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Social behaviour and network therapy Basic principles and early experiences

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Abstract

The present paper reports on the basic principles of a treatment approach currently being used in a National Multicentre Randomised Controlled Trial of Alcohol Treatments in the United Kingdom (UK Alcohol Treatment Trial). The treatment: Social Behaviour and Network Therapy (SBNT) is novel as a package but has been developed by integrating a number of strategies found to be effective in other treatment approaches. The intervention is based on the notion that to give the best chance of a good outcome people with serious drinking problems need to develop positive social network support for change. A brief review of the evidence supporting social treatments for alcohol problems is followed by an outline of the feasibility work and the basic principles that guided the development of SBNT. Process data from the first 33 trial cases and 2 case vignettes are described and discussed. It is concluded that SBNT is a feasible and coherent treatment approach that can be delivered by a range of therapists in the alcohol field.

Keywords: Social behaviour and network therapy; Alcohol treatment; Social intervention; Network support for change

1. Introduction

Inspection of recent overviews of the alcohol treatment literature (Finney & Monahan, 1996; Hodgson, 1994; Holder, Longabaugh, Miller, & Rubonis, 1991; Miller, Brown, &

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Simpson, 1995; Thom, Franey, Foster, Keaney, & Salazar, 1994) suggests that the social components of treatment for alcohol problems, e.g., Community Reinforcement, Social Skills Training and Behavioural Marital Therapy, are amongst those with greatest evidence of positive treatment outcome when compared with other types of treatment.

In addition, over recent years, research has supported the notion that social networks can strongly influence people with drinking problems to initiate treatment (Barber & Crisp, 1995; Meyers & Smith, 1995) and affect the course and outcome of interventions (McCrady et al., 1986; Stout, McCrady, Longabaugh, Noel, & Beattie, 1987). Models of relapse have also stressed the importance of interpersonal factors in influencing the likelihood of relapse and long-term maintenance of change (e.g., Marlatt & Gordon, 1985).

Further evidence of the central role that social factors can play in drinking behaviour is illustrated by the finding from Project MATCH (Project MATCH Research Group, 1997) that patients whose social network was supportive of their drinking had poorer outcomes in all treatment conditions. Furthermore, the most significant matching effect found in Project MATCH involved those clients with networks supportive of excessive drinking having better outcomes in 12 Step Facilitation Therapy (Project MATCH Research Group, 1998). This effect was partly mediated by attendance to Alcoholics Anonymous, a form of treatment that provides a network highly supportive of attempts to achieve and maintain abstinence (Longabaugh, Wirtz, Zweben, & Stout, 1998). Longabaugh, Beattie, Noel, Stout, and Malloy (1993) had previously also shown that poorer outcomes for drinking were associated with networks that were not supportive of abstinence in clients pursuing this goal.

Although potentially concerned others can be highly influential, more commonly their efforts are hampered by their lack of a clear understanding of the problem and possible responses. The importance of a clear and shared understanding of the problem by all those affected is illustrated by previous research into the effects of drinking on the close family (Orford et al., 1975; Yates, 1988) or colleagues at work (Molloy, 1989). This research suggests that when individuals begin to drink heavily, those around them do not always have sufficient knowledge to decide whether or not their drinking is excessive and if they do know it is excessive they often do not know how to respond or what to do about it. A common result is that those concerned about the problem drinker either ignore the problem or talk about the situation to people other than the person experiencing the drinking problem. On occasions, their actions may unwittingly compound the drinking problem.

In relation to alcohol treatment a paradox is also evident. Despite the documented important role of social context, most treatments offered for alcohol problems remain on the whole individually focused with little emphasis placed on the client's social environment. There has been a comparatively recent change of emphasis, however, with the development of some treatments involving the widening of the focus of attention to consider the potential value of including concerned friends and family members in the treatment process.

During the early stages of the design of the United Kingdom Alcohol Treatment Trial (UKATT) the principal investigators became aware of the need to establish the comparative effectiveness of socially versus individually focused treatments for alcohol problems (UKATT Research Team, 2001). Results of Project MATCH had shown that individually focused treatments of different intensities led to similar outcomes across large numbers of

clients entering alcohol treatment (Project MATCH Research Group, 1997). Given that a number of social approaches to treatment appeared to be effective, and none of them had been tested in Project MATCH, UKATT investigators became interested in developing an evidence-based intervention that was mainly socially focused, in order to compare it to an individually focused intervention. The state of knowledge at the time suggested that the most cost-effective individually based treatment was Motivational Enhancement Therapy. Social Behaviour and Network Therapy (SBNT) was therefore developed by drawing together strategies from a number of treatments, briefly reviewed below, in order to compare it to Motivational Enhancement Therapy in a large multicentre randomised trial aiming to recruit 720 clients.

1.1. Alcohol treatments with social components

The following brief review below considers treatments that work with concerned others in order to bring the drinker into treatment; treatments that work with both drinkers and their relatives; treatments that work with wider social networks; and finally approaches that work with relatives as clients in their own right.

An example of an intervention that concentrates on working with the spouse and the family in the absence of the person with a drinking problem is the 'pressures to change' approach (Barber & Crisp, 1995) that uses the family to influence the person who is experiencing a drink problem. It starts by engaging the concerned family member in treatment and working with him/her by increasing the understanding of the problem through education, discussing setting up activities incompatible with drinking, exploring the partner's response to drinking and finally preparing the relative so that he/she can confront the person with the problem and request that he/she approaches services to obtain help with the drinking problem. In essence, this approach aims to create changes in the behaviour of those concerned and affected by the person with a drinking problem with the hope that the latter will be induced into treatment. In a controlled study (Barber & Crisp, 1995) it was found that more people with drinking problems engaged in treatment services after their relatives were treated with the 'pressures to change' approach as compared to those who did not receive this approach.

