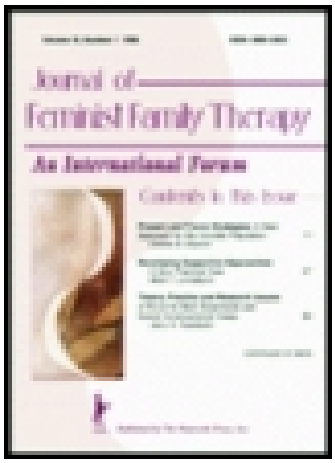

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Therapy with Women Substance Abusers

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Therapy with Women Substance Abusers: A Systemic Couples Approach

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ABSTRACT. This paper outlines an integrated model of systems therapy for substance-abusing women, Systemic Couples Therapy (SCT). Using structural, strategic, behavioral, and Bowen concepts of family therapy, the authors have developed a model to be used in conjunction with standard treatment models of substance abuse agencies. SCT was designed to be used with women and their partners in conjoint therapy and with women whose partners do not attend therapy. Women who are not in committed relationships can also benefit from this model by focusing on important intimate relationship and family of origin patterns. Issues unique to women in substance abuse treatment are discussed, including the important need to pay attention and to intervene in women's relationship issues. *[Article copies available from The Haworth Document Delivery Service: 1-800-342-9678.]*

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INTRODUCTION

While substance abuse has come to be recognized as a major health problem in the U.S., women's interests in the field have received less attention than have men's. More has been published concerning men than women in the substance abuse field (Clayton, Voss, Robbins, & Skinner, 1986; Gomberg & Nirenberg, 1991), and more research has been conducted on men than on women (Ambert, 1982; Clayton et al., 1986). Although one could argue that this situation befits the higher prevalence of substance abuse in men–only about one-third of reported alcohol abusers in the U.S. are women (Oppenheimer, 1991), for example–prevalence rates in younger age groups suggest, sadly, that women may be catching up (Grant et al., 1991).

When research and policy attention is paid to women's substance abuse, the focus is different than when men's addictions are considered. Some (e.g., Wilsnack & Wilsnack, 1991) consider men's substance abuse ''worse'' than women's, claiming that men's abuse is more severe and has more serious consequences, a view that results from the fact that the consequences of men's drug abuse often show up in the public arena through such things as problems at work, dangerous driving, and criminal activity. Concerns about women's substance abuse are more often located in the family and psychological arenas, however. The effects of drug use on unborn children and on women's abilities as mothers is one typical focus (e.g., Alford, Martin, & Martin, 1985; Barrison, & Wright, 1984; Hughes, 1990; Murry-Lyon, 1985), as is substance-abusing women's relationship difficulties (Oppenheimer, 1991; Wilsnack & Wilsnack, 1991) and individual psychological problems such as depression. In short, the consequences of men's substance abuse are generally described given their impact on the arenas of work and society while the effects of women's abuse are seen in the family and psychological realms. This difference affects the availability of research monies since more funding has typically been available for studying problems that have social rather than family impact.

The research that has been done suggests that there are important differences in men's and women's patterns of drug and alcohol abuse. Compared to men, women begin abusing substances later,

experience difficulty from their substance abuse more quickly, and enter treatment sooner, a phenomenon known broadly as the ''telescoping effect'' (Anglin, Hser, & McGlothlin, 1987; Fillmore, 1987; Fisher-Nelson, 1991; Gomberg & Nirenberg, 1991; Griffin, Weiss, Mirin, & Lange, 1989; Hesselbrock, 1991; Hser, Anglin, & Booth, 1987; Kane-Cavaiola & Rullo-Cooney, 1991; Nespor, 1990). Women's reasons for drug use vary. They report drinking when they feel powerless (Beckman, 1980), associate the onset of their substance abuse with a stressful event (Nespor, 1990), drink in response to their needs for autonomy and freedom from domination (Bailly & Carman, 1991), and drink in reaction to events or situations (Anglin, Hser, & Booth, 1987; Anglin, Hser, & McGlothlin, 1987; Bailly & Carman, 1991; Binion, 1982). It could be said that women's generally more ''relationally oriented'' world view affects their paths to addiction or substance abuse (Anglin, Hser, & Booth, 1987). Williams and Klerman (1984), in a review article, note that ''Women are . . . more likely than men to cite marital instability and family problems as reasons both for problem drinking and for seeking treatment'' (p. 291). Anglin, Kao, Harlow, and Peters (1987), in reviewing the literature on the couple relationships of women opiate addicts, concluded that ''women are commonly introduced to narcotics and maintained in their addiction by men, especially when the women are involved in an intimate interpersonal relationship with male addicts'' (p. 500). Similar findings are reported by Darke, Swift, Hall, and Ross (1994) for heroin addicts as well as by Wilsnack, Wilsnack, and Klassen (1984), and Gomberg (1993), for alcoholic women.

