Chapter 1—Substance Use Disorder Treatment: Working With Families

KEY MESSAGES

- Substance use disorders (SUDs) affect not just those with the disorders, but also their families and other individuals who play significant roles in their lives.
- Integration of family-based counseling interventions into SUD treatment honors the important role families can play in the change process.
- Families can greatly influence the treatment of any illness, including SUDs. Family involvement on any level can:
  - Motivate individuals facing addiction to receive or continue treatment.
  - Improve overall family functioning.
  - Foster healing for family members affected by the consequences of addiction.
  - Reduce risk in children and adolescents of being exposed to violence and of developing SUDs/mental disorders.
- Family counseling in SUD treatment is positively associated with increased treatment engagement and retention rates, treatment cost effectiveness, and improved outcomes for individual clients and their families.

The integration of family counseling into SUD treatment has posed an ongoing challenge since the inception of family therapy in the 1950s. Family counseling has been woven into treatment across the continuum of care, from prevention approaches, to treatment interventions, to continuing care services. Even so, it can be difficult for providers and programs to fit family services into existing schedules filled with the demands of SUD treatment and related services. SUD treatment programs may also face challenges related to funding, training, and other administrative aspects of integration.

To ensure use of family counseling and family services to their greatest potential within SUD treatment, it is essential to broaden the focus of SUD treatment from an individual to a family perspective. It is common to acknowledge the unique individual factors (e.g., environmental, genetic, biological) that may influence a person's substance misuse and SUD treatment outcomes. Yet equally important are interpersonal factors—social, occupational, and familial (relationships, dynamics, and interactions). Both individual and interpersonal factors can affect one's access to, initiation of, and engagement in SUD treatment. These same factors influence SUD treatment outcomes.

Just as others can have an impact on an individual's substance misuse, the individual's substance misuse can likewise affect those around them. People who misuse substances are likely to affect at least a handful of others who have or had some form of relationship with them, such as friends, partners, coworkers, relatives, and members of their communities.

The consequences of a person's substance misuse can be especially powerful for his or her family members. Four main theoretical models inform the SUD treatment approaches and family-based interventions that can best address those consequences:

- Family disease
- Family systems
- Cognitive–behavioral therapy
- Multidimensional family therapy (MDFT)

Scope of This TIP

Audience

This Treatment Improvement Protocol (TIP) is structured to meet the needs of professionals with a range of training, education, and clinical experience in addressing SUDs. The primary audience for this TIP is SUD treatment counselors—many, but not all, of whom possess certification in addiction counseling or related professional licensing.

Additional providers among this TIP's primary audience are peer support specialists, psychiatric and mental health nurses, primary care providers (such as family physicians, internal medicine specialists, and nurse practitioners), and allied healthcare professionals who may provide SUD treatment—some of whom may have credentials in couples and family therapy, treatment of SUDs or mental disorders, or criminal justice services. The TIP will refer to these audiences collectively as "providers" for brevity.

This TIP also offers guidance for addiction treatment program administrators, supervisors, and clinical/program directors (called "administrators" for brevity) working in behavioral health programs and agencies that provide SUD treatment and recovery support services.

Secondary audiences include educators, researchers, policymakers, and healthcare and social service personnel beyond those specifically mentioned above.

Organization

This TIP consists of six chapters (Exhibit 1.1). Some readers may prefer to go directly to chapters most relevant to their areas of interest. However, the TIP starts with core concepts laying the groundwork for understanding families and how SUDs can affect them, before moving to more specific family approaches, counseling techniques, and programmatic considerations.

EXHIBIT 1.1. TIP Organization

Chapter 1, *Substance Use Disorder Treatment: Working With Families,* lays the groundwork for understanding the treatment concepts and theories of family discussed in later chapters of this TIP. It is for providers and administrators.

Chapter 2, *Influence of Substance Misuse on Families,* summarizes the ways in which substance misuse affects family dynamics and systems and the ways in which those dynamics and systems can, in turn, influence substance misuse. This chapter is for providers.

Chapter 3, *Family Counseling Approaches,* reviews research-based family counseling approaches specifically developed for treating couples and families in which the primary issue within the family system is an SUD. It describes the underlying concepts, goals, techniques, and research support for each approach. This chapter is for providers.

Chapter 4, *Integrated Family Counseling To Address Substance Use Disorders,* discusses the advantages and limitations of integrated treatment models and the degree of providers' involvement with families. It offers guidelines providers can use to deliver family counseling in combination with specific SUD treatment. It will also help providers match their counseling approaches to specific levels of recovery.

Chapter 5, *Race/Ethnicity, Sexual Orientation, and Military Status,* discusses family counseling for SUDs among families of diverse racial and ethnic backgrounds; families with lesbian, gay, bisexual, or transgender family members; and military families (including active duty personnel and veterans). Each section discusses relevant empirical evidence for family-based addiction treatment with that population as well as suggestions for how providers can adapt family-based interventions for addiction to improve outcomes in specific family populations. This chapter is for providers and administrators.

Chapter 6, *Administrative and Programmatic Considerations,* outlines family-related aspects of substance misuse programs that administrators should note when providing addiction treatment and recovery support services.

Goals

This TIP will help SUD treatment providers and administrators:

- Understand the common concepts of family structure and dynamics, as well as terminology central to these concepts (Exhibit 1.2).
- Learn the impact of SUDs on families and how the presence of SUDs affects every family member.
- Offer SUD treatment via culturally responsive approaches that involve the family as a whole.
- Appreciate the value of family involvement in treatment.
- Integrate specific family counseling models, techniques, and concepts into SUD treatment to enhance effective family coping and healthy communication patterns—paving the road toward recovery for everyone in the family.
- Train and motivate staff to include family members in treatment.
- Support staff in exploring the role of SUDs in family counseling and in developing collaborative relationships to meet the diverse needs of families.

EXHIBIT 1.2. Key Terms

- **Addiction*:** The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery. (This term is not used for diagnostic purposes in the American Psychiatric Association's [APA's] *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition [DSM-5]. This TIP uses "addiction" interchangeably with SUDs for brevity and refers only to addictions related to alcohol or drugs.)
- **Binge drinking*:** A drinking pattern that leads to blood alcohol concentration levels of 0.08 grams per deciliter or greater. This usually takes place after four or more drinks for women and five or more drinks for men (National Institute on Alcohol Abuse and Alcoholism, n.d.; Center for Behavioral Health Statistics and Quality, 2020). However, older adults are more sensitive to the effects of alcohol and treatment providers may need to lower these numbers when screening for alcohol misuse (Kaiser Permanente, 2019). Additionally, other factors such as weight, decrease in enzyme activity, and body composition (e.g., amount of muscle tissue present in the body) can also affect alcohol absorption rates.
- **Continuing care:** Care that supports a client's progress, monitors his or her condition, and can respond to a return to substance use or a return of symptoms of a mental disorder. Continuing care is both a process of posttreatment monitoring and a form of treatment itself. It is sometimes referred to as **aftercare.**
- **Family-based interventions:** Family-based interventions include those that provide psychoeducation and other assistance to family members and those that involve family therapy. This TIP uses **family-based interventions** interchangeably with **family counseling.** In the SUD treatment and recovery support field, families are involved at different points along the continuum of care and engaged in interventions of varying intensity. Most SUD treatment providers who work with families are not licensed family therapists, but they may have training in specific competencies to meet the varying needs of families with SUDs.
- **Family therapy:** Family therapy views the whole family as the primary client and intervenes specifically on a systems level with the family unit. Family therapy may occur across all behavioral health service settings and within behavioral health subspecialties (e.g., mental health services, addiction treatment, prevention). To identify as a marriage and family therapist, a provider must receive specific training and licensing; requirements vary across states. In addition, many family therapists seek specialized training to meet the needs of their clients and the requirements for their profession to treat families.
- **Integrated interventions:** Specific treatment strategies or therapeutic techniques in which interventions for the SUD and mental disorder are combined in one session or in a series of interactions or multiple sessions.
- **Peer recovery support services:** The range of SUD treatment and mental health services that help support individuals' recovery and that are provided by peers. The peers who provide these services are called **peer recovery support specialists** ("peer specialists" for brevity), **peer providers,** or **recovery coaches.**
- **Relapse*:** A return to substance use after a significant period of abstinence.
- **Recovery*:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome their SUDs and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called being in recovery. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, prosocial feature.
- **Substance misuse*:** The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use). (In this TIP, the term describes use of a substance [e.g., illicit drugs, benzodiazepines, opioids] in ways that are harmful or meet SUD diagnostic criteria.)

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- **SUD*:** A medical illness caused by repeated misuse of a substance or substances. According to DSM-5, SUDs are characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. SUDs range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Multiple factors influence whether and how rapidly a person will develop an SUD. These factors include the substance itself; the genetic vulnerability of the user; and the amount, frequency, and duration of the misuse. (DSM-5 no longer uses the terms "substance abuse" and "substance dependence." Rather, it defines each SUD as mild, moderate, or severe. The number of diagnostic criteria an individual meets determines the disorder's level of severity. A mild SUD is generally equivalent to what was formerly called substance abuse, and a moderate or severe SUD is generally equivalent to what was formerly called substance dependence [APA, 2013].)

**Definitions of all terms with an asterisk are based closely on those that appear in* Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health (U.S. Department of Health and Human Services [HHS], 2016). *This resource provides information on substance misuse and its impact on U.S. public health. The report is available online (*https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf*).*

The TIP consensus panel developed this publication from its extensive experience, knowledge, and review of the literature. The panel included representatives from several disciplines involved in family counseling and SUD treatment, including alcohol and drug counselors, family therapists, mental health practitioners, researchers, and social workers. Other professionals also generously contributed their time and commitment to this project. In encouraging counselors, administrators, and others who work in the field to acknowledge substance misuse as a critical issue that can negatively affect families, the consensus panel hopes the guidance in this TIP will help families move toward recovery.

Family Counseling: What Is It, and Why Is It Useful?

Family counseling is a collection of family-based interventions that reflect family-level assessment, involvement, and approaches. A systems model underlies family counseling. The model views families as systems, and in any system, each part is related to all other parts. A change in any part of the system will bring about changes in all other parts (Becvar & Becvar, 2018). Family counseling uses family dynamics and strengths to bring about change in a range of diverse problem areas, including SUDs.

A family is a complex system that attempts to keep equilibrium (or "homeostasis," in family therapy terms). When substance misuse occurs in the family, members will try to manage the behavior of the person who is using drugs or alcohol and the consequences of that use for the family. A family may go through a range of responses to keep the family functioning. Some may view these responses as unhealthy, enabling, compensatory, or counterproductive, but they serve a purpose—to keep the system operating. This operating system directly influences treatment engagement, treatment outcomes, use of support systems, and sustained recovery for each family member.

When a person has an SUD, his or her family members experience significant effects, some more powerfully than others (e.g., older siblings with less direct exposure to parental SUDs may be less affected than younger siblings still living in the home). Families experience hardships, losses,

and trauma as a consequence of a member's SUD (Black, 2018; Reiter, 2015). Some families tend to blame or create excuses for the person's substance misuse. They generally have strong feelings, whether they express them or not, toward the family member who drinks or uses drugs. Family members may direct these feelings toward the substance rather than the person. If families minimize the impact of the SUD, they may blame another family member or stressful situation for the presenting problem (Reiter, 2015).

Integrating family counseling into SUD treatment leverages the important role families can play in helping their family members change their substance use. Integrated SUD treatment and family counseling acknowledges that SUDs affect others beyond those with the disorder (Lassiter, Czerny, & Williams, 2015). Whether an adolescent or adult has the SUD, the entire family system needs assistance.

Family counseling helps each family member understand:

- How the SUD affects him or her as an individual.
- How the SUD affects the whole family.
- How he or she adjusts or changes certain behaviors in response to the individual's progressing SUD.
- How to make changes as an individual and as a family to address the impact of the SUD.

Rather than focusing solely on individuals who have SUDs, family counseling widens the focus by shifting attention to clients and their whole families. This shift in focus supports identification of goals as a family group and as individuals within that group. It also creates a transparent atmosphere that helps individuals with SUDs see that their families are not blaming them for their addiction or ganging up on them to seek treatment. Exhibit 1.3 describes some of the benefits and challenges of this approach.

EXHIBIT 1.3. Benefits and Challenges of Family Counseling in SUD Treatment

Benefits

With new insights and coping skills, families can create an environment that supports recovery for every family member. Here are selected benefits of family counseling in SUD treatment:

Treatment engagement and retention. Family involvement in SUD treatment is linked with increased rates of entry into treatment, reduction of SUD treatment barriers (e.g., lack of finances, untreated trauma), decreased dropout rates during treatment, and better long-term outcomes (O'Farrell & Clements, 2012; Rowe, 2012).

Prevention. Family counseling may play a significant role in prevention. Family-based treatment for individuals with SUDs can help prevent substance misuse in other family members by correcting maladaptive family dynamics (Bartle-Haring, Slesnick, & Murnan, 2018; Horigian et al., 2014). Family counseling that focuses on family functioning and parenting skills can improve behavioral health outcomes in children affected by parental SUDs (Bartle-Haring et al., 2018; Calhoun, Conner, Miller, & Messina, 2015).

Motivation. Engaging family members from the outset gives them an opportunity to learn about SUDs, the biopsychosocial effects of addiction, and how SUDs affect the entire family. Depending on the severity and length of time of addiction, some family members may see SUD treatment as a hopeless cause. Others may be anxious about how treatment may change things for their families. Still others may be opposed to

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treatment, believing that they have spent too many years focusing on the family member with the SUD and its consequences. Counselors can use a family member's view of treatment to guide the initial direction of sessions and to generate motivation.

Lower costs. Compared with individual therapy and mixed therapy (that is, therapy that is neither solely individual nor solely family based), family-based treatments aimed at reducing SUDs are associated with lower costs of delivery (Morgan, Crane, Moore, & Eggett, 2013). Some approaches, such as brief behavioral couples therapy (BCT; Rowe, 2012), also show greater cost-effectiveness compared with standard outpatient treatments. BCT shows a more than 5:1 benefit-to-cost ratio, resulting in at least a $5 savings to society for every dollar spent providing BCT (Schumm & O'Farrell, 2013a). Compared with individual and mixed therapy for SUDs, family counseling results in fewer treatment sessions per episode of care and significantly lower costs per session ($93.45 for family therapy versus $120.96 for individual treatment and $240.20 for mixed therapy; Morgan et al., 2013). Studies on cost-effectiveness do not use consistent outcome measurements and methods, but evidence suggests that family-based SUD treatment approaches are cost-effective (Morgan & Crane, 2010).

The offset factor. Family counseling for SUDs can result in a net savings not just in direct care costs, but also in savings to society—such as reduced healthcare spending and juvenile justice costs. For instance, every dollar spent on SUD treatment in general saves $4 to $7 in reduced drug-related crime, criminal justice costs, and theft (National Institute on Drug Abuse, 2018). A review of family counseling for adolescent externalizing disorders including SUDs (Goorden et al., 2016) suggested that family-involved addiction treatment for adolescents (e.g., family drug court, drug court plus multisystemic therapy) could provide additional cost offset. These treatment approaches were associated with significant reductions in criminal activity-related costs from preintervention to 4-month follow-up (McCollister, French, Sheidow, Henggeler & Halliday-Boykins, 2009).

Treatment outcomes. Evidence from studies mostly focused on adolescent substance misuse suggests that family counseling for SUDs is more effective than treatment as usual (Baldwin, Christian, Berkeljon, & Shadish, 2012; Rowe, 2012; Tanner-Smith, Wilson, & Lipsey, 2013). Family-based interventions appear to (Horigian et al., 2015; Klostermann & O'Farrell, 2013; Morgan & Crane, 2010; O'Farrell & Clements, 2012; Rowe, 2012):

- Improve SUD prevention efforts.
- Reduce substance misuse and positive urine samples.
- Raise rates of abstinence.
- Lessen substance-related problems.
- Decrease juvenile delinquency (including recidivism and drug-related arrests).
- Strengthen family coping abilities.
- Improve family functioning and children's functioning.
- Lessen co-occurring problems (e.g., internalizing conditions, externalizing conditions, suicide attempts).

Outcome studies extending past 1 year are limited (Rowe, 2012). Available data suggest that BCT can yield desirable treatment outcomes, including reduced substance use, days of heavy alcohol consumption, drug-related arrests, legal and family problems, and hospitalizations. BCT is also linked with increased abstinence and treatment adherence (O'Farrell & Clements, 2012; Rowe, 2012).

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Cultural responsiveness. Family- or parenting-based SUD treatment for youth (e.g., MDFT, brief strategic family therapy [BSFT]) had positive effects among African American, Latino, and Asian American teens, as did parent training (Garcia-Huidobro, Doty, Davis, Borowsky, & Allen, 2018; Steinka-Fry, Tanner-Smith, Dakof, & Henderson, 2017). Specifically, BSFT, MDFT, and functional family therapy have been validated for Latino families (Liddle, Dakof, Henderson, & Rowe, 2011; Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009), and MDFT and multisystemic family therapy have demonstrated strong effects with African American families (Henderson, Rowe, Dakof, Hawes, & Liddle, 2009; Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008; Liddle et al., 2009). Family-based interventions that focus on parent–child dyads have been shown to improve outcomes in African American, Asian American, and Latino youth, such as enhancing family relationships, reducing substance use, decreasing risky behavior (e.g., having sex while under the influence of substances), and improving substance refusal skills (Brody, Chen, Kogan, Murry, & Brown, 2010; Brody et al., 2012; Fang, Schinke, & Cole, 2010; Prado et al., 2012; Schinke, Fang, Cole, & Cohen-Cutler, 2011). Although comparatively less research has been conducted on American Indian and Alaska Native populations than other minority groups, evidence suggests that adapting family-based interventions for SUDs to Native American cultures can effectively reduce substance misuse, improve family strength and cohesion, and enhance other SUD treatment outcomes (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018).

Flexibility in treatment planning. Integrated models enable counselors to tailor treatment plans to reflect individual and family factors. Early in treatment, families may need education about substance misuse and its effects. Families in later stages of treatment may need help as they address such issues as trust, forgiveness, acquisition of new recreational skills, role changes, reestablishment of boundaries in the family and at work, and changing the specific interaction patterns that may have evolved from substance misuse in the family.

New perspectives. Family counseling can provide a neutral space in which family members meet to address problems and identify needs. In this safe environment, they can express, identify, and validate feelings. Family members are often surprised to learn that other family members share their feelings. Family members gain a broader perspective and can better understand the perspectives of other family members, which can be empowering and may provide insight and compassion that will foster positive change.

Family functioning. Integration of family-based interventions into SUD treatment improves the psychosocial functioning of the family unit (Cosden & Koch, 2015). For instance, parent–child mediation to reduce problematic child behaviors (including substance misuse) not only improves substance misuse and related intentions, but also increases family communication and cohesion and decreases family conflict (Tucker, Edelen, & Huang, 2017). Compared with treatment as usual, BSFT for adolescents with substance misuse has been associated with more positive parent-reported family functioning (Robbins et al., 2011). Interestingly, some research suggests that improvements in substance use outcomes from family-based interventions are the result of enhanced family functioning (Horigian et al., 2015).

Relapse prevention. Social/family support from those who do not use substances helps people avoid returns to substance use (Cavaiola, Fulmer, & Stout, 2015). The quality and scope of one's social network strongly predicts future abstinence (Korcha, Polcin, & Bond, 2016; Menon & Kandasamy, 2018). Lack of family support can damage recovery, particularly when it results from family members avoiding or withdrawing from the person

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with addiction (Menon & Kandasamy, 2018). Family qualities that can enhance recovery include being honest, being supportive of addiction treatment, providing emotional support, and being a consistent presence in the recoveree's life. Conversely, family member qualities associated with greater risk of relapse and lower chances of abstinence include lacking knowledge about addiction, being unsupportive of recovery, having severe family problems, and using substances actively themselves (Brown, Tracy, Jun, Park, & Min, 2015).

Challenges

Integrating family counseling into SUD treatment does pose some specific challenges:

Complexity. Family counseling as a modality is more complex than individual or group therapies. It requires dealing with more than one person at a time, in contrast to individual therapy. Unlike standard group therapy, family counseling also requires engaging a group of people with a shared history, set rules, roles, and hierarchy, and well-established patterns of communication. For counselors, delivering family counseling can feel similar to serving as a new group therapist for group members who have been together for decades.

Training. Integrating family counseling into SUD treatment settings takes special training and skills, yet training for effective family approaches is not readily available. Making such training available requires administrative commitment in workforce and professional development as well as resources. Integration can increase stress among counselors and administrative staff, given the demand on treatment space, the strain of incorporating family sessions into already-full program schedules, and the addition of new clinical tasks or staff members.

Funding. Outside of adolescent treatment, it has historically been challenging to receive ample, consistent funding or reimbursement for integrated family counseling as a modality in SUD treatment.

False beliefs among providers. Historically, the individual client has been the sole focus of addiction services. Providers of SUD treatment and related healthcare services have often overlooked the families of these individuals (Ventura & Bagley, 2017). Some providers incorrectly believe families to be the direct cause of clients' substance misuse, even though the role of genetics and family environments differ from person to person. Such misperceptions can make providers less willing to involve families in treatment. False perceptions may also perpetuate the belief that families cannot learn appropriate skills to support relatives with SUDs.

Difficulty implementing manualized family counseling. Robust evidence shows manualized family counseling for SUDs to be effective, yet use of such interventions in SUD treatment programs is low (Hogue et al., 2017). Numerous factors contribute to this lack of widespread use, including high costs of using licensed materials for training and maintaining certification; the structured, inflexible design of manualized family approaches; and the challenge of sustaining staff/program training and certification over time (Hogue et al., 2017).

Research limitations. Relatively little research is available concerning the effectiveness of family counseling and SUDs with specific populations, particularly families from diverse racial, ethnic, and cultural backgrounds. More recent research has focused on families with adolescents. Thus, less evidence is being generated in determining efficacy of family-based interventions that involve other family types and other identified individuals in the family unit who have SUDs (e.g., parents or spouses with SUDs).

Family Counseling Objectives

This section summarizes some of the core objectives of family-based interventions for SUDs.

Core objective: Leverage the family to influence change. From the outset, family-focused interventions encourage family members to motivate each other to make important lifestyle changes, including shifts away from alcohol and drug misuse. Family counseling for SUDs also helps families develop effective coping and communication skills that will promote recovery for each member. Family counseling takes advantage of the strength of family relationships to support all family members in their initiation of and engagement in treatment, continuing care services, mutual aid, and peer support services.

