

**WORKING WITH SUBSTANCE ABUSERS
IN THE COLLABORATIVE PROCESS
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I. INTRODUCTION

As professionals, we are all faced with working with a substance abuser, or member of the family, at various times in our careers. It is safe to assume the reader knows it takes a specific skill set, level of knowledge, and commitment to work effectively with this population group. One can also assume that most professionals reading this paper believe that the collaborative process can offer healing to a family during, as well as after, their divorce process. Some of the questions to consider, with this complex matter, are: Is the collaborative process appropriate for substance abusers? Can the process offer healing for the client and family? Can appropriate safeguards be defined and put in place without the strong arm of the court system in place? If so, how does the team work together to define safeguards and implement same? In this paper, we will discuss some of the above questions in hopes of helping our collaborative community be more effective if substance abuse is a concern on a collaborative matter.

II. DEFINITIONS

We are aware that the terms “alcoholic, addict, and substance abuser” are often used interchangeably and without a clear definition in mind. For purposes of this paper, we will focus primarily on the use of alcohol. Drugs, other than prescription drugs, are illegal and bring an entire set of issues attached to the criminal justice system. (Although abuse of prescription drugs often creates criminal behavior such as forging of prescriptions, etc.)

Addiction – The compulsive use of a substance to achieve a desired effect.

Stages of Use –

- a. Social use: Using alcohol without negative consequences. When/if negative consequences do occur, a conscious choice is made to alter use of alcohol or stop using completely.
- b. Abuse: Once negative consequences occur, there is very little to no change in usage. Instead, justification of use begins. “I only received the DWI because the police like to sit on Greenville Avenue on Friday nights.” “I drink because my marriage is really struggling.” While that justification is occurring, more and more negative consequences occur. Examples of these are saying or doing things one regrets, spending money for drinking that

needed to go elsewhere, ignoring commitments to others, loss of energy or interest in everyday activities, and growing feelings of guilt and shame. While these emotions increase, a substance abuser will often drink again to avoid experiencing the feelings. In addition, blackouts may begin in this stage, whether brief or in longer duration. It is during this stage that friends, and particularly family members, begin to notice. Many times, a family member will say, "I noticed a few years ago that he drinks differently than the rest of us. We go out to dinner and have a glass or two of wine with our meal. He continues to drink on his own for the next few hours, long after the rest of us have stopped drinking."

- c. Psychological and/or Physiological Dependence: It is quite common, particularly with alcohol use, that a psychological dependence will develop long before one may progress to physiological dependency. Psychological dependency is in place when using alcohol becomes the most important "relationship" in that person's life. Considerable time, effort and energy is put into how, when and where to drink alcohol. At this point, a compulsion has developed. Often, a person may be drinking to achieve that "buzz" or good feeling that was present in early stages of use. If that is achieved at this stage, it is brief and often unnoticed. This is due to the compulsion to continue putting the substance into one's body. Drinking is occurring despite any, or all, negative consequences that continue to happen.

III. IMPACT ON THE FAMILY

The direct, and subtle, impact on the spouse and children can be tremendous. In addition, members of one's extended family are often impacted by this behavior. One of the most common behaviors that will be observed, in a spouse, is a loss of self. The spouse, by the time he/she meets you, may be highly focused on the drinker. He/she may spend time watching when/where/how and with whom drinking is occurring. In addition, the spouse typically will step in and "take over" many of the household responsibilities that are not being addressed. All of this focus allows for little time to address one's own needs and wants.

The children are, in a variety of ways, impacted every day by a parent's abuse or dependency. As a result of the powerlessness they experience, one will see many different behaviors in children of an alcoholic. Sharon Wegscheider-Cruse researched and defined the roles children may assume in an alcoholic family. See Appendix A for more detail on those roles.

IV. SUBSTANCE ABUSERS IN THE COLLABORATIVE PROCESS

It appears that more and more substance abusers are involved in the collaborative approach to divorce, rather than litigation. The reasons for that are not specifically known, but one can guess that it may be related to several factors: a. Experience – As the lawyers become more experienced and comfortable with the collaborative process, their comfort level in working with this issue increases. b. Teams – This is a complex issue, affecting all members of a family. Having an interdisciplinary team in place to

work with the “ripple effect” of this issue adds value. c. Initial interviews – It is possible that lawyers, when doing their initial interviews for collaborative cases, are asking more detailed questions about the substance use/abuse background of each spouse.