While the research literature suggests important differences between male and female substance abusers, these differences are rarely reflected in treatment approaches. Women tend to find treatment for their substance abuse problems in programs that have been developed based on men's experiences and needs. Such programs, however, may not fit the needs of women clients. Women may need women-only groups, where abused women can feel safe and where women can find others whose problems and struggles toward abstinence are more like their own (McCollum & Trepper, 1995). Women may also require specific counseling for domestic violence and sexual abuse, assertiveness training, treatment for a variety of

psychological problems such as depression, low self-esteem and anxiety, and medical and nutritional counseling concerning pregnancy. In addition, women's concerns about the welfare of their children may necessitate counseling for children as part of the overall treatment program.

Twelve-step approaches to drug treatment, based on men's needs for relief from continual striving for unrealistic ideals of power, may have drawbacks for some women as they ask women to give up power they do not feel they have or have ever had. In relation to power, women's drinking may serve to suppress or express impulses that counter societal admonitions to be dependent and to hide autonomy (Bepko, 1988). The disempowering aspects of 12-step programs may be exactly the opposite of what some women need to recover from substance abuse and maintain a sober life. Flexible chemical dependency treatment programs that recognize this possibility and that encourage but do not require 12-step support, providing alternative supportive groups or encouraging women to maintain sobriety in other ways, may be more effective.

Perhaps the biggest difference in treatment, however, is that models based on men's needs favor an individual focus over a relational one, ignoring a primary factor in women's substance abuse. These male-based models encourage examination of how the client's behavior and substance use affected relationships and important others. They rarely address issues of how *treatment* affects the relationships, however, a factor that may keep women from entering and staying in treatment programs. How these relationships (family of origin, spouse or significant other, children) are affected by the treatment has not been addressed in the literature. Many treatment programs encourage addicts and alcoholics to leave relationships that may promote substance use or abuse. The dilemma for women and for those treating chemically dependent women is to help them develop autonomy and interdependence within relationships and, at the same time, alter those relationships so that they promote sobriety rather than substance abuse. Our model was designed to address this need for autonomy as well as the need to maintain important relationships.

THE TREATMENT MODEL

Our model, Systemic Couples Therapy (SCT), was developed to serve as the basis for a treatment outcome research study in which women drug abusers are the focus of treatment. Our couples counseling component was provided as an adjunct to standard individual drug treatment already being provided at two treatment sites. One agency provides an abstinence-based, intensive-outpatient, group treatment model for polydrug users while the second agency is an outpatient methadone maintenance program. Both agencies use components of 12-step programs but do not take a strict 12-step approach to drug treatment, offering alternative counseling and supportive groups instead. Both were also interested in trying to address the relationship concerns of their women clients. Given the context in which our model was developed, care has been taken to make it compatible with multi-focus treatment programs. The model was designed to be used with substance-abusing women who were in significant heterosexual or homosexual relationships. We believe the model could also be used with single women; however, the focus of this article and the examples provided are with women in relationships that they wanted to keep. The model also does not assume that 12-step programs or their equivalent are necessary for recovery from addiction or substance abuse. These programs are certainly helpful and we recognize that for many people, they are a lifeline. They are not appropriate for everyone, however; thus, our model is not designed from a disease-based theory of substance abuse.

