

## Integrating Psychotherapies in a Systemic Approach to Addiction Treatment in Family Therapy- A Case Study

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### ABSTRACT

*This paper is presented as a case study of a family referred by an Addiction Counsellor. This case study provides a working summary of an integrative, psychodynamic approach to systemic family therapy. The approach integrates Object Relations' theory (relevant to addiction treatment) within an interpersonal/psychoanalytic approach to family therapy. A family assessment will be provided and an analysis of the family dynamics offered using a multi-contextual framework that takes into account family lifecycle, family of origin, relational working models and sociocultural factors. Bowen's therapeutic model for families is also applied as a diagnostic tool and integrated as part of an overall treatment method. This paper will include appropriate interventions for conflict resolution whilst including a flexible and broad scope treatment plan. This paper reflects on the therapist's conceptualization of problematic system functioning and the strategies utilized to help the family grow beyond current and repetitive patterns of distress. The treatment plan for the family focuses on increasing differentiation of family members, recognizing and resolving traumatic stress, the implementing of mourning tasks for moving effectively through the family's unresolved grief process and emotional processing sequences for enhancing parent/child bonds, connections and recalibrating the repositioning of life stage appropriations within the family structure.*

### Keywords

Family systems, Psychoanalysis, Object relations, Addiction, Grief and loss, Family therapy, Relational working models, Lifecycle development, Psychodynamic therapy.

### Clinical Background

The family<sup>1</sup> has entered therapy through the referral of the Social Worker for their eighteen-year-old daughter K who is receiving treatment for substance disorder in a residential addiction treatment center. Her addiction counsellor, as a therapeutic intervention, has also referred K, the younger of two sibling girls to family therapy. K's family, sister R and parents P and A (both separated and re-married) have agreed to attend. The family also have a deceased son who I include in the family system and whose sustained

<sup>1</sup>The term *family* is used as generic. All identifiers in this case study have been removed and initial's for first name identifier's have been changed to protect client anonymity.

undifferentiated absence is a factor in the therapeutic process. As a clinician seeking to treat a clinical problem my first step is to assess the nature of the problem/s for this particular family [1,2]. Whilst K is the point of entrance into the family system I do not view K as the 'problem person' who needs to be 'fixed' but rather as an adult/child within a poorly differentiated family system in whom emotionally reactive symptoms are repetitively being acted out [1].

K has been in residential addiction treatment for nine months and family therapy is being offered, as an intervention to ensure that K's return to the home and the family's ongoing therapeutic journey is guided and enhanced towards the family's most desirable outcomes. As an integrative systems theorist it is important for me to recognize the important collaborative role that Key Workers and the Rehabilitation Clinic, as well as the Alcoholics Anonymous (AA) and (Narcotics Anonymous (NA) groups that K attends are

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an important part of K's and the family's extended psycho-social network and supportive system [3].

### Stage 1.

#### ► Initial Phase of Treatment

- o Establish and develop therapeutic relationship
- o Assessment and Case Formulation
- o Explore individual and shared goals
- o Referral and Key worker collaboration

#### Presenting Problem

K is identified as *having* a 'problem' with substance abuse and this is having a negative impact on her family relationships. K is enacting the role of a rebel in the family system and her history and interactions with others reveal a highly reactive person with a poorly developed sense of self [3,4]. Current family dynamics show patterns of expressed emotions that are currently serving to reinforce negative and painful interactions [5]. There have been disruptions to K's development, communications problems, and disruptions to family events, family violence, and anti-social behavior resulting in damage to property. There have been legal issues for K regarding motor vehicle accidents. K is highly dependent on her nuclear family, particularly her father, for financial and emotional support. Her chronic symptoms indicate the presence of long-term disturbances. Consistent with systems approaches K's symptoms are rooted in the undifferentiated or togetherness aspects of her functioning [3,4]. A systemic approach recognizes that family members also require some help in approaching honest communication and resolution of current and past family conflict [5].

The referral for this family has come through a counsellor at the Addiction Treatment Centre where K's has been resident for nine months. The stated problem is that K is ready to address her deeper family relationship issues and the nuclear family has agreed to attend the family therapy sessions in order to help K address her behavior, i.e. K's substance abuse and negative family/social interactions. As a systems theorist I hold this as a point of entrance to the family system. I equally hold a curious theoretical stance towards the possibility that K may be the adult/child presentation of the undifferentiated symptom projection of deeper issues residing in the family system [1]. The family group therapy sessions will focus on the family processes and move away from focusing on K as *'the problem'*. I hope to create a safe and trusting, collaborative environment through an interpersonal process in which all-family members who attend can explore their roles within identified anxious family patterns. B and the Clinic team will monitor and continually support K in her individual goals to integrate systemic practice within the cycle of change; motivational therapy and twelve-step treatment process.