Core objective: Use a strengths-based approach to involve families in treatment. Family involvement can have a positive influence on treatment engagement—and lack of family involvement can derail SUD treatment. Families can have negative effects on SUD treatment in other ways, too. Certain aspects of family relationships and parenting practices can worsen alcohol and drug misuse, relapse risk, stress, and behavioral problems. Using a strengths-based approach, family counseling addresses such problematic family dynamics (e.g., parent–child role reversals), as well as inconsistent or ineffective parenting practices. Family counseling can encourage parenting practices that help prevent SUDs in children, improve SUD treatment outcomes in adolescents, and enhance the family recovery process.

Core objective: Change family behaviors and responses that may support continued substance misuse. Another core objective is assessing and reorganizing families' behavioral, cognitive, and emotional responses that may unintentionally support the continued misuse of alcohol and drugs, and that place significant stress and responsibility on family members who do not have an SUD. Most families experience stress, loss, and trauma as a direct or indirect consequence of addiction in the family; family counseling focuses on addressing these consequences to improve family functioning and to potentially prevent further stress-related symptoms, substance misuse of spouse or children, and other biopsychosocial effects. Family counseling in SUD services adopts a trauma-informed stance. It also identifies and addresses safety concerns (e.g., domestic or sexual violence), the unique needs of the family, and the potential obstacles a family may face in accessing and using family services.

Core objective: Prevent SUDs from occurring across family relationships and generations. Family counseling aims to keep SUDs from moving from one generation or relationship to another. If a parent misuses alcohol or drugs, the remaining family members are at increased risk of developing SUDs and mental disorders or establishing relationships with someone who misuses alcohol or drugs. If the person misusing substances is an adolescent, successful treatment reduces the likelihood that siblings will misuse substances or commit related offenses (Whiteman, Jensen, Mustillo, & Maggs, 2016).

Understanding Families

What Is a Family?

Although many people view "family" as the group of people with whom they share close emotional connections or kinship, there is no single definition of family. Diverse cultures and belief systems influence definitions, and because cultures and beliefs change over time, concepts of family are not static. In some cultures, the definition of family is narrow and determined by birth, marriage, or adoption. In other cultures, more expansive definitions include in the concept of family those individuals who share a household, values, emotional connections, and commitments. The level of commitment people have to each other and the duration of that commitment also vary across definitions of family.

Family Types

Just as there is no single definition of family, there is also no typical family type. Families are quite diverse in organizational patterns and living arrangements. Some families consist of single

parents, two parents, or grandparents serving as parents. Many families are blended, including children from previous relationships. Many others are intergenerational within the household and include extended family members, such as grandparents, uncles, aunts, cousins, other relatives, and close friends. Still other types are adoptive or foster and other families whose members are not biologically related and instead come together by choice. Different family constellations often present specific and predictable challenges. For instance, in newly formed blended families, conflicts are typical between parents on how to parent and between a parent and stepchild on the rights of who can discipline, who holds authority, and so forth. Common challenges for single parents include the stress of balancing many responsibilities while parenting. Understanding family types can help counselors anticipate expected and normative family issues that SUDs can complicate (Exhibit 1.4).

Common Characteristics of All Families

A systems view of families assumes that some core characteristics influence functioning across all family types. In systems theory, the family is a system of parts that is itself embedded in multiple systems—a community, a culture, a nation. Families strive for balance and self-regulate accordingly (Nichols & Davis, 2017). The next sections summarize key characteristics of families from a systems perspective.

Subsystems

Subsystems are groupings in the family that form according to roles, needs, interests, and so forth. Subsystems appear in most families among parents, siblings, and couples (Gehart, 2018). A subsystem can be one person or several family

EXHIBIT 1.4. Treatment Issues According to Family Type

Certain treatment issues are more likely to arise in some family types than others when addressing substance misuse in a family member:

- **Client who lives with a spouse (or partner) and minor children.** Most data on the effects of parental substance misuse on children demonstrate that a parent's substance misuse often has lasting, negative effects (Calhoun et al., 2015). The spouse of a person who misuses substances is likely to protect the children and assume parenting duties not fulfilled by the parent misusing substances. If both parents misuse alcohol and drugs, the effects on children are likely to worsen.
- **Client who lives in a blended family.** Blended families may face unique challenges even when no one in the family misuses substances. Substance misuse can intensify these challenges, making it harder for the family to integrate and find stability.
- **Older client who lives with an intergenerational family, including their own children and grandchildren.** An older adult with an SUD can affect everyone in the household. Some family members may try to work around the older person, ignoring SUD-related issues or writing off substance misuse as part of "old age." Many family members are committed to being caregivers, yet they are often left out of treatment decisions and recovery planning (National Academies of Sciences, Engineering, and Medicine, 2016). Counselors may need to mobilize additional family resources to treat the older adult's SUD and other comorbid physical conditions.
- **Adolescent client who lives with family of origin.** When an adolescent misuses alcohol or drugs, the needs and concerns of siblings in the family may be ignored or minimized while the parents address continual issues and crises related to the adolescent's substance misuse. In many families with adolescents who misuse substances, parental substance misuse is evident (Ali, Dean, & Hedden, 2016).

members. Subsystems have their own roles and rules in the family. For example, in a healthy family, a parental subsystem (including one or more members) maintains some privacy, takes responsibility for providing for the family, and has power to make family decisions.

Subsystems can significantly affect individuals' behavior in the family. They can motivate and positively influence a family member. But some subsystems are unhealthy, even if they serve a necessary function in the family—as with a parentified child assuming adult roles that are not age-appropriate (Exhibit 1.5).

EXHIBIT 1.5. Homeostasis

Family members work to keep the family stable via emotional, cognitive, and behavioral responses. The idea of stability and balance, or "homeostasis," in the family emerged in the early 1950s, with the development of Bowen's natural systems theory (Rambo & Hibel, 2013). This theory suggests that systems try to maintain balance in the interest of preservation. Following is an example of homeostasis in a family affected by SUDs.

Within this two-parent household, the father developed alcohol use disorder and stimulant use disorder. Prior to having three children, he indicated that his primary use was cocaine. After the birth of their first child 12 years ago, he began drinking more alcohol and using stimulants more sporadically.

As the father's drinking progressed, the mother focused on controlling his alcohol consumption. She started by monitoring how much he drank and checking on him when he was out (e.g., calling him, going to the bar to find him). She also took on increasing responsibilities, like driving their children to all activities, working additional hours out of fear that the father would lose his job, and assuming all household and parenting tasks.

The oldest daughter, age 12, often worried about her father when he went drinking but showed irritation toward him when he was home. She ignored his directives and stopped communicating with him. Meanwhile, she aligned with her mother. Preoccupied with the idea that her father treated her mother unfairly, she began trying to pick up his slack. In so doing, the daughter took on more parenting duties for her younger sister (age 9) and brother (age 6) while she herself had less supervision and more freedom in and outside the home.

After the father entered treatment and accepted continuing care services, both parents felt as if they were having more family difficulties than before, despite working hard to communicate with each other and deal with the effects of addiction on their relationship. They found their oldest daughter hostile and hard to talk to. "She wasn't like this before—but now, if there is a rule to break, she does," the father stated.

Neither parent realized the significant challenges their daughter had faced since her father's treatment. She had held a powerful role in the family by serving as a confidant for her mother and surrogate parent for her siblings. That role granted her authority and certain privileges. Her parents were unable to see through their daughter's anger to her pain. They did not yet realize that, in essence, their daughter had been demoted back to a child's role without enough support. Thus, she was fighting to regain the more powerful role.

In hindsight, the mother stated that her daughter became a "parent replacement, a little adult." She had relied more and more on her daughter for emotional support as her spouse's SUD progressed.

Rules

Families operate with rules. Rules provide guidance on acceptable behaviors and exchanges, and they reflect family values. Most rules are unspoken, but some are more prescriptive, such as not allowing a child to date until he or she is 16 (Goldenberg, Stanton, & Goldenberg, 2017). The structure of rules creates a sense of safety—as long as those rules are not too rigid.

Some families hold rules rigidly even when circumstances call for reevaluation. Other families experiencing duress or operating chaotically may not have enough rules. In families with SUDs, unspoken rules develop in response to the effects of drinking or drug use. For example, children may come to understand that they don't ask permission from their mother when she is drinking.

Shared Values, History, and Narratives

Each family holds certain beliefs and values (e.g., specific moral beliefs). Children may move away from these values and beliefs as adolescents or adults, but they are nonetheless influenced by them.

Families have shared histories and often develop defining narratives around past familial events. Individual family members can adopt these narratives even when they were not personally present for key events within that narrative, such as by hearing stories of past events about ancestors. Events in each family member's life can be incorporated into the defining family narrative over time as well.

Based on their values, histories, and significant life events, families assume certain characteristics and identities, such as always having been risk-takers. These translate across generations and influence the selection of partners, hobbies, and occupations (e.g., intergenerational vocations as first responders, military personnel, or healthcare professionals).

Roles

Family members assume certain roles, which often relate to generation (e.g., parent, grandparent), cultural attitudes, family beliefs, gender, and overall family functioning. Some roles develop in response to stress or the underfunctioning of a family member.

Historically, the addiction field has used role and birth order theory to help families explore how they have adjusted or reacted to SUDs in the family. Roles help families maintain homeostasis, yet certain roles affect the individuals in that role negatively or distract from underlying issues. For example, a family may see a child as the root of their problems, although one or both parents have significant SUDs.

Boundaries

Family boundaries regulate the flow of information in and outside the family. There are individual and generational boundaries within families, as well as boundaries between families and other systems. Appropriate boundaries vary from culture to culture. Families may present with boundaries that initially appear unhealthy but turn out to be a function of culture. Boundary types range from rigid or fixed to diffused. Ideally, boundaries are clear, flexible, and permeable, allowing movement and communication in and outside the family as needed.

However, some families have very strict boundaries that keep people outside the family from engaging with or providing support to family members. Similarly, rigid boundaries can restrict communication or discussions across generations. For example, a father may state, "This is just the way it is in this house," without allowing discussion of the rule or boundary in question.

Other families' boundaries are too loose or too enmeshed. They may reduce privacy and allow inappropriate access to information. For instance, a sister may have a private conversation with her sibling, which the sibling then shares with everyone in the family without the sister's permission. Another example is a child privy to too much adult information about a sibling, parent, or other person.

Power Structures

Some family members have more power or influence than others. Power differences are expected across generations (e.g., between parent and child) but can also occur between parents. There can also be differences in which parent makes which types of decisions for the family.

Sometimes, families give decision-making power to children or to a specific child, allowing the child to control relationships between the two parents, between parents and other siblings, and so forth. This occurs often when a family is under stress, or when a parent who had more influence disengages with the family because of an illness, divorce, or SUD.

Counselors can harness family power structures to foster change. To do so, counselors should realize that power is not always obvious. A family member who seems uninfluential may have more power than one assumes. For example, a family member who appears more subservient may have learned to use somatic complaints to curtail an activity or to communicate disregard for a course of action nonverbally.

Communication Patterns

Each family has patterns of communication. These can be verbal or nonverbal, overt or subtle, and they may reflect cultural influences. They are families' unique means of expressing emotion, conflict, and affection. Communication patterns may not be obvious to one outside the family but can significantly influence how family members act toward each other and toward people outside the family.

Communication patterns reflect relationship dynamics, including alliances. They can indicate support and respect, or lack thereof, between family members. For example, a teenager in family counseling may look to a parent before answering a question; a husband may roll his eyes when his wife speaks.

Directionality is important in family communication patterns. One directional pattern that frequently occurs is called triangulation (Bowen, 1978). Triangulation happens when, instead of communicating directly with a family member who has an SUD, families who are under stress or lack coping skills instead talk around the person or with a third party in the family system. An example would be a mother who calls her daughter to talk about her son's drinking rather than talking to the son himself about his problem with alcohol. The daughter, in turn, does not redirect or set a boundary with her mother. Triangulation often includes a third person as a go-between, an object of concern, or a scapegoat. Triangulation can involve someone who is not considered a family member.

Durability and Loyalty

Families are durable; membership in a family never expires. Even family members who have moved far away, disengaged emotionally, or become estranged from the family are still a part of it. Some family theorists would go so far as to say, "once in the family, always in the family." Even divorced or deceased family members remain a part of their families' shared histories.

Families also tend to be loyal. It can be difficult for family members to divulge secrets or express differences outside the family. Family members can and will oppose certain family beliefs or report certain family incidents, but when they do so, they normally experience shame, fear, or feelings of disloyalty. Loyalty can be a strength or a limitation for counselors in addressing family problems.

Developmental Stage

All families are engaged in one or more family developmental stages. Families are not static across the life span. Marked by transitions, aging, births, and deaths, extended families undergo developmental stages that predicate the normative stresses, tasks, and conflicts they may face. Understanding these normative stages will help counselors better perceive a family's presenting problems, including SUDs.

Counselors can tailor SUD treatment to meet family needs through developmental tasks. Following is an example of a couple who could benefit from treatment that aligns with their family development stage.

A couple met 25 years ago through a shared interest in the club scene, and they married after 2 years of dating. They have three children who are now in college or living independently. Before having their children, the couple's relationship centered around their use of alcohol and drugs.

Their substance misuse was curtailed throughout the parenting years but escalated after the last child left the home. In recent months, the husband stopped drinking and began receiving treatment at an intensive outpatient counseling program. The husband's abstinence has amplified the couple's sense of being strangers in the same house, which initially became apparent when their children moved out. They feel as if they no longer know what to do with each other or how to be together.

The couple first connected through substance use. Now, they must reconnect with each other through different interests and activities and rework their relationship to center on emotional connection. They would likely benefit from the therapeutic tasks suited to new relationships. Such tasks may include prescribed activities, such as formal dates, and spending time without others to get reacquainted.

Context and Culture

Many systems significantly influence family members and the functioning of the family unit. These include educational, community, employment, legal, and government systems. Families operate as parts of these sociocultural systems, which themselves exist in diverse environments. A family-informed, systems-based approach to SUD treatment will take into consideration questions such as:

- What are the current community or geographic stressors?
- What are the effects of acculturation?
- What economic and supportive resources are available to the family?
- Does the family have access to services?
- How do culture, race, and ethnicity influence the family (e.g., how are issues of power or oppression at play for the family)?

Sociocultural interventions often stress the strengths of clients and families in specific contexts; such interventions include job training, education and language services, social skills training, and supports to improve clients' socioeconomic circumstances. Other interventions may involve community- and faith-based activities or participation in mutual-help groups to alleviate stress and provide support.

History of Family-Based Interventions in SUD Treatment

Family Theory—Initial Research

After War World II, research started to explore the role of families in the development and maintenance of mental disorders. In part, family therapy was an outgrowth of research on communication patterns within families who had a family member with schizophrenia (Bregman & White, 2011). Interest in the role of families, family dynamics, and family theoretical approaches appeared to emerge simultaneously in the 1950s among practitioners and researchers in the United States and other countries.

Incorporating the Concept of Systems Into Family Models

Thereafter, family models started to incorporate the concept of systems, which was grounded primarily in psychoanalytic theory (Gladding, 2019). This systems-informed theory of the family evolved into several new schools of thought, each of which began to inform specific treatment strategies and training centers. At first, it was typical for practitioners to subscribe to just one model of family therapy. Yet, as more therapists began endorsing an eclectic approach that synthesized several family treatment models, the field witnessed a burgeoning of family therapy applications. Treatment for SUDs, eating disorders, and adolescent behavioral problems increasingly reflected aspects of family therapy.

> Family counseling is a collection of treatment approaches and techniques founded on the understanding that if change occurs with one person, it affects everyone else in the family and creates a "change" reaction.

At the same time, treatment of SUDs as a primary condition was taking hold. As with family therapy's view of SUDs as a symptom of family issues, SUD treatment often viewed substance misuse as a symptom of underlying pathology. As the SUD treatment field evolved, it started to recognize the influence of biological, familial, cultural, and other psychosocial factors on substance use.

Initial Integration of Families Into SUD Treatment

SUD treatment services, which at first were mainly residential, began to incorporate family activities into their programs. The goal was to rally individual clients' family members in supporting their recovery and to address the ways in which family members, particularly spouses, contributed to clients' substance misuse. It is no accident that the terms "co-alcoholic" and "codependent" were applied to spouses. Early SUD treatment programs began incorporating family psychoeducation, but there was an inherent attitude of "them" (family) versus "us" (those in recovery or treatment).

Drug and alcohol counselors were often in recovery themselves, yet had no experience addressing their own family histories. In earlier attempts to involve families in SUD treatment, spouses were invited to sessions of groups that the family member with the SUD attended regularly with other individuals in residential treatment. This did not often foster a welcoming environment for spouses, who were generally ill-prepared and had no alliances to create a sense of safety in the group. The objective of including spouses and other family members in this way was to gain collateral information from them about patterns of substance misuse in the individual with the SUD—and to highlight spouse or family behaviors that contributed to past use or could trigger a relapse. The focus was on the individual's, rather than the whole family's, recovery from addiction and its effects.

Specialized Family SUD Treatment Programs

By the 1980s, family psychoeducation programs became the hallmark of family-based interventions in SUD treatment programs. As these specialized programs developed, they increasingly addressed the effects of parental SUDs on children and adult children (Wegscheider-Cruse, 1989). Virginia Satir's communication family model (Satir, 1988), adapted by Sharon Wegscheider-Cruse, gained prominence in SUD treatment; programs adopted a systemic perspective to explore how family dynamics and roles shifted in response to family members with SUDs. Some programs included the individual with the SUD and his or her entire family, whereas others involved everyone except the family member with the SUD; some were couples oriented, and still others treated individuals affected by substance misuse (e.g., children and adult children programs).

Many specialized family SUD programs began to close in the 1990s as a result of managed care, pressure to shorten treatment length, and limited funding sources (White, 2014). A persistent view of family services as ancillary meant little or no reimbursement from insurance and other funding sources. Programs self-funded family services or offered them on a cash basis, which was usually unsustainable.

Recognition of family-based SUD interventions as effective has since increased, and funding has improved. In 2018, about 60 percent of SUD treatment programs offered marital/couples counseling; 81 percent provided some family-based interventions (SAMHSA, 2020). Recently, family counseling has thrived, as has research into family-based SUD treatment for adolescents and behavioral couples therapy (Lassiter et al., 2015). Family psychoeducation (Exhibit 1.6), multifamily groups, and limited family sessions are common approaches to integrating family counseling with SUD treatment, and objectives have expanded to support healing of entire families.

Current Models for Including Families in SUD Treatment

Four theories predominantly inform current family-based approaches in SUD treatment:

- **The chronic disease model** views SUDs as similar to other chronic medical conditions and acknowledges the role of genetics in SUDs (White, 2014). Practitioners of this model approach SUDs as chronic illnesses that affect all members of a family and that cause negative changes in moods, behaviors, family relationships, and physical and emotional health.
- **Family systems theory** holds that families organize themselves through their interactions around substance misuse. In adapting to substance misuse, the family tries to maintain homeostasis (Klostermann & O'Farrell, 2013).
- **Cognitive–behavioral theory** assumes that behaviors, including substance misuse, are reinforced through family interactions. Treatment under this model works to change interaction patterns, identify and target behaviors that could trigger substance misuse, improve communication and problem-solving skills, and strengthen coping skills and family functioning (O'Farrell & Clements, 2012).
- **MDFT** integrates techniques that emphasize the relationships among cognition, affect (emotionality), behavior, and environment (Liddle, Rowe, Dakof, Ungaro, & Henderson, 2004). MDFT is not the only family therapy model to adopt such an approach; functional family therapy (Alexander & Parsons, 1982), multisystemic therapy (Henggeler & Schaeffer, 2016), and BSFT (Szapocznik, Muir, Duff, Schwartz, & Brown, 2015) reflect similar multidimensional approaches.

EXHIBIT 1.6. The Matrix Intensive Outpatient Approach

The Matrix Intensive Outpatient Program's *Counselor's Family Education Manual* provides a psychoeducational format for working with families in a nonthreatening way. (There are other manuals in this structured treatment approach for clients with stimulant use disorders that are designed for clients and counselors.) Families have the opportunity to learn about methamphetamine misuse, other drug and alcohol misuse, treatment, and the recovery process. The manual offers guidance to counselors on how to explore with family members the effects of SUDs in the family unit. It also helps counselors teach families how they can support individual family members' recovery.

The manual is available online (https://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA15-4153).

Different Pathways in Working With Families

Parallel, Integrated, and Sequential Approaches

Parallel

Family counseling and family-based interventions can be an addition to SUD treatment. Parallel approaches deliver family counseling and SUD treatment independently, but at the same time. Some concurrent treatment approaches involve the person with SUD; others treat families separately from the family member with SUD. This depends on providers' philosophy and program logistics.

When family counseling and SUD treatment occur at the same time, communication between providers is vital. To prevent treatment goals from conflicting, both providers should have competency in family processes and SUDs. In keeping with the principles of recovery-oriented systems of care (ROSCs), they should work together, in collaboration with the client and family, to improve family functioning, address the dynamics and effects of addiction in the family, and build a family environment that supports recovery for all. Case conferencing is an efficient way for family counselors and SUD treatment providers to address conflicting service objectives and other concerns constructively in a forum that fosters identification of mutually agreeable priorities and coordination of treatment.

RESOURCE ALERT: SAMHSA'S ROSC RESOURCE GUIDE

ROSCs are comprehensive, integrated systems of care that address the full continuum of medical and behavioral health needs. ROSCs make it easier for individuals and families to seek SUD treatment and other behavioral health services by supporting informed decision making and ensuring access to, and continuity of, care across service settings. According to SAMHSA's (2010) *Recovery-Oriented Systems of Care (ROSC) Resource Guide:*

> The central focus of a ROSC is to create an infrastructure or "system of care" with the resources to effectively address the full range of substance use problems within communities. The specialty SUD field provides the full continuum of care (prevention, early intervention, treatment, continuing care, and recovery) in partnership with other disciplines, such as mental health and primary care, in a ROSC. A ROSC encompasses a menu of individualized, person-centered, and strength-based services within a self-defined network. By design, a ROSC provides individuals and families with more options with which to make informed decisions regarding their care. Services are designed to be accessible, welcoming, and easy to navigate. A fundamental value of a ROSC is the involvement of people in recovery, their families, and the community to continually improve access to and quality of services. (p. 2)

The guide offers an overview of ROSCs, outlines steps for ROSC planning and implementation, and provides a collection of ROSC-related supporting resources. It is available online (www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf).