SCT is a refinement of an integrated family therapy model developed by Ault-Riché and Rosenthal (1986). It combines components of structural (Minuchin, 1974); strategic (Haley, 1987; Watzlawick, Weakland, & Fisch, 1974); Transgenerational (Bowen, 1978); and behavioral family therapy. Its central premise relies on (a) the Mental Research Institute's (Watzlawick et al., 1974) notion that problems (in this case, substance abuse) are maintained by solutions that are no longer useful and (b) Bowen's (1978) suggestion that these behaviors are related to family of origin patterns that once served an adaptive purpose but are not useful for the current difficulty. Each component of the integrated model is used from a woman's per-

spective and enhances the woman's relational and contextual worlds.

The model also relies on the premise that family of origin themes and patterns of relating are quite powerful and not always consciously chosen. These patterns evolve through years of observation by an individual who is an integral part of a family, tugged and pulled by the family's belief and relational systems to such an extent that s/he is often powerless to separate from the system. This is particularly powerful when the system includes chemical abuse of one sort or another and rigid, unspoken rules of behavior. These patterns are often carried into adult relationships. When they combine with complementary behaviors of a partner, they may manifest themselves in negative ways and serve as barriers to recovery and sustained sobriety for either or both partners. Indeed, family members may actively impede progress in treatment by directly and indirectly supporting addictive behaviors. Women may be particularly sensitive to these impeding messages and actively avoid behaviors that they perceive may disrupt important relationships. For example, if a woman's primary context for her relationship with her father is one of drinking and related ''comraderie,'' she may fear that disrupting this context will mean disrupting the relationship and resist change in the absence of alternatives for maintaining the relationship.

Since family relationships are important to an addicted woman, she may forego her treatment and recovery rather than risk losing her partner, family, or friends. For this reason, it is necessary to include therapy components that help a woman be more objective about her relationships and to choose behaviors that optimize her chances for abstinence. At the same time, therapy should not risk cutting her off from important relationships that she wishes to keep and should, instead, help her find alternative ways to keep the relationship when possible. By altering the relational environment which maintains a woman's substance abuse, she can develop a sober and functional lifestyle. She does this by changing her role in relationships to one that encourages attitudes and behaviors that use rather than discount her power and resources.

Gender Perspectives and SCT

Overview

The model is a brief approach integrating components of structural, strategic, Bowen family systems, and behavioral family therapy. The goal of the therapy is to help a woman improve her primary relationships, particularly with her partner, so that she can abstain from abusing drugs or alcohol and otherwise meet her treatment goals. In some cases, improvement may mean ending the relationship. We make no assumption that the relationship is causing her difficulties, only that its functioning is central to her maintaining a drug-free lifestyle.

Systemic Couples Therapy was tested with couples in conjoint therapy and with women who were seen alone, but who were in partnered relationships. When both partners are present, the therapist can directly judge the impact of the therapy on the system, gauging the ramifications of different components and moderating the intensity as required. When working in therapy sessions with the woman without her partner, the therapist must be sensitive to feedback from the woman regarding changes in her relationships that may require attention, particularly potential relapses and/or violence. Few people are aware of the changes that significant others must make as they adjust to a partner or family member who is getting off drugs or alcohol. When therapists are aware of these changes, they often see ''change back'' messages as resistance rather than as natural systemic responses. An important component of the therapy model is anticipating such reactions and planning alternative responses so that changes can be resourceful and positive rather than destructive and negative.

Recently, we have begun adding elements of the solution-oriented approach (Berg & Miller, 1992; de Shazer, 1982; Hudson O'Hanlon & Weiner-Davis, 1989) to SCT. We are particularly interested in resources found in family of origin relationships, strengths that women bring to both their relationships and to treatment, and patterns that couples employ that already assist sobriety and functioning in relationships. For example, we place more emphasis on how people get back on track after relapses than on the intrapsychic or interpersonal reasons they relapsed in the first

place. This model focuses on relational strengths whenever possible.

Structural Family Therapy

The structural approach gives a theoretical base for assessing the couple's boundaries, power arrangement, roles, and rules in the relationship. It allows the therapist to monitor feedback related to changes in the system and to continually think about the woman in the context of her relationships, even when significant others are not present. When a partner is present, the structural approach offers solid intervention techniques for helping the couple change their relationship into a more supportive and equal one where both partners' needs are met. The structural approach also provides tools for monitoring and moderating intensity in the system as the couple moves through the stages of therapy.