#### Family Evaluation

*Issues arising from family evaluation:* the presence and interaction of unresolved and complicated grief/enmeshment/family secrets and lack of self-differentiation.

*Symptomatology in child* (addictive behavior of K) re-enactment cycle. Object splitting through traumatic event and poor maternal attachment.

My aim is to gain as much information as possible from the initial interview that I have decided to structure with K and her father P. K appears closest to her father P in the family system and from this strong dyadic resource I hope to gain as much information about the problems and goals for therapy that this family perceives as important and is motivated to achieve [1].

During the initial evaluation, as a family systems therapist, I shall be establishing rapport and relationship with each family member and addressing the following ten basic questions [1,5].

#### 1) *Who initiated the therapy?*

Therapy has been initiated by K through the referral of her addiction counsellor.

#### 2) *What is the symptomatology and which family member or family relationship is symptomatic?*

The symptom is substance abuse, dependency on family resources, unresolved grief and distressed family relationships.

#### 3) *What is the immediate relationship system (nuclear family) of the symptomatic person?*

K lives with her father and stepmother. Her sister R has recently married and moved into her new home. K's mother and stepfather are distanced. She has a deceased younger brother who died in a car accident caused by K some years ago.

#### 4) *What are the patterns of emotional functioning in the nuclear family?*

The family rarely discusses K's younger brother's death and grief is not shared openly. K's biological mother is distanced from the family, both physically and emotionally. She also holds a family secret around why K was looking after her brother on that day? K is labelled as the difficult member and her sister R is a golden child. Kim's father is overcompensating and rationalizes emotional processes for the sake of peace keeping. Blame seems to shift among the family members as each blames the other in various ways for the family stress and emotional pain of unresolved grief – the family has not effectively mourned together.

#### 5) *What is the intensity of the emotional process in the nuclear family?*

The level of emotional pain in the family system is intense. Each member is consumed within their own feelings and appears pre-occupied with an anxious anticipation of K's disordered and unpredictable acting-out behavior. Arguments among members are frequent at family gatherings where interactions are sustained. Arguments have been observed in sessions and carefully monitored for evaluation of interactive processes and patterns. Family members engage in alternating togetherness/distancing behaviors [3] that reinforce negative interactions between them. Both sisters present with insecure attachment and appear to compete for the

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fathers warmth whilst also both suffering in the absence of their mother's warmth and presence or attunement to their emotional needs. Discussions around emotionally laden family issues can lead to violent outbursts, crying and high levels of distress, shame and embarrassment and masking with substances or food. As a skilled therapist I am also aware of the family's propensity to attempt to incorporate me into its problems and use this in my evaluation of the family's symptomatic behavior [1].

**6) What influences that intensity – an overload of stressful events and/or a low level of adaptiveness?**

The emotional intensity in the family system seems to be influenced by stressful events such as family milestones, celebrations or extended family gatherings which precipitate acting out behavior from K, overcompensating from the father or distancing and coldness from the mother. A low level of adaptiveness is also influential in terms of the family's adjustment to loss around the youngest sibling's death.

**7) What is the nature of the extended family systems, particularly in terms of their stability and availability?**

R has recently married and is adapting to her husband's new family system well. R also has a strong network of colleagues since entering her own professional field. Both of K's biological parents have remarried but there is little involvement in family issues from either and neither step-parent appear to be close to the girls. Interactions are observed as polite. K has strong ties to her rehabilitation community, case-worker and extended support systems through her Narcotics Anonymous twelve step group. These extended 'family systems' are important for K's stability and ongoing development of object constancy [6]. Success for K, in terms of adaptability, anxiety levels and differentiation from the stuck family system will depend on her ability to maintain a viable network of emotionally significant relationships', both now and in the future [1].

**8) What is the degree of emotional cut off from each extended family?**

Emotional cut off is high among K's mother/step father. Her step-mother is not distant but is silently supportive. The hidden symptoms of the family are concealed within the strong distancing and emotional cut off between the parents. Some family secrets are apparent and have been alluded to by K during interactions with her biological mother around why K was minding her brother on the day he was killed as her drug use was already symptomatically activated [1].

