National Institute on Drug Abuse

SERVICES RESEARCH MONOGRAPH SERIES

Family Therapy: A Summary of Selected Literature

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

Family Therapy: A Summary of Selected Literature

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

NATIONAL INSTITUTE ON DRUG ABUSE
5600 Fishers Lane
Rockville, Maryland 20857

The Services Research Reports and Monograph Series are issued by the Services Research Branch, Division of Resource Development, National Institute on Drug Abuse. Their primary purpose is to provide reports to the drug abuse treatment community on the service delivery and policy-oriented findings from Branch-sponsored studies. These will include state-of-the-art studies, innovative service delivery models for different client populations, innovative treatment management and financing techniques, and treatment outcome studies.

This report was developed by Burt Associates, Inc., for the National Institute on Drug Abuse, Division of Resource Development, Services Research Branch, under NIDA contract No. 271-77-4519.

DHEW Publication No. (ADM) 80-944
Printed 1980

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

Stock Number 017-024-00979-2

Family Therapy: A Summary of Selected Literature

by
Barbara Sowder
Susan Dickey
Thomas J. Glynn
Burt Associates, Inc.

1979

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

NATIONAL INSTITUTE ON DRUG ABUSE
5600 Fishers Lane
Rockville, Maryland 20857

Foreword

This review summarizes selected literature written or published through 1977 on the subject of family therapy. Specifically, it provides an overview of the findings from empirical research designed to determine the effectiveness of family therapy with drug and alcohol abusers and criminal populations. The authors also discuss the prospects for determining effectiveness of family therapy with various populations.

The report concludes that although the method of family therapy appears to have promise, claims as to its therapeutic effectiveness cannot yet be supported. Outcome studies dealing specifically with family therapy and drug abuse are far too limited in number and scope. It is suggested that more precise family therapy methods need to be defined and developed for work with the various subpopulations and within differing environments.

It is significant that the lack of information on family therapy outcome is not just limited to the drug abuse field. As is evident from this review, there are significant evaluative problems associated with the family therapy approach. The very definition of family therapy has not been agreed upon by the individuals who practice it. Despite these shortcomings, what is clear is the very strong sense of purpose and concern among those who continue to pursue this area--whether they be clinicians, researchers, or administrators.

We hope this document proves useful to those individuals who are committed to family therapy and to those who have not initiated this intriguing therapeutic approach.

Michele M. Basen
Public Health Analyst
Services Research Branch
Division of Resource Development
National Institute on Drug Abuse

Acknowledgments

The authors wish to acknowledge several individuals and organizations for their assistance in the preparation of this report. Staff of the National Library of Medicine, the National Library of Prisons, the National Criminal Justice Reference Service, the National Institute of Mental Health Clearinghouse, and the National Clearinghouse for Alcohol Information were most helpful in providing access to needed information. Others were kind enough to share their own or other people's reports: Drs. Milton Berger, Ronald J. Catanzaro, Sandra B. Coleman, Terry Levey, David H. Olson, Vincent J. Pisani, M. Duncan Stanton, James Williams, and Ms. Iola Scrafford.

We also wish to acknowledge the review and comments on the first draft of the manuscript by Drs. Sandra Coleman, James E. Lieberman, and M. Duncan Stanton.

Contents

Family Therapy: Development, Issues, and Approaches

THE DEVELOPMENT OF FAMILY THERAPY

Family therapy has gradually gained widespread acceptance as a psychosocial intervention technique since its recorded beginnings nearly 30 years ago. Four recent reviews serve as a valuable social history on the development of family therapy. Haley's (1971a) chronological account covers important events in the field and the evolution of the theoretical bases of family therapy. Fox (1976) focuses on important issues--theories, techniques, ethics, assessment, outcome, and training--and the individuals associated with them; other sections of the review are devoted to prominent figures such as Murray Bowen and Theodore Lidz. Guerin (1976) presents a similar developmental history but couches it in the context of the geographical regions associated with different theoretical concepts. Stanton (1979) presents a comprehensive and updated review of this field. The reader with a particular interest in the historical development of family therapy will find these sources excellent supplements to the brief review presented in this report.

Historically, accounts of treating whole families in therapy began to appear in the mental health literature in the early 1950s. These accounts reflect the influence of such pioneers in family therapy as Frieda Fromm-Reichmann (Haley 1970), Nathan Ackerman (1958, 1966a, 1966b), and Gregory Bateson and his colleagues (1956). Fromm-Reichmann's work in the late 1940s pointed to a greater improvement in schizophrenic children when their mothers were included in the therapeutic process. This led others to speculate about the role of the father as well as the mother in the development of mental and emotional problems. Bateson and his colleagues soon began to include both parents in their clinical research on the causes of mental and emotional problems. By this time, Ackerman was already quite experienced in working with families. In the early 1930s, he incorporated into clinical practice his belief that many emotional and mental problems originated in and could be treated within the family. His first writings on the subject were not published until 1958, but knowledge of his work through other channels greatly influenced the practice of many prominent family therapists.

The influence of these diversely oriented practitioners and researchers enabled two broader and interrelated theoretical developments to further the growth of family therapy. These are learning theory and systems theory.

The principles of learning theory (Bandura 1969; Hawkins et al. 1966; Wolpe 1958) are viewed as particularly relevant to family therapy because of their emphasis upon changing behavior, establishing a similar set of operations for behavioral change, and evaluating therapy outcomes. A vital aspect of this learning theory orientation is that it permits each family member to monitor how his or her behavior has changed and how this change affects the behavior of another family member (Patterson 1971; Patterson et al. 1968; Stuart 1969).

The concerns of systems theory--e.g., homeostasis, communication patterns, deviation processes--were adapted to the therapeutic process by Hoffman (1971), Jackson (1957), and Watzlawick and his colleagues (1967). In applying these concerns to family therapy, the primary emphasis has been on helping family members understand that no member acts in isolation, that the actions of each member affect the actions of other members. Helping family members realize and understand this interdependence of behavior among themselves has been a major goal of the systems-oriented family therapy. This therapeutic process seeks to counter and interpret the situation which most often brings a family to the therapy, that is, the symptoms of the one ". . . identified patient, whom the family labels as 'having problems' or 'being the problem'" (Minuchin 1974).

Other theoretical movements have influenced family therapy also, but seemingly to a lesser extent than learning theory and systems theory (Haley 1971b). Accounts of these other movements appear in Fox (1976), Haley (1971a), and Guerin (1976).

FAMILY THERAPY ISSUES AND APPROACHES

Currently, there are many family therapy approaches and techniques, but there is, as yet, no universally accepted definition of family therapy. Still, there are grounds of common agreement. One, obviously, is that the therapist should focus on the family rather than on the individual. Further, each family member is to be equally considered in the therapeutic process. Less universal, but quite common, is the practice of avoiding medical terms such as treatment, patient, mental illness, and therapy. This is done to reduce identification with the medical model of treatment and its accompanying designation of one individual as the source of the family's problems.

Family therapists seem to agree, therefore, that if therapy is to be successful, an "identified patient" cannot be the focus of treatment. This leads to numerous important questions concerning the process involved in the identification of one family member as

"the problem" or the "deviant" one--a process that takes place before therapy. Because the family therapist can only evaluate and help the family deal with the results of the process, rather than its development, it is essential for the therapist to understand the conditions most conducive to the development of the designation of a deviant individual in the family. A number of theoretical assertions have been suggested to help therapists understand these conditions or issues:

1. It is helpful if the family is viewed as a system. When this occurs, the problem or deviant behavior of any one family member is not viewed as an isolated act but may be viewed as either caused by the behavior of other family members or as resulting in changes in the behavior of other family members (Jackson 1957; Watzlawick et al. 1967).

2. The deviant behavior of one family member should not be considered as a random or inexplicable set of occurrences but as a behavior that fulfills a function. For example, a child's deviant behavior might function to draw the family's attention away from the family's feeling of being scorned by the larger community (Vogel and Bell 1960).

3. What may be considered as "deviant" behavior by one family may not be considered so by another family.

4. The causes and effects of deviant behavior in a family should not be viewed in isolation; several levels of the family system may be involved. Hoffman (1971) suggests that amplifying behavior on one level of the system (e.g., a child's defiance) may inhibit further deviance on another level (e.g., tension between parents that may break up the family). He and others (Buckley 1968; Nett 1968) believe it is unfortunate that therapists sometimes fail to view some deviant behavior as potentially beneficial on at least some level (such as a child's deviant behavior functioning to reduce tension, keeping the family together).

Most therapists agree that there is a deviance process similar to that described above, although different therapists use different terminologies in speaking of the process. And most agree that involving the whole family in the therapeutic process is the most efficient way of solving an individual's problems. Following are some examples of several major family therapy approaches used to counter and reverse the deviance process and engage the family's support in therapy.

Multiple Impact Therapy

This approach is a brief, usually 2-day, intensive study and treatment of a family in crisis conducted by a team of clinicians (e.g., a psychiatrist, psychologist, and social worker). Treatment is based on the assumptions that crises are times when families are most receptive to therapy and that greater progress

can be made in the early rather than in later stages of the difficulty (Caplan 1964; Macgregor 1962; Macgregor et al. 1964; Parad 1965; Ritchie 1960).