A similar emphasis on working with family members in order, ultimately, to help the problem drinking individual is used by Meyers, Dominguez, and Smith (1996) in the community reinforcement approach. The latter is a development and refinement of the original community reinforcement treatment reported by Azrin and colleagues (Azrin, 1976; Azrin, Sisson, Meyers, & Godley, 1982; Hunt & Azrin, 1973). The essence of this approach is the restructuring of social, family and vocational aspects of everyday living of those with drinking problems so that sobriety is selectively encouraged. Early evaluations of the community reinforcement approach showed that better outcomes could be achieved with this treatment when compared to a control condition.

A further example of an approach that works with the concerned family member is Unilateral Family Therapy, a form of treatment that aims to affect change through working with the spouse in the absence of the person with the drinking problem. The approach has been shown to produce decreases in drinking in the untreated spouse (Thomas & Ager, 1993).

An intervention which focuses upon using networks to increase pressure on clients to enter treatment is the Johnson's Institute Intervention (Johnson, 1986). As part of this intervention and unbeknown to the drinker, networks of people who approach a service concerned about someone else's drinking are trained to stage a confrontation, during which attempts are made to reduce 'denial' about 'alcoholism' and engage the drinker in treatment. The limited evaluations of this intervention suggest that in a small proportion of cases trained social networks can bring resistant drinkers into treatment through carefully planned confrontation. In most cases, despite preparatory work, the confrontation never takes place (Liepman, 1995). There is also some suggestion in the literature that these techniques can result in decreased retention and increased relapse rates for the drinker (Loneck, Garret, & Banks, 1996a, 1996b).

An approach that has developed from the Johnson's Institute Intervention and has been reported in the recent literature is called the ARISE project (Garrett et al., 1998). In contrast to the Johnson's Institute approach, this intervention attempts to emphasise support both for the client and the network before, during and after treatment entry as well as placing less emphasis on the 'confrontation'.

The evidence reviewed so far supports the importance and influence of networks in bringing people into treatment.

Other marital and family approaches have directly involved both drinkers and their families. These treatments have focused on improving relationships, decreasing behaviours that facilitate drinking as well as drinking control strategies, increasing marital stability and introducing other strategies designed to create a positive basis for change in the drinker's behaviour. In essence, these strategies aim to alter the conditions within the client's environment in order to support change. These treatments have resulted in better outcomes than approaches that do not involve the drinker's family (O'Farrell, Cutter, & Floyd, 1985) and in the long-term show an increase in the number of days spent abstinent compared to minimal spouse involvement conditions (McCrady et al., 1986; Stout et al., 1987).

Some authors have argued that the drinker's larger social network should be included in treatment (e.g., Beattie et al., 1993). One of the few social interventions that directly engages wider social networks in the treatment process is network therapy (Galanter, 1993a, 1993b, 1999). Network therapy is an approach to the treatment of alcohol and drug problems that emphasises the involvement of people from a number of different areas of the identified drinker's life, for example, friends and work colleagues. Selected family members and friends are enlisted in treatment to provide ongoing support and promote both attitude and behaviour change. The networks used can be of any size and everyone who is willing and meets defined criteria can attend the treatment sessions. The role of the network is to work together as a team and hence the treatment defines network members as part of the therapist's team, not subjects of treatment. Abstinence is emphasised as a goal of treatment and cohesiveness is stressed. The influential force of the network upon the drinker's behaviour is utilised. In an evaluation of network therapy (Galanter, 1993a, 1993b), the outcome for 60 patients is described. It was found that 92% of the sample were treated with at least one other network member and the average size of network for this group was 2.3 (S.D. = 1.3) members. Of the 55 clients treated with a network, 36% had a member of their family of origin participating, 27% had a network whose only member was their partner, 7% had networks consisting of

only peers. Overall, 77% of the total group ($N = 60$) experienced 'major' or 'full' improvement. Although these findings are promising, interpretation needs to be cautious given the fact that network therapy was not compared to a control condition.

Yates' (1988) work constitutes a further example of an approach that actively initiates contacts with anyone who may be affected and concerned about someone else's drinking and can potentially benefit the client in his/her efforts to change. The emphasis is on a coordinated strategy for change working with whoever is concerned enough to take positive action in response to the drink problem.

Other approaches of theoretical relevance focus on the needs of those affected by the drinking, mainly family members (e.g., Copello, Orford, Velleman, Templeton, & Krishnan, 2000; Copello, Templeton, Krishnan, Orford, & Velleman, 2000; Howells, 1997). The latter are seen as people who are under stress and at risk of developing health problems in their own right. These approaches emphasise developing with family members' different ways of coping. Both the approach used by Howells and that reported by Copello and colleagues, although relatively brief, have been shown to change coping and result in a general improvement in health for concerned others, mainly family members. Both approaches were informed by the stress-coping-health model of addiction and the family developed by Orford and colleagues (Orford, 1998; Orford et al., 1992, 1998).

Inspection of the above literature suggests that there are a number of socially based treatments for alcohol problems that show promising evidence of effectiveness. The approaches, however, assign very different roles to concerned others. They are mostly seen as adjuncts to the treatment of the person with the problem and most of these interventions are still influenced by individual or systemic models of treatment. There has been no conceptual agreement as to what is the key contribution that concerned others make. Furthermore, the inclusion of concerned others in treatment, mostly partners or close relatives, has often been as part of family therapy interventions in specialist settings and hence not available to the whole range of clients coming into contact with services. In the other approaches, concerned others have received treatment when approaching services in order to minimise their stress and bring the drinker into treatment. Network therapy (Galanter, 1993a, 1993b, 1999) engages the wider social network, but has been limited to those clients who can engage a network. Although all the reviewed interventions have strengths, there has not been an attempt to date to integrate a number of the elements present in social treatments in a theoretically coherent package that can be delivered within a range of treatment settings and to the majority of people accessing alcohol services. SBNT was developed with this aim in mind in order to produce a social intervention that could be used with the whole range of people presenting for alcohol treatment whether they already had social networks or needed help in developing network support for change. SBNT was developed by drawing upon strategies used in a number of treatment approaches with a social focus and integrating them with the aim of maximising the client's available *positive social support for a change in drinking behaviour.*

SBNT brings together elements of network therapy (Galanter, 1993a, 1993b, 1999), social aspects of the community reinforcement approach (e.g., Meyers et al., 1996; Sisson & Azrin, 1989), relapse prevention (e.g., Chaney, O'Leary, & Marlatt, 1978) and approaches with

family and concerned others (Copello, Orford, et al., 2000; Copello, Templeton, et al., 2000; Howells, 1997; Yates, 1988). It integrates aspects of these approaches within a unified social treatment approach that has theoretical coherence. SBNT is a pragmatic approach based on the principle that a critical condition for successful addiction treatment is the availability of social support for change. The therapist's task is to work towards this goal with the problem drinker and those members of his/her social network who are willing to support his/her efforts to change.

