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The 5-Step Method: Principles and practice

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Abstract
This article includes a description of the 5-Step Method. First, the origins and theoretical basis of the method are briefly described. This is followed by a discussion of the general principles that guide the delivery of the method. Each step is then described in more detail, including the content and focus of each of the five steps that include: listening non-judgementally; providing relevant information; exploring ways of coping; discussing social support and establishing the need for further help. Finally, issues of training, supervision and on-going support are discussed. It is concluded that the 5-Step Method offers a flexible response that can be delivered to family members affected by addiction problems by a range of helpers and in a range of settings and health systems.

Background

The theoretical model upon which the 5-Step Method has been developed has already been described in this issue (Orford et al., 2010a). An important principle of the model is that living with a highly stressful experience such as the impact of an addiction problem in the family, may lead to psychological and physical symptoms of ill health for the family members, other than the user of substances.

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Family members in this predicament try to respond to the situation using a range of behavioral strategies that we call coping. Coping behaviors, as well as available social support, can influence the extent of the symptoms of stress experienced by family members, as well as the course and development of the addiction problem. The model is one that emphasizes interactions between members that are part of the family unit. These interactions can have different effects on the various parties, for example, on the family members attempting to cope, on the users of substances or on other family members including children. The model emphasizes the stressful nature of the impact of an addiction problem on a family unit but also finds commonalities with other similar stressful events (e.g. the impact that arises when a member of a family acquires brain injury; someone in the family developing dementia, etc.).

Based on the stress-strain-coping-support model, the 5-Step Method was initially developed and described (Copello, 2003; Copello, Orford, Velleman, Templeton, & Krishnan, 2000a). Each one of the components of the model (e.g. stresses and strains; coping; social support) was incorporated within a step-wise model to be used when supporting family members. Each step can be delivered over one meeting or combined, if circumstances require, into a smaller number of sessions, including in some instances, a single interaction. The five steps are illustrated within Table I with possible contents for each step.

Table I. Five steps to support family members affected by addiction problems.

Step 1: Listen, reassure and explore concerns
Allow family member to describe situation
Identify relevant stresses
Identify need for further information
Communicate realistic optimism
Identify need for future contacts
Step 2: Provide relevant, specific and targeted information
Increase knowledge and understanding
Reduce stress arising from lack of knowledge or misconceptions
Step 3: Explore coping responses
Identify current coping responses
Explore advantages and disadvantages of current coping responses
Explore alternative coping responses
Explore advantages and disadvantages of alternative ways of coping
Step 4: Discuss social support
Draw a social network diagram
Aim to improve communication within the family
Aim for a unified and coherent approach
Explore potential new sources of support
Step 5: Discuss and explore further needs
Is there a need for further help?
Discuss possible options with family member
Facilitate contact between family member and other sources of specialist help

Key aspects and principles of the 5-Step Method

Before providing a description of each step, some of the key principles of the method are outlined below:

The method is focused on affected and concerned family members

In contrast to other methods used with family members in the addiction field, the 5-Step Method is clearly focused on the family members experiencing the addiction problem at home when affected by the substance misuse of a relative within the family. The method is focused on the types of experiences that family members face on a daily basis and the exploration of their circumstances. The research upon which the method is based was conducted through a series of studies of the impact of addiction upon families over a number of years described in Orford et al. (2005). We know from research that other outcomes are possible when working with family members, including, for example, an improvement in the substance-related problem (Copello, Velleman, & Templeton, 2005; Copello, Williamson, Orford, & Day, 2006). Yet, the method and its components are family member-focused and this will become clearer in the remainder of this article.

The method takes a view of family members as ordinary people attempting to respond to highly stressful experiences

As already discussed, the model upon which the method is based, conceives of family members as ordinary people facing highly stressful circumstances. Unlike other models of family and addiction problems, the 5-Step Method does not see the family member as a cause or significant contributor to the development of the addiction problem, but as an ordinary person facing a very challenging problem. Furthermore, one of the key tenets of the model is that with the appropriate level of knowledge and support, family members have the capacity to cope and respond to an addiction problem much like people are able to cope with a range of very difficult and complex problems in life. There is no room within the method to think of family members as part of the 'disease of addiction' or having responsibility for causing the addiction problem.