Power. Power is a key concept in structural family therapy although its focus has often been on power structures in triads or larger groups of people in therapy than with dyads. However, given society's support for status quo power arrangements in heterosexual relationships with women less powerful than men, it is imperative that therapy address these differentials. An addicted woman often is financially dependent on her partner or someone else. If that person also is a substance abuser or dealer, it is even more difficult for her to assert herself in the relationship. She may feel physically threatened if she challenges the power arrangements within the relationship. She may be frustrated that the only other apparent solution is to leave the relationship or go back to using drugs if her partner is not supportive of her treatment and recovery. While our approach certainly works best when women's partners are supportive, it also must deal with power structures when they are not.

We look for ways for each partner to take responsibility for his/her own behavior within the context of the relationship. We deal with notions of blaming in terms of complementarity (one's behavior ''fits'' with the other's and is part of reciprocal patterns) rather than one causing another's behavior. Clients are encouraged to examine their own part in behavioral sequences and to take responsibility for their behaviors. In this way, power differentials are addressed by assuming the potential for equality and self-responsibil-

ity. The model does not assume, however, that complementary patterns are self-induced or that women, in the context of their oppression in society and in relationships, have as many or as effective options available to them for changing their circumstances. We pay attention to the limits and deficiencies of the structural model as it addresses roles and rules for women in relationships (cf. Luepnitz, 1988).

Structural techniques allow us to help couples change their behavior toward each other in the room. By allowing intensity to rise and then intervening, supporting a woman in using her voice and empowering herself, the therapist helps the couple reorganize their power balance in more productive ways. When the partner is not in the therapy room, the therapist can help the client examine the ways the power balance is played out. The client then is helped to reclaim her power and coached to use it at home in ways that work toward her goals. She can then report results back to the therapist, who helps to ''fine tune'' the intervention.

Strategic Family Therapy

Assessing and altering sequences. Strategic approaches offer several useful components that we use in this model. First, clients are asked questions about sequences of behavior as they relate to substance abuse and other identified problems. These often include conflicts, negotiating household and child care responsibilities, and discussing changes that are needed in the couple's social relationships to maintain abstinence. Clients are encouraged to examine ways each can interrupt patterns, focusing on those behaviors that are ''further away'' from the critical point where they usually break apart or break down. For example, a woman may come home tired from work, finding that her partner has not cooked dinner and is angry that she is late. This client is encouraged to think about different ways she can approach the house before the fight escalates into his leaving and her drinking. Her partner may be encouraged to think of different ways to respond to her initial ''tired'' behavior that s/he may be interpreting as attacking and accusatory.

Reframing. Whenever possible, negative attributes are reframed in positive or neutral ways (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978), with violence as a notable exception. In the previous

example, the woman's behavior toward her partner could be reframed from ''accusing'' to ''tired,'' allowing her partner to respond to it by helping her rather than feeling defensive. Negative attributions keep people locked in defensive and negative feedback loops that maintain rather than alleviate problematic relationships. Positive attributions, however, allow people to consider alternative opportunities for responding that may be different from usual, automatic reactions. We are careful, however, not to ''reframe'' behavior simply to mollify a partner; the attribution must fit the situation, must be respectful of the woman and her needs, and must not reduce her status in the relationship.

On occasion, this kind of sequence alteration and positive reattribution of behavior can assist partners in taking caretaking rather than care-receiving roles, relieving the substance-abusing woman of guilt and a sense of over-responsibility and providing her with new resources. These changes serve to alter the woman's context so that she has a partner in maintaining the relationship rather than being primarily responsible for it.

Metaphor and isomorphism. Clients are frequently reluctant to address issues that therapists consider important. This does not need to be frustrating when the therapist works from a strategic perspective that suggests that patterns around several issues are similar and isomorphic (Haley, 1987). That is, the way a couple fights about drugs and alcohol is assumed to be similar to ways they fight about other things. The way a woman expresses her needs in the relationship may, on the surface, appear ineffective. The therapist can place these expressions in a context which socializes women to be indirect and submissive. While this may or may not be ''true'' in the couple's eyes, it is a useful way of working in therapy. Changes in the ways the couple discuss plans for a weekend outing (content issue) may effect changes in the way they discuss the way to rearrange social relationships (relationship issue). One pattern supports the other and change in one is reflected by change in the other. In this way, the therapist can help the couple in an area that may carry less emotional tension with a higher possibility of success than if s/he worked on an intense process that might be more likely to break down (Nelson, 1994). If the couple's ways of discussing the two issues are similar, they may be able to withstand the discomfort

of dealing with the more intense one if they have had success with the other. If the patterns are not the same, at least they have experienced success in therapy and may be more open to help in working on other, more intense issues. In this way, a woman's voice can punctuate her perspective and needs in new ways that are more effective in the relationship.