The interviewing procedures are somewhat unique. Interviews are held with the entire family unit and also with individual family members, both privately and in an overlapping interview. Team members focus on obtaining a family history and interventions are based on this material. In the overlapping interview, a team member who has been talking privately with a family member terminates this interview and joins another conference, either alone or accompanied by the family member s/he has been seeing. In this way, differences of opinion or interpretation between different family members are sometimes aired and resolved. Where there is an "identified patient," his or her communicative behavior may be shaped by being involved in gradually enlarged groups until s/he is comfortable speaking in the presence of the entire family.

A more recent but similar approach based on Milton Erickson's work has been encouraged by Jay Haley (1973, 1976). Sometimes termed "strategic therapy," the approach rests on a communications systems orientation. Intervention during crisis is considered desirable, therapy is brief (though longer than 2 days), and the entire family is seen (though perhaps in different groupings). The focus of therapy, however, is on presenting symptoms (rather than family history), and specific intervention strategies are based on identified symptoms.

Structural Family Therapy

This approach, like strategic therapy, is based on a systems-oriented family therapy (Guerin 1976) and is one of the most widely used techniques. It is the focus of this report because it has recently been used, apparently with some success, with families of heroin addicts (Stanton 1978a; Stanton et al. 1978; Stanton and Todd 1978).

Minuchin (1974), who has been most instrumental in developing structural family therapy, describes it as ". . . a body of theory and techniques that approaches the individual in his or her social context." It is based on three assumptions: (1) that the context of an individual's behavior affects inner processes; (2) that changes in context produce changes in the individual; and (3) that the therapist's behavior is significant in any movement toward change in the family structure. Minuchin considers the third assumption especially important, and stresses the therapist's intimate role in changing or "restructuring" the family's transactional patterns, alliances, subsystems, sensitivity to the individual member's actions, sources of support, and so on.

Minuchin and his colleagues have found these techniques especially effective when working with families they term "disorganized" (Minuchin and Montalvo 1967; Minuchin et al. 1967). Children or

young adults in these families are often the "victims" in the family's shifting alliances, and structural family therapy techniques reportedly help identify and change such subgroupings for the benefit of all, including the person the family has chosen to be the "victim."

Other Systems-Oriented Approaches

In one view, any therapist who ventures into the family area becomes, by implication, a "systems-oriented" therapist. Some approaches, however, are more grounded in systems theory than others. Particularly notable in this regard are those techniques and theories which involve the analysis of a family's communication problems and behaviors.

Although it is difficult to differentiate clearly the several approaches employing communications analysis in family therapy, several individuals have emerged as advocates of this set of techniques. A brief description of the ideas of each of these individuals follows.

Gregory Bateson. Although Bateson is clearly a leader in this field, several researchers/practitioners who have either worked with Bateson or relied on his concepts could lay claim to being on an equal plane in the application of systems and communications principles to family therapy (e.g., Don Jackson, Jay Haley, Paul Watzlawick, and John Weakland). Their clinical research with families led to two concepts which remain important in the theory and practice of family therapy today, namely, the concepts of double bind (Bateson et al. 1956; Weakland 1960) and family homeostasis (Jackson 1957).

The importance of these concepts for family therapy, more than the specific therapeutic techniques derived from them, lies in the way they require the therapist to view the family. The double bind concept emphasizes the disturbed communication patterns present in a family and calls for the therapist to be aware of these patterns and, especially, to make the family aware of them. The concept of family homeostasis requires that the family be viewed as a system which, when its balance is threatened, will take the necessary steps to recover or maintain that balance. Viewing the family from this perspective causes the therapist to radically reorient his/her approach to family therapy, to be aware of changes in the family system as well as the causes of those changes, and, most importantly, to make the family think of itself as a system.

Virginia Satir. In the late 1950s and early 1960s, Satir was associated, at the Mental Research Institute (MRI) in California, with a number of individuals from the Bateson group, notably Jay Haley and Don Jackson. She believes, quite simply, ". . . that by observing and learning to understand communication in a family we can discover the rules that govern each individual's behavior" (1971). Her technique involves viewing the family as

an open system which has developed its own rules about how changes may occur: (1) within individual family members; (2) between family members; and (3) between family members and the demands of the social environment (Satir 1967). She believes that the therapist helps the family to uncover these rules, make them explicit, and analyze how they affect the operation of their family system.

The goals of Satir's therapeutic approach are related to this analysis of family communication. Three changes in the family system are sought in the following ways:

> First, each member of the family should be able to report congruently, completely, and obviously on what he sees and hears, feels and thinks, about himself and others, in the presence of others. Second, each person should be addressed and related to in terms of his uniqueness, so that decisions are made in terms of exploration and negotiation rather than in terms of power. Third, differentness must be acknowledged and used for growth.
>
> (1971)

Satir believes that when these changes are able to be achieved, communication within the family will lead to appropriate outcomes. These "appropriate outcomes" are defined by Satir (1971) as:

> . . . decisions and behavior which fit the age, ability, and role of the individuals, which fit the role contracts and the context involved, and which further the common goals of the family.

Murray Bowen. Bowen has utilized systems theory and communications analysis in a somewhat different manner than have Bateson and Satir. First, Bowen believes that an "undifferentiated family ego mass" exists in varying levels of intensity in all families. This "conglomerate emotional oneness" (Bowen 1961, 1966, 1978) is, in its more intense forms, debilitating for a family. Its effects may be relieved by encouraging differentiation of self among the family members, that is, helping each member of the family to see themselves as individuals who are a part of many systems, including but not limited to, the family system.

Second, Bowen asserts that family problems are the result of a multigenerational transmission process. Intervention in this process may be accomplished by an analysis of current family interaction, as well as through historical analysis.

Finally, Bowen cautions that the identified patient in any troubled family may be involved in a very complex communications pattern. This individual may be "triangled," that is, forced to play the role of the mediator of communication between the parents. S/he may become the scapegoat and receive only negative communication or may remove himself or herself from family communication in order to survive as an individual.

Guerin (1976), in summarizing Bowen's approach, notes that:

> The Bowenian model is cautiously idealistic and optimistic about the human potential for growth and change. It is strongly based on a philosophy of free will. Education at its best is seen as a combination of the implicit knowledge of experiences, solidified and reproduced by cognitive appreciation of its form.

Existential Approaches to Family Therapy

Laing (1969) and Laing and Esterson (1964) suggest a helpful and unique way of considering families in which one or more individuals report emotional difficulties, although they offer no specific techniques.

The approach was derived from studies of families with a schizophrenic child. It involves reformulating the behavioral bases of such families. Ordinarily, the behavior of these families is considered bizarre or senseless because family interactions are seldom considered. However, Laing points out that the behavior may make sense if it is viewed in the original family context; there may be a good reason, however unspoken, for the seemingly bizarre acts of the family members.

Like Bowen, Laing considers the study of several generations of the same family an important diagnostic tool, especially where there is an "identified patient." Considering the identified patient's behavior in the context of other family members' behavior is believed to be especially useful. The patient's behavior that seems so inappropriate in most social contexts may come to be viewed as a necessary means of coping when considered in the family context.

SUMMARY

Each of the broad classes of techniques may be used in resolving difficulties faced by family units. The family structure, the problem at hand, and the particular skill and training of the therapist make up the variables that are considered when choosing a particular therapeutic modality or technique.

Haley (1971a) makes the further point that a family therapist, once he or she gains experience, will begin to view these techniques of family therapy ". . . not . . . as a method of treatment--one more procedure in a therapist's armentarium . . . but as a new orientation to the arena of human problems."

There is evidence that this new orientation is taking hold, that family therapy is being adapted to other than specific mental health problems. It is now being used in several other areas, including drug abuse, corrections, and alcohol abuse.

Family Therapy with Drug Abusers

Studies on the use of family therapy in drug abuse treatment represent a number of different theoretical orientations and therapeutic approaches. As in other fields, it may be used as the single approach, as a primary approach in conjunction with other supplementary treatment, or as a supplement to other services. Its function may depend, in part, upon the type of drug abuse treatment program in which family therapy is offered or on the population that is served.

Support for each of these uses of family therapy with drug abusers may be found in the literature. A serious gap appears, however, when one seeks empirical studies to substantiate the positive claims about the effectiveness of family therapy with drug abusers. Several authors do describe and provide data on the family therapy approach they used and the type of drug treatment clients served. Few, however, provide the type of experimentally controlled outcome data which would enable planners to make efficient decisions on introducing or expanding family therapy services in their programs. These experimentally based studies will be reviewed following a discussion of theoretical studies in the drug abuse field.

THEORETICAL STUDIES

Much of the literature on the use of family therapy with drug abusers represents an author's particular point of view or a review of other theoretical works. Given the fact that drug abuse treatment is a relatively recent development, establishment of a strong theoretical base for the use of family therapy with drug abusers may be a necessary step before conducting extensive experimental studies. Thus, it seems important to discuss some of the theoretical bases of family therapy in drug treatment.

These theoretical studies approach the role of the family in the drug abuse process from two major perspectives. One group attempts to describe the family of the addict either through a review of relevant literature or on the basis of interviews with the families of drug treatment clients (Seldin 1972; Harbin and Maziar 1975; Winer et al. 1973; Coleman 1976; Klagsbrun and Davis 1977). These studies are not covered in depth here because

they do not focus on family therapy per se, however, they do provide an important background for the practitioner. Each of these studies presents either a review of many studies not considered by the others, an approach to the topic from a different perspective than the others, or a unique source of data upon which the author's conclusions are based. Together, they provide a fairly comprehensive view of current considerations concerning the family of the addict.