The remainder of this paper describes the development, key principles, structure and content of SBNT as well as early experiences of applying the intervention within the UKATT. The first stage in the development of SBNT involved a feasibility study described below.

2. SBNT development: feasibility study

Drawing from a number of the interventions reviewed, a treatment was developed and written up in manual form. The treatment, termed Network Support Therapy (Copello, Moore, & Orford, 1997) was a precursor to SBNT and included the same key areas to be used in treatment as well as sharing SBNT's central philosophy, i.e., the enhancement of network support for change. One main difference was the fact that no specific provision was made to work with those clients presenting for treatment who were isolated or who had difficult relationships with potential network members. The feasibility study was conducted using this manual and involved piloting the treatment approach within a National Health Service treatment service in the UK (Ellis, 1998). As part of this study, seven therapists were trained to follow the procedures set out in the manual in order to deliver Network Support Therapy to clients fulfilling a diagnosis of alcohol dependence. Network Support Therapy worked on engaging people's social networks in treatment from the very first therapeutic contact. During the period of this study, 17 clients were recruited. Twelve cases completed the six session intervention (nine male and three female — mean age = 49.5). Twenty-two network members were engaged at some point in the treatment of these 12 cases and included: spouses/partners ($n = 8$), daughters ($n = 4$), sons ($n = 2$), sisters-in-law ($n = 2$), friends ($n = 2$), neighbours ($n = 2$), mother ($n = 1$) and niece ($n = 1$) (Ellis, 1998). The feasibility work showed that therapists could be trained to deliver a socially focused intervention that was acceptable to clients who in turn were able to engage members of their social network in the treatment process. When interviewed as part of the study, therapists, problem drinkers and concerned others provided positive feedback in relation to Network Support Therapy (Ellis, 1998). An important issue to emerge from this work, however, was the need to include coherent strategies to work with those clients who had difficulty engaging a social network. Whilst retaining the overall philosophy of the treatment approach and the focus on the client's environment, a number of strategies based on social skills approaches were incorporated into the treatment. These were included for those clients experiencing difficulties recruiting network members in order to help them to develop other sources of social support for change within their environment. In order to reflect this additional dimension to the approach, the name was changed to include a reference to social behaviour. In addition, all the material to

be used in the sessions was adapted to use both when networks were present and when the work was mainly conducted via one person.

3. SBNT aim and principles

3.1. Overall aim

The overall aim of the treatment is to mobilise and/or develop positive social network support for a change in drinking behaviour. The therapist's task is to work towards this goal in collaboration with a person with a drinking problem and with those members of the problem drinker's social network who are willing to support actively his/her efforts to change. Network members can include family members, friends and work colleagues. The work can be conducted either in network sessions or working unilaterally via the person with the drinking problem. In addition, once the treatment starts the therapist can continue to work with network members even in situations when the person with the drinking problem has stopped attending. Any specific strategy used within the treatment sessions has to be selected in order to work towards the overall aim of developing positive social network support for change. Central to the philosophy of SBNT is the notion that everyone involved in treatment becomes a client in his/her own right. In order to acknowledge this the person with the drinking problem is referred to as the *focal person* whereas others are referred to as *network members*.

A secondary aim of the approach is to explore how to minimise the influence of those parts of the social network that support the continued problematic use of alcohol. This is only undertaken once work has successfully focused on the development of positive social network support for change.

3.2. Basic principle and underlying assumptions

SBNT is a pragmatic and assertive approach based on the key principle that a critical condition for successful addiction treatment and maintenance of change is the availability of social network support for change. SBNT can be used both to pursue a goal of abstinence or moderation. Three underlying assumptions inform the treatment.

3.2.1. Social network support for change is relevant to everyone presenting for alcohol treatment

SBNT is concerned with the development and consolidation of a 'social network for change' using as a baseline the social network as it exists for each individual problem drinker at the time of presentation for treatment. For some problem drinkers, with a group of very supportive close relatives and friends, the work may involve inviting these people to the treatment sessions and developing plans for action. For other problem drinkers the work may involve creating the conditions for the network to function in a supportive way, where the effects of drinking over time may have strained relationships. Some problem drinkers will have no network. For them the work may involve creating a network in such a way that what

might be achieved by the end of the treatment is the involvement of *one* new supportive person for those individuals who were previously totally isolated. What follows from this assumption is the fact that the treatment components are equally relevant and could be applied with people with available social contacts as well as people who are isolated at the time of treatment entry.

3.2.2. Family members and concerned others are central to the treatment process

Given the emphasis on social network support for change, SBNT sees the involvement and contribution of family members and concerned others as central to treatment and as important as the involvement and contribution of the individual experiencing the alcohol problem. Some of the approaches already covered in the Introduction have demonstrated the key role that social networks can play in terms of engagement in treatment and support for change. This remains as the key focus of treatment whether network members are present in the session or accessed and engaged via the focal person outside of the treatment sessions. In addition, the role and influence of network members is so crucial in SBNT that therapists can continue to meet with concerned network members who continue to attend the sessions even in the absence of the focal person. This is a very important component of SBNT and it contrasts with what normally takes place in most individually based treatments. It allows therapists to continue working even when faced with a situation that other approaches would define as treatment dropout.

