Substance Dependency and the Family:

An Exploration of the Efficacy of Systemic Family Therapy and Integrative Approaches to Treatment.

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Abstract

This paper aims to explore the use of systemic family therapy in the treatment of substance dependency. The impact that substance misuse has on the extended family's physical, emotional and psychological well-being emphasises the importance of including the family in the treatment of the identified substance misuser. From an Irish context, there is little to no research on the impact of a family member's substance dependency on the extended family. Research on the use of family therapies and integrated approaches to the treatment of substance dependency in Ireland is also limited to non-existent. International research suggests that the efficacy of *Systemic Family Therapy* in the treatment of substance dependency is high. However, the research that supports the use of systemic therapy is limited and not very representative. Integrative approaches incorporating models from the fields of Family Therapy and Substance Dependency Treatment also showed a positive outcome in the treatment of family's and the identified substance dependent family members. However, there is also a need for further research in this area.

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Introduction

The presence of addictive behaviour in health and social systems is a topic of worldwide concern. The scope of drug and alcohol problems far exceeds the reach of specialist systems, even in countries where systems are well developed. The *World Health Organisation's (WHO)* Regional committee for Europe developed a *European Alcohol Action plan* as a possible model for other regions. It's goals were*: "To ensure accessibility of effective treatment and rehabilitation services, including those integrated into primary health care settings, with trained personal, for people with hazardous, harmful and dependent alcohol consumption and members of their family"* and *"To enhance the capacity for society to deal with alcohol through the training of professionals…and the strengthening of community development and leadership"* (Jernigan et al., 2000 P.495). The move to include family members in treatment is an acknowledgment of the reciprocal relationship between an alcoholic's behaviour and the consequences experienced by members of his/her family. It can also be argued that issues within the family or dysfunctional family rituals can maintain or increase problem drinking behaviour (Leonard & Searles.1990).

The impact that substance dependency has on the family, particularly in relation to the extent of the problem and the capacity of available treatment will be discussed in the opening chapter. The prevalence of substance dependency in Ireland is and has been a topical area of research and debate throughout the decades. The use of addictive substances has also become more common and still remains a major social and health related concern of Irish society. A recent drug prevalence survey conducted between 2010 and 2011 by the *National Advisory Committee on Drugs* (NACD) highlighted that of all adults in Ireland; just over twenty seven per cent reported using any illegal drugs in their lifetime. Seven per cent reported using any illegal drugs in the year prior to the survey and three per cent reported use in the month prior to the survey (NACD & PHIRB, 2012). Merchants Quay, Ireland also highlighted that in the Dublin city base alone they had recorded 20, 847 client visits in their annual report for 2012, showing an increase of almost 2,000 client visits from 2011. They also documented a total of 3,634 individuals that had accessed the needle exchange programme (MQI, Annual Report, 2012, P.6). The statistics presented do not portray the overall significance of the problem in Ireland as a whole but there is also a lack of research on the effects that substance dependency has on the family system.

According to Hope (2011) an intervention with clients regarding alcohol problems generally only occurs when the problems have accumulated to a crisis point, where the parent or child has 'hit the wall' (Hope. 2011). The Impact of drug and alcohol use on the family has been an issue that has remained in the hidden realities of Irish society. The increased number of individuals drinking in the home (from moderate to excessive) has increased in the last decade and has been highlighted in studies such as *'Hidden Realities'* which was published in 2011 by Dr. Ann Hope. This is not a new cultural phenomenon but one that has been in existence and embedded in many Irish families but remained as the burden of the family because of the lack of or limited resources that exist. The Identification of Needs (ION) model where families are asked what their needs are in terms of supportive services is viewed as a step forward (Hope. 2011). This will be further explored, particularly in relation to the report of the expert group on the mental health policy

Research suggests that *Systemic Family Therapy* is one of many effective forms of treatment of substance dependency. An evaluation of this approaches effectiveness and reasons for its popularity in international research will be explored in chapter two. Evidence suggests that *Systemic Family Therapy* is an effective form of treatment for Substance use disorder. However, there are also shortfalls in the use of this approach alone; the efficacy of *Systemic Family Therapy* as a primary form of treatment will be further explored. Also family therapy remains peripheral in most Substance use disorder treatment programmes and the reason for this will also be examined in the final chapter.