The second set of studies specifically cite the need for family therapy or discuss existing family therapy programs for drug abusers. Since these strike the more immediate concerns of the practitioner and/or planner of treatment services, they have been given greater attention here.

BASIS FOR INCLUSION OF THE FAMILY IN DRUG ABUSE TREATMENT

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

Hirsch, for example, advocated group therapy with the parents of adolescent addicts as early as 1961. He cited several studies which 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. Parents were described as generally limited in the "language of feelings" and the ability to introspect, marriages were unhappy, and there was ambivalence reported toward the addict "child."

In Hirsch's report, 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," stated that "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 current decade, 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 but that only small proportions of clients are provided this service (Basen 1977; Coleman 1976).

Dell Orto (1974) reviewed the directions in which this interest was carrying the field through the early 1970s. He considered the important role earlier studies had assigned to the family in the drug abuse process and current therapeutic approaches to treating the family. Two approaches upon which he focused attention were multifamily therapy and systems approaches.

Multifamily Therapy

Klimenko (1968) was an early proponent of the use of multifamily therapy with drug addicts. More recent supporters of this approach are Berger (1973), Brown et al. (1973), and Bartlett (1975).

Berger (1973) describes the application of multifamily therapy in the context of a residential drug treatment program. The multifamily approach was begun to (1) provide staff with a wider network of resources to reach clients, and (2) to consolidate and educate the family members in hopes of making them allies in the therapeutic task. The format involved once-a-month evening meetings; all program residents and 10 to 18 relatives from 4 to 8 families attended. Berger states that the sessions generally focused on--

> . . . interaction, discussion, identification, and examination of those conflicts, attitudes, covert alliances and unconscious arrangements in families which have led to disruptive family patterns and possibly to drug usage. It is made clear that there is no one family pattern or attitude which always leads to drug addiction.

Brown et al. (1973) briefly describe a course of multifamily therapy with hospitalized drug addicts. Sessions were conducted once a week by a male/female cotherapist team with either two or three addicts and their families. A major program goal was to keep discharged addicts from returning to the problems associated with unchanged family patterns that are often stressful and lead to renewed drug use.

Bartlett (1975) describes a multifamily therapy process used in a short-term hospital detoxification program. The sessions were usually conducted with three or four adolescent addicts, their

families (one or two parents, siblings, a marital partner, or relative), two therapists, and a "participant-observer." The therapy was crisis oriented, i.e., designed to intervene in the crisis that precipitated the decision to detoxify. This intervention followed the assumption of traditional crisis theory (e.g., Caplan 1964; Parad 1965), that is, that crisis is a period of time in which possible change might occur. Families were brought into this process with the goals of educating them about the program, examining their relationships, teaching them to provide support for each other, helping them plan for the identified patient's postprogram rehabilitation, and aiding them in finding alternative methods for coping with problems.

A more descriptive and less therapy-oriented discussion of multiple family therapy, drug addiction, and crisis intervention may be found in Fram and Hoffman (1972, 1973).

Callan et al. (1975) broaden the concept of family and introduce social networks as a focus of therapy with the drug abuser. The network process has previously been described by Speck and Attneave (1971, 1973); the network is considered to be the significant members of the drug abuser's social environment, a group which usually includes the client's family. This process is viewed as a therapeutic activity in the same sense as traditional family therapy; it is seen as particularly important because it broadens the range of individuals whom the drug abuser may call upon for aid during the rehabilitation process.

Systems Approaches to Family Therapy

Several practitioners have recommended that principles of systems theory be more specifically applied to therapy with drug abusers and their families (e.g., Alexander and Dibbs 1975; Huberty 1975; Klagsbrun and Davis 1977; Levy and Joffee 1973; Noone and Reddig 1976; Olson 1972; Stanton 1976, 1978a,b; Stanton and Todd 1976, 1978; Stanton et al. 1978). The basis of their argument is rooted in earlier studies (e.g., Harbin and Maziar 1975; Seldin 1972) which described the addict's role in a family as often being a pivotal one that is vital in maintaining the balance of relationships in the family. If the addict is indeed playing this role, the other family members are likely to encourage it to avoid upsetting the family equilibrium. In that case, it is emphasized, treatment of the addict in isolation from the family or in ignorance of his/her role in the family is not likely to be successful. Huberty (1975) emphasizes the importance of this concept when he points out that--

> . . . If change is not made in the family system, which helped produce the drug abuser, and has helped to continue that abusive behavior, even a "rehabilitated patient" will revert back to the same problem behavior once he leaves the treatment facility and returns home to his previous role in the family environment. . . .

Levy and Joffee (1973) expanded upon this concept by suggesting that the addict may not only help maintain a homoestatic state in the family but also may aid by being the family scapegoat, facilitating interpersonal control, fulfilling unmet social needs, and modulating tensions in the family system.

The most comprehensive view of the relationship between systems theory and family therapy for drug abusers has been developed by Stanton and his associates (Stanton 1976, 1978a,b; Stanton and Todd 1976, 1978; Stanton et al. 1978). In a highly condensed summary, their position is that--

> . . . heroin addiction can be thought of as part of a cyclical process involving three or more individuals, commonly the addict and his two parents. These people form an intimate, interdependent, interpersonal system. At times the equilibrium of this interpersonal system is threatened, as when discord between the parents is amplified to the point of impending separation. When this happens the addict becomes activated, his behavior changes, and he creates a situation that dramatically focuses attention upon himself.
>
> (Stanton et al. 1978)

Additionally, they have developed a therapeutic approach based upon their theories, which they have recently detailed (Stanton and Todd 1978). Essentially, their approach is a brief therapy (usually 10 to 12 sessions) consisting of identifiable steps and phases which require the active participation of all involved, including the therapist. The authors have carefully evaluated the results of this program; these are discussed later in this section.

Other bases for including the family of the drug abuser in therapy have involved an examination of one part of the client population presenting itself for treatment, namely, the adolescent drug abuser.

Family Therapy with Adolescents

Hirsch (1961), as noted, early advocated group therapy with the parents of adolescent addicts; his belief that family therapy is particularly appropriate for adolescent drug abusers has since been shared by numerous practitioners (Canerini 1970; Gottesfeld et al. 1972; Gottschalk et al. 1973; Hagglund and Pylkkanen 1974; Kempler and Mackenna 1975; Kovacs 1975; Wellisch and Kaufman 1975; Wieland et al. 1975; Will 1974). Factors that encourage use of family therapy with adolescents are (1) that they are more likely than older drug abusers to have some formal family ties, and (2) that their drug problem may not be a long-standing one.

Several unique programs have been designed to reach this population most effectively. Wieland et al. (1975) describe a network of "family mediation" centers designed primarily to prevent adolescent drug abuse, but which are also utilized by youth currently using

drugs. These centers attempt to attract youth and their families before drug use becomes a serious problem. The attempt to involve the family is based upon the authors' experience and previous research. This suggests that if the therapist can become familiar with the individual in the context of the family system, then intervention in this system may yield more effective change. They further note that "the family may have more problems than the identified client and may sabotage any change if other members are not involved in the process." Gottschalk et al. (1973) describe a similar program primarily aimed at prevention and including the adolescent's parents; the results of a preliminary evaluation of the program's success are presented later.

Adolescent drug abusers and their families have also been treated at a clinic which Kovacs (1975) describes as having "a curious balance of unstructured creativity and traditional professionalism." The family's involvement in the adolescent's treatment is seen as essential to the process of rebuilding relationships.

OUTCOME STUDIES

A thorough review of the literature suggests that there has been little research that provides empirical data on the outcome of family therapy with drug-abusing populations. The paucity of this research has been noted elsewhere. For example, Stanton (1978c) comments that--

> . . . it is somewhat surprising that family treatment of addicts has not received much attention from researchers. While such therapy has gone on at a number of centers and is gaining more visibility and momentum, it has generally not been accompanied by evaluative efforts. In their comprehensive review of the outcome research on marital and family therapy, Gurman and Kniskern (1978) located over 200 studies, and only two (including Stanton and Todd 1976) dealt with drug addicts or abusers. This is unfortunate, as the approach has shown enough promise with other types of disorders for Gurman and Kniskern to note that in every study in which it has been compared with other kinds of treatment, it has emerged with equal or, in two-thirds of the studies, superior results.

Perhaps, as indicated previously, an initial period of theory consolidation has been necessary before meaningful research on effects can be conducted. Additionally, not much family treatment was conducted with drug treatment clientele and, as in all clinical research, a number of methodological problems have made such evaluation difficult; these are discussed in a later section of this report. The few empirical studies that have been conducted are discussed below.

The most comprehensive of the empirical studies is reported upon by Stanton (1976, 1978c) and Stanton and Todd (1976, 1978). Four randomized treatment groups were created for a period of 5 months. The four groups consisted of (1) a paid family therapy group, with payment contingent upon the number of family members attending each session and avoidance of dirty urines ($\underline{N}$=13); (2) an unpaid family therapy group, treated under the same procedures as the preceding group except for lack of payment ($\underline{N}$=11); (3) a family movie treatment group whose members were paid, as in group 1, for viewing noncontroversial anthropology movies selected for their plausibility, generally innocuous content, and lack of opportunity for much family interaction ($\underline{N}$=9); and (4) a nonfamily methadone-only group whose members received no family treatment ($\underline{N}$=13).