3.2.3. The work during treatment aims to create the conditions for future maintenance and support of change

The therapist needs to work with a positive part of the client's social network to provide a coherent set of coping strategies for both the person with a drinking problem and network members. These coping strategies can be used both within the treatment period and following treatment completion. In this respect, the intervention attempts to develop systems that will continue to operate beyond the therapy period. The treatment period is therefore the first step in a longer journey and attempts are made to empower the focal person and network members to continue with a process of change and mutual support. The support mechanisms that operate beyond the therapy are not necessarily different to those that may occur naturally in other cases. The treatment aims to strengthen and develop these natural processes.

4. Therapists' training and core skills

Further details of training within UKATT are described elsewhere (Tober, Kenyon, Barrett, & Godfrey, in preparation). For the purposes of this paper, however, a brief description is offered. Potential therapists were recruited from the services taking part in UKATT (UKATT Research Team, 2001) and were allocated at random to receive training in either MET or SBNT. Following randomisation, therapists allocated to SBNT were invited to attend a 3-day residential workshop where key principles were introduced and case examples and role play practice were used. Following the 3-day workshop therapists were asked to conduct at least

two training cases under videotaped supervision before being assessed for competence on the basis of predefined criteria. Once deemed competent, therapists continued to practice under regular supervision from the Trial Training Centre (Leeds Addiction Unit, UK).

During our work in the development of SBNT four core therapists' skills emerged as central to the delivery of the treatment. A significant part of therapists' training focused on the development of these skills that are discussed below.

4.1. Thinking network

'Thinking network' refers to the therapist's ability to think/understand/select any aspect of the intervention in a way that constitutes a step towards an increase in positive network support for the focal person. Whereas 'thinking network' may be easier when there is a network of people in the room, the ability to think in this way becomes particularly important for those problem drinkers who may be isolated. An example to illustrate this point involves social skills training. If this type of work is undertaken within SBNT, the focus needs to be on how the focal person can develop the necessary skills required to approach people in order to incorporate these people into the supportive social network. This is opposed to the more general social skills work that might be part of other treatment approaches. The specific skills that may be developed within a session of SBNT may be those developed in a general way in social skills training. The context within which this work is done and the purpose are different, e.g., nonverbal communication including body posture, tone of voice, eye contact, etc., are explored and developed within the context of approaching a *particular* person (either known or a new individual) in order to increase positive support for the focal person rather than as a general approach to training someone in social skills. The emphasis of this work is therefore not on the development of social competence in general but only social competence in relation to the development of positive social support for change.

4.2. Focus on positive support

The second core skill involves sustaining a focus on 'positive support' for the focal person. This involves being able to keep a clear focus on opportunities to develop positive support and to minimise the opposite, i.e., high conflict and problematic relationships that may interfere with the focal person receiving positive support for change. The therapist is trained to focus attention during the sessions on positive support and away from potential disagreements or conflict, e.g., a network member's criticism can be reframed as concern and the group can be invited to consider ways of turning that concern into positive support.

4.3. The therapist as an active agent of change

The therapist needs to be an 'active agent of change' focused on the development of positive support for the focal person. This orientation is in sharp contrast to other approaches (e.g., nondirective counselling) and may involve, for example, telephoning network members on behalf of the focal person, visiting a network member together with the focal person, or

writing to potential network members to invite them to the sessions. In addition, therapists are encouraged to use role play and skill practice in the sessions. Therapists are encouraged to ask themselves throughout the intervention whether they have done everything they possibly can to engage and involve network members in treatment.

4.4. The therapist as a task-oriented team leader

As defined by Galanter (1993a, 1993b) in relation to Social Network Therapy, the therapist's relationship to the network is that of a 'task oriented team leader'. There is a clear task for the network to work towards, which involves supporting the focal person to obtain his/her chosen goal. In contrast to network therapy, however, the goal could be either abstinence or moderation. The role of the therapist is to direct and lead the network towards the achievement of the chosen goal in a similar way to that used when leading any team of people with a common goal or task.

5. Intervention structure

As used in UKATT, SBNT consists of eight sessions conducted over a period of 12 weeks. The treatment is divided into three phases. Phase 1 is concerned with the identification of the network and therapists aim to complete this task within the first session. Phase 2 comprises Sessions 2 to 7 and focuses on building/engaging/mobilising the social network. The aim for the final Phase 3, conducted within the last session, is to consolidate the work carried out in previous sessions and preparing for the future. Each phase is described below.

5.1. Phase 1: identification of the network

The first step in SBNT is to identify who is in the social network and which network members are supportive of change in the focal person's drinking. Once identified, provided that the person with the drinking problem thinks that the latter network members will be supportive, the next step is to make contact with them and invite them to take part in supporting his/her efforts to change.

In practice, once the rationale of the treatment is described, therapists work with the focal person constructing a network diagram. Two examples of network diagrams can be seen in Figs. 1 and 2. Towards the end of the first session, the discussion focuses on who to involve and how to proceed in order to contact potential network members.

Network members should fulfil the following eligibility criteria:

1. Be readily available to the focal person, particularly at times of high risk of relapse;
2. Agree with the drinking goal (abstinence or moderation);
3. Offer positive support but be firm if required, encouraging him/her to continue to complete the course of treatment and to continue to work towards the agreed drinking goal;

4. Agree to continue to meet with the therapist and other members of the network in the event of the focal person failing to attend;
5. Be prepared to work with other members of the network, during treatment and afterwards, in order to develop and maintain a consistent, agreed policy with regard to maintenance of drinking change and relapse prevention.

People would be ineligible for network membership if:

1. They have a drug or alcohol problem themselves or have shown in the past that they promote and support problematic drinking;
2. Have a superior or inferior relationship in terms of power to the focal person (e.g., managers at work);
3. Are under the age of 16.

The above criteria has been adapted from the work of Galanter (1993a, 1993b, 1999).

5.2. Phase 2: building/engaging/mobilising the social network

The structure of Phase 2 is based on a combination of core and elective topics. This type of structure has been used in both the 12-step Facilitation Therapy (Nowinski, Baker, & Carroll, 1995) and the Cognitive Behavioural Coping Skills (Kadden et al., 1995) manuals developed as part of Project MATCH. Topics are broad in that the material is presented in ways that can be used when network members are present or also used with the focal person in order to engage potential network members or to develop networks from scratch. Core topics include material on communication, coping, increasing social support and dealing with possible lapse or relapse.