Integrated

Integrated interventions embed family counseling within SUD treatment. The individual with the SUD participates in family approaches as part of the SUD treatment program. Integrated family counseling for SUDs can effectively address multiple problems by taking into account each family member's issues as they relate to the substance misuse, as well as the effects of each member's issues on the family system. The integrated framework assumes that, although SUDs occur in individuals, solutions to substance misuse exist within the family system that will support recovery among all family members.

Exhibit 1.7 explores integrated family SUD counseling for individuals who may not initially wish to include family members in their treatment process.

EXHIBIT 1.7. Understanding Client Reluctance Toward Family Involvement

Most clients are willing to invite a substance-free family member or friend to support their recovery (e.g., when recovering from opioid misuse; Kidorf, Latkin, & Brooner, 2016). However, some people with SUDs do not wish to contact their families, and they may not sign a Release of Information that would allow their providers to initiate such contact. This limits the possibilities of family-based interventions, but family involvement in SUD treatment can still be a goal. Family members generally have additional information about clients' behavioral patterns and the effects and consequences of their substance misuse. Even if solicited, this information may feel overwhelming for the person in treatment—yet it can also motivate the person to recover.

As counselors build therapeutic alliances with clients, they gain insight into clients' hesitancy toward inviting family members into the treatment process. Before promoting family involvement, counselors should understand clients' rationale for preventing it. Their reasons may be well-founded (e.g., a history of abuse or estrangement). Younger clients may try to separate themselves out of a desire to find an identity outside the family. Others may fear what family members will say or feel ashamed of their behavior while using.

Once counselors understand the reasons behind clients' reluctance to include their families in treatment, it becomes easier to develop respectful strategies to integrate family counseling into SUD treatment. Counselors can make informed decisions with their clients about whether, and how, to involve the family if appropriate and if the client grants permission.

Different programs endorse different strategies to promote family involvement. In programs that promote family services during the intake process and reinforce an ongoing expectation of family inclusion, family participation is typically more accepted.

Sequential

Sequential treatment implements family-based approaches after initial SUD treatment. Some SUD treatment programs keep family involvement minimal until the individual with the SUD has obtained and maintained recovery. Sometimes, such an approach results from a lack of program resources. Other times, this approach may reflect the outdated idea that sobriety or recovery must come first, regardless of an individual's unique circumstances and family dynamics—despite family-based SUD treatment interventions typically enhancing outcomes for individuals and families.

In some cases, circumstances and dynamics *do* warrant treating the SUD before involving the family—as when a family member with an SUD also has a co-occurring disorder not yet stabilized in treatment. In this scenario, it may be best to limit or postpone family-based interventions until stabilization. In other cases, sequential treatment is just the natural course of a family's path to recovery.

Families and couples may seek family counseling after SUD treatment. Many families struggle in early recovery, particularly the first year or two, even if they felt united in hope, motivation, and support during SUD treatment. The reality of recovery sets in; couples and families realize that it takes time and can dramatically change interpersonal dynamics, roles, and relationships. For instance, members of a couple in recovery may have different expectations for emotional and sexual intimacy; one partner may want more intimacy, whereas the other may find intimacy uncomfortable without using substances.

Contrasting expectations may produce stress in couples unaccustomed to supporting each other emotionally; some couples at this stage are still relearning how to talk productively with one another. Families and couples may need family counseling and therapy well after their initial recovery from SUDs.

Settings and Formats

Although family-based interventions vary widely from one treatment facility or provider to another, they are applicable across settings. As primary or ancillary approaches to address SUDs, such interventions can be integrated at many points along the continuum of care (e.g., inpatient or outpatient detoxification, outpatient SUD treatment services, medication-assisted treatment settings, short- or long-term inpatient or residential SUD treatment).

Family-based interventions are flexible. Providers can tailor them to match specific family needs and to suit specific treatment settings. The intensity and format of the family-based intervention should align with the stage and duration of an individual's SUD treatment, and should also address the presenting needs of that individual's family. These interventions can be brief, emphasizing psychoeducation, parenting skills training, and supportive services. They can also be intensive, with case management and outpatient or inpatient programming that explores family dynamics and relational issues.

Across settings, families may engage in individual family sessions and educational programs or counseling services involving multiple families. Exhibit 1.8 describes multifamily approaches to address SUDs.

EXHIBIT 1.8. Multifamily Groups

Multiple family therapy (MFT) is a specific model for group family counseling. It originated from Laqueur's family meetings in state hospital settings, which aimed to improve management strategies for patients who had schizophrenia (Laqueur, Laburt, & Morong, 1964). Today, MFT generally appears in residential and intensive outpatient SUD treatment settings and involves numerous families of clients in SUD treatment at the same time. It uses a variety of family models and approaches (see the "Current Models for Including Families in SUD Treatment" section). Some groups are closed; others are open, allowing family members to start attending group sessions at any time. Some groups have a set timeframe, such as four to six sessions, whereas other groups meet continually throughout the year.

MFT groups typically include psychoeducational and experiential activities, such as role plays. The idea is that families are more likely to understand and accept their own dynamics if they witness similar dynamics in another family's interaction in group. Well-facilitated groups can lessen shame and improve coping skills in families while reassuring them that they are not alone. The group process also helps families see that they can benefit from treatment as others have (even if the family member who uses substances does not maintain abstinence). MFT is especially useful for involving a family early in treatment, motivating individuals to continue SUD treatment, and achieving prevention (Steinglass, Sanders, & Wells, 2019).

MFT helps normalize family experiences related to SUDs. For instance, family members in a group MFT session may be asked to stand in a circle with five to six other families of various types, races, and socioeconomic backgrounds, each of whom has unique relational dynamics and has experienced varying effects and consequences of SUDs. The group counselor may ask everyone who feels as if they are different or fears not fitting in to take one step into the circle—and nearly everyone standing might step in.

This is the value of MFT: It shows individuals and families that they are not alone in their experiences, feelings, and reactions to a family member's substance misuse. MFT can be a starting point for family recovery.

Levels of Family Involvement

SUD treatment programs can intervene with families at different treatment phases and levels of engagement. In detoxification, a counselor may first offer psychoeducation and general information about substance misuse and treatment options that seems applicable. Residential treatment programs may provide family intakes, family counseling sessions, and MFT groups to improve family functioning, address effects of SUDs in households, and help families identify their needs in recovery.

Family-based interventions have different functions and require specific counselor and programmatic competencies. For example, in continuing care services, parenting skills training may be implemented after discussing how the SUD and related family dynamics have affected parenting. In residential treatment, family sessions may explore the relational patterns and behavioral consequences of substance misuse or identify specific behaviors associated with drinking or drug use to establish ways for interrupting those patterns and behaviors. In intensive outpatient treatment, a family component can help individual family members define specific goals to help with family functioning.

Where Do We Go From Here?

This chapter provided fundamental information on historical perspectives as well as current models and theories of the family; rationales for including families in SUD treatment; and an overview of family-based interventions. In Chapter 2, readers will find a more detailed exploration of the effects of SUDs on families, family roles and dynamics, and long-term outcomes. Chapter 2 addresses the effects of SUDs on diverse family groups, including those with adolescents who have SUDs and parents who have SUDs.

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Chapter 2—Influence of Substance Misuse on Families

KEY MESSAGES

- Substance misuse and substance use disorders (SUDs) affect families in many ways. Use of alcohol and drugs can influence family dynamics, communication styles, patterns of conflict, and cohesion (degree of closeness with one another), among other effects.
- When substance misuse is present in a family, dysfunctional patterns and relationships often occur as the family struggles to keep their life as normal as possible. Family members are usually doing their best to cope, but sometimes their ways of coping and keeping balance in the family can be unhealthy.
- SUD treatment providers should approach families with empathy and understanding, not judgment and blame.
- Almost all families in which substance misuse occurs share certain features. Even so, family types can influence how families experience and attempt to cope with substance misuse. Families with young children, families with adult children, couples, blended families, same-sex couples, and families in which an adolescent is misusing substances have their own unique family dynamics and outcomes.
- Parental substance misuse is especially damaging to both young and adult children. It increases children's risk of experiencing SUDs and mental disorders, among other negative outcomes.

Chapter 2 of this Treatment Improvement Protocol (TIP) summarizes how SUDs affect families and family functioning. It will help SUD treatment providers understand the types of relationships and patterns of behavior they are likely to encounter in the delivery of family-based SUD treatment and related services. This chapter:

- Summarizes effects of SUDs on families, including family factors associated with substance misuse and the biopsychosocial consequences for spouses/partners, parents, and children of varying ages.
- Introduces the roles of family history and genetics in substance misuse and recovery.
- Identifies common family features and dynamics associated with substance misuse (e.g., high levels of conflict, low-quality communication, low levels of cohesion).
- Discusses the unique dynamics, interrelationships, and effects of SUDs in five specific family types:
  - Couples in which a partner has an SUD.
  - Parents with an SUD who have young children.
  - Parents with an SUD who have adult children.
  - Blended families in which a family member has an SUD.
  - Families with an adolescent who has an SUD.

SUDs affect more than just the person who misuses substances; they can potentially affect the person's entire family as well, influencing breakdown in the ways in which family members get along, communicate, and bond with each other. A family is a system consisting of different

"parts" (the family members), so a change in one part can cause changes throughout the system. When a family member has an SUD, the effects on that person's family can vary significantly, depending on factors such as SUD severity, access to resources, family type, patterns of substance misuse, and the presence of substance misuse or related activities in the family home, to name just a few.

In reading Chapter 2, you will learn to recognize common family features and dynamics associated with substance misuse to help guide you toward the interventions and services that will best meet each family's needs. Improving your grasp of these factors will help you avoid judging or pathologizing families dealing with SUDs and, instead, offer them understanding and empathy.

The Role of Genetics and Family History in the Development of and Recovery From SUDs

Family history of substance misuse is linked to an increased risk of developing SUDs (Huibregtse et al., 2016; Prom-Wormley, Ebejer, Dick, & Bowers, 2017; Reilly, Noronha, Goldman, & Koob, 2017). Genetic research suggests that there are multiple genes for alcohol use disorder (AUD) and SUDs involving nicotine, cannabis, cocaine, and opioids (Prom-Wormley et al., 2017). Genetic risk of SUDs may vary according to parent gender (Nadel & Thornberry, 2017). (For more information on gender differences in families and risk of SUDs, see the section "Traditional Gender Roles, SUDs, and Family Dynamics.")

COUNSELOR NOTE: CAN FAMILIES BENEFIT FROM GENETIC COUNSELING FOR SUDs?

Should you refer families facing substance misuse to genetic counseling? The answer is not clear. Genetic counseling for SUDs is relatively new. More research is needed to determine the extent to which genetic counseling is useful for families with SUDs and how they can act on the information such counseling delivers.

According to a study of families' desire for genetic counseling for AUD, Kalb, Vincent, Herzog, and Austin (2017) surveyed adults with AUD, a family history of AUD, or both and found that:

- Most individuals believed that genetics and family history are important contributors to AUD.
- Although 40 percent of people surveyed had heard of genetic counseling and 32 percent knew what genetic counseling was, only one person had previously undergone genetic counseling (not for AUD).
- **After receiving information on genetic counseling for AUD, 62 percent thought it would benefit them.**
- Of people surveyed, 72 percent expressed some degree of concern about their children developing AUD, and 43 percent had similar concerns about their siblings.
- Only 5 percent of survey respondents reported choosing to not have children or to adopt—in part because of their AUD/family history of AUD. However, a little more than one-quarter (26 percent) were unsure of whether their family history of AUD would affect their future decision making about having children.

Although these promising results suggest that referral to family genetic counseling may be beneficial, these services are still relatively new in the SUD treatment world. Not every family will be interested in these services, and there may not be a genetic counselor in your community to whom you can refer families. Further, it is important for families to understand the context of genetic influences on substance use in terms of epigenetics, which suggest the presence of factors, such as environment, that can affect gene expression. **The best approach is to talk with families about genetic counseling to explain how it may or may not be of use to them, and ask them their thoughts about a possible referral.**

Genes play a role in the development and progression of substance misuse and SUDs (Schuckit, 2014). For example, the quantity and frequency of alcohol, nicotine, and cannabis use in one study were greater among nonadopted adolescent siblings than adopted adolescent siblings, although a shared home environment (a nongenetic factor) that includes substance use was also thought to contribute to an extent (Huibregtse et al., 2016). However, earlier data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) (Yoon, Westermeyer, Kuskowski, & Nesheim, 2013) found lifetime rates of SUDs were greater among adopted adults than nonadopted adults, which also points to the importance of shared environment.

One allele (a variant form of a gene) is associated with an increased risk of relapse for individuals with AUD (Dahlgren et al., 2011). In a comparison of people in recovery from alcohol dependence conducted in Sweden, those with the DRD2 A1 allele had a significantly higher rate of relapse (89 percent) than did those without the allele (53 percent). Other studies suggest that a family history of substance misuse increases relapse risk for people in SUD remission (McLaughlin et al., 2010; Milne et al., 2009). Certain genes/alleles related to reward mechanisms and neurotransmitters in the brain (e.g., dopamine, serotonin) also may increase cravings and, thus, returns to use (Blum et al., 2017; Leventhal et al., 2014).

Exhibit 2.1 further demonstrates how biology fits into a framework for understanding SUDs in families.

EXHIBIT 2.1. The Role of the Medical Model When Working With Families

As SUDs progress, they often change the person's behavior, emotions, and thinking processes. Some family members may see these changes as evidence that the person is caustic, spiteful, or weak. They are not likely to attribute the changes to substance misuse, but rather to a flaw in the individual's personality or decision-making skills. As the SUD progresses, it is harder for some family members to separate the person from the substance misuse. Some counselors use an image of a blanket covering a person as a metaphor to depict how the SUD (the "blanket") hides the person underneath.

The medical model of SUDs emphasizes genetic and physiological factors like long-term changes in brain chemistry after substance misuse (Frank & Nagel, 2017; MacNicol, 2017). This model highlights the genetic predisposition to substance misuse and transgenerational familial patterns of SUDs. Some families may benefit from understanding this model as they come to view SUDs not as a personal weakness, but as a disease.

Although the medical model is widely known and accepted, it is not the only model to explain drug and alcohol addiction. Other models include the public health model, the general systems theory of addiction, the sociocultural model, and behavioral-cognitive models (e.g., social learning theory). Do not assume that all providers and all programs support the medical model of addiction. Descriptions of these models are beyond the scope of this TIP. However, know that the program in which you work may or may not support the medical model of addiction. Similarly, after exploring these different theories, you may or may not come to support the medical model yourself. For more information about explanatory, prevention, and treatment models of SUDs, review *Facing Addiction in American: The Surgeon General's Report on Alcohol, Drugs, and Health* (HHS, 2016), available online (https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf).

Common Characteristics of Families With SUDs

No two families are exactly alike, but **families in which substance misuse occurs often share common features.** They typically (Bradshaw et al., 2016; Elam, Chassin, & Pandika, 2018; Klostermann & O'Farrell, 2013):

- Show a lack of flexibility, rather than an excess.
- Have high levels of distress and dysfunction.
- Have low levels of family expressiveness, cohesion, and agreement.
- Experience what has been termed the "reciprocal causality" of maladjustment. This means the substance misuse leads to family dysfunction, but that family dysfunction and conflict also affect substance misuse and relapse. Thus, the two are interconnected.

See Exhibit 2.2 for more family characteristics linked with SUD onset, maintenance, and recovery.

A literature review and meta-analysis (Yap, Cheong, Zaravinos-Tsakos, Lubman, & Jorm, 2017) identified common factors in the families of adolescents who misuse alcohol. These factors include:

- Parents using alcohol.
- Parents expressing a positive attitude about alcohol use.
- Parents providing children with easy access to alcohol.
- Families experiencing higher levels of conflict.
- Parents and children having low levels of quality relationships with one another.

EXHIBIT 2.2. Family Traits That Affect SUD Initiation, Maintenance, and Recovery

- Family factors affecting SUD initiation:
  - Exposure to substance use by a family member (social learning)
  - Parental control that is either very rigid or very permissive
  - Lack of family connectedness and support (especially during times of stress and difficulty)
  - Certain socioeconomic factors, like families where both parents work and have little time to spend with (and thus monitor) their children
- Family factors affecting SUD maintenance:
  - High use of substances during family events, like gatherings and celebrations (social learning)
  - Weak bonds between family members (especially between parents and children)
  - Ineffective, inconsistent, or otherwise low-quality communication between family members
  - Low-quality parenting skills, including use of severe punishment
  - Both excessive control and excessive permissiveness
- Family factors associated with less successful recovery from SUDs:
  - Any dysfunctional pattern in the family's dynamics, including problems with family boundaries, family cohesion, and family roles
  - Lack of open and consistent communication
  - Low-quality parenting skills
  - Lack of parental warmth and involvement; parental rejection
  - Divorce or death of a parent

Source: Mathew, Regmi, & Lama (2018).

Exhibit 2.3 gives examples of ways in which certain substances commonly affect families.

EXHIBIT 2.3. Effects of Different Substances on Families

SUBSTANCE	EFFECTS ON THE FAMILY
Alcohol	• Problems with communication • High levels of conflict • High risk of chaos and disorganization (e.g., inconsistent parenting practices) • Breakdown of family rituals, rules, and boundaries • High potential for emotional, physical, or sexual abuse, or a combination thereof • Efforts by family members to "cover up" for the family member with alcohol misuse
Opioids	• High potential for illegal activities (e.g., buying illicit opioids, like heroin; diverting prescription opioid medications) • Increased risks of chaos and unpredictability • Greater risk of contracting an infectious disease, such as HIV/AIDS and hepatitis, which can affect family members' roles and responsibilities (e.g., parenting children, caring for dependent others, working to earn a livable income, fulfilling school-related duties) • Increased risk of engaging in sex work to support the cost of opioids, which can affect the family member's health, roles, and responsibilities • High potential for SUDs
Cocaine	• High potential for illegal activities (e.g., buying or selling cocaine) • Increased risk of stealing from family, work, or others to purchase cocaine (which, in certain forms, can be high cost) • Increased chances of legal problems • High potential for SUDs

Source: Mathew et al. (2018).

MINI-CASE EXAMPLE

A stay-at-home mother drinks to the point of not being able to pick up her youngest child from school, manage the bills, or take care of the house. To keep the family functioning as normally as possible, her teenage daughter may take up these responsibilities rather than try to convince her mother to stop drinking. Thus, the mother continues to drink, knowing her daughter is there to "pick up the pieces."

It may seem illogical for the daughter to act in a way that actually supports her mother's AUD. But she is just trying to keep her family functioning as consistently as possible. This is typical of families with SUDs—members do their best to survive and try to prevent further disruptions in their relationships and functioning. "Enabling" behaviors that result from such efforts to keep the balance may seem counterproductive and ill advised, but they are actually adaptive. (Also see the counselor note "How Do 'Enabling Behaviors' Influence Substance Misuse in Families?")

Homeostasis

In nearly all families affected by substance misuse, there is a tendency to try to maintain **homeostasis.** This means that family members will behave in ways to try and keep the family functioning as it always has, even if that means supporting the family member's substance misuse to prevent change or imbalance. Unhealthy family relationships, roles, rituals, and functions often develop in part because families are attempting to maintain homeostasis. The following case is just one example of an attempt to keep the balance in a family dealing with an SUD.

> When one person in a family begins to change his or her behavior, the change will affect the entire family system. It is helpful to think of the family system as a mobile: when one part in a hanging mobile moves, this affects all parts of the mobile but in different ways, and each part adjusts to maintain a balance in the system."
>
> *(Lander, Howsare, & Byrne, 2013, p. 197)*

As an SUD treatment provider, you need to understand the role of homeostasis in family dynamics and help family members develop healthier behaviors and relationships with one another without blaming, lecturing, or judging them.

It also is critical that you identify and understand a family's efforts to maintain homeostasis. The family members' readiness to change (or lack thereof) may affect family functioning, and family functioning may affect their readiness to change (Bradshaw et al., 2016). Both factors—family readiness to change and functioning—may affect the person with an SUD and his or her willingness to seek recovery.

Traditional Gender Roles, SUDs, and Family Dynamics

Traditional gender roles are an important factor in understanding family dynamics and SUDs. In U.S. culture, family functions and roles have traditionally differed by gender, such that men were typically the "breadwinners" and primary decision makers for the family, whereas women were caretakers and sources of emotional support. The relationships, roles, and functions in a family are affected by that family's view of gender roles in general. For example, in a family that believes women should not work outside the home, a wife having to take a job because of family financial strain may become

a major source of stress or shame. Further, it is common for family bonds to differ across gender, with the formation of strong mother–daughter and father–son dyads but, in many cases, comparatively weaker bonds between parents and their children of the opposite gender.

Traditional gender roles relate to substance misuse. Strict adherence to stereotypical gender expectations may increase SUD risk in young people. For instance, adolescents with high scores of male-typicality (i.e., behaviors and attitudes typical in men) had a 70-percent higher frequency of intoxication and 79-percent higher frequency of cannabis use than adolescents with the lowest scores of male-typicality (Mahalik, Lombardi, Sims, Coley, & Lynch, 2015). Similarly, men who are more adherent to male-typical behaviors and norms are 256 percent more likely to use alcohol, tobacco, and cannabis as adolescents and 66 percent more likely to use them as young adults compared with men who are less adherent to male-typical norms (Wilkinson, Fleming, Halpern, Herring, & Harris, 2018).

COUNSELOR NOTE: WHAT DOES GENDER HAVE TO DO WITH SUBSTANCE MISUSE?

According to McHugh, Votaw, Sugarman, and Greenfield (2018) and Kuhn (2015):

- Men have a higher risk of early- and late-onset substance use than women. Yet women may progress from initiation of substance use to SUDs faster than men, particularly for alcohol, cannabis, and opioids.
- The prevalence of SUDs is higher for men than for women.
- The biopsychosocial, functional, and quality of life consequences of SUDs (including problems with family functioning) tend to be more severe in women than in men.
- Women often face unique barriers to SUD treatment, like childcare burdens and lack of family support.
- Adolescents' development of SUDs can differ across genders because of differences in initiation and frequency of use as well as differences in biology, behavior, and personality characteristics, all of which contribute to SUDs. For instance:
  - Differences in cannabis use appear as adolescents age, with boys showing more use than girls.
  - In some research, levels of alcohol use increase more rapidly with age among male adolescents than among female adolescents.
  - Nonmedical use of prescription opioids appears more common in female than in male adolescents.
  - By late adolescence, boys tend to exceed girls in frequency and amount of alcohol, tobacco, and cannabis use.
  - SUD-related biological mechanisms, behaviors, and personality traits in adolescents also can differ by gender. This includes factors like sensation seeking (greater in men); inhibitory or self-control abilities (greater in women); history of childhood abuse (greater in female adolescents); presence of depression, anxiety, or bipolar disorders (greater in female adolescents); presence of conduct disorder or attention deficit hyperactivity disorder (greater in male adolescents); and reactivity of the hypothalamic–pituitary–adrenal axis system in puberty (higher reactivity in pubertal female adolescents).