Six months after treatment was terminated, followup interviews were held with the addict and at least one or both of his parents; often a supplemental interview was held with a spouse, sibling, important relative, parole officer, and/or drug counselor. The five dependent or outcome variables measured were the percentage of days during the 6-month period when the ex-client was (1) working or in school; when s/he was free of: (2) heroin and opiates; (3) heroin, opiates, and methadone; (4) all illegal drugs, including marijuana; and (5) illegal drugs and alcohol.

The paid structured therapy group had statistically significant ($\underline{p} < 0.005$) lower mean scores on variables 2 through 5. Thus, although the sample sizes are quite small, the study results suggest that brief, paid, structured family therapy may be an effective method of therapeutic intervention for drug-abusing populations.

Hendricks (1971) describes an evaluation of the effectiveness of a multifamily therapy program for male drug addicts; 85 addicts were randomly selected for the study. Eleven groups of addicts and their families were formed; the modality used for each group differed. The mean length of participation in the program of weekly sessions was 5.5 months. No comparison group was included, although the participants were compared, on selected variables, to the total inpatient population, there is no guarantee of client comparability.

Followup interviews were conducted 1 year after termination. Remaining in outpatient status was the outcome variable used. The results indicated that 41 percent of the individuals remained in outpatient status after 1 year of supervision; Hendricks notes that this figure "compares most favorably with the one year followup rate of 21 percent for all male outpatients released during the same year." Although Hendricks does not subject these data to statistical analysis, such an analysis was done for this report. The results suggest that the difference between the outpatient status adjustment of the study group and the general male clinic population is statistically significant (χ^2=10.73, df=1, $\underline{p} < 0.01$).

Ziegler-Driscoll (1977) presents some preliminary findings on the effectiveness of family therapy provided to residents of a therapeutic community. These data also suggest that family therapy may be a fruitful approach. At 1-month followup, only a slight difference in drug usage was found between 37 treated clients and 12 nontreated groups (55 and 54 percent, respectively); at a 4- to 6-month followup, however, the prevalence of drug use had remained stable among the treated group (52 percent) but had increased among the nontreated group (75 percent). It is not clear from the presentation whether the treated and nontreated groups were randomly assigned. It is also not clear whether the observed differences were statistically significant.

Similar but independent studies by Funk (1974) and Gottschalk et al. (1973) provide additional outcome data. Funk describes a program for both youths adjudicated on drug charges and their families. The program goals were to educate the participants about drug use and to involve the youths and their families in exercises designed to improve family communication. Although the program activities are not termed "family therapy," applying the term to these activities would not be incorrect. Three family sessions were held. Nine-month followup interviews were conducted to compare the mean number of offenses (total and drug-related) with which the 62 youths were charged before and after program participation. The results suggest that the program was quite successful in its attempt to reduce recidivism. The mean number of total preprogram offenses for each youth was 2.0, compared to a postprogram mean of 0.55; the difference was statistically significant ($t=6.27$, $p < 0.001$). The mean number of preprogram drug offenses for each youth was 1.1 compared to a postprogram mean of 0.15; this difference was also statistically significant ($t=10.74$, $p < 0.001$).

Gottschalk et al. describe a similar program and present outcome data in the form of participant self-reports. These data were collected from parents ($N=17$) and youths ($N=12$); they suggest that the program was seen as meeting the needs of most participants (82 percent of the parents and 52 percent of the youths); that it would be recommended for others (100 percent of parents and 92 percent of youths); and that it should be continued for many (89 percent of the parents and 58 percent of the youths). The bases for these figures and recommendations, however, are not clearly stated.

SUMMARY

Clinically based reports argue for the utility of family therapy in assisting the drug abuser, especially the adolescent, in overcoming his or her problems. There are, however, few outcome data to support the positive statements found in the clinical literature. Existing studies are based on small sample sizes, different family therapy approaches, and they often lack equivalent comparison groups. The findings cannot be generalized to all

family therapy services in the drug treatment field. However, they suggest that several family therapy approaches (e.g., structural and multifamily therapy) are effective in treating drug abuse clients.

Family Therapy with Alcohol Abusers

The literature contains many positive claims about the effectiveness of family therapy with alcoholics. As in other fields, such claims are based mostly on clinical impressions which have been supported by a few recent empirical studies. These studies will be discussed after a brief presentation of major theoretical orientations related to the use of family therapy in the alcoholism field. It can be noted that the theoretical considerations and studies are limited to alcoholism; there appear to be no attempts yet to focus on concurrent use of alcohol and other drugs.

THEORETICAL ORIENTATIONS

The use of family therapy with alcoholics is a relatively recent development. During the 1950s, the prevailing theories on alcoholism were not compatible with the psychosocial concepts underlying the emerging field of family therapy. Alcoholism was then viewed as a disease which absolved the patient of any responsibility for his or her behavior. Treatment reflected such theories of causation as biochemical sensitivity and oral dependency (Davis et al. 1974).

In the late 1960s many investigators began to believe that environmental factors were important contributors to alcoholism. The behavioral model gained in prominence and family therapy was introduced into the field. Alcoholism began to be viewed as a symptom of larger family problems (Steinglass 1976; Steinglass et al. 1971).

Since that time, no standard definition of family therapy has been adopted in the field. Many definitions appear in the alcoholism literature, and they reflect diverse opinions about who should be included in family therapy and/or which method of intervention should be used and in which setting.

There are also various different theoretical concepts related to the drinking process; these generally incorporate a systems theory approach, and alcoholism and family treatment are viewed in the context of that system. Among the most influential theorists and/or practitioners on this subject are Bowen, Ewing, Fox, Steinglass, Davis, and their associates.

In Bowen's (1974) framework, "excessive drinking occurs when family anxiety is high." This excessive drinking heightens the anxiety of family members who are dependent upon the drinker; they, in turn, "react by anxiously doing more of what they are already doing." Bowen states that this "process of drinking to relieve anxiety" and "increased family anxiety in response to drinking, can spiral"; the result may be "functional collapse" or the development of a "chronic pattern." In his view the goal of family therapy is to reduce the level of spiraling anxiety so that family functioning patterns can be examined and improved. Bowen believes that any "significant" family member who can "'cool' the anxious response," or their own anxiety, "can make a step towards deescalation"; thus, family therapy sessions may be limited to one or two family members without the drinking member necessarily being present.

Ewing and Fox (1968) view alcoholism as an established part of rigid family interactional patterns which maintain family homeostasis. All family members strongly resist changes in drinking patterns--including abstinence--because the changes threaten the family "status quo." Steinglass (1976) also notes that alcoholism may serve as a stabilizing factor in the family, one which produces "extremely patterned, predictable, and rigid sets of interactions." In his view, these interactions reduce uncertainties not only about family life but also about the family's relationship to society. Thus, the goal of family therapy is to increase understanding about the role of drinking in the family so that interpersonal relationships may be improved. Treatment is focused on nurturing family growth, rather than on a reduction in drinking, and the entire family is viewed as "the patient."

Davis and associates (1974) include aspects of behaviorism in their theoretical approach. They view alcoholism as having certain adaptive consequences which all family members reinforce in ways that maintain the drinking habit. In this framework, the goals of family therapy are to discover the adaptive functions and reinforcements of drinking, to help the family members use this adaptive behavior during periods of sobriety, and to assist members in learning adaptive alternative behaviors.

OUTCOME STUDIES

There is very little published research on the effectiveness of family therapy with alcoholics. Most of this research has been conducted by specialists in alcohol rather than by family therapists.

Most of the research based on family therapy outcomes with alcoholics appears in two reviews by Steinglass (1976, 1977). The 1977 Steinglass review includes only 10 studies. All of these support the use of family therapy with alcoholics. However, these studies are so limited in number, comparability, and methodological rigor that one cannot draw any firm conclusions about the effectiveness of family therapy with alcoholics. For example,

outcome measures ranged from highly subjective measures such as social and marital satisfaction to measures of abstinence from alcohol. The use of abstinence as an outcome measure is especially controversial because of existing research which indicates that some alcoholics are able to drink socially after receiving treatment (Ewing 1974; Pattison 1968; Pattison et al. 1968).

The studies included in the Steinglass reviews are further limited by the nearly universal failure of the researchers to use comparison groups or to include many female alcoholics in their samples. The failure to include female alcoholics in outcome studies may introduce a bias that has serious implications for treatment. Meeks and Kelly (1970), for example, have argued that--

> . . . wives of alcoholics seemed better able to shift the focus to the family unit and to view their own behavior within the framework; husbands, with their masculinity and competence at stake, may have a greater need to keep the alcoholic wife in the sick role. When the husband is the alcoholic he may have less difficulty relinquishing the role of identified patient.

A large-scale and as yet unpublished study of family therapy outcomes supports the claims of sex differences in treatment for alcoholics. These differences were found by Williams (1972) in his evaluation of the Hospital Improvement Project at the Center for Alcoholics in Avon Park, Florida.

In that study, 44 percent of 647 patients offered family therapy chose to participate in that treatment. Only 17 percent of the total 647 completed the 4 sessions (initially in the office and later at the client's home) that were intended. Intact families were far more receptive to the treatment than other families; about three-fourths of the patients living with a spouse and children received the therapy. Also more likely to participate in the family therapy were patients of "middle class and above" social status. While nonwhite patients were as likely as white patients to accept the therapy initially, nonwhites were less likely to complete all three home sessions.