Attempted solutions. Early in the assessment phase of this model, clients are asked about the previous ways they have attempted to change things. While we do not operate in a ''strict'' MRI way of analyzing these attempted solutions (Watzlawick, Weakland, & Fisch, 1974) so that we can choose a different class of solution, it is important to know the general nature of clients' efforts to change. Failed solutions should not be tried again. Women, particularly, may become discouraged when their efforts to foster effective and satisfying relationships have failed. Also, if it seems that many different kinds of solutions have been attempted with little or no change, particularly when they involve helping professionals, therapists are alerted to a need to be cautious of their roles in therapy. People who are not ''customers'' (Berg & Miller, 1992) may appear resistant to therapy when their helpers work too hard at making them change, particularly when clients seem to blame other people and situations for their problems without examining their own behavior.

In a larger sense, it is not helpful for therapy to repeat itself to no avail. That is, on a meta level, we want to be sure that we don't do ''more of the same'' as a therapeutic modality. In some cases, no more therapy is the best therapy and most respectful of a woman who does not need to fail again.

Bowen Transgenerational Family Therapy

According to Bowen (1978), families develop patterned ways of responding to stress over several generations. Some family members respond during emotionally intense situations by overinvolving themselves, others by withdrawing. Similarly, some families may have members who use drugs or alcohol during times of emotional stress while others develop an aversive or reactive stance to using chemical substances. Our model is interested in two primary areas of Bowen's theory: (1) how people have learned to deal with

conflict in general and (2) what role drugs or alcohol may have played in family members' functioning positions during times of stress. A corollary to (2) is learning how family members responded to others' use of drugs/alcohol. We are especially aware of gendered patterns in families. Substance-abusing women have often learned to support and protect family members through using along with them, protecting and covering up for them, or reactively attempting to get them to change. Similarly, women often learn to protect themselves in abusive families through substance abuse. One woman reported that using alcohol was an important affiliative behavior in her family. Her decision to enter treatment and abstain from alcohol was seen as betrayal by the family who criticized her for acting ''better than you are'' and said she had made the change only because she ''got religion'' and that her sobriety would not last.

We are also interested in general family of origin themes that clients may bring up, such as issues of abuse (physical, sexual, emotional) or frequent moves or losses. Finally, we are interested in potential resource areas that may have been previously overlooked. Knowing how a grandmother, who seemed cold and aloof, managed to care for her children in the midst of an abusive marriage may help a woman client see herself differently and to appreciate women's strength in her family, hence in her.

In looking at family of origin patterns, we look for typical patterns that may be potentially problematic in the way of triangles (involvement of a third person in a dyad's problems) and cut-offs (resolving intense anxiety by excessive emotional distance) (Bowen, 1978). To the extent that clients participate in intense triangles that include drugs or alcohol in their families of origin, they may have difficulty in changing their behavior in the present. This may be particularly true for women who are often responsible for maintaining relationships in families, watching the other women in their families, and taking on behaviors that maintain relationships at the expense of their individual well-being. They may find themselves duplicating these behaviors or relationships from the past with their partners, unwittingly keeping themselves caught in attempted solutions that don't work.