The final chapter will explore the use of integrative approaches to the treatment of substance dependency in collaboration with the family. Steinglass's (2009) proposed a *motivational-systemic approach* to treatment will be discussed as well as the Community Reinforcement and Family Training project that incorporates elements of unilateral family therapy, cognitive behavioural therapy, motivational enhancement therapy and community reinforcement strategies. These approaches work in collaboration with the family members in motivating the substance dependent family member into treatment while also involving the family members in the treatment process. The validity and the evidence that supports these integrative models will be explored.

Chapter 1: The Impact of Substance Dependency on the Family

The conceptualisation of addiction remains a difficult task. At its origin addiction simply refers to "*giving over*" or being "*highly devoted*" to a person or activity, or engaging in a behaviour habitually which could have positive or negative implications (Sussman & Sussman, 2011). In the last two centuries the definition of addiction has been considered more and more disease-like in connotation. Sussman and Sussman (2011) identified five elements that contribute to the definition of addiction; feeling different, preoccupation with the behaviour, temporary situation, loss of control and the existence of negative consequences. Substance Use disorder in the recently published DSM-5 combines the DSM-IV categories of substance abuse and substance dependency into a single disorder measured on a continuum from mild to severe. The DSM-IV defines Substance dependency as a maladaptive pattern of substance use leading to clinically significant or distress, as manifested by three or more of the criteria outlined (refer to full criteria in appendix one) (DSM-IV, 1994). According to Peele (1985) "*Addiction is defined by tolerance, withdrawal and craving. We recognise addiction by a person's heightened and habituated need for a substance; by the intense suffering that results from discontinuation of its use; and by the person's willingness to sacrifice all to the point of self-destruction for drug taking"* (Peele. 1985, P.1).

The idea of family implies an enduring involvement on an emotional level. Family members may disperse around the world, but still be connected emotionally and able to contribute to the dynamics of family functioning. One distinction is the level of commitment that people have for each other and the duration of that commitment. Another distinction is the source of connection. Families are connected by alliance, but also by blood and mostly powerful emotional ties (Kaufman and Yoshioka, 2004). While substance dependency has historically been viewed as a problem of the individual, substance abuse frequently affects the entire family of that individual. The stereotypical view of the "loner" alcoholic and drug addict is a perceived misconception. The vast majority of substance abusers live in family settings (Gruber & Taylor. 2006, P.1). According to Stanton and Sadish (1997) most substance dependents under the age of 35 either live with or have at least weekly contact with one or both parents. As a consequence of this it is important to consider how the role of the family and the relationship to the family relates to the incidences and occurrence of substance abuse (Gruber & Taylor. 2006, P.1).

According to Lander et al. (2013) each family and each family member are in some way uniquely affected by the individual using the substance including but not limited to unmet developmental needs, impaired attachment, economic difficulties, legal issues, emotional distress and in some cases violence being perpetuated against him or her. Children are also at a higher risk of developing substance dependency when exposed to an environment that is characterised by one or more of the above mentioned (Lander et al., 2013, P. 194). A survey on the impact of parental drinking among adults in Ireland reported that for those who had parents that consumed alcohol during their childhood, almost one in ten felt ashamed or embarrassed by their parents drunken behaviour, or had often witnessed conflict between their parents when they were drinking or felt afraid or unsafe as a result of their parents drinking (AAI, 2009 as cited in Hope, 2011). According to Butler (2002) the impact of excessive parental drinking on children can manifest itself in broader social and psychological disorders such as withdrawal and shyness, acting out in more aggressive ways, under-preforming at school or regressing back to earlier behaviours such as bed wetting (Hope, 2011. P.3). According to some of the key findings in Hope's (2011) study on adult's risky drinking patterns in Ireland; over half (56%) of adult drinkers (who had children living in their home) engaged in regular hazardous drinking at least once a month, almost half (46%) reported regular drinking at home at least once a month and one in seven (14%) adults reported family problems as a result of someone else's drinking. Hope also suggests that *"the estimate figure of children of all ages living in families with parental hazardous drinking is over half a million (587,000)"* (Hope, 2011 P. 13).