Participation in the family therapy appears to contribute to full-time employment and increases in attendance at Alcoholics Anonymous among patients at followup (i.e., 6 to 12 months after discharge); these findings were more characteristic of male than of female patients. The family therapy also seemed to influence the likelihood of abstinence at followup; this finding was more characteristic of patients who completed all four therapy sessions. At followup, a majority of the males showed significant changes in "gains in self-awareness"; these changes were not found in the majority of females, even though females were judged to have a "less severe" degree of impairment on psychiatric formulation measures at the time of intake.

Data from two small-scale studies raise the question of whether many alcoholics hold as positive a view of family therapy as professional proponents of the method.

Price and Curlee-Salisbury (1975) obtained attitudinal data from 51 male alcoholics after their discharge from alcoholism treatment at the Veterans Administration Hospital in Indianapolis. These men rated eight treatments they received on eight "helpfulness" dimensions; treatment included such interventions as group therapy, individual counseling, lectures, and family counseling. Of the treatments, family counseling received among the least favorable ratings on "worth," "therapeutic benefit," and "pleasantness" and was not ranked highly on the remaining five dimensions.

Similar results have been reported by Hoffman et al. (1975-76). They compared attitudes toward treatment among two groups of male alcoholics who had previously completed a 6-week Alcoholics-Anonymous-oriented program where they received the six types of treatment (detoxification, lectures, group therapy, individual counseling, work therapy, and family therapy). In rating treatments, a significantly higher percentage ($p=0.03$) of the "successful" group rated family therapy as "most helpful";[1] however, the percentages of "most helpful" responses were quite low in both groups (22 versus 7 percent in the "successful"--N=37--and "unsuccessful" groups--N=46). In terms of the "total" group, family therapy was as likely to receive a "least helpful" (14 percent) as a "most helpful" (13 percent) rating. Treatments that received the highest percentages of "most helpful" ratings from the total group were group therapy (54 percent) and individual counseling (26 percent).

While one obviously cannot generalize the findings from the two studies on attitudes toward family therapy to the large universe of alcoholics, these studies do suggest significant optimism in this area.

SUMMARY

Reports based on clinical impressions suggest that various types of family therapy are effective in the treatment of alcohol abuse. Positive claims have been made by professionals for a systems approach using concurrent therapy, conjoint therapy, and marital-couples therapy. Two small-scale studies on client attitudes raise the question of whether alcoholics view family therapy as positively as do clinicians.

Empirical studies provide limited support for the clinical impressions. These studies generally are based on small samples, lack

---

[1] These differences in group ratings may be related to statistically significant group differences in marital status and educational backgrounds. Compared to the "successful" group, the "unsuccessful" group was less likely to be married at the time of the study (41 versus 73 percent) and had fewer mean years of education (9.5 versus 11.8 years).

comparison groups, focus on male alcoholics, and use a variety of therapies and outcome measures. The research findings cannot be generalized to all treatment programs and all alcoholic clients.

Family Therapy with Offenders

There are two rather distinct types of literature on the use of family therapy with offenders. One focuses on the institutionalized adult offender, the other on the juvenile offender. The theoretical bases for the use of family therapy differ for the two populations and empirical studies apparently have been conducted only on the juvenile populations.

The brief discussions that follow are limited to (1) major clinically based studies on adult offenders and (2) major empirical studies on juvenile offenders.

FAMILY THERAPY WITH ADULT OFFENDERS: THEORETICAL AND TREATMENT PERSPECTIVES

Although there has been an increasing number of small experimental family therapy programs for adult offenders, the method is not well established in the correctional system. The reasons for its slow acceptance are at least twofold. First, the traditional system has operated on the assumption that the individual is responsible for his or her own actions; therefore, most rehabilitation has been directed toward effecting change in the individual offender, rather than the offender's family. Second, family therapy was developed initially to assist intact families; modifications were required before it could be used with families separated by the institutionalization of a family member (Bell 1975). Literature on the use of family therapy with adult offenders is largely based on clinical impressions.

Institutionalization reportedly results in special problems common to inmates and their families. Fearing their families will reject them, offenders are seen frequently as rejecting their families first. Often offenders experience a division of loyalty between their family and their prison inmates and eventually identify primarily with the institution. During the extended separation, the family may label and depersonalize the offender and members may reorder their lives by finding new friends, activities, and values. When these events occur, it becomes difficult to reintegrate the offender into the family upon release (Bell 1975).

Further, children may not be told of their parent's imprisonment; they may feel their parent has abandoned them and experience feelings of rejection and separation anxiety. Such problems have been associated with delinquency among offenders' children (Wilmer et al. 1966).

The few descriptions of institutional family therapy programs suggest that this approach may alleviate the special problems experienced by offenders and their families. When family members discuss their difficulties during the therapy, an atmosphere of understanding and mutual support develops, and family boundaries are strengthened to foster family unity (Bell 1975; Ostby 1968). As this identification and involvement with the family is nurtured, the offender's strong identification with the institution weakens. The family's tendency to label and depersonalize the offender may be prevented also as the family begins to understand the offender's motivations for committing the crime and their own contributions to those motivations (Bell 1975). Moreover, including children in the institutional family therapy reportedly prevents delinquency (Wilmer et al. 1966). Finally, because family therapy provides access to the individual's established social system (rather than treating the individual in isolation), it is said to achieve a major goal of the correctional system--the positive socialization of the offender (Chaiklin 1971; Bell 1975).

Based on his work, Selsky (1962) recommends that family therapy be initiated immediately after sentencing so that family members can (1) be referred to proper agencies for needed assistance, (2) be helped to discuss and understand the events that occurred during the hearing and sentencing, and (3) become acquainted with the rules and routines of the correctional facilities.

Bell (1975) discusses several different approaches available to the correctional family therapist: (1) working with the family as a unit while assuming that as change occurs in the family the individual will also change, (2) working simultaneously with the family unit and with each member separately, (3) working with the offender while the family is present but not participating, and (4) working with each family member, but in separate groups. He contends that the first approach has the most rapid, manageable, and functional impact.

Common institutional practices and lifestyles, of course, may present special problems to the family therapist. For example, if custodial problems arise, a stranger (escort) may be present in the family therapy session. Visiting rules may limit the frequency of family visits and, therefore, the frequency of the therapy sessions. Rules that prohibit expressions of physical affection among spouses and children may be another inhibiting factor present in the therapy session. And, offenders may be dissuaded from participating in the therapy by inmates who are not in the family therapy program.

Based on their pilot program, Wilmer et al. (1966) concluded that the common problems facing correctional family therapists can be

overcome if administrators are committed to the program and the therapy is made available to and accepted by most prisoners. They note also that visiting restrictions and other rules which have an adverse impact on the therapy can be relaxed under the therapist's supervision; such procedures, in fact, may be an incentive for offenders to participate in the therapy. To best ensure the success of a family therapy program for adult offenders, Bell (1975) recommends a well-developed institutional policy that clearly defines the relations between institutional staff and participating families.

FAMILY THERAPY WITH JUVENILE OFFENDERS: THEORETICAL PERSPECTIVES AND OUTCOME STUDIES

Three major approaches to family therapy with delinquents appear in the literature; these are based on structural systems and behavioral theories (e.g., Alexander and Parsons 1973; Beal and Duckro 1977; Minuchin 1964). The three approaches share two major therapeutic goals. One goal is to improve family communicaton and understanding and to increase parental responsibility and control of the child. This goal is based on the assumption that the family acts to generate the individual's delinquency. The second goal is to avoid or reduce the impact of the correctional system on the adolescent; it rests on the assumption that the system affects the youth adversely (Beal and Duckro 1977; Schregardus 1974; Summerhays 1974).

Assignment of the juvenile offender to family therapy rather than to an institution is proposed because retention in the community (1) avoids the effects of labeling, (2) improves the home situation, and (3) avoids placing the offender in close contact with juveniles who have committed serious crimes. In cases where the offender is released from the institution and returns home (as most do), family therapy ensures that s/he will not return to the same "untreated" environment that contributed to the delinquency (Beal and Duckro 1977).

Only a few studies have been conducted to determine the effectiveness of family therapy with juvenile offenders; most of these have focused more on evaluating pilot diversionary programs than on assessing individual client outcomes. The major evaluations and their outcomes are described briefly below.

Two evaluations were conducted by Alexander. In one study, 40 families were assigned to 1 of the following 4 groups: (1) group family therapy combined with active individualized supervision by a probation officer, (2) group family therapy only, (3) no family therapy but active supervision by a probation officer, and (4) a "no treatment" group. Improvement was seen in all groups, but none of the families attained the levels of communication characteristic of "normal" families. The first group showed the most

improvement; this finding suggested that the group family therapy outcome is enhanced when it is accompanied by the probation officer's individualized contact with the youth. In a later study, Alexander and Parsons (1973) examined the outcomes of different types of family therapy. Eighty-six families were assigned to three groups: (1) a short-term behaviorally oriented family therapy group, (2) a client-centered family group therapy and a psychodynamic family therapy group, and (3) a "no treatment" group. Although all groups showed a reduction in delinquent behavior, recidivism was not entirely eliminated. Only the group provided the behaviorally oriented therapy significantly modified family interactions; these changes included clarity and precision in communication, increased reciprocity of communication, and social reinforcement involving the equivalence of rights and responsibilities of family members.