Some substance abuse programs seem fond of propagating the

notion that clients come from ''toxic'' parents or ''dysfunctional'' families and must find ways of preventing these families from influencing them. This too often means cutting off from these important relationships that often contain resourceful as well as ''toxic'' features. We are interested in *how* families work and in members' functioning roles in them, not in blaming families for clients' difficulties. For women, this approach often elicits a sense of relief since their ambivalence about these relationships may also be present in the relationship with the therapist. When this happens, and the therapist takes a position of helping her get away from family relationships even when she doesn't want to or is not ready to do so, she may acquiesce to the therapist in much the same way she learned to acquiesce in other relationships. The cut-off, however, leaves her feeling guilty and alone, and may lead to relapse so that she can remain true to the rules of the (unaltered) relationship. We also look for patterns related to rituals, especially around times of transition and holidays. Steinglass et al. (1987) have found that alcoholic families are often under-ritualized and that family rituals often have specific patterns of alcohol use and meaning attached to them. In our model, we are interested in how people use alcohol and drugs as part of rituals and how others respond to them during these times, which can help in planning different responses within families without cutting off from them. One couple reported that their families of origin, both with substance-abusing members, used the holidays as major times to get high. Both unconsciously continued this pattern in their own marriage at holiday times. After discussing this pattern during their genogram assessment, they negotiated a plan to closely watch both themselves and each other during the coming Christmas holiday season. They gave themselves and each other permission to call ''time-out'' if either observed behaviors that would typically lead to trouble. They devised an unobtrusive signal that enabled them to support each other during the holiday family get-togethers and that also served as a symbol of their coupleness in the midst of their families.

Behavioral Family Therapy

Behavioral marital therapy models offer many useful ideas as couples learn how to interact without drugs or alcohol as part of

their systems. Therapists coach clients in new communication skills, different observational skills, problem-solving (Jacobson & Margolin, 1979), and ways of negotiating with each other around issues in the relationship as well as issues related to drug or alcohol use. Negotiating contracts in therapy becomes a metaphor for negotiating contracts in the relationship, providing the couple with practice in new relationship skills. Therapists pay particular attention to stereotypic, gender-socialized patterns of communication and work to alter these so that women's power is increased in relationships.

Process of Therapy

Assessment

Our model has several logical phases. The first is an assessment of the woman (and her partner if s/he is in therapy with her), the couple, and their context. This includes mental status examinations, assessing power arrangements, and tracking typical sequences of interaction. In the research project, women were treated in an outpatient detoxification program and/or given initial methadone treatment before being seen for their first standard treatment group meeting or our therapy. We believe that it is important for physical issues related to withdrawal to be dealt with for treatment to be effective. However, we do not subscribe to a notion that clients must be clean and sober for a certain amount of time before SCT begins. Indeed, accomplishing the initial sobriety may be the first goal of treatment. We believe that the couple work may help the client achieve and maintain early sobriety when other approaches (e.g., requiring sobriety as a condition for individual or couples therapy) have not worked. Assessment also includes a genogram assessment (McGoldrick & Gerson, 1985) of each partner in terms of drug and alcohol use, typical responses to problems, and client/partner complementary patterns of functioning that might have developed from respective functioning roles in family of origins. We assess the nature of rituals and ritualized behaviors in the families of origin, particularly as they relate to drug/alcohol use and others' responses to this behavior. We pay particular attention to the gendered and cultural nature of different aspects of assessment, learning how the woman has been similar to or different from the typical

or ''normal'' gender relationships of her culture and family. One woman had a tendency to emotionally and physically withdraw whenever she and her partner fought. If he pursued her, she left the apartment and went to a bar, looking for other women to drink with. When asked if this was the way women in her family reacted during fights, she began to notice that she was following a pattern learned from her mother and grandmother about ''not rocking the boat,'' being quiet when men ''got going,'' and seeking consolation with other women.

Goal-Setting

The problem definition and goal-setting phases are client-driven, an important aspect of SCT that is designed to be sensitive to women's needs. Since the hosting agency is in charge of the primary substance abuse treatment, our treatment focuses on the client and her relationships. We believe these relationships must be functioning and supportive to maintain her sobriety and/or abstinence. Therefore, the primary goal of our treatment may not overtly relate to drug use. Clients frequently cite relationship issues with partners or family members that they would like to change. Therapy then focuses on solutions to these agreed-upon goals and contracts. For one client, her goal for therapy had more to do with her relationship with her female partner than with her drinking *per se*. She recognized that her own pain centered on feeling unloved and lonely in her relationship. She even suspected that her drinking may have served the function of getting her partner's attention and thus confirming her love, which was later confirmed in therapy. At this early goal-setting stage, however, the therapist merely validated the client's goal of improving the relationship. The partner's goal was first that the client remain sober, but she agreed that for her, an important second goal was to improve the relationship, especially ''. . . making her stop worrying that I don't love her.''