The method is very flexible and adaptable to a range of settings and circumstances

One of the strengths of the 5-Step Method is that it can be adapted to the specific circumstances and needs of services and settings. Even though the components are described as part of five steps, in our research and clinical experience, we have found that the steps can be combined and even delivered over one single meeting if this is necessary. There are two caveats to this. The first is that we know from what family members have told us that the first step is one of the most important ones. Family members value the opportunity to tell their stories and be listened to by someone who has got the time and does not judge the situation. On the basis of this evidence, we would suggest that if possible, the first step should always be

delivered and enough time should be devoted to this. The second important issue is that a premature discussion of coping methods (i.e. the contents of step 3) may leave family members feeling that they are not coping in the right way and they may perceive the discussion of coping behaviors as a criticism of how they are coping.

The orientation of the person delivering the 5-Step Method is highly important

In our work, we have found that the 5-Step Method can be delivered by a range of helpers without the need for lengthy training. Training is further addressed later in this article. However, it is important to note that the style and orientation of the helper is very important for the success of the work. Those delivering the intervention should approach the interaction using a non-judgemental stance, being curious about the family member's circumstances and prepared to explore the experience in depth using a problem-solving approach. As much as the method is flexible, so should be the person delivering the five steps, looking for opportunities to increase knowledge and confidence and reduce stress for the family member. The orientation is not that of an expert but someone who works within a collaborative framework.

Having considered the general aspects and principles, each step, its contents and special considerations are described in more detail in the following sections.

Step 1: Getting to know the family member and the problem – Exploring stresses and strains

We have found in the course of our work that this is one of the most important steps, as perceived by family members. The work in this initial encounter aims to elicit from the family member the perception of the way in which the problem is affecting the family member (him or herself) and where relevant the impact on the rest of the family. It is important that the person delivering the 5-Step Method focuses on the experience of the family member as someone who is responding to an addiction problem affecting the family, hence balancing the focus of the discussion so that it includes some of the details of the addictive behavior as well as the impact of that behavior on the family member and the rest of the family. The interview style involves active listening, the development of empathy and the ability to deal with emotions. A further important issue is the promotion of realistic optimism in relation to the problem. It is important to remember that when a family member comes forward and is prepared to talk about his or her experience, this may have been a very difficult step to take. In some cases, family members might have already attempted to talk to other helpers or professionals and received negative or hopeless messages about their situation. It is important as part of this step to encourage the family member to describe the situation as fully as possible. Open questions and reflective listening techniques are particularly useful, e.g. 'what has it been like to live with this situation at home?'; 'Tell me more about it.'; 'It sounds like you are really concerned about

Table II. Universal stressors for family members facing addiction problems.

– Concern over drinker/drug user's health or performance
– Drinker/drug user not pleasant to live with
– Financial irregularities and effects
– Impact on the whole family and the home
– Other members of the community become involved
– Concern over frequency, quantity or form of the relative's drinking/drug-taking
– Alcohol/drug user disappears or comes and goes
– Social life for the family member or whole family affected
– Incidents, crises

the impact on other family members.' 'So you feel very much on your own trying to respond'. These types of questions and statements encourage family members to continue to explore the situation.

An important component of this part of the work is the identification of the stresses faced and the way in which these have impacted on the particular family member. Table II summarizes some of the core aspects of the experiences of family members facing addiction problems that were elicited in the course of a series of research studies (Orford et al., 1998a, 2005, 2010b).

The way in which family members' strain manifests itself is in the form of physical and psychological symptoms. Research has shown consistently that family members living with people with alcohol and drug problems show high levels of symptoms of strain, on par with people experiencing significant mental health problems (e.g. anxiety; depression) (Ray, Mertens, & Weisner, 2007; Svenson, Forster, Woodhead, & Platt, 1995). Equipped with an awareness of the most common stresses and strains that are likely to affect a family member, the professional needs to encourage an open discussion and exploration of these issues during the first meeting. An important aspect of the first step is to communicate to the family member the notion that these problems are common, highly prevalent and not unusual. More specific and detailed guidelines on how to conduct this step are provided in Copello et al. (2000a).

