NETWORK THERAPY:

Using Family and Peer Support To Improve Your Treatment Outcome

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ABSTRACT

It is a pleasure to present this treatment model in the first issue of "International Addiction." It is designed to help clinicians better manage their patients and has been found useful in many national settings. In order to direct this at the clinician's needs, I have made this article brief and straightforward. The references at the end offer recourse to further printed material.

Managing an addicted patient in office practice can be difficult in terms of the denial of illness they present and their tendency to relapse and become non-compliant. In order to overcome this, the clinician needs to draw on resources available in the patient's immediate environment. One way to do this is to engage family and friends in parallel with individual counseling to bolster therapeutic engagement. A supportive group of people close to the patient can provide valuable help in rehabilitating an addicted person, employing an approach called Network Therapy, a pragmatic multimodal format for treatment (1).

In using this approach, a small group of specific family members and friends are enlisted to provide ongoing support and to promote attitude change. Network members are part of the therapist's working "team," and not subjects of treatment themselves. The goal of this approach is the prompt achievement of abstinence with relapse prevention and the development of a drug-free adaptation. The need for this approach arises from the confounding problem that physicians have only a marginal ability to influence their patients' behavior outside the office. If an addicted patient has a slip into drug abuse, his therapist may not be apprised, and even if he has found out, he can bring little influence to bear. A physician on his own is limited in the degree to which he can make demands on the patient's life, and the patient is free to walk away from the therapeutic situation if it is uncomfortable for him, that is to say, if it challenges a potential relapse to addiction. All these factors make the engagement and orchestration of family and friends into the therapy with a substance-abusing patient an invaluable resource, one which offers remarkable opportunity for the modification of traditional office techniques for treating the substance abuser (2-4).

CONFRONTING THE PROBLEM

We can make the nature of this option more clear with the example of one particular patient. A consulting physician was contacted by Paul, a physician practicing at a local hospital, who was concerned that the woman he hoped to marry was alcoholic. As he explained, when they were getting to know each other, there were periods when Ann, seemingly functioning well, was unavailable in person or by phone. It was only after they moved in together that he realized the reason for these periods of absence, as he became aware that Ann would regularly go on drinking binges, and that she sometimes did not

show up the next day at the law office where she worked. She once threatened to kill herself when she was drunk. Paul turned to her parents, but they preferred to minimize the issue, apparently not wanting to tarnish their daughter's image. He pleaded with Ann to go to Alcoholics Anonymous (AA); she said she would think about it. Ann had been in treatment for a few years with a reputable general psychiatrist, who had unsuccessfully tried to convince her to stop drinking.

At Paul's request, she came to the consultant for an alcoholism consultation, but said that she was quite comfortable in her current analytic treatment, and that it was offering her valuable insights. Furthermore, she did not think it useful for the consultant to speak directly with her doctor. When it was pointed out that her continued drinking argued for additional intervention, or at least some visits to AA, she fell back on the contention that her relationship in therapy should be enough to deal with her problems.

A few months after this initial meeting, Ann became annoyed at her physician for "pestering her" about going to AA and dropped out of treatment. The drinking continued unabated, and later that year she lost her job at the law office because of her unreliability. Paul was ready to walk out as well but said he would give her one more chance if she saw the consultant, "the doctor who said she had to stop drinking." This time, she acknowledged in the consultation that it was reasonable for her to get some support to help her look at her situation, and the consultant asked her to bring Paul and a friend of hers to the next session to discuss the issue. This was the beginning of her Network Therapy.

The two network members, Paul and her friend, were certainly more revealing about the extent of Ann's alcoholism than she had been. They described how it now often left her in awkward social situations, and incapacitated as well in facing the day that would follow her heavy drinking. The consulting psychiatrist now encouraged Paul and the friend to voice their feelings and concerns, to soften her inclination to avoid the problem. The impact of their orchestrated input moved Ann to acknowledge that she had a problem with alcohol. The network members helped to prevail on her to accept the idea of abstinence.
Together, all four developed a regimen to support her recovery, one that included individual sessions as well as meetings with this network. AA meetings were added as well, and the

network members supported her in attending the meetings during later sessions, when she expressed misgivings about them. Importantly, Ann and the consulting physician continued to meet with her network while she focused on ways to protect her continued abstinence and on the psychological issues that would allow her to achieve a full recovery.

She had a slip back into drinking while in treatment and was once prepared to give it all up. Her network was behind her continued abstinence, though. The patient and network members worked together to understand what certain drinking cues - situations and emotional states - led to the relapse, and then planned together how Ann could handle these cues when they came up again.