For additional discussion about substance misuse and recovery services for women specifically, see TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009).

Research suggests that there are gender-related differences in the dynamics and functioning of families in which substance misuse occurs:

- Among parents in SUD treatment (Burstein, Stanger, & Dumenci, 2012):
  - Mothers were significantly more likely than fathers to identify internalizing, externalizing, and substance use-related behaviors in their adolescent children.
  - Maternal, but not paternal, scores on a measure of psychopathology predicted adolescents' internalizing problems and substance use.
- Family functioning and adolescent substance misuse may differ by gender. In their survey of more than 1,000 high school students, Ohannessian, Flannery, Simpson, and Russell (2016) found that:
  - Decreased family functioning (such as low-quality father–adolescent communication) predicted greater alcohol use among girls but had no bearing on boys' alcohol use.
  - Low level of quality mother–daughter communication plus family dissatisfaction predicted alcohol use in girls, but only because of girls' depressed mood.
- In boys, lower quality adolescent–mother communication, family cohesion, and family adaptability were linked to greater alcohol and cannabis use (Russell, Simpson, Flannery, & Ohannessian, 2019):
  - The relationship between adolescents' alcohol use and low levels of family cohesion and adaptability were accounted for by boys' depression but not girls' depression.
  - Instead, among girls in the study, there was a relationship between higher depression and lower family functioning but no relationship with substance misuse and family functioning.
- Gender differences in parent–child dynamics also may influence substance misuse in families with adult children. In one study (Reczek, Thomeer, Kissling, & Liu, 2017), parent–child relationships influenced adult sons' but not daughters' smoking behaviors. For sons only, more contact with mothers was associated with a steeper decrease in smoking over time; less contact with mothers, with a steeper increase in smoking over time. Greater support from fathers also was associated with greater smoking in sons (but not daughters) at baseline but a steeper decline over time.

Different family members may be at different risk for harmful outcomes of family-related substance misuse. Do not assume that mothers, fathers, sons, daughters, or other family members all experience the same effects. In providing family-based SUD treatment, keep in mind that:

- A family's expectations and beliefs about gender roles may influence dynamics and functioning as well as substance misuse among family members. For instance:
  - A family's belief that a son's alcohol misuse is not as serious as a daughter's and not worth treating because "boys will be boys" may contribute to the son's continued substance misuse.
  - A wife who believes it is her job to support her family and "keep the peace" may feel the urge to "cover up" her husband's opioid use disorder (OUD) rather than confront him about it directly.
- You may need to address a family's unhealthy dynamics and dysfunction. One approach is to provide education about the effects of gender-related beliefs and expectations, especially if such beliefs and expectations are worsening a family member's substance misuse.
- Because of gender-based differences, female and male members of the family may benefit from different interventions and services to address their unique risk factors and needs.

Family Types: SUDs and Family Dynamics

Not all families develop the same patterns or dynamics in response to SUDs. Families are incredibly diverse, and their presenting problems and concerns are influenced by many contextual factors and life events. However, there are common threads among families with similar family types and identified SUDs. Common relational dynamics and issues surrounding SUDs arise when you work with couples without children, families with

adolescents, or blended families. So, too, do different treatment issues emerge based on the age and role of the person who uses substances in the family, whether small children or adolescents are present, and the type of SUD.

Using available research and organized according to family type, the following section highlights the effects, dynamics and patterns, and experiences of five different family types:

- Couples in which a partner has an SUD.
- Parents who have SUDs and young or adolescent children.
- Parents who have SUDs and adult children.
- Blended families in which a family member has an SUD.
- Families with adolescents who have SUDs.

Descriptions of the five family types in the following sections reflect availability of relevant research. If you provide SUD treatment or recovery support services for other family types, you are still likely to see some patterns and effects of substance misuse similar to those in the types this TIP does address.

Couples in Which a Partner Has an SUD

Substance misuse can be toxic to intimate partnerships (i.e., married and nonmarried couples). Relationships often have difficulty sustaining when at least one person in the relationship has an SUD. Data from the NESARC (Cranford, 2014) show that rates of marriage dissolution among couples with lifetime AUD are significantly higher than in couples without lifetime AUD (48 percent versus 30 percent). A 10-year follow-up on the National Comorbidity Survey (Mojtabai et al., 2017) similarly found that alcohol or drug misuse significantly increased the risk of future divorce by 1.62 times.

Be aware that one of the most well known factors associated with SUDs in intimate relationships is the occurrence of violence, especially when the person with the substance misuse is male. Pooled data from years 2008 through 2015 of the National Survey on Drug Use and Health (NSDUH) (Harford, Yi, Chen, & Grant, 2018) found that symptoms of SUDs were associated with significantly higher rates of self- and other-directed violence. Results from the NESARC-III match these findings and show an increased risk of violence among people with AUD, cannabis use disorder, or other drug use disorders (Harford, Chen, Kerridge, & Grant, 2018).

Drug use and alcohol misuse are associated with increased intimate partner violence specifically (Reyes, Foshee, Tharp, Ennett, & Bauer, 2015). For example:

- The American Society for Addiction Medicine reports that substance misuse occurs in about 40 percent to 60 percent of cases of intimate partner violence (Soper, 2014).
- In women who have experienced intimate partner violence, rates of substance misuse are 2 to 6 times higher than in women without intimate partner violence, ranging widely from 18 percent to 72 percent (SAMHSA, 2017).
- Rates of lifetime intimate partner violence among SUD treatment-seeking women vary from 47 percent to 90 percent (SAMHSA, 2017).

COUNSELOR NOTE: WHAT ARE THE EFFECTS OF SUBSTANCE MISUSE BEYOND THE NUCLEAR FAMILY?

- Extended family members may experience feelings of abandonment, anxiety, fear, anger, concern, embarrassment, or guilt; they may wish to ignore or cut ties with the person misusing substances.
- Some family members even may feel the need for legal protection from the person misusing substances.
- Moreover, the effects on families may continue for generations:
  - Intergenerational effects of substance misuse can have a negative effect on role modeling, trust, and concepts of normative behavior, which can damage the relationships between generations.
  - For example, a child with a parent who misuses substances may grow up to be an overprotective and controlling parent who does not allow his or her children sufficient autonomy.

COUNSELOR NOTE: WHAT IS CODEPENDENCE?

Although the term **codependent** originally described spouses of people with AUD, it has come to refer to any relative of a person with any type of behavioral or psychological problem. The term has been criticized for pathologizing caring functions, particularly those that have traditionally characterized women's roles, such as empathy and self-sacrifice. Despite the term's common use, Klostermann and O'Farrell (2013) note a lack of consensus in the field about using it to refer to people who misuse substances and the families of those people. They further note that usage ranges from a shorthand label for family members affected by an individual's SUD to a synonym for a personality disorder. Indeed, little scientific inquiry has focused on codependence. **It is best to avoid using this term both directly with clients and in discussing families with SUDs.**

Just because a person is in an intimate relationship with someone with an SUD does not mean that violence will occur in that relationship. However, intimate partner violence is common in such relationships and leads to negative, unhealthy dynamics. **It also creates ethical and safety concerns for counselors and clients.**

Consequences of a partner's substance misuse may go beyond issues of trauma and physical safety; there also can be financial effects (e.g., money spent on drugs rather than rent, medical costs related to treating SUDs or related physical problems) and psychological consequences, which may include:

- Denial or protection of the person with the substance misuse.
- Anger.
- Stress.
- Anxiety.
- Hopelessness.
- Neglected health.
- Shame.
- Stigma.
- Isolation.

When substance misuse is present in an intimate relationship, both partners need help. The treatment for either partner will affect both, so SUD treatment programs should make both partners feel welcome.

COUNSELOR NOTE: HOW DO "ENABLING BEHAVIORS" INFLUENCE SUBSTANCE MISUSE IN FAMILIES?

Watching a family member struggle with substance misuse is difficult, as is not knowing how best to help him or her. Many times, family members (and often partners/spouses) will engage in behaviors that help maintain the person's substance misuse, not because they want the person to keep misusing substances but because they do not know what else to do or how exactly to help. For instance, the parents of an adult son who misuses prescription opioids might continue to give him money, let him live at home, and bail him out of jail. All of these behaviors keep the son from experiencing the negative effects of prescription opioid misuse and thus make it easier for him to continue misusing (and give him less of a reason to seek recovery). But because his parents clearly love their son and don't want to see him suffer, they think they are doing the "right thing" by continuing to house him and support him financially.

These behaviors are often called **enabling** behaviors. As a counselor, you should **understand that enabling is a common, normal reaction among family members of people with SUDs. Do not shame, blame, or lecture family members who are enabling substance use-related behaviors.** In general, families are just trying to do the best they can to help their family member in the best way they know how. Instead, gently offer education about why these behaviors, although well intended, actually work against recovery. Help family members come up with more adaptive ways to support the individual but without supporting the substance misuse.

Even when people are in recovery and seeking to improve their lives, relationships can suffer. For instance, during early stages of recovery, partners may (Ast, 2018):

- Have difficulty adjusting to and expressing feelings about their partner's recovery.
- Experience loneliness/separation (e.g., physically, upon the person entering residential treatment).
- Struggle with changes in intimacy and communication with their partner.
- Feel threatened by their partner forming new and emotionally intimate bonds with others in recovery (e.g., 12-Step sponsors and attendees) or spending much of their time participating in recovery activities that do not involve the partner (e.g., attending "90 meetings in 90 days").
- Struggle with no longer being the person's only source of support.
- Feel that their partner has made recovery, not the relationship, the primary focus and top priority.
- Feel left out of the recovery process (especially if not invited to participate in services).

CLINICAL CASE EXAMPLE: UNDERSTANDING FAMILY CHANGES THAT OCCUR WITH SUBSTANCE MISUSE

As an individual progresses from SUD initiation to maintenance and recovery, the individual's relationships with family members and partners also will undergo change. It is important for counselors to understand this parallel process. Changes in family relationships and dynamics can affect a person's substance misuse and recovery effort (either by worsening it or supporting it). It can be helpful to point out to families and couples that a person's entry into treatment or recovery can lead to improvements in family relationships.

Consider the following case example from Robin, a 32-year-old woman who is married to Ron, who has AUD. Robin discusses how her relationship with Ron changed over the course of their 10-year marriage and how these changes seemed to mirror the stages of Ron's AUD.

"Ron and I met at a bar. He was there with friends, and I was there for a bachelorette party. We both had a lot to drink that night, but neither of us minded or thought that was bad. There was no judgment there. We both thought drinking was fun and, frankly, enjoyed getting drunk.

"Throughout our relationship, our activities often centered around alcohol use—going out drinking with friends, going on wine tours and tastings, having happy hour after work. It was almost as if drinking brought us closer together. It gave us a shared activity, and we truly enjoyed it.

"After we were married for about a year, I noticed a real change in Ron's drinking. He was drinking more, I think in part because of his promotion at work that resulted in him having a lot more responsibilities and longer working hours. He no longer seemed to drink because it was fun; he seemed to drink because it was the only way he could deal with stress or escape his work life. As a result, he was drinking more heavily and more often. This caused a rift between us. I didn't want to drink as frequently or as much as he did, and often he would get completely drunk while I remained sober. This meant that I had to be the one to drive us home or to help him into bed or to make sure he got up and went to work the next morning. I started to feel more like his mother than his wife. He constantly complained that I wasn't 'fun' anymore.

"Then things really took a turn for the worse. When he drank, Ron would become argumentative and angry. He even shoved a guy in a bar who he thought was staring at me. If we were in the presence of friends or out in public, I'd get so embarrassed by his drunken tantrums and loud voice. At that point, I didn't want

Continued on next page

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to touch the stuff myself. I started pulling away from Ron, wanting less and less to spend time with him. Because I pulled away, he spent more time with his drinking buddies. I realized that most of our friends and family also were drinkers—and some of them were quite heavy drinkers, like Ron. It was so hard for me to find someone who understood and could sympathize with the negative feelings I was having about alcohol.

"Just as Ron's life was falling apart and he did everything he could to hide it at work, I did everything I could to put on a happy face to the world and to make it appear as though we had 'the perfect' marriage. But really, it was anything but perfect. Ron lost his job because he kept failing to keep up with his duties because of constantly being hungover. I had to take a second job to help make up for the lost income. I also had to hide his firing from my parents. The constant lying to them and the rest of our family made me sick to my stomach.

"Alcohol played a big role in our problems. Our relationship changed as his alcohol use changed and became more dangerous. At first, the drinking was fun, and our relationship was filled with fun times, playfulness, and laughter. But as he started having problems and drinking more heavily, our relationship became strained.

"But on the upside, once Ron decided to pursue recovery, our relationship changed again—this time, for the better. Once he got sober, we reconnected. He opened up to me about his drinking and apologized for all of the ways it hurt me and our marriage. We even started finding things to do together—things that did not involve drinking, for once! Now, we go on hikes or catch a movie sometimes. I am so grateful that Ron finding recovery not only helped him heal but helped our relationship heal as well."

A review of quality of life issues affecting partners of people who misuse substances (Birkeland et al., 2018) found that substance misuse was linked to partner reports of low quality of life—even more so when substance misuse was severe. In many studies included in the review, the partner's quality of life was worse than that of the general population—sometimes as low as that of the partner with the SUD.

The disruption of family life and the stress of being a caregiver not only increase the risk of relapse for people with SUDs and mental disorders, they also contribute to SUDs and mental disorders among family members. On the other hand, family members (particularly between spouses, intimate partners, or parents and their adolescent or transition-age children) who can provide general support to the recovering person; goal direction; and monitoring of substance use, medication adherence, and early warning signs of relapse can have a positive influence on recovery by lessening the risk of relapse and reducing hospitalizations, healthcare costs, and family stress.

Parents Who Have SUDs and Young or Adolescent Children

Substance misuse among parents with young or adolescent children affects family dynamics, often because substance misuse makes it hard for parents to fulfill their childrearing responsibilities. For example, parents with SUDs often have affective dysregulation that can make it hard for their children to develop healthy attachments, form trusting relationships with others, and learn how to regulate their own emotions and behaviors (Lander et al., 2013). Children often develop complex systems of denial to protect themselves against the reality of the parent's SUD. But denial is harder for children to maintain in a single-parent household in which the parent misuses substances. In such circumstances, children are likely to behave in a manner that is not age-appropriate to compensate for the parental deficiency—for example, they may act as surrogate spouses for the parent with the SUD. (For more information, see TIP 51 [SAMHSA, 2009].)

COUNSELOR NOTE: IS IT COMMON FOR CHILDREN TO LIVE WITH PARENTS WHO MISUSE SUBSTANCES?

Approximately 14 percent of children living with two parents have at least one parent with an SUD, and around 8 percent of children live in single-parent households in which the parent has an SUD. The annual average percentage of children and adolescents (from birth to 17 years of age) living in a household with at least one parent with AUD or an illicit drug use disorder is 10.5 percent and 2.9 percent, respectively.

The 2009 to 2014 NSDUHs suggest that nearly 9 million children ages 17 and younger live with at least one parent who has an SUD. This includes:

- Almost 13 percent of children ages 0 to 2.
- About 12 percent of children ages 3 to 5 and ages 6 to 11.
- 12.5 percent of children ages 12 to 17.

Source: Lipari & Van Horn (2017).

SUDs in families may increase the likelihood of child abuse/neglect (Kepple, 2017; Smith, Wilson, & Committee on Substance Use and Prevention, 2016). Per the National Survey of Child and Adolescent Well-Being (Kepple, 2018), past-year SUDs increased occurrence of child physical abuse by 562 percent; emotional abuse by 329 percent; and neglect by 140 percent. Past-year light-to-moderate drinking, heavy drinking, or illicit drug use significantly increased chances of physical and emotional abuse and neglect.

Substance misuse by parents is itself considered an adverse childhood event (others include domestic violence and child abuse/neglect). Parental substance misuse is associated with significantly increased risk in children of later developing an SUD (Finan, Schulz, Gordon, & Ohannessian, 2015; Smith et al., 2016) or an impairment in the ability to cope with stress, which can affect relapse (e.g., among heroin users who were abstinent, as per Gerra et al., 2014).

Most data on enduring effects of parental substance misuse on children suggest its effects to be often detrimental (Calhoun, Conner, Miller, & Messina, 2015). Parental substance misuse can have cognitive, behavioral, psychosocial, and emotional consequences for children (Smith et al., 2016), including:

- Receiving inconsistent parenting.
- Experiencing disruptions in family routines.
- Witnessing parent conflict.
- Lacking a sense of security and stability from parents.
- Being involved with Child Protective Services or other child welfare programs.
- Living in an unsafe home (e.g., open flames or access to lighters; if crystal methamphetamine is being made at home, possible exposure to toxic chemicals).
- Living in a dirty or cluttered home.
- Having household needs go unmet, given lack of money (e.g., not enough food, unpaid utility bills).
- Living with a relative or unrelated caregiver (e.g., foster parent), especially if child safety is at risk.
- Being exposed to strangers coming and going in the house (e.g., to purchase, sell, or use drugs), which increases the risk of harm to the child (e.g., sex trafficking).
- Witnessing criminal behavior.
- Becoming separated from the parent because of incarceration.
- Being exposed to harsh discipline.
- Having an increased risk of missing school.
- Having an increased risk of medical illness and hospitalization.
- Having an increased risk of mental disorders, including co-occurring mental disorders.
- Incurring permanent neurodevelopmental changes affecting later risk of mental/physical disorders.

As with people who were maltreated and believe the abuse was their fault, children of parents with SUDs may feel guilty and responsible for their parents' substance misuse as well as for finding

COUNSELOR NOTE: GRANDPARENTS AND YOUTH SUBSTANCE MISUSE

U.S. families are diverse and often include cohabitating grandparents. According to U.S. Census Bureau data (2019a), in 2018, about 6.0 million children under age 18 lived in a household in which a grandparent was the householder. That same year, 7.1 million grandparents reported living with grandchildren under age 18 (U.S. Census Bureau, 2019b).

What does this type of family structure mean for child/adolescent risk of substance misuse?

- Children living with grandparents because of parental substance use may have a history of abuse or neglect by their parents. This history increases risk of later substance misuse. In such cases, grandparents who offer love, support, and stable resources (e.g., housing, food, clothing, education access) may be protective against SUDs, other stressors, and negative outcomes (Lent & Otto, 2018).
- However, in some research, grandparent-only households are linked to a greater risk of substance misuse. Among almost 80,000 youth in the Florida Department of Juvenile Justice, living in a grandparent-only home was associated with a 28-percent greater risk of 30-day opioid misuse than living in a single-parent home (Shaw, Warren, & Johnson, 2019). This risk was particularly high among youth ages 10 to 15.
- The relationship between grandparents and grandchildren, and youth substance misuse may be linked to culture.
  - For instance, in American Indian/Alaska Native communities, grandparents often play a central role in childrearing and may be a positive source of communication with grandchildren about culture, family, and the dangers of substance misuse (Myhra, Wieling, & Grant, 2015).
  - Among a small sample of Native American grandparents raising grandchildren, 36 percent of households included a child, parent, or grandparent with an SUD (Mignon & Holmes, 2013).
  - In American Indian youth (Martinez, Ayers, Kulis, & Brown, 2015), grandparents' negative attitudes/ beliefs about alcohol/ cigarette use influenced grandchildren's choices not to use alcohol more than parents' attitudes/beliefs.

them treatment (Smith et al., 2016). Children whose parents use illicit drugs must cope with knowing their parents' actions are illegal, and they may be forced to engage in illegal activity on their parents' behalf.

Generally, children with parents who misuse substances are at increased risk for negative consequences, but positive outcomes are possible. In a review of the literature on children of parents with SUDs, Wlodarczyk, Schwarze, Rumpf, Metzner, and Pawils (2017) identify some positive developments, including resiliency and reduced risk of substance misuse. These were especially likely in children who had certain protective factors, such as:

- Secure attachments to parents.
- Flexible use of multiple coping strategies.
- A high degree of parental support.
- A high degree of family cohesion.
- Low levels of parent-related stress.
- High levels of social support for the child.

Nonetheless, substance misuse can lead to inappropriate family subsystems and role taking. For instance, in a family in which a mother uses substances, a young child may be expected to take on the role of mother. When a child assumes adult roles and the adult misusing substances plays the role of a child, the boundaries essential to family functioning are blurred. The developmentally inappropriate role taken on by children robs them of a childhood, unless healthy, supportive adults intervene.

The spouse of a person misusing substances is likely to protect the children and assume parenting duties that are not fulfilled by the parent misusing substances. If both parents misuse alcohol or use illicit drugs, the effect on children worsens. Extended family members may have to provide

care as well as financial and psychological support. Grandparents frequently assume a primary caregiving role. Friends and neighbors also may be involved in caring for the young children. In cultures with a community approach to family care, neighbors may step in to provide whatever care is needed.

Because of its potential effects on recovery and relapse, another factor in family life you should assess for is the need to care for dependent others, such as children. Losing custody of a child, whether formally (i.e., removal from the home by child welfare or other legal authorities) or informally (e.g., sending the child to live with a relative), is associated with an increased risk of maternal substance misuse (Harp & Oser, 2018). Fear of loss of custody can be a barrier to a mother accessing SUD services. This has implications for the safety and well-being of her child and also affects the family unit. Loss of custody among women who misuse substances is more likely when those mothers face socioeconomic stressors (e.g., unstable housing, unemployment, low education level), have a history of childhood trauma, or have co-occurring mental disorders (Canfield, Radcliffe, Marlow, Boreham, & Gilchrist, 2017). Other research has associated caregiving for a child or an ill family member with increased odds of remaining abstinent from alcohol or reducing drinking (Jessup et al., 2014).

Parents Who Have SUDs and Adult Children

Parental SUDs can negatively affect both young children and grown children. Compared with research on young children affected by parental SUDs, comparatively less research has examined the effects in adulthood. And much of the available literature concerns adult children of parents with AUD, so less is known about adult children of parents with OUD or cannabis use disorder, for instance.