Step 2: Providing relevant information

In a large number of cases, an important contributor to the stress experienced by family members is the lack of accurate knowledge about alcohol and drugs and their effects as well as other issues such as the development of dependence or other problems associated with substance misuse. The second step provides an opportunity to equip family members with useful information. Some of the key areas that are commonly explored include types of drugs or alcoholic beverages that the relative might be consuming; patterns of harmful drug and alcohol use; issues related to dependence on substances; and motivation to change or seek help. The style in which this information is provided is extremely important. The issues discussed within Step 1 related to interviewing style are also relevant to this

stage and all other stages of the intervention. It is important to strike a careful balance between providing too little information that may increase concern and providing too much information that may appear overwhelming. It is also important to have available details of a range of agencies both at local and national level that can provide advice and support to families affected by alcohol and drug problems as well as relevant websites and telephone help lines.

Step 3: Exploring and discussing coping behaviors

The work in this step is informed by the typology of coping behaviors developed as part of the programme of research (Copello, Templeton, Krishnan, Orford, & Velleman, 2000b, 2009; Orford et al., 1992, 2001, 2005, 2010b). Coping is used to refer to any actions, feelings or positions that family members adopt in response to the addiction problem. Research has suggested the existence of three broad distinct ways of coping/responding to the addiction that are used by family members: 'standing up to it'; 'putting up with it' and 'becoming independent'. In practice, coping responses are almost always experienced as dilemmas by family members, given that any action is always associated with both potentially negative and positive outcomes. How to help the family member think through possible responses, weigh up pros and cons of each response and make decisions about the perceived best way of coping is the essence of this step. Detailed illustrations of the three broad types of coping are provided in Table III. These examples also illustrate the difficult dilemmas often voiced by concerned family members, e.g. trying to keep life as normal as possible *versus* feeling that something more active ought to be done; confronting *versus* keeping away, etc. In our experience, knowledge of the three broad types of coping is useful as a framework for both the practitioner delivering the 5-Step Method as well as the family member who up to that point may not have had access to a coherent way of understanding coping behaviors. In practice, when coping behaviors are explored, more detailed examples of behaviors are described by family members such as those illustrated in Table IV. The coping examples illustrated in Table IV are all sub-types of the main categories shown in Table III.

The important aim of step 3 is to explore with the family member his or her current ways of responding to the situation at home. It is important to use the same interview styles as previously discussed and to be curious about the family member's circumstances. This stands in contrast to a more prescriptive style that would favor one or other form of coping. In essence, we know from research that no particular way of coping is universally better than another. Each family is unique and any response from a family member will be associated with the potential advantages and disadvantages that the family member will have to weigh up. We do know, however, that tolerant (i.e. 'putting up with it') styles of coping actions are associated with worse symptoms of ill health for family members and this can be highlighted.

Table III. Three broad types of coping established through research.

Engaged 'Standing up to it'	
	'I won't have anyone in the house who has anything to do with drugs. The only contact I have had with other drug takers was when we visited the person that was selling him amphetamines. I went round and said I want you to stop selling amphetamines to him and he agreed' (female partner of a problem drug user)
	'Shouting has been the most helpful thing for me . . . I can get it out of my system. It is still a good release . . . I feel better for shouting . . . than walking away and ignoring the situation. . . if I walk out, it's almost like giving him approval. At least by shouting I know he knows the effects he's had on me' (male partner of a man with a drink problem)
Tolerant 'Putting up with it'	
	'He can look like an animal and that is the time to keep quiet because he is not going to take any notice of what anyone says. The textbooks might tell people to be consistent but in reality if he is confronted he will throw everything about; you will clear it up; he's out the door; he will be back next day as if nothing has happened and you are so relieved at that, that you carry on from there' (father of a problem drug using man)
	'I ring in for him at work and cover for him because he is my son. I feel I shouldn't ring in. . . but I don't want to see him lose his job' (mother of a man with a drink problem)
Withdrawal 'Withdrawing and gaining independence'	
	'I am trying to keep life as normal as I can. I play an active role in the community as a school governor for example. So far we haven't had a crisis that has interfered with these activities, only with our attendance at church and I have been able to explain my absence. Both me and my husband make sure that we have an evening out. We have decided to lead our own life and deal with this on the side. We are much stronger now. We will go to work and to church regardless of what's going on at home unless he is ill. We sometimes wondered whether we ought to be doing these things, but you can't be yourself unless you have sometime away from the problem' (mother of a young drug user)
	'Despite there being nobody fully aware of the problem I find it useful to sometimes get away for a while. I will sometimes spend a week at my mother's or go round to a friend's although I have never stayed the night at a friend's house' (female partner of a man with a drinking problem)