The network also drew on one particularly meaningful relationship to bolster Ann's abstinence. In sessions, they often spoke with her sister on a speaker-phone. Although her sister lived in a remote city, Ann had a particularly trusting relationship with her, and the sister had been very distressed for years over her drinking problem. This relationship was one that added strength to the bonds of affiliation that supported Ann's recovery.

BACKGROUND OF THE APPROACH

How does Network Therapy fit into our evolving understanding of addiction? Addicted persons generate great conflict and resentment among their family and friends. On the one hand, persons close to the addict have long been frustrated by his lack of responsiveness and by a history of many disappointments that he has conferred on them. On the other, they are remorseful over his unhappiness and the losses that he has suffered. The tension between anger and guilt makes it all but impossible for those close to the addicted people to approach them in an objective way. They are likely to overreact at one time and castigate them, and at another time they may shrink from asserting their concerns and be overly permissive, even enabling their addictive behavior.

In recent years, we have begun to consider the orchestration of family dynamics to move the addicted person toward bringing the family together to plan a confrontation designed to impress the addicted person with the immediate need for hospitalization. With aid from a professional, family members can thereby work together to have a meaningful impact,

spurring the patient on to action, although a more tempered approach is often indicated. Multiple family therapy groups for substance abusers have also come into use so as to create a setting where a diversity of issues are melded together to neutralize individual resentments. The sense of community engendered in such groups can be supportive, and at the same time aid in achieving compliance with an expected norm of abstinence. These trends have been invaluable in developing our thinking about bringing family and peers into addiction treatment and associating them with a program of relapse prevention.

A variety of techniques have been employed in order to minimize the likelihood of substance use in the course of addiction treatment, so as to avoid a patient's relapse into heavy drug use. In general, this approach is based on the need to avoid the compelling effects of the conditioned abstinence syndrome in addiction. This syndrome serves to explain the vulnerability of addicted people to relapse to drug use whenever they are exposed to cues which have previously been associated with exposure to the drug. Cues to drug- or alcohol-seeking can be intrinsic, like specific moods; they can be extrinsic, like certain situations, or encounters with certain individuals. Any of these would have previously been associated with drug ingestion (2).

In Network Therapy, the emergence of craving precipitated by such cues can be examined with the patient in both individual and in network sessions, in order to clarify the cues that produce a vulnerability to relapse for that person. Because patients may exercise denial in avoiding the awareness of some of these cues, the availability of people on the network who are well acquainted with their patterns of addictive behavior may present a unique opportunity to gain access to relevant information that would otherwise be unavailable. Once these cues have been defined, plans to avoid them can also be made at sessions held with network members. The patient can be given social support to avoid the cues and can receive practical assistance from network members in an attempt to avoid these cues if it is necessary.

THE NETWORK'S ROLE

At the outset of therapy, it is important to see the patient with the group on a weekly basis, for at least the first month. Unstable circumstances demand more frequent contacts with

the network. Sessions can be tapered off to bi-weekly and then monthly intervals after a time. Contacts between network members at the earliest stage typically include telephone calls at the therapist's or patient's initiative, dinner arrangements, and social encounters, and should be pre-planned to a fair extent during the network session. These encounters are most often undertaken at the time when alcohol or drug use is likely to occur. When planning together, however, it should be made clear to network members that relatively little unusual effort will be required for the long term, and that after the patient is stabilized, the network's participation will come to little more than attendance at infrequent meetings with the patient and therapist. This is reassuring to those network members who are unable to make a major time commitment to the patient, as well as to those patients who do not want to be placed in a dependent position.

The network is established to implement a straightforward task, that of aiding the therapist to sustain the patient's abstinence. It must be directed with the same clarity of purpose that a task force is directed in any effective organization. Competing and alternative goals must be suppressed, or at lease prevented from interfering with the primary task. Unlike family members involved in traditional family therapy, network members are not led to expect symptom relief or self-realization for themselves. This prevents the development of competing goals for the network's meetings. It also assures the members protection from having their own motives scrutinized and thereby supports their continuing involvement without the threat of an assault on their psychological defenses. Since network members have volunteered to participate, their motives must not be impugned. Their constructive behavior should be commended. It is useful to acknowledge appreciation for the contribution they are making to the therapy. There is often a counterproductive tendency on their part to minimize the value of their contribution.

The approach presented here can serve as a basis for the clinician expanding his or her repertory of treatment options and can provide a basis for reading further as well (5-8). Each clinician will ultimately adopt a style suitable to them, but the effectiveness of that style can be enhanced by support from a network of family and peers. This presents an option.

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