Adult children of people with SUDs are at risk for negative biopsychosocial outcomes, and they may:

- Feel stigmatized, especially when parental substance misuse is severe (Haverfield & Theiss, 2016).
- Hesitate to disclose parents' SUDs to others for fear of rejection (Haverfield & Theiss, 2016).
- Have more negative life events (Drapkin, Eddie, Buffington, & McCrady, 2015).
- Have an increased mortality rate. One study looked at data from the National Health Interview Survey Alcohol Supplement-Linked Mortality File (Rogers, Lawrence, & Montez, 2016). Compared with people who did not grow up in a household with problem alcohol use:
  - People who lived with a mother with problem drinking had a 23-percent higher risk of death.
  - People who lived with a father with problem drinking had a 14-percent higher risk of death.
  - People who lived with both parents with problem drinking had a 39-percent higher risk of death.
- Have increased risk of SUDs (Eddie, Epstein, & Cohn, 2015), major depressive disorder (Klostermann et al., 2011; Marmorstein, Iacono, & McGue, 2012; Yoon, Westermeyer, Kuskowski, & Nesheim, 2013), and persistent depressive disorder (Thapa, Selya, & Jonk, 2017).
- Be at increased risk for suicide attempt (Alonzo, Thompson, Stohl, & Hasin, 2014).

A study of personality features and functioning among adult children of parents with AUD identified five personality types that commonly occur in this population (Hinrichs, Defife, & Westen, 2011):

- **Inhibited adult children,** who may feel anxious, depressed, and guilty about their parents' SUDs. They may behave passively and may be at an increased risk for generalized anxiety disorder.
- **High-functioning adults,** who are emotionally healthy, responsible, and empathic.
- **Adults with externalizing features,** such as alcohol misuse and psychopathology.
- **Emotionally dysregulated adults,** who may have a history of childhood abuse or otherwise traumatic childhood environment and are especially at risk for depression or bipolar disorder.

- **Reactive/somaticizing adults** may react to stress via physical symptoms and be anxious, angry, and controlling.

Having grown up in traumatic, unstable environments, adult children of parents who misuse substances may feel angry with, resentful of, or otherwise negatively toward their parent with an SUD (Haverfield & Theiss, 2016). Difficulties in establishing trusting, healthy relationships as a child or adolescent may carry over into adulthood. Similarly, problems with affective regulation that arose during childhood may remain later in life (Haverfield & Theiss, 2016). Other emotional and behavioral features and patterns that may appear in these individuals include anxiety, dysfunctional intimate relationships, low self-esteem and insecurity, antisocial behaviors (e.g., aggression), problems communicating with others, and ignoring one's own needs to care for others (Haverfield & Theiss, 2016).

Unhealthy family patterns that emerge when a parent of a young child has an SUD also may occur in families in which the children are grown. For instance, adult children may engage in "enabling" behaviors to try to maintain homeostasis. Their families often experience chaos and unpredictability. See Exhibit 2.4 for more discussion of family roles and dynamics that can occur among adult children of parents with SUDs (as well as among young children and spouses of people with SUDs).

Blended Families in Which a Family Member Has an SUD

The Census Bureau estimates that, in 2018, about 2.4 million U.S. households included stepchildren under 18 years of age (U.S. Census Bureau, 2019c). Blended families, in which a nonbiological parent lives in the household (typically because one or both spouses have had children from a previous relationship), face their own challenges apart from intact nuclear families. For instance (Papernow, 2018):

- One or both of the people in the couple have a child from a previous relationship, so the couple has not had time to experience being a couple alone, without children.
- The "architecture" of the family is often different from traditional nuclear families, where both parents are living and are residing in the same household.
- Blended families come in many forms and can join together because of separation, divorce, death, or a combination thereof. The partners may not necessarily be married or be a heterosexual couple.

You are likely to observe unique dynamics in blended families, which may worsen or intensify in the presence of substance misuse. These dynamics also may increase the chances of substance misuse by family members. Common blended family dynamics and struggles include (Papernow, 2018):

- Stepparents and stepchildren feeling like "outsiders," especially in relationship to the nonbiological parent/child. This can result in family members feeling anxious, lonely, or rejected.
- Children struggling with the loss of a biological parent, loyalty to a biological parent, or both. Children may worry that bonding closely with a stepparent is "betraying" their biological parent. This worry may be stronger in adolescents and girls versus young children (under age 9) and boys.
- Divisions between stepparents, especially related to parenting tasks like discipline. This can create conflict between couples and confusion among children.
- Attempts by couples to build their own family culture while respecting and honoring biological family members not living in the home. The desire to quickly "blend" the new family together may be strong, but doing so too quickly or forcefully can be stressful for children.
- Struggling with the fact that biological family members living outside the home are also part of the blended family and need to be included.

Substance misuse in blended families can lead to additional strain that can weaken family bonds and cause unhealthy patterns of behavior.

EXHIBIT 2.4. Family Roles When a Parent Has an SUD

When a parent misuses substances, it is common for children to take on certain roles within the family. These roles are determined in part by the child's personality and innate features and are designed to help the family maintain homeostasis, or balance. Although these roles are often discussed in literature describing spouses and young children of parents with SUDs, they apply to adult children as well. **As a counselor, you should be aware of whether family members (spouses and young or adult children especially) are falling into these roles and how that might be affecting any unhealthy family dynamics.**

ROLE	DESCRIPTION
The Enabler	• Protects the individual from experiencing the negative effects of substance misuse • May deal with negative effects of the relative's substance misuse to protect the person • May spend little time on his or her own needs in caring for the person with an SUD
The Family Hero	• Often is the role taken by the older child • Is focused on being responsible for and taking care of the individual with an SUD • May feel overwhelmed and as though the entire family is relying on him or her
The Lost Child	• Has needs/wants that are overlooked by the rest of the family (e.g., achievements unrecognized) • May exist in his or her "own world," separate from the family • May feel lonely and sad and have few close relationships
The Mascot	• Takes on the role of distracting the family from the person's SUD, often through humor, charm, or becoming "the life of the party" • Often wants to avoid conflict, which, as an adult, may result in difficulties dealing with problems and establishing healthy relationships • May not be taken seriously by others in the family (e.g., low expectations)
The Scapegoat	• Draws attention away from the family member with an SUD by getting into trouble or engaging in other maladaptive behavior patterns • May be likely to engage in substance misuse or spend time with friends who do • May be at risk for future legal, educational, and vocational problems

Sources: Vernig (2011); Wegscheider-Cruse (1989).

Furthermore, the challenges of being a blended family may increase the chances of family members misusing substances. Indeed, children in blended families appear to have higher rates of substance use (such as tobacco and cannabis use) than children in traditional intact families (van Eeden-Moorefield & Pasley, 2013).

By helping blended families build strong, supportive relationships with one another, you play a critical role in addressing or preventing families' substance misuse. Consider the following:

- High relationship quality with the residential biological parent predicts a lower likelihood of nonmedical use of prescription drugs by emerging adults (Ward, Dennis, & Limb, 2018). The authors suggest that closeness may help protect against stress and strain common in blended families.
- **Having a close bond with a stepparent living in the home also can protect against substance misuse in children.** Per Amato, King, and Thorsen (2016), adolescents with weak or moderately strong ties to their resident parents (the parents with whom the adolescent lives, regardless of biological relation) were more likely to report tobacco use, cannabis use, and binge drinking than adolescents with strong ties to their resident parents (but no ties to their nonresident parent).

Families With Adolescents Who Have SUDs

Substance misuse among adolescents continues to be a serious condition that affects cognitive and affective growth, school and work relationships, and all family members. In the 2019 NSDUH (Center for Behavioral Health Statistics and Quality, 2020), an estimated 4.9 percent of adolescents ages 12 to 17 engaged in past-month binge use of alcohol (five or more drinks on one occasion for males and four or more for females), and approximately 0.8 percent took part in heavy alcohol use (at least five binge episodes in the previous month). Additionally, in the same survey, about 8.7 percent of adolescents ages 12 to 17 were currently using illicit drugs.

> Divorce significantly increases the risk of adolescents' binge drinking and use of alcohol, tobacco, and cannabis compared with adolescents of married couples (Gustavsen, Nayga, & Wu, 2016).

Like adults, adolescents who misuse substances are at an increased risk for many negative individual and societal consequences (Gutierrez & Sher, 2015; Welsh et al., 2017). These include:

- Co-occurring mental disorders (e.g., anxiety, depressive, conduct, and bipolar disorders).
- Sexual activity at an early age.
- High-risk sexual behavior.
- Car accidents.
- Medical visits/hospitalizations.
- School dropout.
- Continued substance misuse into adulthood.
- Risk of suicide (especially when substance misuse co-occurs with mental disorders).

Family functioning, including parent–child bonds and communication, is connected to adolescent substance misuse in many ways. In a systematic literature review (Hummel, Shelton, Heron, Moore, & van den Bree, 2013), family factors associated with adolescent substance initiation and misuse included:

- Poor family functioning.
- Low levels of mother–child warmth.
- High levels of mother–child hostility.
- Low parental monitoring.
- Harsh maternal parenting practices.

Other family factors that appear to increase risk of adolescent substance misuse are (Ali, Dean, & Hedden 2016; Barfield-Cottledge, 2015; Cordova et al., 2014; Gutierrez & Sher, 2015; Kim-Spoon et al., 2019; Kuntsche & Kuntsche, 2016; Lee et al., 2018):

- Parental substance misuse.
- Parental mental disorder.

- Parental co-occurring mental disorders and SUDs (especially among mothers).
- A lack of rules, or failure to enforce rules, about underage substance use.
- Lower quality parent–child communication.
- Household chaos.
- High family risk-taking behaviors (e.g., criminal behaviors, substance misuse).
- Socioeconomic strain.
- Low parental education level.
- Low levels of parental support.
- Low levels of family attachment.

Parental substance misuse is especially problematic for adolescents, as it models unhealthy behavior and can lead to a dangerous combination of physical and emotional problems for the youth. If a responsible adult offers calm, consistent, rational, and firm responses to adolescent substance misuse, the effect on adolescent learning is positive. However, if a parent who misuses substances attempts to address an adolescent's substance misuse, the hypocrisy will be obvious to the adolescent, and the result is likely to be negative. In some instances, a parent with an SUD may form an alliance with an adolescent who is misusing substances to keep secrets from the parent who does not misuse substances. Sometimes in families with multigenerational patterns of substance misuse, extended family members may feel that the adolescent is just conforming to the family history.

Adolescent substance misuse can affect families in the following ways (Smith & Estefan, 2014):

- Common family reactions include confusion, fear, shame, anger, and guilt.
- Parent conflict may arise or, if already present, worsen in response to feelings of blame and disagreements over how to handle the child's substance misuse. When parents differ in their conflict and communication styles (e.g., avoidant versus direct), this can further increase tension.
- Families often feel isolated, alone, and unsure of what to do or where to turn for help.
- In some families, a family member with an SUD is considered a family "secret" that should be kept well hidden from others. In these cases, the silence is a form of protection, and talking about "the secret" may be seen by other family members as an act of betrayal against the family as a whole.
- Because mothers are typically the primary caregivers, it is not unusual for mothers to feel guilty, blame themselves, and question whether they did something to "cause" their child's SUD.

When an adolescent misuses alcohol or uses illicit drugs, siblings may find their needs and concerns ignored or minimized while their parents react to constant crises involving the adolescent who misuses substances. Neglected siblings and peers may look after themselves in ways that are not age appropriate. They also may feel that the only way to get attention is to act out. **Do not miss opportunities to include siblings in family-based treatment, because siblings often are as influential as parents.** (See also the counselor note "How Does One's Substance Misuse Affect One's Siblings?")

When working with families to address an SUD in one family member, note that other family members may engage in "hidden" substance misuse. Take, for example, adolescents in SUD treatment. Their parents' substance misuse may be just as problematic as the adolescents' misuse, but families may consider the adolescents' to be the problem. In a couple, one person's misuse may be more pronounced than another's, but the other person also may have an SUD. Use of substances may be a significant activity throughout some relationship histories.

COUNSELOR NOTE: HOW DOES ONE'S SUBSTANCE MISUSE AFFECT ONE'S SIBLINGS?

In "The Forgotten Ones: Siblings of Substance Abusers," Smith-Genthôs, Logue, Low, and Hendrick (2017, p. 130) asked siblings of people who misuse substances about problematic experiences and difficulties they endured. Not surprisingly, many of the siblings reported being exposed to substances at earlier ages than people without siblings who misused substances. Siblings' comments about their struggles included the following:

- "My brother began abusing alcohol when he was 18. It completely changed who he was under the influence. He became a mean and angry person and it affected my whole family drastically."
- "I have had a problem being close with my mom as we used to be because E— has taken up all of her attention because of his addiction. The reason this problem is important is because my mom was like my best friend; now I feel like we are not that close anymore. Having E— constantly needing her attention has hindered my relationship with my mom and I have yet to get it back to the way it used to be."
- "Because of his substance abuse and the things he did while he was on drugs, he broke my parents' hearts, almost ruined their marriage, and made my family lose the majority of our savings."
- "Having two brothers that are both drug addicts and alcoholics makes me sad. I never had siblings like other people did. I never had brothers I could count on because they were more interested in getting high. I gave up on trying to be there for them."
- "One of the main problems I have experienced as a result of her abuse is anxiety. I feel anxious and often overwhelmed because I want to help her and know that she needs help, but don't know how."

Where Do We Go From Here?

Families are all unique in their structure, functions, and needs. But families in which SUDs occur often share common features that contribute to substance misuse and can make recovery difficult. As a counselor, once you identify the dynamics and patterns in a family dealing with substance misuse, what should you do next? How can you help them improve dynamics and patterns that are unhealthy and enhance ones that are supportive of recovery? Chapter 3 answers these questions by exploring the latest evidence-based family counseling approaches for couples and families affected by SUDs. It includes not only a summary of recent research but also practical guidance to support you in implementing and assessing the effectiveness of family-based interventions and services.

Chapter 3—Family Counseling Approaches

KEY MESSAGES

- You can help clients and their family members initiate and sustain recovery from substance use disorders (SUDs) by actively involving family members in treatment.
- When family members change their thinking about substance misuse and their behavioral responses to substance misuse, the entire family system changes.
- Family-based SUD interventions focus on encouraging clients with SUDs to initiate and sustain recovery, improving their family communication and relationships to support and sustain their recovery, and helping family members engage in self-care and their own recovery.

All family counseling approaches for SUD treatment reflect the principles of systems theory. Systems theory views the client as an embedded part of multiple systems—family, community, culture, and society. Family counseling approaches specific to SUD treatment require SUD treatment providers to understand and manage complex family dynamics and communication patterns. They must also be familiar with the ways family systems organize themselves around the substance use behaviors of the person with an SUD. Substance misuse is often linked with other difficult life problems—for example, co-occurring mental disorders, criminal justice involvement, health concerns including sexually transmitted diseases, cognitive impairment, and socioeconomic constraints (e.g., lack of a job or home). The addiction treatment field has adapted family systems approaches to address the unique circumstances of families in which substance misuse and SUDs occur.

It is beyond the scope of this TIP to cover all family therapy theories and counseling approaches. This chapter reviews the most relevant and research-based family counseling approaches specifically developed for treating couples and families where the primary issue within the family system is an SUD. It describes the underlying concepts, goals, and techniques for each approach. This chapter covers the following family-based treatment methods (Exhibit 3.1):

EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3

APPROACH	PHILOSOPHY AND KEY PRINCIPLES	CORE METHODS/GOALS	POPULATIONS/ ISSUES
FOR SUD TREATMENT			
Multisystemic Family Therapy (MST)	Intensive family counseling approach that seeks to alter environmental influences associated with an adolescent's serious clinical problems; uses goal-oriented and family-strengthening strategies	Shifts primary agent of change from parents to emerging adults and their social networks	Adolescents with SUDs and criminal justice involvement; emerging adults aging out of child welfare system; mothers with SUDs
Systemic–Motivational Therapy	Combines elements of systemic family therapy and motivational interviewing (MI)	Assessing the relationship between substance misuse and family life, understanding family beliefs about substance misuse, and helping the family work as a team to develop family-based strategies for abstinence	Suitable for all families dealing with SUDs
Psycho-education	Including family members in the psychoeducation process can improve treatment outcomes for clients, reduce returns to use, and enhance the entire family's functioning and well-being	Engaging family members in treatment, providing information, enhancing social support networks, developing problem-solving and communication skills, and providing ongoing support and referrals to other community-based services	Primary treatment choice for people with serious co-occurring SUDs and mental disorders; useful component of relapse prevention in individual, family, and group work

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EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3 *(continued)*

APPROACH	PHILOSOPHY AND KEY PRINCIPLES	CORE METHODS/GOALS	POPULATIONS/ ISSUES
FOR SUD TREATMENT			
Multi-Dimensional Family Therapy (MDFT)	Behavior change occurs via multiple pathways, in different contexts, and through diverse mechanisms; change can be achieved by following 10 principles: • Adolescent substance misuse is multidimensional • Family functioning helps create new, developmentally adaptive lifestyle alternatives • Problem situations provide information and opportunity • Change is multifaceted, multidetermined, and stage oriented • Motivation is malleable, but it is not assumed • Multiple therapeutic alliances are needed as a foundation for change • Individualized interventions foster developmental competencies • Treatment occurs in stages; continuity is stressed • Counselor responsibility is emphasized • Counselor attitude is fundamental to success	Combines individual counseling and multisystem methods to treat adolescent substance misuse and conduct-related behaviors by addressing four treatment domains with specific goals: adolescents, parents, family members and relevant extrafamilial others, community MDFT occurs in three stages: • Stage I: Build the foundation • Stage II: Prompt action/activate change • Stage III: Seal the change and exit	Suitable for diverse populations (available in Spanish, French), including ethnically diverse adolescents; families in low-income inner-city communities; youth in early adolescence at high risk; older adolescents with multiple problems, juvenile justice involvement, and co-occurring SUDs and mental disorders

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EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3 *(continued)*

APPROACH	PHILOSOPHY AND KEY PRINCIPLES	CORE METHODS/GOALS	POPULATIONS/ ISSUES
FOR SUD TREATMENT			
Behavioral Couples Therapy (BCT)	Structured approach that focuses on an intimate partner's ability to reward abstinence and other efforts to change and to promote continuing recovery for the person with an SUD	Lessens relationship distress, improves partners' patterns of interaction, builds more cohesive relationships to reduce risk of returns to use for the partner with an SUD, supports abstinence, improves relationship functioning	Appropriate participants are generally couples in which: • Partners are married or living together. • Neither partner has a significant co-occurring mental disorder. • Only one member has substance misuse. • There is no indication of risk of severe intimate partner violence.
Behavioral Family Therapy (BFT)	Based on social learning and positive and negative reinforcements to change behavior; emphasizes the client's substance use behaviors within the family context; counselors view substance misuse as a learned behavior that peers, parents, and role models may reinforce and help maintain	Contingency management strategies to reward abstinence, reduce reinforcement of substance use, and increase positive behaviors and social interactions incompatible with substance use	Suitable for all families dealing with SUDs
Brief Strategic Family Therapy (BSFT)	Draws on structural and strategic family theory and interventions; assumes that adolescent substance misuse and other risk behaviors are linked to dysfunctional family interactions	Interventions target family interactions that are most likely to affect youth substance misuse and other risk behaviors; strategies include: joining, enactments, working in the present, reframing negativity, reversals, working with boundaries and alliances, addressing power structures that affect conflict, and opening closed systems	Adolescents and other relatives dealing with cultural factors around engagement; families in which parental alcohol use is present

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EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3 *(continued)*

APPROACH	PHILOSOPHY AND KEY PRINCIPLES	CORE METHODS/GOALS	POPULATIONS/ ISSUES
FOR SUD TREATMENT			
Functional Family Therapy	Behaviorally based family counseling approach based on an ecological model of risk and protective factors	Changes the dysfunctional family behavioral and interactional patterns that maintain the adolescent's substance misuse and reinforces positive problem-solving responses to adolescent risk behaviors; has three treatment phases and associated counseling strategies: engagement and motivation, behavior change, and generalization	Suitable for all families dealing with SUDs; widely disseminated in the United States and other countries
Solution-Focused Brief Therapy	Pinpointing the cause of problematic family functioning is unnecessary; counseling focused on solutions to specific problems is enough to help families change	Helps family members find solutions to their problems instead of emphasizing the problem-solving techniques of structural and strategic counseling approaches; counselors emphasize exceptions to the problem (e.g., substance use) when it does not happen and help identify achievable solutions that enhance motivation and hope for behavioral change	Adults with SUDs or mental disorders; families with a member who has a mental disorder; parents with SUDs and trauma-related symptoms in the child welfare system
Community Reinforcement and Family Training (CRAFT)	Structured, family-focused approach that assumes environmental contingencies are important in promoting treatment entry	Teaches family members and CSOs strategies for encouraging the family member who is misusing substances to change his or her substance use behaviors through positive reinforcement and enter SUD treatment	Suitable for all families dealing with SUDs

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EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3 *(continued)*

APPROACH	PHILOSOPHY AND KEY PRINCIPLES	CORE METHODS/GOALS	POPULATIONS/ ISSUES
FOR SUD TREATMENT			
Network Therapy	A team-based approach to SUD treatment that enlists the help of family and friends to work with the counselor in promoting abstinence; includes components of various approaches to SUD treatment (e.g., cognitive–behavioral therapy, community reinforcement) as well as individual plus group sessions	Engaging family and friends to work with the counselor to help the client to achieve and maintain abstinence; the network also serves as a source of emotional support and encouragement	Adults with SUDs
FOR RECOVERY SUPPORT			
Family Treatment Engagement as a Foundation for Ongoing Recovery	Family, social supports, and community resources are keys to successful long-term recovery for people with SUDs; recovery is not a solo endeavor, but rather, a social process—and family members and CSOs often need their own recovery supports, in addition to the person with the SUD needing such supports	Forging emotional bonds; establishing social cohesion and support; maintaining goal direction; gaining structure; monitoring by family, friends, and other recovery supports; observing good role models; expecting negative consequences for risk behaviors; building self-efficacy; developing coping skills; and participating in rewarding, substance-free social activities	Suitable for all families dealing with SUDs
Family Recovery Support Groups	Family members of people recovering from SUDs benefit from gathering together to help one another learn how to cope with living with a person who has a chronic, debilitating illness	Counselors link families to groups and, in counseling sessions, explore family members' reflections on group participation	Suitable for all families dealing with SUDs

EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3 *(continued)*

APPROACH	PHILOSOPHY AND KEY PRINCIPLES	CORE METHODS/GOALS	POPULATIONS/ ISSUES
FOR RECOVERY SUPPORT			
Case Management	Addresses the needs of the client with an SUD and family issues related to the client's substance misuse via comprehensive, integrated management of services and service linkages	Assesses major life concerns (e.g., substance misuse), develops an action plan, actively links clients to community-based resources, coordinates care, and monitors participation in services	Families who are or should be involved intensely with larger systems (e.g., criminal justice, child welfare, mental health)
Family Peer Recovery Support Services	Family peer recovery support specialists have lived experience with having a family member with an SUD, mental disorder, or co-occurring disorder; they offer education, emotional support, and resources to family members of those with an SUD	Actively links family members to family-based resources for SUDs, mental health, criminal justice, and child welfare service systems; introduces and actively links them to community-based recovery supports	Suitable for all families dealing with SUDs
Relapse Prevention	Just as people with SUDs are at risk for a return to substance misuse after initiating recovery, family members can also experience a "relapse" or return to old behaviors and strategies for trying to manage the stress of living with a family member's active substance use	Family members create their own relapse prevention plans: • Identify triggers/cues of returns to problem behaviors. • Identify cognitive distortions that may precede relapse. • Learn or reengage coping skills to manage stress of family members' returns to misuse. • Plan for self-care activities to do and supportive people and crisis numbers to call.	Suitable for all families dealing with SUDs

Note: The Johnson Intervention, which was included in the previous version of this TIP, has been removed. After further scrutinizing the research on this treatment approach, several factors raise serious concern. Although there is some evidence of potential benefit in terms of treatment engagement and SUD outcomes (mainly negative urine tests), this evidence is largely from 1999 to 2004 with no recent data in support. Also, it appears this model may do more harm than good, with several researchers noting that many families find it overly confrontational, judgmental, and blaming, and hence most families do not go through with the session wherein they actually confront the client. More importantly, the Surgeon General's recent report on addiction singles out the Johnson Intervention as being ineffective and notes that confrontational approaches in general may lead to negative outcomes (https://addiction.surgeongeneral.gov/executive-summary/report/prevention-programs-and-policies).