A brief rationale and description of SBNT components is illustrated in Table 1. The content and focus of the work for all three phases and core topics are illustrated in Table 2. Information is provided for each topic that is used as part of SBNT to guide the therapist's decision making and to ensure that the network addresses areas of life that are frequently problematic to those drinking excessively. All the objectives that are set aim to support the overall goal of the client's decreased drinking or abstinence, or should work to provide help and support to other network members who should thereby be better able to positively help the client either in the present or in the future. This support can be available for clients attempting to maintain a change in their drinking behaviour or, if not successful initially, at any time when the client is ready to change.

As a rule, the four core topics are covered with all clients in Sessions 2 to 5. Exceptions to this rule apply when there is a particular need for an elective topic at an early stage of treatment. Alcohol education might be an example. Any core topic can be repeated if necessary to complete the schedule during Sessions 5 to 7. The precise contents of core sessions can be varied depending on whether a social network has already been engaged in treatment or whether development or engagement of a network is the focus of sessions. In addition, elective topics can be chosen by therapists normally in Sessions 6 and 7, according

Table 1
Brief rationale and components of SBNT

Establishing social network	The drinking problem may have alienated some or all of the potential network members. A first step in SBNT is to identify who these individuals are and, provided the focal person thinks that they will be supportive, make contact with them, and invite them to take part in supporting the focal person in his or her efforts to change.
Drinking goal	Members of the network may not agree with the focal person or amongst themselves about the appropriate drinking goal. An agreed goal should be negotiated.
Communication	The focal person and members of his/her social network may have been communicating ineffectively. Together they may plan and practice improved ways of communicating.
Coping	Network members may have been coping with the drinking problems in ways that they recognise, on reflection, to be counterproductive. They will need discussion and practice about ways of coping, including role-play practice and 'homework'.
Support	The focal person may not be using network members in a way that is supportive. He or she should be helped to develop ways of using positive network members more effectively (e.g., by contacting network members at times of risk).
Relapse	Network members may have different views about how to support the focal person and how to respond in the event of relapse. An agreed strategy should be negotiated with network members and with the focal person.
Relapse and support	The focal person may find it difficult to enlist support from network members when relapse occurs. There is a need to develop a shared understanding of the relapse process and to discuss joint strategies for dealing with lapses. This may include the identification of early signs of impending risk for lapse and possible responses to these.
Alternative activities	The focal person and members of his/her network may have been undertaking few joint activities which have been pleasant, and hence the focal person may have little access to activities that are alternatives to drinking. Together they may be helped to plan such activities and to increase their frequency.
Developing network support	In some cases, it may be difficult for problem drinkers to identify anyone who might join a positive network for change and it may be necessary to recruit a 'buddy' (e.g., an ex-problem drinker or a volunteer worker) who can, for a period of time, perform the functions otherwise served by a natural support network.
Social behaviour	Problem drinkers, at the time of seeking help, often show a lack of skill in social behaviours necessary to make contact with potential network members and use them effectively. Skills training can then be used: communication skills such as starting conversations, reestablishing contact by telephone with a potential network member, composing a letter to a potential network member, dealing with criticism from a potential network member. The focus of this work is on engaging potential network members as opposed to general social competence.

to the relevance to each particular client. Elective topics include: education about alcohol and its effects; increasing pleasant activities; minimising drinking support and occupation.

During Phase 2 therapists are instructed to use role play and skill practice within sessions and homework tasks between sessions.

5.3. Phase 3: preparing for the future

The final phase covered within the last session is common to all cases and focuses on planning for the future and maintenance of the progress achieved as well as responding to

Table 2
Phases and core topics for social behaviour and network therapy

Phase 1 (common to all cases)	Identification of social network — network diagram		
Phase 2	Focus		
Four core topics	Working with engaged network and focal person	Working with focal person in order to engage network	Working with focal person to develop network from scratch
Communication	Network communication skills	Communication skills to engage potential network members	Communication skills to build a network
Coping/responding to drinking	Exploring how everyone responds to the drinking	Exploring network coping that may prevent network engagement	Exploring coping from others that may prevent network engagement and maintain isolation
Enhancing social support	Social support between all network members including the focal person	Barriers to receiving social support	How to develop social support from scratch
Network relapse management	Developing a network relapse management plan with everyone present	Developing a relapse management plan attempting to engage potential network member	Developing a relapse management plan using new/untapped sources of social support
Phase 3 (common to all cases)	Preparing for the future		

Phases 1 and 3 are common to all cases. Phase 2 involves a combination of core and elective topics.

changed circumstances in the future. The aim of this phase is therefore to create the conditions necessary for the network to continue to provide 'positive support for change' and hence increase the chances of long-term success. The therapist encourages both the focal person and the network members to share responsibility for the success of treatment. Future roles in supporting the maintenance of change as well as responses to possible drawbacks are discussed in detail.

6. Results: early experiences

6.1. Therapy process

The information reported relates to the first 33 cases that received SBNT as part of UKATT. They include a mixture of training and randomised trial cases. Treatment was delivered by 16 therapists: 9 community psychiatric nurses; 3 psychiatrists; 2 counsellors, 1 occupational therapist and 1 general practitioner (working within an addiction service). In relation to the drinking problems, 9 of the cases were female and 24 male. The mean number

of sessions received was 5.24. The largest number of sessions delivered per case was eight ($n = 13$). The remainder broke down thus: one session ($n = 7$); two sessions ($n = 3$), three sessions ($n = 1$); five sessions ($n = 4$); six sessions ($n = 2$) and seven sessions ($n = 3$).