Negative Consequences of Change

Along with the client-driven goals, the therapist explores with the client and her partner the unintended negative consequences of

change. This is not meant to be a paradoxical intervention, designed to overcome a client's ''resistance'' by anticipating it (Papp, 1983), but derives from a belief that all change brings both positive and negative consequences. Stopping drug use is no exception and we often find that women's relationship systems are challenged to respond in helpful ways to her changes. By discussing the possible negative consequences of her or her partner's desired changes, she and the therapist can plan for them and find ways of meeting her goals that do not elicit these consequences. Alternatively, they can plan ways to respond differently to ''change back'' messages. One woman was seen without her partner. He had been supportive of treatment as long as it didn't disrupt the household or his life. He was not willing to provide child care or transportation so that the client could attend either her primary treatment or SCT. The client realized that her getting sober might mean admitting disappointment about her partner's participation in the day-to-day parenting and household maintenance, forcing her to confront him about this issue, something she previously had been unwilling to do.

Interventions

The intervention phase of therapy typically involves helping the couple strengthen and renegotiate their relationship so that it is more satisfying and is a resource for maintaining sobriety. This includes interrupting dysfunctional sequences and developing new ones since many of these relationships have been built on drug use and couples have never learned, in families of origin or elsewhere, how to negotiate relationships without chemicals as part of their context. One couple decided that they would take a ''time-out'' early in conflictual interactions to break the sequences that led to escalating conflict: withdrawal by the client to spend time with a girlfriend who was still using, and the subsequent abuse of drugs by the client. This case was interesting in that the client was maintained on methadone as part of her heroin addiction treatment but still used other drugs, including heroin, in the wake of an argument with her partner. Both partners' agreeing ahead of time on a ''time-out'' plan helped them to actually use it as tension began to rise. Their plan included the client's going to another room in the house

to cool off (instead of leaving the house) and the partner's not following her, demanding that she talk to him, which he had done in the past. Although it may seem artificial to some clients, some couples profit from a ''rehearsal'' of their plan in session, role-playing something different in their customary sequence.

Therapists also help women to negotiate drug-free activities with their partners. When couples are in agreement about stopping the drug use, this often serves as a way of assisting them in developing new, non-stereotypic communication styles in general and as a metaphor for ways for them to resolve other issues. Our couples were quite creative in finding ways to spend time together that did not involve drug use. One couple planned a weekend trip to a national park with another recovering couple. Not all activities required money or travel, however; taking a walk, sitting on the front porch, or taking their children to the park allowed couples a drug-free way to spend time together.

Family of Origin Patterns and Issues

Using genogram information, the therapist helps the client and her partner detriangle from family of origin issues in such a way that the resources of the family are left intact but the destructive anxiety is managed more successfully. Helping clients and their partners alter their functioning roles in families can be very powerful. Therapy also assists clients in planning for changes with members of their families of origins in relation to rituals and ritualized events. Rather than advise clients to stay away from their ''dysfunctional'' or ''toxic'' families during emotionally intense times or situations that typically involve drugs or alcohol, our model helps clients and partners change their functional roles within their families. For example, partners can use prearranged signals when clients are in potentially destructive interactions from which they may have difficulty disengaging. Partners can help clients by going for walks with them for gaining distance without cutting off, staying in motels rather than the family's house, role-playing how they want to respond to invitations to drink, planning to leave on their own schedule, etc. This also can alter the couple's caretaking relationship, putting the partner in a caretaking role that can add to the complementarity of the relationship and strengthen it. Having a partner be a

caretaker rather than needing care can be a very powerful and different support for a woman who is not accustomed to this in a relationship.

Some partners are not willing to examine their family of origin patterns or help the client with hers. In these cases, clients are encouraged to gather facts about their partners' families so that they can discuss patterns that they may be unconsciously replicating and make new choices about their behavior that are less reactive and more thoughtful. This is especially important for women who typically feel responsible for maintaining relationships, even when those relationships are destructive to them and they feel powerless to change others' behavior.