Overview of Family-Based SUD Treatment Methods

Family counseling had its origins in the 1950s, adding a systemic focus to previous understandings of the family's influence on an individual's physical health, behavioral health, and well-being. The models of family counseling that have developed over the years are diverse. They generally focus on either long-term treatment emphasizing intergenerational family dynamics and the family's growth and well-being over time or brief counseling emphasizing current family issues and cognitive–behavioral changes of family members that influence the way the family system operates.

Family-based counseling in SUD treatment reflects the latter family systems model. For example, in SUD treatment, family counseling focuses on how the family influences one member's substance use behaviors and how the family can learn to respond differently to that person's substance misuse.

When family members change their thinking about and responses to substance misuse, the entire family system changes. These systems-level changes lead to positive outcomes for the family member who is misusing substances and improved health and well-being for the entire family.

Family counseling in SUD treatment also differs from more general family systems approaches because it shifts the primary focus from being on the *process* of family interactions to planning the *content* of family sessions. The counselor primarily emphasizes substance use behaviors and their effects on family functioning. For example, in a couples session in which the couple discusses the husband's return to drinking after a period of abstinence, the counselor would note the interactions between the husband and wife but zero in on the return to use. In doing so, the counselor can develop strategies the couple can use as a team to learn from the experience and prevent another return to use.

Although the specific family-based methods this chapter describes reflect different strategies and techniques for addressing substance use behaviors, they share the same **core principles of working with family systems.** These core principles include (Corless, Mirza, & Steinglass, 2009):

- **Recognizing the therapeutic value of working with family members,** not just the individual with SUD, as they deal with SUDs.
- **Incorporating a nonblaming, collaborative approach** instead of an authoritative, confrontational approach in which the counselor is the expert.
- **Having harm reduction goals other than abstinence,** which can bring positive physical and behavioral health benefits to the individual and entire family.
- **Expanding outcome measures of "successful" treatment** to include the health and well-being of the entire family, as well as the individual with the SUD.
- **Acknowledging the value of relationships within the family and extrafamilial social networks** as critical sources of support and positive reinforcement.
- **Appreciating the importance of adapting family counseling methods** to fit family values and the cultural beliefs and practices of the family's larger community.
- **Understanding the complexity of SUDs and the importance of working with families to manage SUDs,** as with any chronic illness that affects family functioning, physical and behavioral health, and well-being.

Some family-based interventions in the following sections are SUD-specific adaptations of general family systems approaches. Others were developed specifically to address SUDs from a family perspective. Each description includes an overview and goals of the approach, supporting research specific to SUD treatment, and relevant techniques and counseling strategies.

> As an SUD treatment provider incorporating family-based interventions into your practice, you should take care to work within the limits of your training, license, and scope of practice. Also take note of the specific licensure and other treatment-related professional requirements specific to your state.

MST

Much research on family-based SUD treatment interventions is on adolescents. A meta-analysis found family counseling for adolescent SUDs to be more effective than several individual and group approaches or treatment as usual (Tanner-Smith, Wilson, & Lipsey, 2013). Advances in **family-based treatment approaches for adolescent SUDs can serve as pilot models for adult treatment.**

For example, **MST was specifically developed as a method for treating adolescents with SUDs who are involved in the criminal justice system.** A recent adaptation of MST for emerging adults who are aging out of the child welfare system follows the principles of MST but shifts the primary agent of change from parents to the emerging adult and the emerging adult's social network, which may or may not include the parents. Pilot testing of this adapted approach shows promising outcomes (Sheidow, McCart, & Davis, 2016). Another pilot study of MST adapted for mothers with SUDs (MST-Building Stronger Families) found significant reductions in substance use among adults and significantly fewer symptoms of anxiety among children paired with their mothers (Schaeffer, Swenson, Tuerk, & Henggeler, 2013).

Systemic–Motivational Therapy

Systemic–motivational therapy is a model of SUD family counseling that combines elements of systemic family therapy and MI. It was developed by Steinglass (2009) to treat alcohol use disorder (AUD) in the family but can be applied to other substance misuse. **Goals include assessing the relationship between substance misuse and family life, understanding family beliefs about substance misuse, and helping the family work as a team** to develop family-based strategies for abstinence.

You can help the family make a hypothesis about the causes of SUDs and create "mini-experiments" to address alcohol misuse in the family. You and the family will collaborate to develop specific criteria to assess the relative success of the mini-experiments. Then adjust treatment strategies according to how successful the mini-experiments were in addressing misuse (Steinglass, 2009).

> Family interventions are good options in SUD treatment. Use them starting with the least intensive (e.g., counseling and Al-Anon or CRAFT) before moving to the most intensive.

Psychoeducation

Psychoeducation was the first family-based SUD treatment approach providers used extensively. It **introduced the value of engaging family systems in treatment and has been an auxiliary part of SUD treatment programming for decades.** Psychoeducation is more than just giving families information about the course of addiction and the recovery process. **Goals include engaging family members in treatment, providing information, enhancing social support networks, developing problem-solving and communication skills, and providing ongoing support and referrals** to other community-based services (McFarlane, Dixon, Lukens, & Lucksted, 2003). Psychoeducation can take place in individual or group sessions with family members, single family group sessions, and multiple family group sessions.

Engaging family members in more intensive SUD treatment is a possible outcome of psychoeducation, but **many family members benefit just from learning about addiction, recovery, and ways to respond to a family member's substance misuse.** Psychoeducation can include providing Internet access and links to information and family recovery resources such as pamphlets, multimedia, and recovery-oriented books. Psychoeducational interventions can also inform families about and provide referral to community-based family supports like Al-Anon and Nar-Anon.

Psychoeducation helps family members:

- **Understand the biopsychosocial effects of SUDs** on the client and family.
- **Learn what to expect from SUD treatment** and the ongoing recovery process of their relative.
- **Grasp the importance of their support** in helping the client initiate and sustain SUD recovery.

- **Build their own support systems** and learn coping strategies and skills from other family members.
- **Increase a sense of support and reduce feelings of isolation and shame.**

Including family members in psychoeducation can improve treatment outcomes for clients, reduce returns to use, and enhance the entire family's functioning and well-being. Family psychoeducation has emerged as a primary treatment choice for people with serious co-occurring SUDs and mental disorders (McFarlane et al., 2003). It has demonstrated effectiveness in reducing returns to use in medium-term outcomes in this population (Zhao, Sampson, Xia, & Jayaram, 2015) and is an empirically supported cognitive–behavioral therapy (CBT) approach to SUD relapse prevention (Sudhir, 2018).

Psychoeducation is a useful component of relapse prevention in individual, family, and group work. **Psychoeducational strategies that can help prevent returns to substance use include:**

- **Offering brief in-session education** on SUDs, returns to use, and strategies for relapse prevention.
- **Assigning homework** in the session for the client and family members to do between sessions.
- **Teaching and practicing problem-solving and communication skills** during sessions.
- **Providing educational handouts** for the client and family members to take home and review.
- **Suggesting reading, audio, or video material** the client and family members can review at home.
- **Creating a family recovery maintenance notebook** with educational handouts, homework exercises, in-session exercises, and journal notes on new insights and awareness, the effectiveness of problem-solving and communication strategies, and topics and questions for further exploration.

MDFT

MDFT is a flexible, family-based counseling approach that combines individual counseling and multisystem methods to treating adolescent substance misuse and conduct-related behaviors (Horigian, Anderson, & Szapocznik, 2016). MDFT targets both intrapersonal processes and interpersonal factors that increase the risk of adolescent substance misuse (Horigian et al., 2016).

Counselors work in four MDFT treatment domains (Liddle et al., 2018). Each domain has **specific goals:**

- **Adolescents:** Enhance their emotional regulation, social, and coping skills; communicate more effectively with adults; discover alternatives to substance use; reduce involvement with peers who use substances, antisocial peers, or both; and improve school performance.
- **Parents:** Increase their behavioral and emotional involvement with the adolescent, reduce parental conflict, work as a team, discover positive and practical ways to influence the adolescent, improve the relationship and communication between parent and adolescent, and increase knowledge about positive parenting practices.
- **Family members and relevant extrafamilial others** (e.g., neighbors, teachers, coaches, spiritual mentors): Decrease family conflict, increase emotional attachments, improve communication, and enhance problem-solving skills.
- **Community:** Enhance family members' competence in advocating for themselves in larger social systems such as school and criminal justice systems.

The multidimensional approach suggests that **behavior change occurs via multiple pathways, in different contexts, and through diverse mechanisms.** MDFT "retracks" the adolescent's development via treatment in the four domains. Knowledge of adolescent development and family dynamics guides overall counseling strategies and interventions.

In MDFT, counselor focus shifts as the adolescent and family progress through three stages. The stages and related counseling strategies are (Horigian et al., 2016; Liddle et al., 2018):

- **Stage I: Build the foundation.**
  - Develop therapeutic alliances with all family members.
  - Explain the MDFT process.
  - Assess risk and protective factors of the individual, parents, family, and extrafamilial systems.
  - Identify personally relevant treatment goals of family members.
  - Use crises and stress to build motivation for change.
- **Stage II: Prompt action/activate change.**
  - Promote positive change in feelings, thoughts, and behaviors of all family members.
  - Use active listening to empathize and raise hope that change is possible and aligned with goals.
  - Encourage the adolescent to share inner thoughts and experiences.
  - Enhance parenting skills through psychoeducation and behavioral coaching.
  - Encourage parents to set limits on, monitor, and support the adolescent.
  - Teach parents to manage difficult family interactions in the session.
  - Teach advocacy skills to improve family interactions with extrafamilial community systems.
  - Engage community-based supports to help family members sustain family system changes.
- **Stage III: Seal the change and exit.**
  - Reinforce behavioral changes of all family members.
  - Explore strategies to maintain change and prevent recurrence of adolescent substance misuse and conduct-related behaviors.
  - End treatment when changes have stabilized.

The MDFT treatment format includes individual and family sessions, sessions with various family members, and extrafamilial sessions. Sessions are held in the clinic; in the home; or with family members at the court, school, or other community location. The format of MDFT has been **modified to suit the clinical needs of different clinical populations.** A full course of MDFT ranges between 16 and 25 sessions over 4 to 6 months, depending on the target population and individual needs of the adolescent and family. Sessions may occur multiple times during the week.

Research supports the efficacy of MDFT, and counselor adherence to the MDFT model improves substance use treatment outcomes (Rowe et al., 2013). MDFT has been applied in geographically distinct settings **with diverse populations** (it is available in Spanish and French as well as English), including ethnically diverse adolescents at risk for substance misuse. Most families in MDFT studies have been from low-income, inner-city communities; adolescents in these studies have ranged from youth in early adolescence who are at high risk to older adolescents with multiple problems, juvenile justice involvement, and co-occurring SUDs and mental disorders.

Several randomized clinical trials have shown clinically significant effects of MDFT on reducing adolescents' drug use and related behavioral problems in controlled and community-based settings (Rowe, 2012). Data also show that family functioning improves during MDFT, and families and adolescents maintain these gains at follow-up (Rowe, 2012). For some adolescents, MDFT may be an **effective alternative to residential treatment** (Liddle et al., 2018).

Behavioral Couples and Family Counseling

Behavioral couples and family counseling promote the recovery of the family member with an SUD by improving the quality of relationships, teaching communication skills, and promoting positive reinforcement within relationships. Two variations of this approach are BCT and BFT.

BCT

BCT is a structured counseling approach for people with SUDs and their intimate partners. It focuses on an intimate partner's ability to reward abstinence and other efforts to change and to promote continuing recovery for the person

with an SUD. BCT aims to lessen relationship distress, improve partners' patterns of interaction, and build more cohesive relationships to reduce risk of returns to use for the partner with an SUD (Klostermann & O'Farrell, 2013). **The goals of BCT are to support abstinence from substances and improve relationship functioning** (O'Farrell & Schein, 2011).

Typically, clients with SUDs and their partners attend 12 to 20 weekly sessions. Although there are exceptions to these criteria (McCrady et al., 2016), appropriate participants for BCT are generally couples in which (Klostermann & O'Farrell, 2013):

- Partners are married or living together for at least 1 year.
- Neither partner has a co-occurring mental disorder that would significantly affect participation.
- Only one member of the couple has a current problem with substance misuse.
- There is no indication of risk of severe intimate partner violence.

The overall counseling approach has two main components (O'Farrell & Clements, 2012):

- Substance-focused interventions to build support for abstinence.
- Relationship-focused interventions to enhance caring behaviors, shared activities, and communication.

> [T]he goal of BCT is to create a 'virtuous cycle' (i.e., enlisting the . . . partner's support in the client's recovery) between substance use recovery and relationship functioning by using interventions designed to address both sets of issues concurrently and reinforcepositive behaviors."
>
> *(Klostermann, Kelley, Mignone, Pusateri, & Wills, 2011, p. 1503)*

RESOURCE ALERT: MDFT ONLINE

The MDFT website (www.mdft.org) provides information about the MDFT method, summaries of its effectiveness in SUD treatment, and training resources, including a no-cost, downloadable clinician manual and training videos.

Counselors begin with substance-focused interventions to promote abstinence, then add relationship-focused interventions after abstinence is stable, with an emphasis on teaching communication skills and increasing positive relationship activities (O'Farrell & Schein, 2011). Relapse prevention interventions occur during the final phase of BCT (Klostermann & O'Farrell, 2013).

Benefits of BCT in Relapse Prevention and Recovery Promotion

There is a mutual relationship between substance use and marital conflict. Unpredictable behavior associated with substance misuse contributes to high levels of relationship dissatisfaction, instability, conflict, and stress—all linked to returns to use in people with SUDs. Substance use and relationship conflict reinforce each other in a damaging cycle of interactions that partners have difficulty breaking.

Couples counseling helps couples take substance misuse out of the equation, harness partner support to positively reinforce the client's efforts to remain abstinent, and change relationship dynamics to promote a family environment that is more conducive to ongoing recovery. Stress decreases, the risk of return to use for the person with the SUD is lowered, and interpersonal violence and other relationship problems are reduced (Klostermann, Kelley, et al., 2011).

BCT Interventions

BCT sessions are very structured. Each session has three counselor tasks: (1) review any substance use, relationship concerns, and homework assignments; (2) introduce new material; and (3) assign home practice (Klostermann, Kelley, et al., 2011). Much of the work in BCT happens during

completion of out-of-session assignments. The counselor initially works with the couple to develop a recovery contract that lays the foundation for the ongoing couples work. Counseling strategies include a recovery contract between the couple and counselor, activities and homework exercises that increase positive feelings between partners, shared activities, constructive communication, and relapse prevention planning. Exhibit 3.2 describes counseling strategies and interventions for different stages of treatment.

BCT is a family-based treatment with strong evidence of efficacy in treating SUDs. BCT is significantly more effective than individual treatment for both men and women with SUDs in reducing substance use, increasing abstinence, and improving relationship functioning and satisfaction (O'Farrell & Clements, 2012). A review of the research on BCT also found **that it is a cost-effective approach to SUD treatment, especially when the cost of fewer returns to use is factored in** (Fletcher, 2013). Although earlier research focused on men with SUDs and their female partners, BCT used with female clients with SUDs is also associated with better substance- and relationship-related outcomes than the use of individual therapy (O'Farrell, Schreiner, Schumm, & Murphy, 2016; O'Farrell, Schumm, Murphy, & Muchowski, 2017). Some evidence shows that BCT is effective in treating lesbian and gay couples (Fletcher, 2013).

It is generally recommended that BCT be used when only one partner has an SUD (Klostermann & O'Farrell, 2013), but BCT appears as effective in couples when both partners have a current SUD and are pursuing recovery as in couples when just one partner is in treatment (Schumm, O'Farrell, & Andreas, 2012). Research on elements of BCT that are related to treatment outcomes found that the partner's involvement in couples treatment, less confrontation, and more supportive language for the client's efforts to change drinking behaviors were associated with greater couple satisfaction and reduced drinking (McCrady et al., 2019). Thus, BCT treatment may be particularly effective when both partners are motivated to change and are willing to support each other.

The following sections discuss adaptations of BCT that have been found to be effective in pilot studies. These adaptations open up possibilities for SUD treatment programs to integrate BCT in ways that might better fit your treatment philosophy and approach than standard BCT.

EXHIBIT 3.2. BCT Interventions

FOCUS	INTERVENTIONS
Substance Use	***Create a daily recovery contract.*** The counselor creates a recovery contract with the couple that it will review at the beginning of each day. Elements of the contract include: • Trust discussion. The client states his or her intention not to drink or use drugs that day, and the partner expresses support for the client's efforts to stay abstinent. • Contract review. The couple reviews contract elements (e.g., medication adherence, urine screens, recovery support group attendance, agreement not to discuss past misuse). • Adherence record. The couple records performance of the daily contract on a calendar. ***Counselor review.*** To start each session, the counselor asks the couple about substance use behaviors, thoughts, urges, or cravings, and then reviews the daily contract adherence record.

Continued on next page

EXHIBIT 3.2. BCT Interventions *(continued)*

FOCUS	INTERVENTIONS
Relationship Concerns	***Increase positive activities.*** • "Catch Your Partner Doing Something Nice." Each partner records one caring behavior performed by the other partner in a daily log. The counselor models how to acknowledge the caring behavior, and the couple practices at home. • Shared rewarding activities. Partners make a list of activities that they can do together, with their children, or as a family. The counselor models planning an activity and instructs the couple not to discuss conflicts during the activity. • "Caring day" assignment. The counselor instructs each partner to give the other a "caring day" during the coming week by performing special acts that show caring for the partner. ***Teach communication skills.*** • Listening skills. The counselor instructs the couple to summarize the content and feelings of the speaker's message and then to check whether the message received was the message intended by the partner. The couple practices during the session and at home. • Expressing feelings directly. The counselor invites the couple to express both positive and negative feelings directly instead of blaming or avoiding and models using "I" statements. • Communication sessions. The counselor assigns private, face-to-face (no texts, emails, phone calls) sessions; partners take turns expressing their views without interruption. • Negotiating requests. The counselor shows how to make positive, specific change requests and negotiate for mutual (not coerced) agreement. The couple practices during the session. • Conflict resolution. The counselor teaches problem-solving and conflict resolution skills.
Relapse Prevention	***Create a continuing recovery plan.*** The counselor and couple create a continuing recovery plan before treatment ends; the plan lists behaviors and activities the couple would like to continue. ***Anticipate high-risk situations.*** The counselor and the couple identify situations where the partner with SUD is at risk for a return to use and early warning signs of a possible return to use. The couple discusses and rehearses coping strategies to use to prevent returns to use. ***Create a written relapse prevention plan.*** The counselor and the couple create an action plan that includes specific steps each partner will take (e.g., go to a recovery support group meeting, call a sponsor, call the BCT counselor) and emergency contact information. The couple discusses and rehearses how to manage a return to substance use if it happens.

Sources: O'Farrell & Schein (2011); Schumm & O'Farrell (2013b.)

CLINICAL SCENARIO: COUPLES COMMUNICATION SKILLS

The following scenario, developed by the consensus panel, shows the BCT strategies of enhancing a couple's communication skills.

Family: Delbert, a 49-year-old man with AUD, had stopped drinking during inpatient treatment, which he entered after an arrest for driving under the influence (DUI). He attended Alcoholics Anonymous (AA), worked every day, and saw his probation officer regularly. Delbert was progressing well in his recovery, but he and his wife, Renee, continued to have daily arguments that upset their children and left both Delbert and Renee thinking that divorce might be their only option. Delbert had even begun to wonder whether his efforts toward abstinence were worthwhile.

Treatment: Delbert and Renee finally sought help from the continuing care program at an SUD treatment center where Delbert was a client. Their counselor, using a BCT approach, met with them to assess their difficulty.

What became obvious was that their prerecovery communication style was still in place, even though Delbert was no longer drinking. Their communication style had developed over the many years of Delbert's drinking—and years of Renee's threatening and criticizing to get his attention. Whenever Renee tried to raise any concern of hers, Delbert reacted first by getting angry with her for "nagging all the time" and then by withdrawing. The counselor, realizing the couple lacked the skills to communicate differently, began to teach new communication skills. Each partner learned to listen and summarize what the partner had said to make sure the point was understood before responding.

To eliminate overuse of blaming, the couple learned to report how their partner's actions affected them. For example, Renee learned to say, "I feel anxious when you don't come home on time," rather than to attack Delbert's character or motivation with judgments like, "You're as irresponsible as ever, so I can't trust you."