In 2 out of the 33 cases unilateral sessions were held with network members as part of the treatment, in the absence of the focal person. In the first case two sisters met with the therapist once and in the second case the mother, father and husband of the focal person held a unilateral meeting. Both cases led to the reengagement of the focal person in treatment. In 10 out of the 33 cases no network members were involved, although 6 of these cases only received the first session. Conversely, of the 13 cases who attended all eight sessions, 12 engaged network members and only 1 received the full treatment without a network member ever being present. A total of 42 network members were involved in 23 of the 33 cases. Taking into account only those cases where networks were involved, the mean number of network members per case was 1.82 whereas across all 33 cases the mean number of network members involved per case was 1.27. The two largest categories of network members were partners ($n = 11$) and friends including one neighbour ($n = 11$). In addition, there were parents ($n = 5$); daughters ($n = 3$); sisters-in-law ($n = 2$); brothers ($n = 2$); sisters ($n = 2$); sons ($n = 2$); and one nephew, niece; mother-in-law and brother-in-law.

Below, two case studies are described in more detail.

6.2. Case studies

The two cases described illustrate two common ways of delivering SBNT. The first case illustrates work conducted with a network that operated as a small team with network members present in the sessions. The second example describes how the therapist worked with the focal person alone while concentrating on mobilising network support for change within her social environment.

6.2.1. Case 1

Kevin was a 48-year-old man living alone, having separated from his wife for the past $4\frac{1}{2}$ years. The couple had three children. Kevin had recently renewed contact with his two adult sons. Kevin had been a regular social drinker for much of his adult life until the death of his father 5 years ago. His alcohol consumption since consisted of one bottle of whisky every day. Kevin kept his bottle of whisky by his bed in case he woke up during the night with a strong desire to drink. Kevin received SBNT following detoxification.

During Session 1, an explanation of SBNT was followed by a review of progress since detoxification. The drinking goal was discussed and Kevin stated his wish to pursue abstinence. An exploration of Kevin's network contact revealed a network map (illustrated in Fig. 1) consisting of:

Melanie, his mother who was 70 years old and supportive of Kevin.
Alan, his 21-year-old son with whom he had recently renewed contact.
Pat, his 23-year-old son who lived with his partner and a 2-year-old son. Kevin recently renewed contact with Pat who remained cautious about the relationship.

Bernie, his 15-year-old daughter with whom Kevin had had no contact for 4 years.
Raul, a close friend whom Kevin trusted and shared his feelings with.

The tasks assigned at the end of the first session included Kevin approaching and speaking to his son Alan and his friend Raul and inviting them to the next session.

Kevin attended the next session with Alan and Raul. The treatment was described to the network and the remainder of the session focused on communication. Communication problems were identified as Kevin's ability to accept compliments and receive criticism. It was agreed that during the week both Alan and Raul would give Kevin positive feedback and comments about his progress and that they would be open about feelings. In case of relapse, Alan and Raul agreed to attempt to be positive rather than critical.

Kevin attended the third session with Alan and Raul. Kevin had been in regular contact with both during the week and was positive about the progress achieved. The initial plan was to focus on coping but time was spent on the elective topic; increasing pleasant activities. This was done as a result of the feeling of Kevin and the network members that it was important to help Kevin develop activities alternative to drinking at that time.

During Session 4 it transpired that Kevin had relapsed during the week. The focus of the session was on coping with particular emphasis on network coping in the face of relapse.

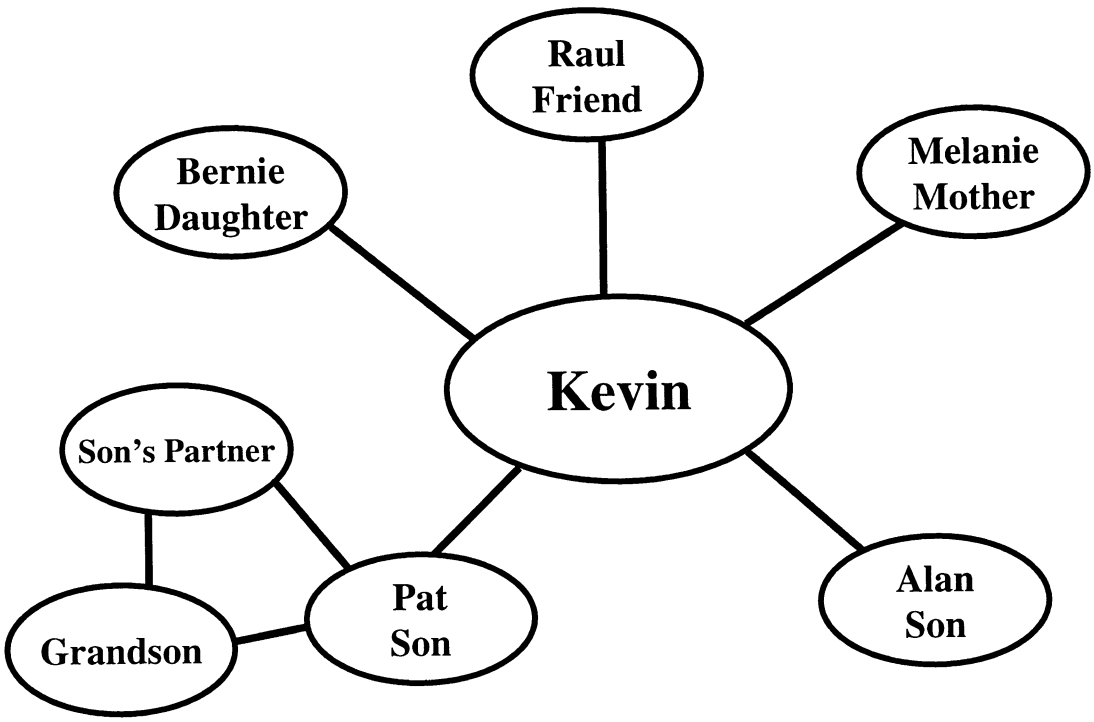

Fig. 1. Network map for Kevin.

Alan acknowledged that he felt tempted to withdraw from Kevin in response to his relapse but recognised that this was not the best strategy for supporting Kevin.