As a rough guide, it is useful to think of four key tasks within this step. The first task is to discuss the family member's current ways of coping; the second is to explore advantages and disadvantages of the current ways of coping as perceived by the family member; the third is to explore alternative ways of coping with the family member and the fourth and final is to explore advantages and disadvantages of these new alternative ways of responding. It is important that during this process of exploration of both existing and alternative coping responses, the practitioner is aware of the need for safe practice, being aware of the potential risk of domestic violence and taking appropriate steps to respond to this eventuality. In our experience, family members, once they have carefully considered options are able to make their own decisions based on this exploration and find the process of discussion very helpful. Table IV has some illustrations of different coping behaviors described by family members and some

Table IV. Family members' views for and against different ways of coping with a relative's alcohol or drug misuse.

	For	Against
Resigned, accepting	May be more realistic than some other ways of coping	FM may continue to feel very unhappy with circumstances
	May help FM become more independent	FM may feel nothing is being done to change the situation
Sacrificing, compromising	Arguments are avoided and life at home may seem less stressful	FM may feel R is taking advantage
	It may help create a trouble-free atmosphere for the rest of the family	FM may feel the problem is simply being kept going and not confronted
Supporting the relative	Makes FM feel that R is not being rejected	If R does not respond FM may feel it is a waste of time
	Maybe more effective in helping R change than direct attempts at controlling drinking or drug-taking	FM finds its difficult to know when being supportive becomes over-protective or over-tolerant
Standing up to the substance misuse by confronting, being emotional	FM is acting naturally and expressing real feelings	May annoy R and contribute to escalating arguments and fights
	It may at least temporarily relieve FM's feelings of tension and anger	May upset other members of the family, particularly children
		R doesn't listen to FM's arguments, and it leaves FM feeling guilty
Standing up to the substance misuse by refusing, resisting and being assertive	Gives FM the feeling that the situation is not simply being accepted and FM is not being pushed around	R may not respond favorably
		Runs the risk of alienating R or of losing R altogether
	May be more effective in helping R change than trying to control drinking or drug-taking directly	
Standing up to the substance misuse by controlling, protecting self and family	Helps FM feel something positive is being done	May make R feel resentful and may not be effective in controlling R's drinking or drug taking
	May help FM feel there is some hope for change	
		It maybe very stressful trying to control R's behavior, and very frustrating when attempts to control drinking or drug taking don't work
Avoiding, escaping	May help FM feel less stressed	May make R feel rejected and isolated
	May help FM feel more in control	
		Instead of helping R it could make matters worse
		It can contribute to a feeling of lack of family cohesion

(*continued*)

Table IV. Continued.

	For	Against
Not worrying, gaining independence	May be helpful to FM in dealing with stress May prevent FM becoming over-involved in worrying about or trying to change R's drinking or drug taking	FM may feel that R is being excluded or rejected FM may feel that not all is being done to try to help R change

Note: FM, family member; R, relative who is misusing alcohol or drugs.

possible advantages and disadvantages associated with each. In addition, an illustrative example of an interaction exploring coping actions using the method is shown in Figure 1.