**9) What is the prognosis?**

The family, from my initial interview and evaluation is responsive to therapy. The primary emotional triangle is between the father and K and R. They responded enthusiastically and co-operatively to the *genogram* activity which was conducted during the second family evaluation session [1,5]. K is the symptomatic person [1] and is the result of *projective identification* and *splitting* within the family system [7]. Symptoms of anxiety binding through food,

drugs, sex and alcohol were present in both K and R as a result of marital discord and lack of family system adaptation to the loss of a child [6]. Since the death of the son K and R have been identified projectively as 'good' (R) and 'bad' (K) objects within the family system. This aspect of the failure within the parental relationship to bond and adjust during times of extreme stress (death of a child, infidelity) contributed to poor self-integration among both K and R [1,6]. K uses substances to 'bind anxiety' whilst the family members use distancing to act together and bind their anxiety. The pre-existing and existing family dynamic/s have hindered effective grief processing and interpersonal adjustment to significant loss. Family secrets, unresolved and complex grief as well as addiction symptomatology undermine the family's attempts at togetherness and K's attempts at separation: sobriety, self-differentiation and ultimately individuation (Jung, 1954). The family lives under moderate to severe stress with a high level of chronic anxiety and emotional reactivity [1]. However, the family show indications of being able to recover from chronic clinical family dysfunction through adaptation to the development and conscious design of a healthier functioning family system. The agreement of the need and participation in family therapy process is the strongest indicator of this hopeful prognosis.

**10) What are important directions for therapy?**

Directions for therapy with the family shall include:

- Identifying the emotional processes and patterns of interactions
- Assisting the family to define the problem/s they wish to work on together
- Coaching the family on new interactive possibilities and patterns in order to reduce anxiety and increase levels of differentiation
- Facilitation grief processes and mourning tasks developed organically by the unique family systemic environment
- Identifying stressors in the nuclear and extended family systems
- Working collaboratively with K's care worker/counsellor
- Addressing of unresolved attachment processes among parents and adult/children [1].

**Stage 2**

**► Working Phase of Treatment**

- o Monitor Progress
- o Monitor Relationship
- o Working client Goals

**Treatment Plan:**

During the *first* of nine family therapy sessions that the family has agreed to attend the clinical observations and methodology were explained and outlined to the family. The *second* session involved K, R, (father) and (mother) with respective new partners and R's husband present. The *third* and *fourth* sessions included process questions and ongoing family evaluation. Process and differentiation questions also were used to create a multigenerational lens [3] to connect thinking around the present situation and reveal how others have dealt with problems. I used this to diffuse volatile interactions through blaming and to encourage the recognition of patterns and generational repetition of automatic reactions to stress and life

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processes [2]. I also drew attention to the connection between the death in the family and the historic development of symptoms of distress. The location of the parent's divorce also provided a significant timeline to the pathogenic of chronic anxiety and defensive behaviors among family members [1]. Throughout the *fifth* session I drew attention to how family members are triangled (protective alliance formation) by others and helped the family to see their role in triangling behavior – this allowed me to introduce the concept of neutral position communication and to encourage each member to practice a more open form of interacting around feelings. The *sixth* and *seventh* sessions I structured around specifically attending to grief processes and mourning task planning. I used *Family and Personal Changes Game Questions* and had each member share and respond when they identified with other answers in the game [8]. Togetherness goals were highlighted and family mourning tasks were acknowledged and shared as the departed brother's new place in the family system was established in the present nuclear and extended setting. This allowed for the emotional shock waves to be fully acknowledged and the adjustment to occur. Intergenerational patterns of dealing with illness, death and grief were located and acknowledged and new and creative commitments were shared together.

### Stage 3

#### ► Closing Phase of Treatment

- o Termination plan
- o Closing client goals

Sessions *eight* and *nine* were structured around evaluating change, identifying new stances and positions in family interactions. A plan for terminating the family therapy sessions was discussed

and formed. A and P (parents) had expressed their continued commitment to working on their own family of origin issues in personal therapy. K is still in personal therapy with her addiction counsellor but is now exploring working with a psychoanalyst. She feels that this will continue to foster her individuation process. A report was sent to the clinical team at the Rehabilitation center at K's request.

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