In this view, family members inevitably adapt to the behaviour of the person with a substance use disorder. They develop patterns of accommodation and ways of coping with the substance use (e.g., keeping children extraordinarily quiet or not bringing friends home) (Kaufman and Yoshioka., 2004). In Adelson's (2010) review of how substance abuse impacts family rituals, she suggests that in these situations the families are challenged to make a choice with regard to how they plan to continue or discontinue their participation in the ritual process of the family defined by substance dependency.

Even though there is merit and in some cases it is only plausible to treat the individual without family involvement, this can also limit the long term effectiveness of the treatment outcome for two main reasons. Firstly, it ignores the devastating impact of substance dependency on the family system, leaving family members with possible unresolved issues, such as trauma, anxiety, anger, denial and blame to name but a few. Secondly, it could be

suggested that individual therapy does not to some degree, recognise the family as a potential support system for change; however, this is debatable (Lander et al, 2013. P. 195).

Older theories tended to hold the family responsible for the substance misuse problems of its member. Blechman (1982) suggested three hypothesises that reinforce substance dependency; the broken home hypothesis, the over protective or dominant mother with or without neglectful fathers and the control hypothesis. Even though Blechman's theory has plausible points with regard to how family functioning or dysfunction can contribute to a family member's substance dependency; such views can also make it difficult to underpin the root of the problem by isolating the family from the mode of treatment and support. The long term effectiveness of treatment for some individuals can be further supported by a family that has had the family's needs in their own right understood. The United Nations Offices on Drugs and Crime (UNODC) (2014), identified four areas of the extended family members lives that are impacted by a family members substance dependency The Physical impact on the families interviewed suggested that there was a greater chance of domestic violence due to confrontations with the drug user, 53.3 per cent of interviewees involved in such a confrontation said that they had been physically hit by or had hit out at the concerned. A greater prevalence of self-harm among family members affected by another members drug use was also highlighted; of the interviewees who had admitted to having committed self-harm, the majority of both males (69.3%) and females (55.6%) listed drug use by a family member as a contributing factor. Moreover, a relatively high percentage of females (23.9%) identified violence in the household as a reason for their actions (UNODC, 2014).

The emotional impact of a family members drug use was also high, particularly in relation to the extent of worry and stress that is experienced by other family members. An overwhelming majority of interviewees (82.3%) answered in the affirmative. A minority (4.6%) of interviewees said that they had consumed drugs or had thought about consuming drugs in order to deal with depression or family problems caused by a family members drug use. Drug use also had a very clear economic impact on the families particularly in regard to the substance abusers loss of income (60%) and a large proportion of interviewees (67.9%) experiencing financial problems because of a family members drug use. Finally, there is also the social stigma attached to drug use which not only affects the person using the substance but also members of that person's family (UNODC, 2014).

It is clear from the review of literature that the scope of the problem is vast. The argument that family members may be the cause of a person's drug use is valid in certain cases but as identified throughout this chapter there is validity in the inclusion of family members in therapy.

Chapter Two: Systemic Family Therapy in the Treatment of Substance Dependency

The most prominent reason for evaluating the systemic approach in the treatment of addiction is because of its frequent reoccurrence in literature relating to the treatment of addiction and its claimed positive effectiveness in treatment outcomes as recorded by its advocates. According to Walsh (2011) systems family theory has become an essential framework in understanding human functioning and dysfunction in context. Systemic family therapy has become more responsive to the growing diversity and complexity of family's. Systemic therapy can be defined as a form of psychotherapy that conceives behaviour and especially mental symptoms within the context of the social systems people live in, focusing on interpersonal relations and interactions, social constructions of realities, and the recursive causality between symptoms and interactions (Sydow et al. 2010, P. 459). According to Kaufman et al. (2004), *"in system family therapy, the unit of treatment is the family, and the individual within the context of the family system. The person abusing substances is regarded as a subsystem within the family unit"* (Kaufman and Yoshioka, 2004. P.4). Walsh (2011) suggests that family members are so interconnected that each individual affects all others, who in turn affect the first member in a circular chain of influence. Sydow et al. (2010) highlighted two meta-analysis studies that identified a systemic intervention for substance use disorder as being more effective in comparison to individual counselling (Sydow et al. 2010, P. 475). Carr (2009) also suggests that the systemic approach in relation to alcohol abuse is a more favourable form of intervention. Sydow et al. (2010) concluded from their study on the efficacy of *Systemic Therapy* that 34 out of the 38 studies show Systemic therapy to be effective; they also discovered evidence-base for the efficacy of systemic therapy for *adult index patients* with mental disorders in at least five broad diagnostic groups, including substance disorders (Stratton. 2011, P.9).