In addition, because Delbert and Renee were focused on the negative aspects of their interactions, the counselor suggested they try a technique from BCT known as "Catch Your Partner Doing Something Nice." Each day, Delbert and Renee were asked to notice one pleasing thing that their partner did. As they did so, their views of each other slowly changed. After 15 sessions of couples counseling, their arguing had decreased, and both saw enough positive aspects of their relationship to merit trying to save it.

Parenting Skills Training in BCT

BCT not only positively affects the couple, but also has a secondary effect on children in the family (e.g., enhancing children's psychosocial adjustment) even when the children do not participate in treatment (Fletcher, 2013). Adding specific content to BCT on parenting skills enhances the positive effects of this approach, not only on the couple but on the entire family. A randomized controlled study of BCT plus parenting skills training (PSBCT) found significant differences in child adjustment measures between PSBCT and individual treatment of the parent with an SUD and clinically meaningful effects between PSBCT and standard BCT (Lam, Fals-Stewart, & Kelley, 2008). Adding six sessions of parent training, which reinforced the skills training sessions in BCT (e.g., adding a "Catch Your Child Doing Something Nice" exercise after the couple practiced the "Catch Your Partner Doing Something Nice" activity), did not compromise the effectiveness of traditional BCT for the couple and enhanced parenting skills to a greater degree than BCT alone (Lam, Fals-Stewart, & Kelley, 2009).

BCT for Family Counseling

Many clients live with a family member other than an intimate partner. Behavioral family counseling is an adaptation of BCT (O'Farrell, Murphy, Alter, & Fals-Stewart, 2010) in which a client and a family member (usually a parent of an adult child) attend 12 adapted behavioral family counseling sessions. The sessions **focus on helping the client and family member establish a "daily trust discussion."** The family member reinforces the client's intention to remain abstinent from substances, reduce conflict, improve communication, and increase positive alternative activities for the client.

Behavioral family counseling emphasizes daily support for abstinence as in BCT, but focuses less on sharing rewarding activities and practicing communication skills at home. These adaptations provide a better fit with the developmental needs (e.g., increased autonomy, separation) of an emerging adult living with a parent. Research supports the efficacy of this adaptation over individual treatment on treatment retention, increased abstinence, and reduced substance misuse (O'Farrell & Clements, 2012).

BFT

BFT treatment approaches are based on social learning and operant conditioning (i.e., using positive and negative reinforcements to change behavior) theories. BFT emphasizes clients' substance use behaviors in a family context (Lam, O'Farrell, & Birchler, 2012). Counselors **view substance misuse as a learned behavior that peers, parents, and role models may reinforce** (Lam et al., 2012).

To counteract these influences, **treatment emphasizes contingency management strategies that reward abstinence, reduce reinforcement of alcohol and drug use, and increase positive behaviors and social interactions incompatible with substance use** (Lam et al., 2012). The counselor coaches family members to engage in new behaviors that increase positive interactions and improve communication and problem-solving skills (Lam et al., 2012). BFT is not manual based, but it applies evidence-based practices in SUD treatment (e.g., contingency management, communication skills training, CBT) to family counseling.

To facilitate behavioral change in a family to support abstinence, use **BFT techniques, including:**

- **Contingency contracting:** These agreements stipulate what each member will do in exchange for rewarding behavior from other family members. For example, an adolescent might agree to call home regularly while attending a concert in exchange for her parents' permission to attend it.
- **Skills training:** The counselor may start with general education on communication or conflict resolution skills, practice skills in sessions, and get the family to agree to use the skills at home.
- **Cognitive restructuring:** The counselor helps family members voice unrealistic or self-limiting beliefs that contribute to substance misuse or other related family problems. An example of a self-defeating personal belief might be: "To fit in (or to cope), I have to use drugs." Distorted messages from the family might include: "He uses drugs because he doesn't care about us." or "He's irresponsible; he'll never change." The counselor helps the family replace these self-defeating beliefs with those that facilitate recovery and individual and family strengths.

Family Behavior Loop Mapping

The family behavior loop map is a step-by-step behavioral chain analysis of the family's interactions and the sequence of events that lead to substance use behaviors and episodes when the client with an SUD refrains from substance use (Liepman, Flachier, & Tareen, 2008). **The entire family is involved in the mapping process.** Older children and adolescents contribute verbally to mapping, and younger children offer information about family interactions via their behavior (Liepman et al., 2008). **This visual representation helps family members see their contributions to this systemic, interactive process. It emphasizes that no one person is the cause or victim** of the negative effects of substance use behaviors

CLINICAL SCENARIO: INDIVIDUAL COUNSELING WITH A FAMILY FOCUS

If you work with adult clients in individual counseling, you can still work with them following a family systems perspective. This clinical scenario, developed by the consensus panel, describes how the counselor brings the family of origin into counseling metaphorically by using a family genogram to help the client make the connection between his substance misuse and family-of-origin issues. The counselor also initiates brief couples work to help the client stabilize an intimate relationship as a way to support his recovery.

Darius, a 21-year-old man, was referred to a clinic for court-mandated SUD counseling after his third DUI violation; he had been on probation since age 13 for charges including burglary and domestic violence. He had a long history of substance misuse, had been on his own for 8 years, and had no family involved in his life. Darius had participated in several residential treatment programs, but he could not maintain abstinence on his own.

When Darius entered outpatient treatment, he was furious with "the system" and refused initially to cooperate with the counselor or participate in his treatment plan. The counselor was pleased that he did show up for his weekly sessions. The following interventions seemed to help Darius:

- The counselor suggested that one treatment goal might be for Darius to get off probation. At the time, he had 18 months of probation remaining.
- The counselor helped Darius see how his substance misuse was linked to his criminal justice involvement.
- The counselor made a genogram of three generations of Darius' family of origin. It showed family disintegration linked to poverty, substance misuse, and intergenerational trauma (e.g., Darius' experience of childhood neglect; his parents' and grandparents' experiences of racism and culturally influenced childhood trauma).
- The counselor initiated couples counseling to help Darius stabilize a significant relationship. After conferring with the probation officer, the counselor decided Darius would benefit from a 6-month trial of naltrexone.
- The probation officer required that Darius find regular employment.

During the course of treatment, Darius was able to stop drinking and reevaluate his belief system against the backdrop of his family and the larger judicial system in which he had been so chronically involved. He came to be able to express anger more appropriately and to recognize and process his many losses from family dysfunction. Although many of his family members continued to misuse alcohol, Darius reconnected with an uncle who was in recovery and who had taken a strong interest in Darius' future. Eventually, Darius formed a plan to complete his GED and to begin a course of study at the local community college. The counselor helped Darius examine how his behaviors and the family responsibilities he took on shaped his substance use.

(Liepman et al., 2008). The map identifies alternative behaviors, thoughts, and feelings that lead to "not using" and presents possibilities for discussing ways to break the chain of events.

This strategy is rather involved. Providers who wish to use it in their work with families in SUD treatment should seek training by a family counselor experienced in its application.

Family Check-Up

A lack of parental involvement in the activities of their children predicts later substance use, according to research. Conversely, research consistently shows that parental monitoring and parent–child communication about substance use reduces the risk of early initiation of substance use and lowers rates of adolescent substance use (Hernandez, Rodriguez, & Spirito, 2015).

Family Check-Up (FCU) is a brief assessment and feedback intervention that targets family risk factors linked to substance use, including lack of parental monitoring and low-quality parent–child relationships (Hernandez et al., 2015). FCU integrates principles and techniques of MI and individualized feedback to motivate families to change current family practices **to prevent future substance use in children and address current substance use in adolescents** (Hernandez et al., 2015).

FCU for adolescents consists of two family sessions (Hernandez et al., 2015):

1. **An initial intake interview** to identify family strengths and challenges, engage the family, and videotape a structured assessment protocol of parent–adolescent interactions.
2. **A feedback session** using MI to support parents to maintain positive parenting practices and change parenting practices associated with adolescent substance misuse.

The feedback session has four components (Hernandez et al., 2015):

- **Self-assessment:** Parents are asked what they learned about their family from participating in the family interactional assessment.
- **Support and clarification:** The counselor provides support and clarifies family issues and practices that reduce the risk of adolescent substance use.

CLINICAL SCENARIO: COGNITIVE RESTRUCTURING AND PROBLEM-SOLVING

The following clinical scenario, developed by the consensus panel, demonstrates the BFT strategies of promoting cognitive restructuring and enhancing problem-solving.

Family: Peter, a 17-year-old White adolescent, was referred for SUD treatment. He acknowledged that he drank alcohol and smoked marijuana but minimized his substance use. Peter's parents reported he had come home a week earlier with a strong smell of alcohol on his breath. The next morning, they confronted him about drinking and drug use. He denied currently using marijuana, saying, "It's not a big deal. I just tried marijuana once."

Despite Peter's denial, his parents found three marijuana cigarettes in his bedroom. For at least a year, they had suspected Peter was using drugs. Their concern was based on Peter's falling grades, his increasingly disheveled appearance, and his new tendency to borrow money from relatives and friends, usually without repaying it.

Peter, his older sister Nancy (age 18), and his parents attended the first two family sessions. During the sessions, Peter revealed that he resented his father's overt favoritism toward Nancy, who was an honor student and popular athlete in her school, and his parents' conflicts with each other about unequal treatment of Peter and Nancy. The father was often sarcastic and sometimes hostile toward Peter, criticizing his attitude and problems. Peter viewed himself as a failure and experienced depression, frustration, anger, and low self-esteem. Peter wanted to retaliate against his father by causing problems in the family. In this respect, Peter was succeeding. His substance misuse and falling grades had created a stressful environment at home.

Treatment: The counselor used CBT to address Peter's irrational thoughts (e.g., seeing himself as a total failure) and teach him and other family members communication and problem-solving skills. The counselor also used BFT to strengthen the marital relationship between Peter's parents and to resolve conflicts among family members. The family ended treatment prematurely after eight sessions, but some positive treatment outcomes were realized—an improved relationship between Peter and his father, improved academic performance, and an apparent cessation of drug use based on negative urine test results.

- **Feedback:** The counselor provides personalized feedback on family expectations about substance use, parental supervision and monitoring, and parent–adolescent communication.
- **Parenting plan:** The counselor facilitates a discussion of the adolescent's strengths and the importance of parents praising positive behavior. The counselor works with the parent to develop a brief written plan to improve family communication and monitor the adolescent's behavior.

Research shows lower levels of adolescent substance use and risk for SUD diagnosis when parents complete the FCU intervention (Hernandez et al., 2015). A systematic review and meta-analysis found that FCU as part of a larger school-based approach reduced marijuana use among adolescents (Stormshak et al., 2011; Vermeulen-Smit, Verdurmen, & Engels, 2015).

BSFT

BSFT aims to reduce or eliminate youth drug misuse and change family interactions that support drug misuse through its problem-focused, directive, and practical approach (Gehart, 2018; Horigian et al., 2016). Drawing on structural and strategic family theory and interventions, Szapocznik, Hervis, and Schwartz (2003) first developed BSFT to address drug misuse among Cuban youth in Miami. The central assumption of BSFT is that adolescent substance misuse and other risk behaviors are linked to dysfunctional family interactions (e.g., inappropriate alliances, boundaries that are too rigid or loose, parents' tendency to blame adolescents for family problems) (Horigian et al., 2016). Exhibit 3.3 summarizes the underlying concepts that shape BSFT interventions.

BSFT interventions target family interactions that are most likely to affect youth substance misuse and other risk behaviors. Structural family counseling strategies in BSFT include (Gehart, 2018):

- **Joining:** The counselor establishes a working alliance with each family member and connects with the family system. The counselor identifies and adjusts to family members' ways of relating to one another, conveys understanding and respect, and listens as each family member expresses feelings.
- **Enactments:** The counselor invites the family to recreate dysfunctional interactional patterns that support substance misuse to assess and then restructure them through coaching, modeling alternative ways of interacting, or both. These patterns are typically rigid, so the counselor must take a directive role and have family members develop and practice different interaction patterns.
- **Working in the present:** The counselor emphasizes current interactions and focuses less on the past. The family is more likely to get stuck in negative interactional patterns if the conversation focuses on past events. The discussions emphasize events happening in the present.
- **Reframing negativity:** The counselor reframes negative interpretations of thoughts, feelings, and actions to promote caring and concern in the family. For example, a counselor may reframe a parent's insistence on a 9:00 p.m. curfew as an act of caring, not a way of controlling the adolescent.
- **Reversals:** The counselor may coach one or more family members to do or say the opposite of what they typically do or say to shake up typical interactional patterns. Doing so encourages other family members to change their position in the interaction as well. The counselor then explores the effect on the family's typical interactional pattern.
- **Working with boundaries and alliances:** Roles, boundaries, and power establish the order of a family and determine whether the family system works. Standard structural techniques are used to loosen or strengthen boundaries to better meet the developmental needs of family members. The counselor helps family members mark individual boundaries while respecting the individuality of others. To strengthen boundaries, the counselor supports parents' efforts to reestablish authority as a parental unit and makes the family aware when a family member:

  - Speaks about, rather than to, another person who is present.
  - Speaks for others, instead of letting them speak for themselves.
  - Sends nonverbal cues to influence what another person says or to stop that person from speaking.

- **Detriangulation:** In families dealing with SUDs, a child or less powerful person in a conflict is often involved in interactions that can deflect or diffuse tension between two family members who are in conflict. This involvement is called "triangulation." One strategy is to literally or metaphorically remove the third, less powerful person from a conflict between two other family members so they can resolve the conflict directly.
- **Opening closed systems:** Families dealing with SUDs tend to be "closed" systems that disallow open conflict. Counselors should "open" the system to let each family member express feelings and coach the family on constructive ways to resolve differences instead of avoiding or diffusing conflict.

Research over more than three decades shows the effectiveness of BSFT in engaging and retaining adolescents and family members in treatment, addressing cultural factors related to engagement, reducing adolescent drug use, reducing parental alcohol use, and improving

EXHIBIT 3.3. Concepts Underlying BSFT

Systems	The family is a whole system, and every action a family member takes affects the entire family. Negative behavior affects the family negatively, and positive behavior change in the youth or parents brings positive change to the whole family structure. Repetitive ways in which family members interact create structures that can promote substance misuse or other adolescent risk behaviors. The counselor uses traditional structural family therapy concepts (e.g., subsystems, hierarchy, leadership, alliances) to assess the structure, organization, and communication patterns in the family. The counselor helps the family adapt its structure to support the developmental life stage of each member.
Strategy	Per the counselor's assessment, interventions are strategically selected to change family structure. The focus is on problem-solving and staying close to the family's theory of the presenting problem.
Process Focus	The process of the family's interactions is more important than the content of what is said in helping the counselor assess the situation and formulate interventions. The counselor emphasizes the quality of listening, sharing, and interacting of family members to identify repetitive patterns.
Context	Individuals are affected by all the systems within which they live, including the immediate family, extended family, peers, neighborhoods, culture, schools, criminal justice systems, and the larger society. Family counseling is also a context that can support positive change.

Sources: Gehart (2018); Horigian et al. (2016).

family functioning (Horigian, Feaster, Robbins, et al., 2015; Rowe, 2012). BSFT is effective in long-term reductions in adolescent arrests, incarcerations, and externalizing behaviors like aggression and rule-breaking (Horigian, Feaster, Brincks, et al., 2015).

BSFT is a somewhat complex, manual-based treatment approach. Fidelity in community-based settings tends to be low (Lebensohn-Chialvo, Rohrbaugh, & Hasler, 2019). Implementation **requires extensive training and ongoing supervision.**

Functional Family Therapy

Functional family therapy is another behaviorally based family counseling approach. Its goals are to change the dysfunctional family's behavioral and interactional patterns that maintain the adolescent's substance misuse and reinforce positive problem-solving responses to adolescent risk behaviors (Rowe, 2012). It is based on an ecological model of risk and protective factors.

This approach has three treatment phases and associated counseling strategies: engagement and motivation, behavior change, and generalization (Hartnett, Carr, Hamilton, & O'Reilly, 2017; Horigian et al., 2016):

- **Phase 1: Engagement and motivation**
  - Engage all members of the family to enhance motivation.
  - Frame the counselor–family therapeutic relationship as a cooperative effort between experts.
  - Reduce negativity and blaming interactions through reframing.
- **Phase 2: Behavior change**
  - Assess risk factors and evaluate relational patterns.
  - Help families develop behavioral competencies for parenting, communication, and supervision.
  - Encourage active listening and clear communication.
  - Help parents develop/implement rules and consequences for substance use and risk behaviors.
- **Phase 3: Generalization**
  - Teach families how to generalize the skills they developed in Phase 2 to new situations and contexts other than the initial target behavior.
  - Anticipate and plan for the possibility of future problems.
  - Reframe continuing challenges as normal, not as failures of the family or the counseling process.
  - Actively link family members to community-based supports.

Functional family therapy has been widely disseminated in the United States and other countries. A meta-analysis of comparison and

COUNSELOR NOTE: CULTURAL CONSIDERATIONS

Culture: Become familiar with roles, boundaries, and power structures in families from cultures that differ from your own. These elements influence the techniques and strategies that will be most effective in family counseling.

Age and gender: Cultural attitudes toward age and gender can affect how you assume the directive role that you take in structural and strategic family-based counseling approaches.

Hierarchies: Certain cultures are very attuned to relative positions in the family hierarchy. Sometimes, children may not ask questions of the parent. Other children will remove themselves from the situation until the parent notices they are not there. You should attend to who is who in the family. Who is revered? Who are friends? What is its history? Where is its place of origin? These are clues to understanding a family's hierarchy.

For more information on cultural considerations in family counseling for SUDs, see Chapter 5 of this TIP. See also Treatment Improvement Protocol (TIP) 59, *Improving Cultural Competence* (https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849).

CLINICAL SCENARIO: JOINING AND ESTABLISHING BOUNDARIES

The following clinical scenario, developed by the consensus panel, describes strategies for joining and establishing boundaries in the family.

Family: The client is a 22-year-old White woman who misuses prescribed medication and has depression and schizophrenia. She is the younger of two children whose parents divorced when she was 3. She stayed with her mother, while her brother (age 7 at the time) went with their father. Both parents remarried within a few years. Initially, the families lived near each other, and both parents were actively involved with both children, despite ill feelings between the parents. When the client was 7, her stepfather was transferred to a location 4 hours away, and the client's interactions with her father and stepmother were curtailed. Animosity between the parents escalated. When the client was 8, she chose to live with her father, brother, and stepmother, and the mother agreed. The arrangement almost completely severed ties between the parents. At the time the client entered a psychiatric unit for detoxification, the parents had no communication at all. The initial family contact was with the father and stepmother. As the story unfolded, it became clear that the client had constructed different stories for the two-family subsystem of parents. She had artfully played one against the other. This was possible because the birth parents did not communicate.

Treatment: The first task was to persuade the father to ask the mother to attend a family meeting. He and the stepmother agreed, although it took great courage to make the request. The father believed his daughter's negative stories about her relationship with her mother. The older brother (the intermediary for the past 4 years) and his wife also attended the next session. The relationship between the counselor and the paternal subsystem was well established, so it was critical to also join with the maternal subsystem before starting family system work. The counselor helped the mother and stepfather build equal parental status in the group, which gave the mother free rein to tell the story as she saw it and express her beliefs about what was happening.

A second task was to establish appropriate boundaries in the family system. Specifically, the counselor sought to join the separate parental subsystems into a single system of adult parents and to remove the client's brother and sister-in-law as a part of that subsystem. This exclusion was accomplished by leaving them and the client out of the first part of the meeting. This procedural action realigned the family boundaries, placing the client and her brother in a subsystem different from that of the parents.

This activity proved to be positive and productive. After the first hour of a 3-hour session, the parents were comparing information; reframing incorrect assumptions about each other's beliefs and behaviors; and forming a healthy, reliable, and cooperative support system for their daughter. This outcome would have been impossible had the counselor not joined with the mother and father in a way that allowed them to feel equal as parents. Removing the brother from the parental subsystem required the client to deal directly with the parents, who were committed to communicating with each other and to speaking to their daughter in a single voice.

randomized controlled studies found significant support for the effectiveness of functional family therapy compared with other treatment approaches, including CBT, psychodynamic, individual, and group counseling for adolescents, parenting education groups, and probation and mental health services (Hartnett et al., 2017).

Solution-Focused Brief Therapy

In the 1980s and 1990s, Berg and Miller (1992) and de Shazer (1988) developed a family counseling approach to help family members find solutions to their problems instead of using the problem-solving approach of structural and strategic counseling. The **main assumptions of solution-focused therapy are that pinpointing the cause of problematic family functioning is unnecessary and that counseling focused on solutions to specific problems is enough to help families change.**

In solution-focused brief therapy, families generate treatment goals. The role of the counselor is to emphasize times when the problem (e.g., substance use behavior) does not occur and help the family identify achievable solutions that enhance motivation and optimism for behavioral change (Klostermann & O'Farrell, 2013).

In solution-focused brief therapy, the counselor helps the family develop a detailed, carefully articulated vision of what the world would be like if the presenting problem were solved. The counselor then helps the family take the necessary steps to realize that vision. Because of its narrow focus on a specific target problem, this therapeutic approach works well with many SUD treatment strategies.

Many family counseling strategies and techniques in solution-focused therapy are basic to any family counseling approach—joining with the family, managing the emotional intensity of family sessions, negotiating treatment goals with the family, and attending to family patterns of interaction (McCollum & Trepper, 2013). **The following techniques characterize solution-focused therapy, specifically.**

Developing a vision of the future: The counselor invites family members to envision what life would be like without the problem, such as substance misuse. This process engages family members in using their imagination to open up new possibilities for generating solutions to the problem, enhances the family's hope that things can and will change, and highlights the benefits of change.

Asking the miracle question: This is perhaps the most representative of the solution-focused therapy techniques. It elicits each family member's vision of life without substance misuse. The miracle question traditionally takes this form (De Jong & Berg, 1998):

> I want to ask you a strange question. Suppose that while you're sleeping tonight and the house is quiet, a miracle happens. The miracle solves the problem that brought you here. But you're asleep, so you don't know that the miracle has happened. When you awake tomorrow morning, what will be different to show you that a miracle happened and that the problem that brought you here has been solved?

Envisioning interpersonal change: Counselors help family members set goals that respect the views and needs of other family members. Ask the person with the SUD questions like (McCollum & Trepper, 2013):

- What will other family members notice about you as you move closer to your goal to stop drinking?
- If we video recorded your family at Sunday dinner after you quit drinking, what would it look like?
- How would family members be interacting differently?

Identifying exceptions to the problem: Sometimes the substance use behavior that brings the family to counseling is absent or less severe. It is important to help the family identify these exceptions and build solutions from there. For example, you might ask each family member about a time when the substance use behavior did not happen. You might ask a spouse, "Can you tell me about a time when you and your spouse were arguing, but he did not grab a beer from the refrigerator?"