Consolidation

Near the end of therapy, changes that have taken place are consolidated and celebrated. Therapists emphasize gains that have been made, even when goals are not complete. Therapists should be careful to highlight successes rather than focus on issues that remain unresolved. It is more helpful to anticipate and plan for ''staying on track'' rather than ''recovering from relapses.'' Relapses are anticipated, but framed as potential learning experiences. The therapist helps the client plan for the immediate future for herself and her relationships. Sometimes, a closing ritual helps to ''set'' the changes and mark the end of this phase of therapy as positive (Roberts, 1992). One client and her partner came to their last session of therapy ready to talk about ways to continue the progress they had made, both toward the client's sobriety and their ability to work together as parents. The therapist first asked them to comment on the specific changes each had made in improving their relationship. She helped them plan, for a few minutes, for potential lapses. Finally, she asked them to discuss the things each saw the other doing to maintain their goals. At this point, the couple and the therapist each wrote positive changes on pieces of paper and placed them in an envelope marked ''Carol and Al's Resource Kit.'' The couple discussed a place in their house where they could keep the envelope, ready to remind them of their gains and to give them ideas during times of stress.

Booster Sessions

The last phase of treatment consists of booster sessions after three and six months. These sessions are not used as opportunities to invite women to reenter therapy. Rather, they are used to ''check in,'' get back on track if necessary, and focus on positive changes. When there have been lapses, the therapist focuses on how the client got back on track and can stay there, or what she needs to do to get back to her desired path rather than focusing on what happened that led her to lapse. While looking at antecedent behavior can be helpful in substance abuse treatment, our model assumes that women do this anyway and that overfocusing on it in therapy can serve to solidify her disappointment and shame, rather than help her get moving in positive directions.

Booster sessions are useful when issues of violence, previous or current sexual abuse, ongoing couple dysfunction, concerns about parenting, or other intense individual or relationship issues are prevalent. It may be important to refer clients for other treatment, if this wasn't done previously. At times, it may be important to suspend our model while a client undergoes other treatment. If it seems that the substance use is most salient, the therapist may suggest that other issues can be put on the back burner until the drug treatment is accomplished or the woman is at least physically stable. Some chemical dependency therapists recommend sobriety for several months before women tackle tough issues like childhood sexual abuse. While all of these issues are systemic and, ideally, would be worked on concurrently, therapists should be very aware that this is an intense and stressful time for clients, with many physical, emotional, and relational changes taking place, and that concurrent treatment can be too stressful. Substance abuse issues and violence or sexual abuse issues are systemic and therapists must use good clinical judgment and, perhaps, consultation, to decide with a woman which to tackle first.

DISCUSSION AND IMPRESSIONS

Designing and using this model from a woman's perspective has forced us to focus on women's issues in a new way. The challenge

of resolving women's issues of autonomy/intimacy and interdependence related to substance abuse has led us to a new awareness of how stuck women can feel when they do the things they were socialized to do, but find those same things leading to problems in other relationships. Avoiding violence, for example, can too easily place women in the position of needing to be responsible for another adult's behavior, a position that does not support sobriety and abstinence. The women in our project have commented on how the non-blame position of the therapy has enabled them to take responsibility for their own behavior and to hold their partners accountable for *their* behavior without using pathologizing constructs such as ''co-dependency,'' for example. Looking at patterns of behavior as not only learned during growing-up years, but as complementary pieces in cycles with their partners, has been freeing and empowering for many. One woman commented that this therapy allowed her to change her behavior without feeling that she had been a bad person, simply an uninformed co-participant in an intense relationship.

The model was designed to pay particular attention to women's issues, since existing treatment focused more on men's issues from a male perspective. We would like to test the model on men, also. While many aspects of the model address issues from a woman's perspective, we do not know what happens when therapists or therapy validate men's need for relational effectiveness. It is possible that men will be able to achieve and maintain sobriety and abstinence also, when their relationship systems are strengthened.

The testing of the model also used exclusively female therapists. While we did not design the project this way, it simplified the research design. We need to know, however, how well male therapists apply the model and how women clients respond to them. It is possible that the particular model or model components are less necessary than a therapist who is cognizant of women's issues in chemical dependency treatment as different from men's and takes these differences into account during treatment. The supervisors for the project included three men and one woman and exclusively male treatment coordinators. These differences also need to be ex-

plored. While much has been written about gender differences and dynamics in families and in family therapy, little is known about gender differences in supervision or how these dynamics affect therapy as well as supervision (Nelson, 1991).

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