The main key concepts of family systems theory include feedback, homeostasis and boundaries (Landers et al., 2013). Most family theory models share the basic principal of family systems theory that is the individual cannot be fully understood or successfully treated, without first understanding how that individual functions in his or her system (Landers et al., 2013). Homeostasis refers to the idea that it is the tendency of a system to seek stability and equilibrium. The idea of homeostasis is key to understanding the effects of substance dependency on the family in that each family member tends to function in such a way that keeps the whole system in balance even if it is not healthy for specific individuals (Landers et al., 2013). Feedback is another important element in the family system.

Feedback refers to the circular way in which parts of a family system communicate with each other and is vital to how the parent-child attachment relationship is formed, as each person's behaviour becomes reinforcing feedback for the other. The final concept involves the existence or lack of boundaries in the family. Boundaries define internal and external limits of the system and are established to conserve energy by creating a protective barrier around a system. In a 'healthy family' boundaries surround the parental subsystem and the child subsystem by keeping them separate (Landers et al. 2013).

Substance dependency can have a significant negative impact on all three concepts described. Family members, particularly children that constantly receive negative feedback or a minimal form of stimulating communication because of a parental figures substance dependency are more likely to be affected developmentally and psychologically. The child that must become the parent or the peace keeper to maintain the homeostasis of the family system also has a negative impact. Another factor must be considered in how the family system maintains or even drives the substance misuser's addiction. In the safe environment of therapy, pent-up feelings such as fear and concern can be expressed, identified, and validated in relation to the identified maladaptive behaviours taken on by family members including the identified substance abuser as a result of their substance misuse (Kaufman and Yoshioka., 2004).

According to Steinglass (2009) many of the treatment approaches that have been included under the term "family therapy" continue to focus on the substance abuser as the primary target of treatment. Steinglass (2009) suggests that the majority of treatment approaches in the substance dependency field continue to be built around the user as the main focus of therapy, with families often included after individual treatment and detoxification of the substance dependent has been achieved.

From the literature that is available a number of key reasons to support the inclusion of family in the treatment of addiction recur. Firstly, the family members involvement during the pre-treatment phase significantly improves engagement of substance abusers in treatment, involvement of the family also improves retention in treatment, there is a minimisation of isolation experienced by the abuser, exposure of other problem areas that may also require treatment are flagged and finally, long-term outcomes are more positive when families and or social networks are components of the treatment approach (Steinglass, 2009; Collins et al. 1990). *Walitzer (1999) analysed two forms of family therapy (behavioural marital therapy and family systems therapy) for treating substance abuse. She concluded that the model of*

choice depended on the problem at hand. If problems (such as poor communication) centred in the marriage, behavioural marital therapy was the better approach. If the problem involved a whole family organized around alcohol or illicit drugs, family systems therapy could be a superior strategy. In either case, her review "strongly indicates the critical role family functioning can have in both subtly maintaining an addiction and in creating an environment conducive to abstinence" (Walitzer 1999, p. 147; cited in Kaufman and Yoshioka., 2004, P. 11).

The studies to date on the efficacy of systemic family therapy in the treatment of substance dependency have been hindered by small sample sizes and limited outcome measures. A possible and most likely the most concerning issue with the use of *family systems therapy* is the actual attendance of the family members, in some cases the family may be the cause of the drug dependents behaviour but do not want the system to change because of the implications this change may have on their own behaviour (e.g. violence, sexual abuse, psychological abuse). Another issue that may limit the use of this approach is the financial implications on the family; family therapies can be very costly and is very rarely covered by health insurance or funding.