Once a collaborative case begins and substance abuse is present, what is the responsibility of the team? The clients? The spouse? There are many “layers” to this answer and, perhaps, each discipline may have a different answer; based on ethical considerations. At the very least, we assume all will agree there is a responsibility to address any concerns that are impacting the process, the substance abuser, the spouse and potentially the children.

It appears, although the collaborative process has been in place for years, many of us are still exploring how to work with this issue in a collaborative setting. Each case, of course, presents with a different set of facts. Each substance abuser may be in a different stage of use, or, recovery. (i.e. someone comes to a meeting mood altered and slurring words to someone who has been to inpatient treatment and has 90 days of recovery) The first step, therefore, is to determine the stage of abuse, dependency or recovery for the substance abuser. Making that determination can be confusing to a team, or more specifically, the Neutral Mental Health Professional. If the Neutral MHP has years of experience working with this population group, it may appear appropriate to meet with the abuser (and spouse) to do an evaluation and make a recommendation for next steps. Stop! Although our profession often has the experience and expertise to do this, it is not appropriate while in the neutral role to do so. Why? The protocols do not allow for this as it creates a dual role. In addition, once a recommendation is made, one can predict that the following words will soon follow from at least one of the clients, “He is no longer neutral.”

V. CONSIDERATIONS AND ACTION ITEMS FOR MEMBERS OF THE COLLABORATIVE TEAM

As mentioned earlier, we are still developing the appropriate steps for working with substance abusers in the collaborative process. It appears that each team, and each case, needs to be evaluated based on its own needs and fact pattern. The following list may be helpful for any team when potential substance abuse is present:

1. What are the facts about alcohol use in the family? Do both clients present the same fact pattern/details? Do their “stories” differ?
2. If the “stories” are different, which team member(s) work on gathering the accurate information? (Neutral MHP, Lawyers, or a combination of both with each client)
3. What treatment providers are already in place? What treatment providers have been in place in recent past? (i.e. recently released from an outpatient or inpatient treatment center)
4. Is it appropriate to have clients sign a release of information to gather information from those treatment providers? Who gathers that information? (Often the MHP)

5. Once all information has been initially gathered, what is the next step?
 - i. Does it appear that client needs a substance abuse evaluation?
 - ii. If so, how is that accomplished within the collaborative process?
 1. Meeting with Neutral MHP (both clients or each client)
 2. Meeting with Lawyer
 3. Meeting with Lawyer and Neutral MHP

NOTE: Keep in mind this is a place in which having neutrality in the process clearly provides value. The Neutral MHP may be able to have this delicate discussion with both spouses, at once, and stress the value to their family and children.

6. If client agrees to have an evaluation, it is suggested that a release of information is signed so results can be shared.

NOTE: Sharing of that information is often sensitive. It is suggested that team members discuss when/where/how to do this. (i.e. joint meeting, in lawyer's office, in MHP's office, etc)

7. Now that we have the information, what do we do about it? Because orders are typically not utilized in collaborative process, honoring the recommendations becomes an issue of integrity and accountability. It is important that the team frequently discusses how to determine if the recommendations are being honored and what to do if they are not being upheld. Determining specific safeguards, and clearly defining them, for the client(s) is crucial. It typically takes input from treatment providers, both spouses, Neutral MHP, Lawyers, and the children to put effective safeguards in place.
8. Speaking of the children, having a Neutral Child Specialist, or therapist, for the children is very important in cases with substance abuse. All of us certainly have an awareness, and concern, for children living around substance abuse; particularly if another parent is not present to monitor the use. It is strongly suggested that a treatment professional, for the children, is in place (with a release of information to speak with Neutral MHP and/or the team as a whole) as soon as possible.
9. Parenting Plan – In order to develop an effective parenting plan, all the above steps will be needed. A parenting plan, with a substance abuser or someone in recovery, should address safeguards for use/abuse and changes that may occur in parenting time when/if a relapse occurs. Parenting time is often developed in stages, based on the length of recovery; defining safeguards to determine if the client is sober.
10. Spouse – Let's not forget the spouse. As mentioned earlier, it can be expected that he/she may be "shouldering the world" based on how long substance abuse has occurred in the family. It is strongly recommended that the spouse participate in individual therapy, Al-Anon, and attend Family Week if an inpatient treatment center is part of the plan.