Identifying problem sequences: The counselor helps the family identify a specific target behavior, like the adolescent leaves the house and smokes marijuana to reduce stress during a parental argument. You then ask a series of questions to identify the sequence of behaviors of all family members that contributed to the problems. These questions might include (McCollum & Trepper, 2013):

- When does Tony typically leave the house to get high with his friends?
- Who is there during this event?
- What happens first?
- What did each of you do first?
- What happened next?
- How did this situation end?

Identifying solution sequences: The next step is to identify the solution sequence of family member behaviors during an exception to the problem sequence. This helps the family shift the focus from the problem to the solution. Families often get stuck in the problem sequence and begin to believe that there is only one outcome to the problem. Questions you can ask to identify the solution sequence during an exception might include (McCollum & Trepper, 2013):

- Can you tell me about a time when the sequence started, but Tony didn't go get high with his friends?
- How was this different?
- What did each of you do differently to short-circuit the problem sequence and help with a solution?
- What did each of you do first?
- What happened next?
- What can each of you do differently to make the solution sequence happen again?

Solution-focused brief therapy replaces the traditional expert-directed approach aimed at correcting pathology with a collaborative, solution-seeking relationship between the counselor and the family. It encourages the family to focus on what life will be like when the problem is solved. The emphasis is on the development of a solution in the future, rather than on understanding the development of the problem in the past or its maintenance in the present.

COUNSELOR NOTE: ASKING THE MIRACLE QUESTION

If the answer to the miracle question is "I don't know," as it often is, encourage the client to take time before answering. Prompt the client, if necessary, with questions like: "Lying in bed, what would you notice that would tell you a miracle had occurred? What would you notice at breakfast? What would you notice at work?" Then:

- Expand on each change noticed. For example, the counselor might ask, "How would that make a difference in your life?" If the client answered that he would not wake up thinking about drinking, ask, "What would you think about? How would that make a difference?"
- Accept the client's answer and do not request alternative responses. Some clients say their miracle would be to win the lottery. The counselor should not dismiss the response by saying, "Think of a different miracle." Instead expand the response by asking questions such as: "What would be different in your life if you won the lottery?" "What would be different if you paid all your bills on time?"
- Make the vision interpersonal. Ask, "If your miracle comes true, what would others notice about you?"
- Help the client see that elements of the miracle are already part of life. Even if those elements are small, ask, "How can you expand the influence of those small parts of the miracle?"

Research supports the effectiveness of solution-focused brief therapy. A review of controlled outcome studies found that it provided significant positive benefits to adults with mental disorders and showed promise for improving family functioning, particularly for families under stress of having a family member with a mental disorder (Gingerich & Peterson, 2013). A study of parents with SUD and trauma-related symptoms who were involved in the child welfare system found that solution-focused brief therapy was effective in reducing substance use and trauma-related symptoms (Kim, Brook, & Akin, 2018).

CRAFT

Another much-studied family-based intervention that focuses on CSOs is CRAFT. **CRAFT is a structured, family-focused, positive reinforcement approach, usually four to six sessions in length, that teaches family members and CSOs strategies for encouraging the family member who is misusing substances to change his or her substance use behaviors and enter SUD treatment.** For example, a positive reinforcer may tell the family member how much the CSO enjoys spending time with him when he is not smoking marijuana or going to a movie with him after a day without drinking. The underlying assumption of CRAFT is that environmental contingencies are important in promoting treatment entry (Bischof, Iwen, Freyer-Adam, & Rumpf, 2016). The counselor's role in CRAFT is to work with family members to change the way they interact with the person who has an SUD and that, in turn, will have an impact on his or her substance use behaviors. **The focus of this intervention is the family.**

Community Reinforcement

CRAFT is a prime example of an SUD treatment approach that uses community reinforcement, which promotes SUD recovery by engaging family members and other natural supports in treatment. The **goal of community reinforcement is to work together to provide positive incentives for people with SUDs to stop using substances; get progressively involved in alternative, meaningful, positive social activities not associated with substance use; and enter or stay in treatment.** Community reinforcement helps family, friends, and social supports positively reinforce behavior change instead of confronting continued substance use or other risk behaviors. People pressed into SUD treatment by confrontation are more likely to return to use than those encouraged to enter through positive reinforcement. CRAFT is effective for clients with SUDs, people with co-occurring SUDs and mental disorders, and people in urban and rural communities.

A Less Structured Approach

CRAFT is highly structured, which works well in some scenarios. It can also be adapted to provide a less structured family-focused approach. This involves providing families and CSOs with psychoeducation on the effects of substance misuse on the family and coaching on communication skills, which include:

- Refraining from blaming and shaming the family member.
- Expressing concern about the family member's substance use behavior and its effects on the family.
- Expressing hope that the family member will get help.
- Offering affirmations and positive reinforcement for any positive change in substance use behaviors.

Family members and CSOs may need encouragement to attend community-based recovery support groups like Al-Anon and Nar-Anon. Research has associated Al-Anon with positive psychosocial and physical outcomes for family members and CSOs (Roozen, de Waart, & van der Kroft, 2010).

Network Therapy

Network Therapy combines aspects of individual, group, and family-based counseling by enlisting the help of a client's family and friends (ideally, three or four people) to work with the counselor to help the client achieve and maintain abstinence (Galanter, 2014; Galanter, 2015). It uses three key elements to help people with substance misuse attain lasting recovery: cognitive–behavioral relapse prevention techniques, the client's existing

supportive social "networks," and community-based resources that support abstinence (e.g., mutual-aid support programs).

Goals and objectives of Network Therapy designed to help clients stabilize and abstain from substance use include (Galanter, 2014; Galanter, 2015):

- Having the client participate in individual sessions with the counselor as well as group sessions with the counselor and the network of family and friends.
- Making abstinence the immediate and primary treatment goal from the outset. This is achieved by using an ecological approach (that is, focusing on engaging family and social resources) or a problem-solving family therapy approach (that is, focusing on the substance misuse problem itself rather than the inner workings and relationships within the family).
- Helping clients achieve long-term stability using a variety of SUD treatment tools. For example, avoiding relationships with others who are actively misusing substances, initiating medication-based treatment, attending mutual-aid support programs, and developing contingency contracts are all potential options.
- Ensuring sessions have a "teamwork" feel and not a confrontational feel to them. Unlike some family-based therapy approaches, the goal is not to work out unhealthy dynamics, personality conflicts, or relationship problems between the client and the network. Network Therapy is also not intended to be an "intervention" in the sense that there is no confrontation of the client or threats to withdraw support if the client does not seek abstinence. The goal is simply for the network to remain supportive and engage in behaviors that help the client become and remain abstinent.
- Emphasizing to the network the importance of solidarity and remaining committed as a group to supporting the client. For instance, counselors should emphasize the importance of all network members regularly attending sessions and engaging in supportive activities designed to help the client abstain from substances.

Research has found Network Therapy is associated with decreased substance use as reflected by opioid-free and cocaine-free urine tests over time (Galanter, Dermatis, Glickman, et al., 2004; Galanter, Dermatis, Keller, & Trujillo, 2002). Some research on Network Therapy suggests these outcomes result from improvements to the therapeutic alliance (Glazer, Galanter, Megwinoff, et al., 2003). Researchers have adapted Network Therapy by combining it with behavioral therapy and naltrexone (Rothenberg, Sullivan, Church, et al., 2002) as well as by combining it with community reinforcement approaches (known as Social Behavior and Network Therapy [Orford, Hodgson, Copello, et al., 2009; Williamson, Smith, Orford, et al., 2007]).

Family Approaches To Support Ongoing Recovery

You can integrate family-based interventions into SUD treatment to greater or lesser degrees along a continuum. **Counseling approaches to involve family in treatment and continuing care may include:**

- Engaging family members and CSOs in helping the individual with an SUD get into treatment.
- Engaging family members and CSOs while those with an SUD are in treatment.
- Linking actively to family/CSO recovery supports and comprehensive case management services.
- Facilitating behavioral contracting between family members and clients around such issues as abstinence and medication adherence.
- Improving communication to help clients and partners address relationship conflicts and stressors.
- Enhancing family members' problem-solving skills and supportive behaviors to avoid returns to use.

Engagement of Families in Treatment

It is well documented that **family, social supports, and community resources are keys to successful long-term recovery for people with SUDs and co-occurring disorders. Recovery is not a solo endeavor; it is a social process.** Recovery

supports can include spouses, intimate partners, CSOs, parents, extended family members, friends, community members, spiritual mentors, teachers, clergy, recovering peers, employers and coworkers, case managers, and primary care and behavioral health service providers.

Moos (2011) noted that **social factors protect people from developing SUDs and may also help them initiate and maintain recovery.** These include forging emotional bonds; establishing social cohesion and support; maintaining goal direction; gaining structure through school, work, or faith-based organizations; monitoring by family, friends, and other recovery supports; observing and imitating positive role models; expecting negative consequences for engaging in risk behaviors; building self-efficacy; developing effective coping skills; and participating in rewarding, substance-free social activities. These processes "are reflected in the active ingredients that underlie how community contexts, especially family members, friends, and self-help groups, promote recovery" (Moos, 2011, p. 45).

Although family members can be a source of support for the person with the SUD, they also need their own recovery support. Family structure, roles, relationships, rules, and rituals are altered by addictive and risk behaviors associated with SUDs. These changes are "deeply imbedded within family members and habitual patterns of family interaction and will not spontaneously remit with recovery initiation" (White & Sanders, 2006, p. 63). Family members can experience stress related to the behaviors of the person with an SUD, increased dependence on them, and difficulties dealing with the complexities and limitations of SUD treatment services. In addition, financial stressors for families can include high healthcare costs; lost jobs; and large losses of family income, savings, and assets. These stressors take a tremendous toll on families.

You can help clients and family members initiate and sustain recovery by actively involving family members in treatment. The following are some guidelines for engaging family members in SUD treatment:

- **Talk with your client in the early stages of treatment** about the importance of having family members, CSOs, and recovery support people involved in his or her treatment.
- **Discuss issues around safety and cultural appropriateness** of inclusion of family members and recovery supports, including boundaries around confidentiality.
- **Have your client sign releases** to have family members and recovery supports involved.
- **Work collaboratively with your client to develop a plan** for identifying supportive family members and recovery supports; inviting them to an initial counseling, family group session, or psychoeducational session; and deciding what issues will be addressed.
- **During initial recovery support sessions, offer culturally appropriate information** regarding the nature of your client's substance use or mental disorders; early warning signs of returns to use; the impact of these chronic conditions on family members and recovery supports; and the importance of family and recovery support involvement in treatment.
- **Facilitate behavioral contracting between family members and the client** around such issues as abstinence and medication adherence.
- **Improve communication skills** to help the client and his or her spouse or intimate partner address conflicts and stressors in their relationship.
- **Ask recovery supports to share** positive, non-substance-using experiences with the client.
- **Get input from family and recovery supports** on the client's early warning signs of returns to use.
- **Discuss the importance of self-care with recovery supports.**
- **Share information on community resources and mutual-help groups** for family members and CSOs.
- **Discuss the purpose and location of resources,** and what to expect at support group meetings.
- **Facilitate contact between your client's recovery supports and a peer recovery support specialist,** if available, to link them actively with and expedite participation in community-based programs.

- **Plan for follow-up meetings** to address ongoing recovery and relapse prevention concerns.
- **When appropriate, refer for assessment or individual counseling** family members or recovery supports who have their own substance use or mental health concerns—or refer them to family therapy to address family issues beyond your scope of practice.
- **Involve supportive family members and other recovery supports in developing and implementing the continuing care plan;** ask for their help to address barriers to continued treatment engagement.
- **Work collaboratively with your client and recovery supports to develop a relapse prevention and emergency plan** (in the event of a lapse) that includes appropriate roles for recovery supports (take care not to burden them with responsibilities that your client should handle).

Family Recovery Support Groups

Strategies for incorporating family recovery support group participation in family counseling include:

- Exploring family member's understanding of and prior participation in mutual-aid (referred to as recovery support or mutual-help) groups.
- Discussing and dispelling misconceptions about family recovery support groups.
- Exploring the challenges and benefits of participation in family recovery support groups.
- Actively linking family members to community-based recovery support groups that are in alignment with the recovery support the client is participating in.
- Offering space in family counseling sessions to explore family members' reflections on recovery support group participation (e.g., likes and dislikes, education on SUDs and their effects on families, coping strategies, differences between recovery support and family counseling approaches).

There are a number of family-focused, community-based mutual-aid groups with which you should be familiar. The mostly widely available U.S. groups are 12-Step groups like Al-Anon. However, other family-focused mutual-aid groups are available in some areas and online, including Families Anonymous and SMART Recovery Family and Friends. You should be familiar with both local and online family recovery support groups and maintain up-to-date contact information so that you can easily link family members to appropriate recovery supports.

12-Step Groups

The oldest mutual-help group for family members is Al-Anon Family Groups. It was started in 1951 (Al-Anon Family Group Headquarters, Inc., 2016) in **recognition of the need among family members of people recovering from AUD to gather together and help one another learn how to cope with the stress of living with a person who has a chronic, debilitating illness.** Al-Anon is based on the 12 Steps of AA (Al-Anon Family Group Headquarters, Inc., n.d.) and helps family members learn self-care and stress coping strategies, such as letting go of responsibility for a relative's substance use and allowing him or her to experience its natural consequences. **Family members learn to focus on their own mental, physical, emotional, social, and spiritual needs while still supporting their relative's recovery.**

Other 12-Step recovery groups for family members are based on the Al-Anon model. Nar-Anon is for family members of people with SUDs other than AUD; Co-Anon, for family members of people with cocaine use disorder. Adult Children of Alcoholics is for adults with a parent who has AUD, and Alateen is for adolescents with a parent who has AUD.

Mutual-Help Groups for Family Members of Individuals With Co-Occurring Disorders

The National Alliance on Mental Illness (NAMI) offers **peer-led psychoeducation courses for families, partners, and friends of people with mental illness to help them understand the illness and increase their coping skills.** These activities, which vary in length and in frequency of meeting, empower participants to become advocates for their family members. These groups can help family members (NAMI, 2019):

COUNSELOR NOTE: SEE FOR YOURSELF! ATTEND OPEN RECOVERY SUPPORT GROUP MEETINGS

If you have never attended a recovery support group meeting for yourself or as a family member of someone with an SUD, you would benefit from attending a few open meetings to understand the concepts and to observe the principles that might be helpful to clients and family members. Anyone can attend a recovery support meeting that is open to the public. In meeting directories of 12-Step groups like Al-Anon, there is designation of "open" in the description to let you know that the public is welcome to attend. A benefit of attending meetings is that you can enhance your ability to prepare family members for attending recovery support groups and give an overview of what to expect at a meeting. For example, attendees can say "pass" if they are not interested in speaking. You can also answer questions about issues that come up in recovery support groups that might seem to conflict with family counseling. For example, in Al-Anon groups, family members may be encouraged to "detach with love" from the family member with the SUD. This idea might be confusing and in conflict with some family counseling approaches that guide family members to get involved in close monitoring of the behavior of the person with the SUD, including drug testing. You can help family members reframe this slogan from detaching emotionally to a suggestion—for example, not to take responsibility for the family member's substance misuse, while continuing to support and love them.

- Improve coping skills.
- Find strength in sharing their experiences.
- Avoid judging another's pain.
- Reject guilt and find greater self-acceptance.
- Embrace humor as healthy.
- Accept that they cannot solve every problem.
- Understand that mental disorders are chronic illnesses.

Case Management

Case management is a psychosocial intervention that assesses major life concerns (e.g., substance misuse), develops an action plan, actively links clients to community-based resources, coordinates care, and monitors participation in services (Rapp, Van Den Noortgate, Broekaert, & Vanderplasschen, 2014). A meta-analysis of studies on clients with SUDs found that case management interventions were associated with better outcomes than standard treatment in active linkage to and retention in ancillary and SUD treatment services (Rapp et al., 2014).

Family case management addresses not only the needs of the client with an SUD, but also family issues related to the client's substance misuse. For example, criminal behavior, unemployment, financial and food insecurity, domestic violence, and child maltreatment are often present in families where one or more family members are misusing substances. Family case management is for families who are or should be involved intensely with larger systems, which include the workplace, schools, healthcare clinics, the criminal justice system, foster care and child welfare agencies, mental health facilities, and faith-based organizations. People with SUDs can receive family case management services in a variety of settings, including specialty SUD treatment programs, mental health service programs, adult drug courts, family courts, and child welfare agencies.

If your clients need intensive case management, your role as an SUD treatment provider is to link them and their families to specialized services. These services can range from less intensive (e.g., general case management support services)

to more intensive (e.g., wraparound services, assertive community treatment programs) (Rapp et al., 2014). If clients and their families need less intensive case management services, act as a community liaison by initiating contact with other agencies that can provide services to them. You can inform clients about resources in the community, collaborate with other service providers, and advocate for clients and their families when needed.

Family Peer Recovery Support Services

Peer recovery support services for people with SUDs have demonstrated efficacy in helping people initiate and sustain recovery (Bassuk, Hanson, Greene, Richard, & Laudet, 2016). Peer recovery support services for family members are also available. A family-focused peer recovery support specialist is a nonclinical provider who is trained and supervised in providing education, support, and resources to family members who have a family member with an SUD. **Family peer recovery support specialists have lived experience of having a family member with an SUD,** mental disorder, or co-occurring disorder.

Family peer recovery support specialists understand the perspective of family members living with the effects of substance use behaviors and the challenges and successes of recovery. They provide education and emotional support to family members and actively link them to family-based resources in the addiction treatment, mental health, criminal justice, and child welfare service systems. Family peer recovery specialists also introduce and actively link family members to community-based recovery support services like Al-Anon.

> "Meeting complex family needs requires coordination across systems. Most families with substance use disorders are involved in multiple service delivery systems (e.g., child welfare, health, criminal justice, education). Coordination and collaboration prevents conflicting objectives and provides optimal support for family members."
>
> *(Werner, Young, Dennis, & Amatetti, 2007, p. 13)*

You should become familiar with family peer recovery support services in your community so that you can actively link family members to a peer recovery support specialist who can help family members follow through on their own recovery goals in concert with the family's treatment plan.

RESOURCE ALERT: FAMILY-FOCUSED RECOVERY SUPPORT GROUP ONLINE RESOURCES

Faces & Voices of Recovery Family- and Friend-Focused Mutual Aid Groups
https://facesandvoicesofrecovery.org/resources/mutual-aid-resources/

SMART Recovery Family & Friends
www.smartrecovery.org/family

Friends of Recovery Family Resources
https://for-ny.org/family-resources

CLINICAL SCENARIO: DEBBIE'S CASE MANAGEMENT

The following scenario, developed by the consensus panel, describes strategies for providing case management.

Debbie, a 24-year-old single mother of a 4-year-old, received general public assistance, which kept her involved with the child welfare system. Her Child Protective Services (CPS) social worker noted that Debbie's financial and parenting difficulties were related to her alcohol misuse. After multiple attempts to achieve stable recovery in outpatient treatment, Debbie was faced with losing custody of her child. Debbie's daughter was placed in foster care. It was at this time that Debbie entered an inpatient program for women with SUDs.

After Debbie's completion of the inpatient program, she transitioned to a continuing care program. There, the counselor initiated family-centered treatment. Debbie asked a female friend from church to attend these sessions as a CSO. The counselor contacted the CPS case manager and collaborated with her to start supervised visits between Debbie and her daughter. Debbie's friend agreed to be present and supervise the visits.

As Debbie made progress in SUD treatment, the frequency and length of the visits increased. After a year in recovery, the counselor and CPS case manager recommended family reunification for Debbie and her daughter. Unfortunately, the court hearing was scheduled for 3 weeks after the start of the kindergarten program Debbie had enrolled her daughter in. The counselor recognized that delaying the daughter's entry into the class might create more adjustment stress for the child, potentially resulting in school problems. Debbie told her counselor she was already worried about the stress of readjustment for herself and her daughter when the daughter returned home. The counselor and case manager collaborated to seek an earlier court date, giving Debbie and her daughter time to adjust to living together again before the daughter entered the school program.

The counselor encouraged CPS and the larger criminal justice system to consider the needs of the family system in adjudicating Debbie's case. This family-focused SUD intervention incorporated some family case management activities, including service linkages, collaboration and coordination with other agencies, and client advocacy.

Relapse Prevention for Families

Just as people with SUDs are at risk for a return to substance misuse after initiating recovery, family members can also experience a "relapse" or return to old behaviors and strategies for trying to manage the stress of living with a relative's active substance use. Family members are often acutely aware of the signs that a relative is using again. Seeing such signs may activate family members' anxiety, anger, and feelings of helplessness; it can trigger old behaviors like blaming, shaming, ineffective communication, neglecting self-care, and becoming overly responsible for family functioning. Family members may reengage in risk behaviors like smoking, drinking, and overeating to manage their stress.

A seemingly small cue that the relative has returned to substance use can set off a family member. These cues can be linked to previous traumatic events. For example, Bev's husband (Harry) is a police officer. When Harry is not drinking, he leaves the car in the driveway. When he is drinking, he puts the car in the garage so that neighbors will not notice that he is drunk. When Bev sees the car in the garage, she remembers the many times that Harry came home drunk. Bev goes

into a panic and starts screaming at him when she sees the car in the garage, even though Harry has not been drinking.

The same principles of relapse prevention counseling apply to both family members and the individual with the SUD. Family members can create their own relapse prevention plans if you help them:

- Identify their own triggers or cues that signal a return to old behaviors.
- Identify cognitive distortions (e.g., all-or-nothing thinking) that may precede a behavioral relapse.
- Learn or reengage effective coping skills to manage the stress of the individual's return to misuse.
- Create a written plan for family members, including specific self-care activities they can do, support people they can contact, and crisis numbers to call if the situation warrants.

See the updated TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (Substance Abuse and Mental Health Services Administration, 2019a; https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003), for more information about relapse prevention plans.

Where Do We Go From Here?

Family counseling approaches in SUD treatment reflect the principles of systems theory. Such approaches view the client as an integral part of the larger family system. In SUD treatment, family counseling focuses on how the family influences one member's substance use behaviors and how the family can learn to respond differently to substance misuse. When family members change their behavioral responses to substance misuse, the entire family system changes, leading to improved health and well-being for everyone. Chapter 4 advances the systems theory approach and provides counseling strategies to apply during intakes, initial sessions, and other stages of treatment.