Chapter Three: Integrated approaches to the treatment of substance dependency

The use of systemic family therapy has its benefits; however, there are possible alternatives that are more integrative and possibly more effective than *Family Systems Therapy* or individual therapy alone. According to Steinglass (2009) and McGovern et al. (2003) more focus and research needs to be applied to the integration of treatment models for both the individual and the family. Miller and Wilbourne (2002) in their review of evidence-based treatment approaches to substance misuse disorders, highlight that as many as nine of the eleven approaches that they identified as effective, emphasises a focus on family or social networks as a key *"active ingredient"* of the treatment approach (cited in; Steinglass., 2009, P. 156).

An integrated model would work with family members to promote the entry and engagement of misusers into treatment, a joint collaboration is formed between the family members and the misusing family member, in the treatment of the misuser and the needs of the family members in their own right would also be identified (Copello et al. 2005). The use of integrated models; that is an approach that uses elements from the substance abuse treatment models such as motivational interviewing, the 12-step model and/or cognitive behavioural therapy and combines them with elements from, for example, systemic family therapy, unilateral family therapy or community reinforcement strategies to form a cohesive and collaborative form of treatment that suits both the substance misuser and the other family members. Such an integrated approach holds many values that contribute to the potential success of treatment, these include positive treatment outcomes, increased chances of long term recovery for the substance misuser in the family, family's chances of recovery increase which in turn further supports the recovery of the substance misuser because there is a greater understanding and the focus of treatment is not solely on the substance abuse. Integrated models can also help reduce the impact and recurrence of substance abuse in different generations (Kaufman and Yoshioka, 2004).

According to Steinglass (2009) there is a shift from the primary focus of cessation from alcohol or drug use as the sole criterion of success, to an expanded view that includes the substance user's interpersonal relationships and social functioning; a reflection of a more multidimensional definition of substance abuse. Steinglass introduced the idea of combining elements of systemic family therapy and motivational interviewing to create an integrated approach he coined as *Systemic-Motivational Therapy*. What is most important in this

approach is the stance the therapist takes in interacting with the family; a stance that is sufficiently described as that of a clinician-researcher who, first, collects data from the family about how substance misuse intersects with family life. The therapist then explores in collaboration with the family its beliefs about why substance use has become so central in its life and finally aides in the identification of potential resources within the family that might be constructively applied to a better resolution of the substance abuse problem (Steinglass., 2009, P. 160). Steinglass (2009) claims that in this evolving treatment approach it is the entire family that is being targeted as the primary focus of interest and intervention; and it is the uncovering of family-level beliefs about substance use and its concomitants that become the main focus for therapeutic inquiry. It is also the family as a group that will be mobilised to develop ideas about how to actively address the substance abuse issue.

An alternative form of intervention and treatment was formulated; Community Reinforcement and Family Training (CRAFT). The CRAFT approach was designed to engage adult drug users in treatment through unilateral family therapy with one or more concerned significant other (Meyers et al., 1999, P. 294). The findings of Meyers et al. (1999) research on the effectiveness of CRAFT suggests that it provides a positive alternative to confrontational and detachment approaches in counselling concerned significant others. The primary focus of this research was whether or not family members could change their own behaviours towards the drug dependent family member(s) and engage in motivating the substance dependent family member to seek or attempt treatment. A consistent and available level of integrated treatment models were used in the treatment of the resistant substance abuser; such models included the use of cognitive behavioural therapy in the second phase combined with motivational enhancement therapy and community reinforcement strategies (Meyers et al., 1999). Even though the concerned significant other's treatment focused on the drug use of the identified substance dependent family member, the results of the project show the supporting family members improved their physical and emotional well-being during treatment and maintained these improvements after the completion of therapy (Meyers et al., 1999).

Discussion

The most common positive outcome for family members in treatment or involved in the treatment of the substance abusing family member is a positive change in their own physical and emotional well-being, particularly in relation to how to relate to and cope with another family members struggle with their addiction (Meyers et al. 1999). The objective of this literature review is to explore and evaluate the efficacy of *family systems theory* in the treatment of substance dependency. Research conducted on family treatment methods has influenced the criteria sets being used to define treatment success in the addiction fields (Steinglass, 2009). However, there is a need for improved research methodologies in this area, particularly in relation to trial methodology and the use of qualitative research methods to gain a greater insight into the use of systemic treatment from the perspective of the family unit.