The suggestions above assume that the spouse, who is a substance abuser, has a willingness to address the issue. When or if that is not the case, there are larger questions to consider:

Is this a case that is appropriate for the collaborative process?

Is there anything that any team members can do to deal with the denial or lack of willingness to address the problem?

If anything we offer is ineffective, what is the next step?

It appears that the questions above are a work in process. In addition, it is a case-by-case decision. Experience with this resistance, to date, has reinforced the value of having a team of professionals working together to make appropriate decisions.

VI. CONCLUSION

To say the least, working with substance abusers (in any setting) can be a challenge. To offer effective options for families, and have appropriate safeguards in place, requires collaborative team members to put conscious effort and planning into their requests, action steps, and interactions with both spouses. There are still many unanswered questions about working with this population group in collaborative practice, but it is clear that talking about it openly (with family members and professionals) can offer another layer of support and healing. We believe skills and knowledge for working with this group, in collaborative practice, is evolving.

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WORKING WITH SUBSTANCE ABUSERS IN THE COLLABORATIVE PROCESS

Six family roles developed by Wegscheider-Cruse, Satir, and Kellogg, describe the different dysfunctional roles parents and children are assigned when a parent in the family is suffering from substance abuse.

Role 1. The Addict. The person who abuses or is dependent on alcohol or drugs. Also includes the “dry drunk” a person who is no longer using alcohol or drugs but still think, feel and act as they did when they were under the influence.

- i. Internally, some emotions the addict may feel:
 1. Shame
 2. Guilt
 3. Fear
 4. Anxiety
 5. Inadequacy and
 6. Self-pity
- ii. Externally the addict would display:
 1. Blame
 2. Denial
 3. Hostility
 4. Aggression
 5. Charm and
 6. Grandiosity

Role 2. The Enabler. This is the person in the family who tries to hold the family together.

- i. Internally, some emotions the enabler may feel:
 1. Hurt
 2. Guilt
 3. Anger
 4. Self doubt
 5. Inadequacy
- ii. Externally the enabler would display:
 1. Denial
 2. Super responsible
 3. Hostility
 4. Playing the martyr role.

Role 3. The Hero. This child provides the self-esteem for the family.

- i. Internally, some emotions the hero may feel and behavioral characteristics observed by outsiders:
 1. Loneliness
 2. Inadequacy
 3. Perfectionist
 4. Over Achiever

- 5. Readily available to help everyone
- 6. "Being the best" at everything he does to keep the addiction a secret.
- ii. Externally the hero would display:
 - 1. Working hard for approval
 - 2. Intellectualizes
 - 3. Follows the rules
 - 4. Very responsible

Role 4. The Scapegoat. This child gets to act out all the family's dysfunction.

- i. Internally the scapegoat may feel:
 - 1. Rejected
 - 2. Hurt
 - 3. Guilt
 - 4. Jealousy
 - 5. Lots of anger
- ii. Externally the scapegoat would display:
 - 1. Hostility
 - 2. Defiance
 - 3. An overall rule breaker.

Role 5. The Lost Child. This child deals with their family dysfunction by means of escape. But actually, in a sense, this child is taking care of the family's needs for separateness and autonomy.

- i. Internally the lost child may feel:
 - 1. A deep loneliness
 - 2. Isolated
 - 3. Fear
 - 4. Unworthy
 - 5. Unimportant
- ii. Externally the lost child would display:
 - 1. Aloofness
 - 2. Withdrawn
 - 3. Super independent
 - 4. Avoidant of anything stressful.

Role 6. The Mascot. This child is usually one of the younger children in the family. Provides humor and comic relief, gives a false sense of healthiness.

- i. Internally the mascot may feel:
 - 1. Anxiety
 - 2. Loneliness and
 - 3. Anger
- ii. Externally the mascot would display:
 - 1. Humor, the class clown
 - 2. Hyperactivity