An evaluation of crisis family therapy as a diversionary program for juveniles in need of supervision and adjudicated delinquents was conducted by Baron and Feeney (1976). It included 1,785 youths who received crisis family therapy and 769 youths whose cases were handled in the traditional manner (the "control group"). The findings indicated that the crisis family therapy was successful in reducing recidivism and in diverting delinquent youths away from the criminal justice system. Evaluations of other family therapy projects support these findings (Beal and Duckro 1977; Schregardus 1974; Stratton 1975; Summerhays 1974). Baron and Feeney also reported that the cost of the family therapy project was less than half the cost of traditional methods of handling delinquency and supervision cases (i.e., detention and probation).

Many of the program evaluation reports include discussions of the willingness of families to participate in family therapy and their satisfaction with the therapy (Alexander and Parsons 1973; Hunt and Hoffman 1975; O'Neil 1971; Schregardus 1974; Stratton 1975; Weaver et al. 1977). Schregardus reported a high degree of participation in and satisfaction with family therapy among 163 program clients and their families; by the end of the first year of program operation, the major referral source was no longer the police but the juveniles themselves or their families. Weaver et al. (1977) also reported very favorable client responses to a similar family therapy diversion project. Their survey of an undefined number of families in this project caseload revealed that 30 percent found family counseling to be "very helpful"; 50 percent found it "helpful"; 15.4 percent found it "somewhat helpful"; and 3.8 percent found it "not helpful." All families said they would contact the program again if there were further family difficulties.

Some cautionary statements appear among these positive findings. For example, Alexander and Parsons (1973) reported that the families they studied showed an initial (but not later) resistance to facing major issues that had led to the delinquency. Stratton (1975) states that the positive family responses he obtained to a family therapy diversion project should be viewed with caution. He suggests that minority group families and/or families of low

socioeconomic status may give favorable responses to diversion programs because they believe such responses will keep them in good standing with authorities. Obviously, more studies are needed on client satisfaction, as well as on behavioral outcomes and their relationship to different types of family therapy programs.

SUMMARY

The use of family therapy with adults in the correctional system has been limited to pilot or experimental programs. The literature on the subject tends to focus on the rationale for the use of family therapy rather than on empirical outcome data or on practical guidelines for integrating this approach into existing correctional programs. The approach, however, has been credited with overcoming or preventing problems associated with institutionalization, extended family separation, the inadequate socialization of the offender, and the family's contribution to antisocial behavior.

Family therapy is more widely accepted as a treatment for delinquent youths, particularly in association with diversion from the criminal justice system. Studies of family therapy with juveniles include some empirical data on client outcomes, but they are primarily program evaluations. In all studies reviewed, family therapy is reported to be an important element in diverting youths from the criminal justice system and reducing recidivism. Family conditions, however, may influence the degree of improvement derived from therapy, and there are conflicting reports concerning family acceptance of and satisfaction with the family therapies provided to juvenile offenders and their families.

Drug Abuse, Family Therapy, and Evaluation

The central question facing any program administrator who is considering implementing a new treatment modality is a deceptively simple one: Does it work? When analyzed more carefully, this question spawns numerous others. For example, is the new treatment modality a single entity or is it an umbrella term for several related submodalities? If so, do any "work" better or worse than others? And, for what type or types of problem behaviors? What does "work" mean--does it refer to a specific outcome or to a generalized change in behavior?

These and many other questions are likely to be raised by the clinical and administrative staff of any drug treatment program when they consider introducing family therapy as a treatment modality (e.g., Coleman 1976). As previously cited studies show, several of these questions may now be successfully addressed. However, the question which may be the determining factor in the decision to use family therapy with drug abusers concerns its effectiveness in reducing or eliminating drug use--and it is the answer to this question which remains a moot point.

Certainly, the evidence on drug abusers cited previously (e.g., Funk 1974; Stanton 1979, 1978a,b; Stanton and Todd 1976, 1978; Ziegler-Driscoll 1977) suggests that family therapy may be an effective treatment method for this population. However, it is difficult to use terms stronger than "suggest" because of the limitations of current research. These limitations include a paucity of adequate outcome studies, inadequate sample sizes, lack of adequate control or comparison groups and the limited number of valid "success" measures.

In the absence of a sufficient number of outcome studies to either indicate or contraindicate the use of family therapy with drug abusers, one must ask if there are not other resources to aid a program administrator in deciding whether or not to introduce family therapy into a program. The answer is that some guidance may be provided in the growing body of literature on family or marital therapy outcome not limited to specific problems such as drug abuse. A brief review of the major family therapy outcome studies follows below.

OUTCOMES OF FAMILY THERAPY

In discussing the results of family therapy, Fox (1976) notes that "the evidence for the efficacy of family therapy is short of overwhelming." Fox points out, however, that it may not be the technique itself that is ineffective but, rather, the means used to measure its effectiveness. Fox acknowledges that--

> Family therapy researchers face all the problems attendant on research in individual psychotherapy . . . together with other problems particular to this field:
>
> 1. The unit of study is larger and more complex.
>
> 2. Events that transpire are often the result of many factors.
>
> 3. The identification and control of variables is complex and difficult.
>
> 4. The unit of study is in a state of continuous change.
>
> 5. The observer is often part of the system he observes and may change with it.
>
> 6. The area of study is wider, encompassing communication and group variables, as well as contextual variables such as community, cultural, and social pressures.

In addition to these problems, Fox cites the list of difficulties inherent in all outcome research. These include the lack of (1) adequate "success" criterion measures, (2) an acceptable method of comparing different treatment methods, and (3) a universally acceptable diagnostic or classification system for the clinical conditions being studied. Fox concludes that--

> . . . outcome studies are plagued by major problems at every stage of the scientific enterprise, from specification of the important antecedent conditions in the participants, through precise delineation of the intervening treatment variables, to measures of specific results.

Other reviews of family therapy outcome studies, including Olson (1970), Winter (1971), and Goodman (1973), have concurred with Fox's assessment. Still others, such as Beck (1975) and Wells et al. (1972), view the efficacy of family therapy more optimistically, while acknowledging the fact that the treatment method has thus far been ill served by the research methods used to assess its effectiveness.

In a recent comprehensive review, Gurman and Kniskern (1978) carefully, critically, and systematically cover over 200 relevant studies. Although only two of these studies deal with family

therapy with a drug-abusing population (Stanton 1978; Hendricks 1971), the results are nevertheless important for this field. Among the conclusions of Gurman and Kniskern is the cautious assessment that--

> Family therapy appears to be at least as effective and possibly more effective than individual therapy for a wide variety of problems, both apparent "individual" difficulties as well as more obvious family conflicts.

Even this muted endorsement is given tentatively because of the methodological difficulties outlined in Fox (1976) and reiterated in Gurman and Kniskern.

PROSPECTS FOR DETERMINING THE EFFECTIVENESS OF FAMILY THERAPY WITH DRUG ABUSING POPULATIONS

This review of studies on the outcomes of family therapy with drug abusers and other problem populations suggests that this method has promise but that few claims for its therapeutic effectiveness have been or can be made. Those outcome studies dealing specifically with family therapy and drug abuse, although limited in number and scope, suggest more strongly than many of the studies reviewed in Gurman and Kniskern that family therapy may be an effective modality. A drug treatment program administrator or clinician interested in either instituting or expanding family therapy in a program can only be advised to become familiar with the literature and to keep abreast of current developments and applications of family therapy to drug-abusing populations.

It will be particularly important to monitor developments as more extensive findings are reported from research projects instituted over the past several years. As such projects proliferate, research methods will probably become more sophisticated; this will enable researchers to better clarify the effectiveness/ineffectiveness of family therapy with drug-abusing populations.

Implications for Treatment and Research

At this stage of its development, family therapy treatment and family therapy research should not be considered as separate entities. Any drug abuse problems treated through either the exclusive or the supplementary use of family therapy should be regarded as an opportunity to study the essential question--does it work?

As noted previously, the implications of this question are not as simple as they may appear initially, and they give rise to a growing spiral of other questions. Some treatment and research approaches drawn from the implications of the original question and designed to answer a number of subsidiary questions are outlined below.

First, there is a strong need for well-controlled longitudinal studies of the effects of family therapy with drug-abusing populations. Although longitudinal studies are desirable when conducting clinical research of any type, the need is especially relevant in this case. Gurman and Kniskern (1978) report that their review of family therapy studies suggests that deterioration of effectiveness may occur when the longitudinal technique is employed. Additionally, the psychological nature of the drug abuse situation may produce false positive errors when evaluation of treatment effectiveness is monitored only for a short period (e.g., 6 months). To achieve the most accurate assessment of effectiveness of family therapy with drug-abusing populations, posttreatment monitoring should be conducted for several years.

Second, there is a need for research and family therapy treatment with different types of families. Much of the research conducted thus far in this area has been with white middle-class families, a most unrepresentative group in terms of drug abuse treatment according to DAWN and CODAP data (Burt et al., in press).

Third, as use of this technique grows, it will be necessary to determine how family therapy can best be used in the treatment of drug abuse. That is, there may be instances where family therapy (or a specific type of family therapy) may be most effective as a subsidiary part of a client's treatment rather than the primary treatment. Different types of therapy may be effective for different problems (e.g., a systems approach may be superior to a behavioral approach to family therapy with more complex family and drug abuse problems). Carefully controlled research

will enable administrators and therapists to match clients and therapy in the most effective manner.

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. These last two questions appear not to have been addressed to date by researchers interested in family therapy with drug-abusing populations.