The final chapter also explores the more integrative approaches that theoretically provides a valid argument for the potential effectiveness in relation to the treatment of substance dependency; however, these studies lack valid empirical research to support their claims of efficacy. One of the major weaknesses in proving the efficacy of both family systems therapy and the integrated approaches, such as, systemic-motivational therapy and community reinforcement and family training; all were limited to very small sample studies which hinders the studies ability to relate the findings to the general population of the given society. Another area of concern is the evident struggle between services in terms of merging each other's models of treatment to create a more collaborative and workable form of treatment for the family (Steinglass, 2009). In terms of the Irish system, Hope (2011) acknowledges that referrals between professional services have improved; however, there is still a need for interagency work.

Study after study suggests that if a person in a family abuses alcohol or drugs, the remaining family members are at increased risk of developing substance abuse problems. Research has also identified the physical, emotional, financial and social impact that the behaviour of a substance dependent family member can have on the family, it also suggested an increased chance of another family member engaging in substance misuse; motivated by his/her inability to cope with the situation (United Nations on Drugs and Crime, 2014). This view is further supported by Copello et al. (2005), his research also suggests that family members develop problems in their own right, often manifested in high levels of physical and

psychological symptoms. From an Irish perspective, the amount of research that relates to the impact of substance abuse on the family and the efficacy of family therapy models is limited, and in some cases is non-existent. To date in Ireland the struggle to provide an integrative system of treatment and support still exists and few resources exist to help families cope with the impact that substance dependency has on their family life. The most current published study that exposes the realities of the effects of substance abuse on the family in Ireland is Dr. Ann Hope's (2011) research into the *"Hidden Realities: Children's exposure to Risks From Parental Drinking in Ireland".* This is the most in-depth piece of research that represents the extent of the problem in Ireland . Even though this study highlights the impact of drinking in the home and how it can affect the family it still does not fully represent the reality of the problem of Ireland, this is something that could be further researched.

Studies to date have been hindered by small sample sizes, limited outcome measures, and the lack of a clear theoretical rationale for intervention. Apart from scientific quality, a clinical research-developed evidenced based intervention may also be practically irrelevant or unfeasible by virtue of its being too complicated, too expensive or too narrowly focused on certain types of patients (McGovern and Carroll., 2003). Overall, in terms of the evaluation of the models of treatment available to families, the picture is mixed. For both systemic family therapy and the more integrated models of treatment studies show a low or limited number of participants, weak control groups and limited follow up studies.

Conclusion

This study has offered a glimpse of the impact that substance dependency can have on the family. The three main areas of focus has been the impact of substance dependency on the family, the efficacy of *systemic family therapy* in the treatment of substance dependency and an exploration of the integration of substance abuse treatment, family therapy and community reinforcement models to treat substance dependency. Family therapy for substance dependency treatment demands the management of complex treatment situations. The research in relation to the use of systemic family therapy and integrative models such as systemic–motivational therapy and CRAFT also suggest positive outcomes, but the field of treatment for families' remains fragmented both in terms of national and international research. The studies on the impact of substance dependency on the family draw a clear picture of the physical, emotional and psychological distresses endured by families that are affected by their family member drug use. This would further strengthen the need for further research into the treatment needs of the family as whole as well as the substance abusing family member.

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Appendix 1:

DSM-IV Substance Dependence Criteria

Addiction (termed substance dependence by the American Psychiatric Association) is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same

12-month period:

1. Tolerance, as defined by either of the following:

(a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect

or

(b) Markedly diminished effect with continued use of the same amount of the substance.

2. Withdrawal, as manifested by either of the following:

(a) The characteristic withdrawal syndrome for the substance

or

(b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

3. The substance is often taken in larger amounts or over a longer period than intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time is spent in activities necessary to obtain the substance (such as visiting multiple doctors or driving long distances), use the substance (for example, chain-smoking), or recover from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the

substance (for example, current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

DSM-IV criteria for substance dependence include several specifiers, one of which outlines whether substance dependence is with physiologic dependence (evidence of tolerance or withdrawal) or without physiologic dependence (no evidence of tolerance or withdrawal). In addition, remission categories are classified into four subtypes: (1) full, (2) early partial, (3) sustained, and (4) sustained partial; on the basis of whether any of the criteria for abuse or dependence have been met and over what time frame. The remission category can also be used for patients receiving agonist therapy (such as methadone