cases were the ones most difficult to engage in treatment, in that 92 percent of those assigned to treatment but not getting it resumed use of drugs, compared to 44 percent of those receiving treatment. Another finding was that it was noticeably more difficult to involve black families in treatment. Results also indicated that family therapy appears to reinforce the abstinence pattern learned at Eagleville and also to improve the family's ability to cope when the index patient returns to drug use. Family therapy appeared to facilitate the process of disengagement of the adolescent or young adult from an overly dependent position in the family system toward a more differentiated and independent one. In addition, parents of the treated families have reported that they are relating better to each other and to their children and that the behavior and school performance of their children have improved. Thus, family therapy may prove to be an important preventive intervention.

A project in Eagleville's network, the Community School Program for junior and senior high school students in three Montgomery County school districts, was undertaken to provide honest alcohol and drug education to the students, their parents, and the schools. The program appears to be a promising alternative to earlier cognitive methods. The key worker in the program is the community counselor, who works in close cooperation with school personnel at the junior high school level but supplements their roles by providing a link between the student and the school-family-community triad. Following an orientation period of about 6 weeks, the counselor works individually with the students to develop trust and eventually approval to include their parents in the process. Meetings to get acquainted with parents are then begun. Parent Interaction Groups are designed to facilitate communication between and problemsolving by family members, and also better understanding of the family's role in preventing drug and alcohol use. The schools are gathering data indicating significant improvement in academic performance and school attendance as well as a decrease in disruptive behaviors among the students. The schools have also supported the projects financially.

CONCLUSIONS

Results indicate that conjoint family therapy and relatives' groups appear to be useful for white families and may be useful for black families as well. The Community School Program demonstrates a potentially effective primary prevention program. A longitudinal study of present treatment projects, such as the Family Program, is needed to determine long-term effectiveness and results for both the index patient and other family members. The possible relationship of enuresis (involuntary urination) to later drug use should be investigated. Such a study might seek to determine whether primary intervention can stop a progression to drug use and could be used to further examine the hypothesis linking "high risk" families and individuals to later drug and alcohol use. Positive responses to the idea of such a study from parents in the community school program indicate that cooperation is readily forthcoming when parents feel that helpers are truly concerned about trying to meet their needs.

Supplementary Bibliography

This selective bibliography should be viewed as a supplement to Stanton's comprehensive bibliography of the family and drugs field through early 1978 (see page 62, this volume). As such, the following bibliography is retricted to (1) those relevant articles abstracted in Research Issues Series Volume 4, noted by an asterisk (*), (2) those relevant articles abstracted in Research Issues Update, Research Issues Series Volume 22, noted by a dagger (†), (3) relevant articles listed in the supplementary bibliography in Research Issues Series Volume 4, (4) Peer Review Panel recommendations not abstracted in this volume, and (5) a noncomprehensive list of relevant literature published since Stanton's review. The bibliography does not include abstracts that appear in this volume. While the general family therapy literature is vitally important to the field of the family and drugs, this bibliography is of necessity restricted to the family literature that deals with drug use.

Babst, D.V.; Deren, S.; Schmeidler, J.; Lipton, D.A.; and Dembo, R. Study of family affinity and substance use. Journal of Drug Education, 8(1):29-40, 1978.

Balaban, B.J., and Melchionda, R. Outreach redefined: The impact on staff attitudes of a family education project. The International Journal of the Addictions, 14(6):833-846, 1979.

Becker, H.S. History, culture and subjective experience: An exploration of the social bases of drug-induced experiences. Journal of Health and Social Behavior, 8(3):163-176, 1967.

Bender, L. Drug addiction in adolescence. Comprehensive Psychiatry, 4(3):181-194, 1963.

Blum, R.H. Students and Drugs. San Francisco: Jossey-Bass, 1970. 399 pp.

*Blum, R.H., and Associates. Horatio Alger's Children: The Role of the Family in the Origin and Prevention of Drug Risk. San Francisco: Jossey-Bass, 1972. 327 pp.

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INDEXES

Terms are indexed to the first page of each abstract.

DATA COLLECTION INSTRUMENT

The specific instrument or scale used in the research reported by the study.

DRUG

The general and specific names of all drugs mentioned in the abstracts, as used by the author of the document.

GEOGRAPHICAL AREA

Organized by State; includes the cities, counties, or regions where the study was carried out.

INVESTIGATOR

All authors named in the citation to each abstract are listed.

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Terms that describe as specifically as possible the sample population studied.

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Terms that describe the subjects or concepts of the studies.

AGE, SEX, and ETHNICITY of the subjects are also indexed, as are the METHODOLOGIES employed in the studies.

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