The fifth session focused on the development of a network-based relapse management plan. Early warning signs were identified and included a low tolerance on the part of Kevin for other people's mistakes, feeling angry and thinking of past rejections. Kevin's feelings of rejection mainly related to his family and therefore plans were made for Kevin to contact his other two children. Alan agreed to 'test the waters' by talking initially to Bernie and Pat and would feedback to Kevin on how to progress. The initial plan was for Kevin to write to his daughter Bernie and to telephone his son Pat to enquire about his grandson.

At the sixth session, a review of the previous week revealed that Kevin had maintained abstinence. Kevin had also made contact with Pat but following advice from Alan had not written to Bernie, as Alan had established that she did not want to have contact at the time. The remainder of the session focused on enhancing support networks. Tasks were identified; these included Alan helping Kevin with forms that needed to be completed and Alan accompanying him when visiting Pat and his grandson.

The seventh session revisited communication and relapse management. Alan did not attend but Raul did and was active in suggesting strategies for Kevin to use. Shortly after the end of treatment Kevin relapsed and he was drinking at the time of follow-up. The network members were in regular contact with Kevin, however, and several weeks later Kevin contacted the therapist to report that he had achieved abstinence once again, having received support from Alan and Raul.

6.2.2. Case 2

At the time of presenting to the service Mary was a 51-year-old unemployed mother of two daughters. Her eldest daughter Sonia was in her 20s and had a drug problem and her younger daughter Trish had recently gone into foster care as a result of Social Services involvement due to Mary's drinking. Being reunited with her daughter Trish constituted a strong reason for Mary to attempt to change her behaviour. Mary had a 20-year history of heavy drinking. Over the past 8 years following her divorce and an operation to remove an eye, her drinking escalated. At the time of referral Mary was drinking 30–40 units of alcohol daily, mainly vodka and strong lager. Following a community detoxification Mary received six sessions of SBNT over an 8-week period.

The first session was spent describing the treatment, agreeing the drinking goal for treatment and constructing a network diagram. Mary was unsure whether any of her friends would be able to attend future sessions. Mary wanted to work towards abstinence. Mary's network map is illustrated in Fig. 2 and includes relatives, friends and professionals.

Key homework tasks were identified during the first session and included:

1. Informing her sister Frances of the therapy.
2. Speaking to her friend Amy about the therapy and inviting her to attend the next session.
3. Avoiding contact with drinking companions and her older daughter Sonia to prevent stress.

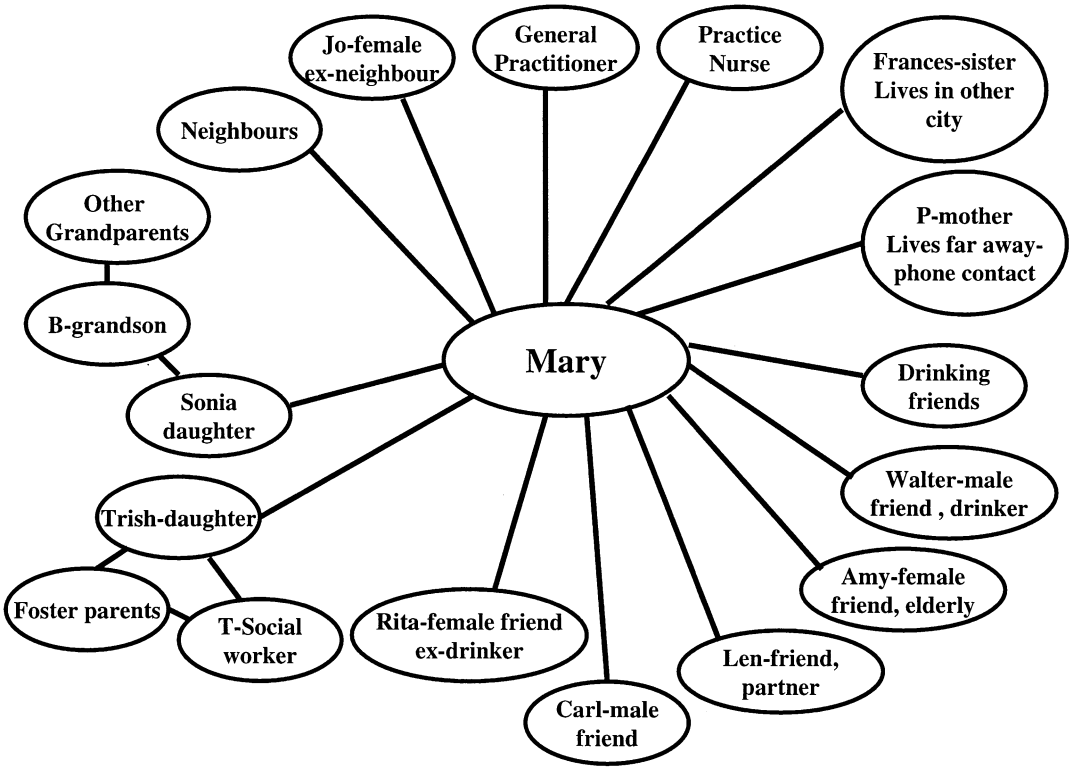

Fig. 2. Network map for Mary.

The second session started with a review of progress focusing specifically on progress with the drinking goal and key tasks. Mary had remained abstinent during the prior week and had spoken to her sister but not mentioned therapy. Mary also contacted Amy who stated that she would find it difficult to attend sessions due to her physical problems. Mary had successfully avoided contact with drinking companions and Sonia during the previous week. This session focused on communication and more specifically on how Mary could talk to her sister Frances about her treatment. Role-play was used to help Mary practice the necessary skills to approach the topic with Frances. Further homework tasks included continuing to talk to Amy and approaching Frances.

The review in the third session revealed that Mary was in daily contact with Amy who was proving to be supportive of Mary's efforts to change. The session focused on coping. Mary felt that Amy, her mother and her sister all offered advice. Mary also identified that her younger daughter Trish responded to her drinking by spending time outside of the home. Mary felt that no network members had been overcritical or unhelpful in relation to her drinking behaviour.