References

Ackerman, N. Psychodynamics of Family Life. New York: Basic Books, 1958.

Ackerman, N. Family psychotherapy--theory and practice. American Journal of Psychotherapy, 20:405-414, 1966a.

Ackerman, N. Treating the Troubled Family. New York: Basic Books, 1966b.

Alexander, B., and Dibbs, G. Opiate addicts and their parents. Family Process, 14:499-514, 1975.

Alexander, J., and Parsons, B. Short-term behavioral intervention with delinquent families--impact on family process and recidivism. Journal of Abnormal Psychology, 81(3):219-225, 1973.

Bandura, A. Principles of Behavior Modification. New York: Holt, Rinehart, and Winston, 1969.

Barlett, 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.

Baron, R., and Feeney, F. An Exemplary Project--Juvenile Diversion Through Family Counseling. Washington, D.C.: National Institute of Law Enforcement and Criminal Justice, 1976.

Basen, M.M., ed. The Use of Family Therapy in Drug Abuse Treatment: A National Survey. Services Research Report Series. Rockville, Md.: National Institute on Drug Abuse, 1977.

Bateson, G.; Jackson, D.; Haley, J.; and Weakland, J. Toward a theory of schizophrenia. Behavioral Science, 1(4):251-264, 1956.

Beal, D., and Duckro, P. Family counseling as an alternative to legal action for the juvenile status offender. Journal of Marriage and Family Counseling, 1:77-81, 1977.

Beck, D.F. Research findings on the outcomes of marital counseling. Social Casework, 56:153-181, 1975.

Bell, J. Family Therapy. New York: Jason Aronson, 1975.

Berger, M. Multifamily psychosocial group treatment with addicts and their families. In: Rosenbaum, M., ed. Drug Abuse and Drug Addiction. New York: Gordon and Breach Science Publishers, 1973.

Bowen, M. Family psychotherapy. American Journal of Orthopsychiatry, 31:40-60, 1961.

Bowen, M. The use of family theory in clinical practice. Comprehensive Psychiatry, 7:345-374, 1966.

Bowen, M. Alcoholism as viewed through family systems theory and family psychotherapy. Annals of New York Academy of Science, 233:115-122, 1974.

Bowen, M. Family Therapy in Clinical Practice. New York: Jason Aronson, 1978.

Brown, E.; Pitkin, E.; and Bates, C. Multiple family therapy with hospitalized drug addicts and their families. American Journal of Orthopsychiatry, 43(2):256, 1973.

Buckley, W. Society as a complex adaptive system. In: Buckley, W., ed. Modern Systems Research for the Behavioral Scientists: A Sourcebook. Chicago: Aldine, 1968.

Burt, M.R.; Glynn, T.J.; and Sowder, B.J. Psychosocial Characteristics of Drug-Abusing Women. Rockville, Md.: National Institute on Drug Abuse, in press.

Callan, D.; Farrison, J.; and Zerger, F. Working with the families and social networks of drug abusers. Journal of Psychedelic Drugs, 7:19-25, 1975.

Canerini, L. Social and family factors of teenage drug addiction. European Journal of Toxicology, 3:397-401, 1970.

Caplan, G. Principles of Preventive Psychiatry. New York: Basic Books, 1964.

Chaiklin, H. Social work with the family on release from prison. In: Social Work Practice 1971: Proceedings of the 98th Annual Forum, National Conference on Social Welfare, Dallas, Texas, May 16-21, 1971. New York: Columbia University Press, 1971.

Coleman, S.B. Final Report, a National Study of Family Therapy in the Field of Drug Abuse. Rockville, Md.: National Institute on Drug Abuse, 1976.

Davis, D.; Berenson, D.; Steinglass, P.; and Davis, S. The adaptive consequences of drinking. Psychiatry, 37:209-215, 1974.

Dell Orto, A. The role and resources of the family during the drug rehabilitation process. Journal of Psychedelic Drugs, 6:435-445, 1974.

Ewing, J. Some recent attempts to inculcate controlled drinking in patients resistant to Alcoholics Anonymous. Annals of New York Academy of Science, 233:147-154, 1974.

Ewing, J., and Fox, R. Family therapy of alcoholism. In: Masserman, J.H., ed. Current Psychiatric Therapies. Vol. 8. New York: Grune & Stratton, 1968.

Fox, R. Family therapy. In: Weiner, I., ed. Clinical Methods in Psychology. New York: Wiley, 1976.

Fram, D.H., and Hoffman, H.A. Treatment of middle class heroin abusers: Preliminary observations. Medical Annals of the District of Columbia, 41(5):301-303, 1972.

Fram, D.H., and Hoffman, H.A. Family therapy in the treatment of the heroin addict. In: National Association for the Prevention of Addiction to Narcotics. Proceedings of the 5th National Conference on Methadone Treatment. New York: the Association, 1973.

Funk, M. Recidivism rate following a volunteer communication program for families with juvenile drug offenders. Journal of Voluntary Action Research, 3:26-30, 1974.

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

Goodman, E.S. Marriage counseling as science: Some research considerations. Family Coordinator, 22:111-116, 1973.

Gottesfeld, M.; Caroff, P.; and Lieberman, F. Treatment of adolescent drug abusers. Psychoanalytic Review, 59(4):527-537, 1972.

Gottschalk, L.; Morrison, G.; Drury, R.; and Barnes, A. The Laguna Beach experiment as a community approach to family counseling for drug abuse problems in youth. In: Barten, H.H., and Barten, S.S., eds. Children and Their Parents in Brief Therapy. New York: Behavior Publications, 1973.

Guerin, P., ed. Family Therapy Theory and Practice. New York: Gardner Press, 1976.

Gurman, A.S., and Kniskern, D.P. Research on marital and family therapy: Progress, perspective and prospect. In: Garfield, S.L., and Bergin, A.E., eds. Handbook of Psychotherapy and Behavior Change: An Empirical Analysis. 2nd ed. New York: Wiley, 1978.

Hagglund, T., and Pylkkanen, K. Psychotherapy of drug using adolescents in a hospital special care unit. Psychiatric Fennica, 1974. pp. 249-256.

Haley, J. Approaches to family therapy. International Journal of Psychiatry, 9:233-242, 1970.

Haley, J. Approaches to family therapy. In: Haley, J., ed. Changing Families: A Family Therapy Reader. New York: Grune & Stratton, 1971a.

Haley, J. Family therapy: A radical change. In: Haley, J., ed. Changing Families: A Family Therapy Reader. New York: Grune & Stratton, 1971b.

Haley, J. Uncommon Therapy. New York: Norton, 1973.

Haley, J. Problem-solving Therapy. San Francisco: Jossey-Bass, 1976.

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

Hawkins, R.; Peterson, R.; Schweid, E.; and Bijou, S. Behavior therapy in the home: Amelioration of problem parent-child relations with the parent in a therapeutic role. Journal of Experimental Child Psychology, 4:99-107, 1966.

Hendricks, W. Use of multifamily counseling groups in treatment of male narcotic addicts. International Journal of General Psychotherapeutics, 21:84-90, 1971.

Hirsch, R. Group therapy with parents of adolescent drug addicts. Psychiatric Quarterly, 35:702-710, 1961.

Hoffman, L. Deviation amplifying processes in natural groups. In: Haley, J., ed. Changing Families: A Family Therapy Reader. New York: Grune & Stratton, 1971.

Hoffmann, H.; Noem, A.; and Peterson, D. Treatment effectiveness as judged by successfully and unsuccessfully treated alcoholics. Drug and Alcohol Dependence, 1(4):241-246, 1975-76.

Huberty, D. Treating the adolescent drug abuser: A family affair. Contemporary Drug Problems, 4:179-194, 1975.

Hunt, J., and Hoffman, D. Effects and Outcome of Institutionalization upon Juveniles--A Follow-Up Evaluation of the Iowa State Training Schools. Eldora, Iowa: Department of Social Services, 1975.

Jackson, D. The question of family homeostasis. Psychiatric Quarterly Supplement, Part I, 31:79-90, 1957.

Kempler, H., and Mackenna, P. Drug abusing adolescents and their families: A structural view and treatment approach. American Journal of Orthopsychiatry, 42:223-224, 1975.

Klagsbrun, M., and Davis, D. Substance abuse and family interaction. Family Process, 16(2):149-174, 1977.

Klimenko, A. Multi-family therapy in the rehabilitation of drug addicts. Perspectives in Psychiatric Care, 6:220-223, 1968.

Kovacs, J. An approach to treating adolescent drug abusers. In: Senay, E.; Shorty, V.; and Alksne, H., eds. Developments in the Field of Drug Abuse. Cambridge, Mass.: Schenkman, 1975.

Laing, R. The Politics of the Family and Other Essays. New York: Random House, 1969.

Laing, R., and Esterson, A. Sanity, Madness and the Family. New York: Basic Books, 1964.

Levy, T., and Joffe, W. "The Family Systems Approach to Substance Abuse." Miami, Fla.: Biscayne College Family Life Center, 1973.

Macgregor, R. Multiple impact psychotherapy with families. Family Process, 1:15-29, 1962.

Macgregor, R.; Ritchies, A.; Cerrano, A.; and Shuster, F. Multiple Impact Therapy with Families. New York: McGraw-Hill, 1964.

Meeks, D., and Kelly, C. Family therapy with the families of recovering alcoholics. Quarterly Journal of Studies on Alcoholism, 31:399-413, 1970.