Step 4: Exploring and enhancing social support

The positive value of social support has been established in the context of a range of physical and psychological problems. The level of social support available for family members can have a significant impact on their ability to cope and the experience of stress. Step 4 is therefore concerned with the exploration of social support available to family members, followed by a discussion about how to access potential sources of support that might not be operating well at the time. There are a number of reasons, why social support for family members fails and these are summarized in Table V (Orford et al., 1998b, 2010b). It is not an uncommon scenario that family members appear to identify a significant number of people in their social support network, yet find it impossible to gain any support from the array of potential supporters. An important aspect of this step is therefore for the professional to discuss with the family members ways in which they could attempt to maximize positive support, while at the same time attempting to neutralize or reduce unhelpful actions from others. The practitioner delivering the 5-Step Method is encouraged to draw a social network diagram including the people who are seen as important by the family member in order to guide the work of this step. Once this is completed, a discussion can follow, identifying the extent to which each person identified is perceived as supportive, having potential to become supportive or not-supportive. An example of a social support network for Cynthia, the mother of Mary, a drug user can be seen in Figure 2. Each person identified by Cynthia is depicted in the diagram and a plus or minus sign is used to represent the perceived positive or unhelpful level of support from Cynthia's perspective. It is important to note that the negative sign is sometimes indicating that a person may have the potential to be supportive but at that particular point in time, support from this person is not forthcoming (e.g. another family member with whom the problem is not discussed).

Professional:	I was interested in that last example that you mentioned…
Wife:	You mean what I told you about going to the off license to buy him drink
Professional:	Yes. You seemed to be unhappy about doing that.
Wife:	Well, I think this makes me feel a part of the problem.
Professional:	Would it be helpful to think about the advantages and disadvantages of continuing to buy him drink
Wife:	OK.
Professional:	What do you think are the good things about buying him drinks
Wife:	Well, I guess that if I do not, he may become angry and abusive
Professional:	Anything else?
Wife:	It makes me feel more in control. At least I know what he is drinking
Professional:	So, it avoids possible arguments and makes you feel in control
Wife:	Yes, I guess that is right
Professional:	What, on the other hand are the things in your view which are not so good about it?
Wife:	Well, I feel that I am being taken advantage of and it makes the problem continue. But I am not sure what I can do. I feel pretty hopeless
Professional:	Would it be helpful to think together about the options?
Wife:	Well, I suppose I could try to say to him that I will stop buying him his drink… [the discussion continues focusing on the potential difficulties that the family member could foresee if she were to carry out each of a range of possible options]
Wife:	Later within the meeting she stated: I can see more clearly now that I am only making the problem worse by continuing to buy him drinks. This evening when the situation arises I will say to him as calmly as I can that I am not going to carry on buying his drinks and that I am happy to stay with him if he does not drink. If he starts shouting at me I will leave the room and say that I will talk to him when he calms down
Professional:	That sounds like a positive way to tackle that problem. Let me know how you get on when we meet again

Figure 1. An example of the use of step 3 in order to explore coping behaviors with a family member.

In common with a number of other cases, the mother is identifying some sources of positive support and other people who at that particular time are perceived as unhelpful.

The overall aim of step 4 is to explore the support available in order to help the family member build a stronger support system and to improve joint problem solving in the family or wider social network, where appropriate.

Table V. Sources of support failure.

• We do not get on
• Our relationship is tense
• I'm ashamed to tell them
• We never talk about it
• They won't face it
• They don't know what it's like
• They know what he's like, so they keep away
• They are not on my side
• They encourage her
• They disagree with me about how to cope

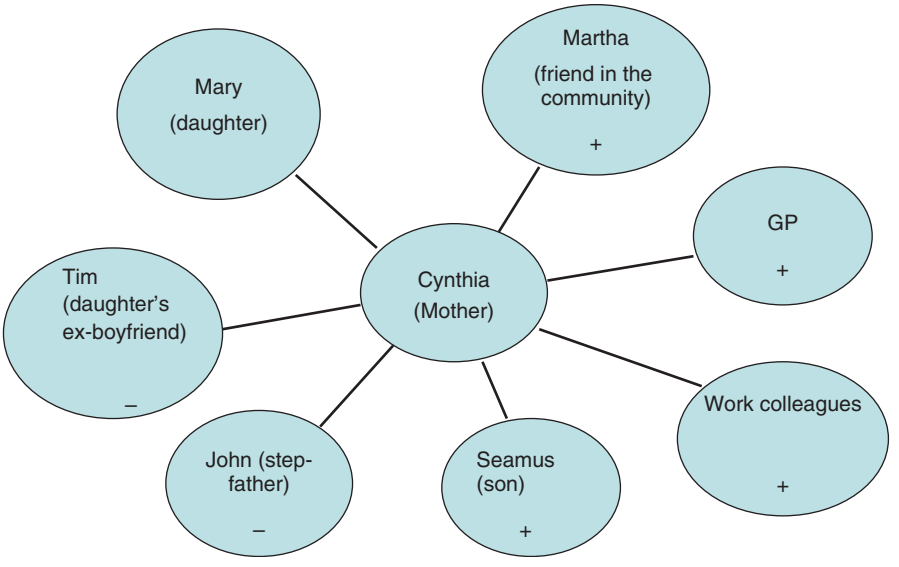

Figure 2. A mother's network diagram.