By the fourth session, Mary's younger daughter had been allowed to return home on account of Mary's progress in treatment. Mary had spoken to Frances and discussed her

treatment and continued to be in daily contact with Amy. The session focused on enhancing social support networks. Mary felt that most of her support needs were being met. Amy and Frances offered moral support and Trish had been providing practical support since her return. Mary mentioned three additional people in this session not previously identified: Rita, a female friend who used to have a drink problem and was now abstinent; Jo, a female ex-neighbour whom Mary saw occasionally; and Walter, a previous drinking companion who had recently had a stroke. Mary felt that Rita was someone who could understand her drinking problem and offer help to solve any difficulties she was experiencing. It was therefore agreed that Mary would approach Rita and ask her for support and the details of how to do it were further worked on in the session.

At the fifth session, a review of the previous few days revealed that Mary had contacted her female friend Rita who was willing to support Mary but unable to come to sessions due to her own commitments. Mary had maintained contact with other key network members: Amy, Frances and her mother Paula. In addition Mary was avoiding contact with Sonia. The focus of this session was on developing a network-based relapse management plan. Two high-risk situations were identified: dealing with Sonia in relation to her drug problems and Mary feeling depressed. Mary felt that she could talk to a number of network members when these situations arose and in addition Rita offered to accompany Mary to Sonia's court case.

At the sixth session, the focus was on 'enhancing social support' and 'increasing pleasant activities'. Mary focused on two further people not mentioned in earlier sessions: Carl, a male friend who had helped her in previous treatment 2 years before, and Len, a boyfriend whom Mary saw once a week. Both had helped with practical activities in the past such as decorating. Mary enjoyed the company of Len but felt unable to see him more regularly because Trish did not like him being around. A plan was developed where Mary and Amy would speak to Trish regarding this, given that Trish related well to Amy as a sort of 'grandmother' figure. A plan was also made for Mary to do some decorating with Carl and Len.

No further sessions were held due to one cancellation followed by a hospital admission for a health-related problem. Several weeks later contact with Mary revealed that she had relapsed but managed to become abstinent again by enlisting the support from people in her social network. Mary did not feel that she needed further contact with the service at that point. The final discussion focused on 'planning for the future and termination' and was conducted over the telephone.

7. Discussion

The present paper described the development and early experiences of a treatment approach to alcohol problems that aims to work on the individual's social environment in order to increase the available social support for change. An important issue to emerge from the work is that the majority of people with drinking problems entering specialist treatment who received SBNT were able to engage social networks in order to gain support for change. Furthermore, the results so far suggest that it is possible to develop an approach that focuses

on the problem drinker's social environment even in cases where the individual is unable to directly engage his/her social network in the treatment sessions, as is clearly illustrated by Case 2. As this case illustrates, a powerful result can be obtained from accessing networks even when network members are not physically present in the treatment sessions. This is achieved in SBNT through the establishment of an overall aim that applies to all cases (the development of positive social support for change) and a range of strategies can therefore be used as part of the therapy provided that they are consistent with this aim.

The way of working was acceptable to the people with drinking problems and to network members as well as the therapists delivering the treatment. The latter included professionals from a range of backgrounds.

The results showed that networks engaged in the treatment process included similar numbers of close relatives and friends and suggest that SBNT can reach beyond the close family network and hence increase the potential for tapping into wider sources of social support for change. In relation to network density, the case examples illustrate two contrasting presentations. In Case 1 the network was small by comparison to the large network described in Case 2. It is of note, however, that in both cases network engagement was achieved, although in different ways. The value of network support, over and above being present in the sessions with the focal person, was evident from both unilateral sessions and the ability of network members to continue to support the focal person beyond the treatment period. In two cases reported within the therapy process section, unilateral sessions were held and network members managed to reengage the focal person in treatment. In Cases 1 and 2, the focal drinkers also stated the value of the continued support of the network beyond the therapy period. Whether this process occurs in other treatments that do not specifically focus on the development of this type of support remains to be established and the results of UKATT will shed some light on this issue.

Preliminary evidence suggests that a significant number of cases where network members were present went on to receive all eight scheduled sessions and overall the average number of sessions received was high (mean = 5.24). One could hypothesise that a number of strategies used in SBNT can help to achieve a good level of treatment engagement (e.g., unilateral sessions that can continue in the absence of the focal person; the influence of network members in supporting the attendance of the focal person). Although early indications are promising, there is need for caution given that the results are preliminary and descriptive.

Although SBNT originally developed from a number of other evidence-based approaches, a number of contrasts with some of them are apparent. In contrast to a number of approaches that commence through contact with a concerned person (e.g., Barber & Crisp, 1995; Meyers et al., 1996), SBNT is initiated through contact with the focal drinker as opposed to concerned others. Once engaged (via the focal drinker), concerned members of the network, invited to attend sessions, are seen as having a right to the service equal to that of the focal person. In contrast to other approaches (Howells, 1997; Copello, Templeton, et al., 2000) the focus remains on supporting the focal person as opposed to the concerned network members' own needs. These are only addressed if they are relevant to the development of social support for change.

SBNT also contrasts with more coercive approaches in that network members are only involved with agreement from the focal person. This is done in collaboration with the therapist but the focal person is always in control of who attends or is contacted. In addition, every time a new network member joins a session it is agreed that any member of the network can continue to attend and carry on working towards the resolution of the problem, even if the focal person is not present.

SBNT has been influenced by the work of Galanter (1993a, 1993b, 1999) and hence shows a number of commonalties with Network Therapy, particularly when sessions are conducted with the focal person and network members. Contrasts are also evident, however; for example, focusing and working with the network is not restricted to those who can engage network members in treatment but is the core element of the approach for all clients and also the goal of treatment can include both abstinence and controlled drinking.

Finally, in our experience, SBNT although initially developed from components that were shown to be effective in other treatment approaches, has developed into a treatment in its own right. It is an approach that current evidence suggests can be applied to a range of people presenting for help. The key concept is the development of 'social network support for change'. The case examples illustrate some of the key elements of therapy. They include network support to manage change in terms of alternative activities and dealing with temptation; responding in supportive ways in the face of relapse; helping to reestablish contact with other potential supportive people and giving support and practical help in the face of high risk situations for relapse.

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