Minuchin, S. The study and treatment of families that produce multiple acting-out boys. American Journal of Orthopsychiatry, 34(1):125-133, 1964.

Minuchin, S. Families and Family Therapy. Cambridge, Mass.: Harvard University Press, 1974.

Minuchin, S., and Montalvo, B. Techniques for working with disorganized low socioeconomic families. American Journal of Orthopsychiatry, 37:880-887, 1967.

Minuchin, S.; Montalvo, B.; Guerney, B.; Rosman, B.; and Schumer, F. Families of the Slums. New York: Basic Books, 1967.

Nett, R. Conformity-deviation and the social control concept. In: Buckley, W., ed. Modern Systems Research for the Social Scientist: A Sourcebook. Chicago: Aldine, 1968.

Noone, R., and Reddig, R. Case studies in the family treatment of drug abuse. Family Process, 15:325-332, 1976.

Olson, D.H. Marital and family therapy: Integrative review and critique. Journal of Marriage and Family, 32:501-538, 1970.

Olson, D.H. "Therapy for addicts: A family affair." Paper presented to the Narcotic Addict Rehabilitation Branch Contract Agency Conference, Rockville, Md., May 1972.

O'Neil, C. Family therapy in the treatment of delinquency. American Journal of Orthopsychiatry, 41(2):295, 1971.

Ostby, C. Conjoint group therapy with prisoners and their families. Family Process, 7(2):184-201, 1968.

Parad, H., ed. Crisis Intervention: Selected Readings. New York: Family Service Association of America, 1965.

Patterson, G. Families. Champaign, Ill.: Research Press Co., 1971.

Patterson, G.; Ray, R.; and Shaw, D. Direct intervention in families of deviant children. Oregon Research Institute Research Bulletin, 8(9):1-62, 1968.

Pattison, E. A critique of abstinence criteria in the treatment of alcoholism. International Journal of Social Psychiatry, 14:268-276, 1968.

Pattison, E.; Headley, E.; Gleser, G.; and Gottschalk, L. Abstinence and normal drinking: An assessment of changes in drinking patterns in alcoholics after treatment. Quarterly Journal of Studies on Alcohol, 29:610-633, 1968.

Price, R., and Curlee-Salisbury, J. Patient-treatment interactions among alcoholics. Journal of Studies on Alcohol, 36(5):659-669, 1975.

Ritchie, A. Multiple impact therapy: An experiment. Social Work, 5:16-21, 1960.

Satir, V. Conjoint Family Therapy: A Guide to Theory and Technique. Palo Alto, Calif.: Science and Behavior Books, Inc., 1967.

Satir, V. The family as a treatment unit. In: Haley, J., ed. Changing Families: A Family Therapy Reader. New York: Grune & Stratton, 1971.

Schregardus, D. Youth diversion and the myth of parental indifference. Police Chief, 41(12):48-51, 1974.

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

Selsky, C. Postcommitment family counseling. Federal Probation, 26:41-43, 1962.

Speck, R., and Attneave, C. Social network intervention. In: Haley, J., ed. Changing Families: A Family Therapy Reader. New York: Grune & Stratton, 1971.

Speck, R., and Attneave, C. Family Networks. New York: Pantheon Publishing Co., 1973.

Stanton, M.D. A structural approach to family therapy with drug addicts. In: Critical Concerns in the Field of Drug Abuse: Proceedings of the National Drug Abuse Conference, New York City, March 25-29, 1976. New York: Marcel Dekker, 1978.

Stanton, M.D. Family therapy for the drug addict: Conceptual and practical considerations. Drug Forum, 6(3):203-205, 1978a.

Stanton, M.D. Family therapy: Systems approaches. In: Sholevar, G.P.; Benson, R.M.; and Blinder, B.J., eds. Treatment of Emotional Disorders in Children and Adolescents. New York: Spectrum, 1978b.

Stanton, M.D. Some outcome results and aspects of structural family therapy with drug addicts. In: Smith, D.; Anderson, S.; Buxton, M.; Chung, T.; Gottlieb, N.; and Harvey, W., eds. The Selected Proceedings of the National Drug Abuse Conference-1977. Cambridge, Mass.: Schenkman Publishing Co. 1978c.

Stanton, M.D. Family treatment of drug problems: A review. In: DuPont, R.L.; Goldstein, A.; and O'Donnell, J., eds. Handbook on Drug Abuse. Rockville, Md.: National Institute on Drug Abuse, 1979.

Stanton, M.D., and Todd, T. "Structural family therapy with heroin addicts: Some outcome data." Paper presented at the Society for Psychotherapy Research, San Diego, June 1976.

Stanton, M.D., and Todd, T. Structural family therapy with heroin addicts. In: Kaufman, E., and Kaufmann, P., eds. The Family Therapy of Drug and Alcohol Abusers. New York: Gardner, 1978.

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

Steinglass, P. Family therapy in alcoholism. In: Kissin, B., and Begleiter, H., eds. The Biology of Alcoholism. Vol. V: Treatment and Rehabilitation of the Chronic Alcoholic. New York: Plenum, 1977.

Steinglass, P. Experimenting with family treatment approaches to alcoholism, 1950-1975: A review. Family Process, 15(1):97-123, 1976.

Steinglass, P.; Weiner, S.; and Mendelson, J. Interactional issues as determinants of alcoholism. American Journal of Psychiatry, 128:275-280, 1971.

Stratton, J. Effects of crisis intervention counseling on predelinquent and misdemeanor juvenile offenders. Juvenile Justice, 26(4):7-18, 1975.

Stuart, R. Operant interpersoal treatment for marital discord. Journal of Consulting and Clinical Psychology, 33:675-682, 1969.

Summerhays, J. Siskiyou County Juvenile Diversion Project--Evaluation Project Year November 1972-November 1973. Sacramento, Calif.: State Office of Criminal Justice Planning, 1974.

Vogel, E., and Bell, N. The emotionally disturbed child as the family scapegoat. In: Bell, N.W., and Vogel, E.F., eds. A Modern Introduction to the Family. New York: The Free Press, 1960.

Watzlawick, P.; Beavin, J.; and Jackson, D. Pragmatics of Human Communication. New York: Norton, 1967.

Weakland, J.H. The double bind hypothesis of schizophrenia and three-party interaction. In: Jackson, D.D. The Etiology of Schizophrenia. New York: Basic Books, 1960.

Weaver, R.; Pearson, M.; Mulligan, R.; Spangler, T.; and Sterling, R. Aldersgate Youth Service Bureau Family Counseling Approach to Delinquent Youth: Self Assessment Report January 1, 1976-December 31, 1976. Willow Grove, Pa.: Aldersgate Youth Service Bureau, 1977.

Wells, R.; Dilkes, T.; and Trivelli, N. The results of family therapy: A critical review of the literature. Family Process, 7:189-207, 1972.

Wellisch, D., and Kaufman, E. Family therapy. In: Senay, E.; Shorty, V.; and Alksne, H., eds. Developments in the Field of Drug Abuse. Cambridge, Mass.: Schenkman, 1975.

Wieland, W.; Yarnes, A.; and Bellows, B. 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.

Will, J. Near North Family Guidance Center. In: Cull, J.G., and Hardy, R.E., eds. Organization and Administration of Drug Abuse Treatment Programs National and International. Springfield, Ill.: Charles C Thomas, 1974.

Williams, J. "Final Report: Short-Term Family Therapy for Alcoholics; a Research and Evaluation Study." Avon Park, Fla.: Department of Health and Rehabilitation Services, Division of Mental Health, Bureau of Alcoholic Rehabilitation, 1972.

Wilmer, H.; Marks, I.; and Pogue, E. Group treatment of prisoners and their families. Mental Hygiene, 50:380-389, 1966.

Winer, L.; Lorio, J.; and Scrafford, I. Effects of Treatment on Drug Abusers and Family. Washington, D.C.: Georgetown University, School of Medicine, Department of Psychiatry, 1973.

Winter, W.D. Family therapy: Research and theory. In: Spielberger, C.D., ed. Current Topics in Clinical and Community Psychology. Vol. 3. New York: Academic Press, 1971.

Wolpe, J. Psychotherapy by Reciprocal Inhibition. Palo Alto, Calif.: Stanford University Press, 1958.

Ziegler-Driscoll, G. Family research study at Eagleville Hospital and Rehabilitation Center. Family Process, 16(2):175-189, 1977.

☆ U. S. GOVERNMENT PRINTING OFFICE : 1980 313-770/1368

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

ALCOHOL, DRUG ABUSE, AND
MENTAL HEALTH ADMINISTRATION
5600 FISHERS LANE
ROCKVILLE, MARYLAND 20857

OFFICIAL BUSINESS
Penalty for private use, $300

POSTAGE AND FEES PAID
U.S. DEPARTMENT OF H.E.W.
HEW 396

THIRD CLASS
BULK RATE

NOTICE OF MAILING CHANGE

☐ Check here if you wish to discontinue receiving this type of publication.

☐ Check here if your address has changed and you wish to continue receiving this type of publication. (Be sure to furnish your complete address including zip code.)

Tear off cover with address label still affixed and send to:

Alcohol, Drug Abuse, and Mental Health Administration
Printing and Publications Management Branch
5600 Fishers Lane (Rm. 6C-02)
Rockville, Maryland 20857

DHEW Publication No. (ADM) 80-944
Printed 1980

END