Step 5: Ending and exploring additional needs and further sources of help

Brief interventions are highly effective and in most cases in our work we have found little need to refer family members for further specialist help. However, as we have developed and delivered the 5-Step intervention in the course of our programme of research, we have found a whole additional range of needs that emerge when you start working with family members in these circumstances. In our original work, we had identified four possible scenarios indicating further needs:

- Further help needed for the family member in his/her own right.
- Further help needed for the alcohol/drug user in his/her own right.
- Further help needed for the family as a whole.
- Further help needed for other family members (i.e. not the family member who received the intervention) (Copello et al., 2000a).

Through our subsequent direct work with family members in our research studies, we also found that additional needs might emerge at this stage of the intervention. On some occasions, family members may wish to explore particular activities or interests that they want to pursue in order to become more independent (e.g. a particular form of training or the development of a new skill) or in order to look after themselves (e.g. joining a gym; taking up a sport). In addition to advice about substances, family members may need guidance, for example, on pregnancy or financial matters. It is important that any identified need is explored and addressed.

Network sessions

There are also opportunities to respond to the scenario, which commonly emerges, and involves the user becoming more interested in accepting help for his or her alcohol or drug problem. In such cases, we have found that what we term a 'network session' can be helpful (Copello, Orford, Hodgson, & Tober, 2009). During the network session, other family members, as well as the user, can be invited to meet together and discuss and explore the situation. We have used some of the strategies for communication and interactions that are part of Social Behavior and Network Therapy (Copello et al., 2009) in order to facilitate and improve the family experience and environment. Whatever approach is pursued, it is important at this stage that the family member remains at the centre of the 5-Step intervention. It is also important to be aware of services for alcohol and drug problems that are available for those users ready to tackle the addiction problem.

Overall, the main aims of the final step are, to consolidate the work conducted and where possible to increase a sense of hope that the situation may improve in the future.

Training, supervision and on-going support

Following the initial development of the 5-Step Method, we ran a series of studies (Copello et al., 2000b, 2009; Templeton, Zohhadi, & Velleman, 2007; Velleman, Arcidiacono, Procentese, & Copello, 2008) in which training was provided for a range of professionals, both in primary care and specialist settings. A group format was adopted where possible and the training was delivered over a half-a-day workshop, supported by a manual for trainees. The manual described each of the five steps in some detail and provided illustrative examples of interactions. In cases where the professional could not attend one of the available group sessions, the training was delivered by a member of the research team in an individual session (again supported by a manual and other materials including summary cards for each step).

In subsequent dissemination of the 5-Step approach, we have expanded the training to be delivered over a full day workshop. This offers the opportunity to explore in more depth the theoretical underpinnings of the method and the

general principles as well as the practical aspects of each step, including the practice and development of relevant skills. Skills practice is a major component of the training with participants trying out the various strategies of each step. We have also produced a training DVD with illustrative examples of each step, based on real-life case scenarios.

Finally, in our latest dissemination work, we have broadened the training to focus on a range of family approaches including the 5-Step Method and Social Behavior and Network Therapy (Copello et al., 2009) in order to develop a flexible family-focused approach that can be delivered in routine addiction services (Orford et al., 2009). An important aspect of the 5-Step Method is the need to consider carefully the training and on-going support for those delivering the approach.

Conclusion

The 5-Step Method has been developed based on the stress-strain-coping-support model of addiction and the family. It is a pragmatic and flexible approach that considers the impact of addiction upon family members to be a very stressful experience that can be improved by working systematically with family members, through a series of steps covering the key components of the model. The research evidence for the approach is discussed in a separate paper in this issue (Copello, Templeton, Orford, & Velleman, 2010).

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