

Substance Use Disorder Treatment and Family Therapy

Contents

Foreword	vii
Executive Summary	ix
Introduction	ix
Overall Key Messages	ix
Content Overview	x
TIP Development Participants	xvii
Consensus Panel	xvii
KAP Expert Panel and Federal Government Participants	xviii
Field Reviewers	xix
Resource Panel	xxi
Cultural Competency and Diversity Network Participants	xxii
Publication Information	xxiii
Chapter 1—Substance Use Disorder Treatment: Working With Families	1
Scope of This TIP	2
Family Counseling: What Is It, and Why Is It Useful?	5
Family Counseling Objectives	10
Understanding Families	10
Common Characteristics of All Families	11
History of Family-Based Interventions in SUD Treatment	15
Different Pathways in Working With Families	17
Where Do We Go From Here?	21
Chapter 2—Influence of Substance Misuse on Families	23
The Role of Genetics and Family History in the Development of and Recovery From SUDs	24
Common Characteristics of Families With SUDs	26
Family Types: SUDs and Family Dynamics	30
Where Do We Go From Here?	42
Chapter 3—Family Counseling Approaches	43
Overview of Family-Based SUD Treatment Methods	50
Family Approaches To Support Ongoing Recovery	68
Where Do We Go From Here?	74
Chapter 4—Integrated Family Counseling To Address Substance Use Disorders	75
Appropriateness of Integrated Family Counseling for SUDs	76
Whom To Involve in Integrated Family Counseling for SUDs	79
Screening and Assessment in Integrated Family Counseling	80
Goals of Integrated Family Counseling for SUDs	89
Where Do We Go From Here?	94



Chapter 5—Race/Ethnicity, Sexual Orientation, and Military Status	95
Scope of This Chapter.	96
Why Focus on Diverse Family Cultures?	97
Culturally Responsive Family Counseling.	98
SUD Treatment for Specific Family Cultures	105
Where Do We Go From Here?	117
Chapter 6—Administrative and Programmatic Considerations	119
Developing a Family-Centered Organizational Culture as an Administrator	120
Incorporating Family Counseling and Family Programming	121
Supporting Workforce Development	125
Encouraging Collaboration as an Administrator	133
Addressing Other Programmatic Considerations	136
Where Do We Go From Here?	141
Appendix—Bibliography	143

Exhibits

Exhibit 1.1. TIP Organization	3
Exhibit 1.2. Key Terms	4
Exhibit 1.3. Benefits and Challenges of Family Counseling in SUD Treatment.	6
Exhibit 1.4. Treatment Issues According to Family Type	11
Exhibit 1.5. Homeostasis	12
Exhibit 1.6. The Matrix Intensive Outpatient Approach	17
Exhibit 1.7. Understanding Client Reluctance Toward Family Involvement	19
Exhibit 1.8. Multifamily Groups	20
Exhibit 2.1. The Role of the Medical Model When Working With Families	25
Exhibit 2.2. Family Traits That Affect SUD Initiation, Maintenance, and Recovery	26
Exhibit 2.3. Effects of Different Substances on Families	27
Exhibit 2.4. Family Roles When a Parent Has an SUD	39
Exhibit 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3	44
Exhibit 3.2. BCT Interventions	55
Exhibit 3.3. Concepts Underlying BSFT	62
Exhibit 4.1. A Narrative Approach to Family Assessment	82
Exhibit 4.2. Genogram Symbols	87
Exhibit 4.3. O’Neill Genogram	88
Exhibit 5.1. Eight Questions To Consider When Offering SUD Treatment for Families of Diverse Racial/Ethnic Backgrounds	100
Exhibit 5.2. Family-Based SUD Services for Youth of Diverse Races/Ethnicities	105
Exhibit 6.1. Levels of Program Integration	122
Exhibit 6.2. Cross-Training	123
Exhibit 6.3. Sample Policies and Procedures To Support Integrated Family Counseling for SUD Treatment	123
Exhibit 6.4. Developing a Supervision Contract With a Family Counselor	131
Exhibit 6.5. Multicultural Supervision	132
Exhibit 6.6. Systemic–Developmental Supervision	134
Exhibit 6.7. SCORE-15 Index of Family Functioning and Change	140

Executive Summary

Introduction

This Treatment Improvement Protocol (TIP) update provides information and guidance on the latest science-informed, family-based interventions and family counseling approaches for substance use disorders (SUDs). Intended audiences include SUD treatment providers such as drug and alcohol counselors, licensed clinical social workers, licensed marriage and family therapists, psychologists and psychiatrists specializing in addiction, psychiatric and mental health nurses (specialty practice registered nurses), and peer recovery support specialists. The TIP's audience also includes SUD treatment program administrators, supervisors, and clinical/program directors.

SUDs are complex, lifelong conditions that affect not just people in recovery but their families as well. To give a person struggling with alcohol and drug addiction the greatest chance at lasting, successful recovery, families often need to be included in treatment and services. This TIP is designed to help providers and administrators better understand how to do this by describing the unique impacts of SUDs on families; how family functioning and dynamics can both support and interfere with recovery; and how treatments, services, and programs can best be tailored to families' needs.

An expert panel developed the TIP's content based on a review of the most up-to-date literature and on their extensive experience in the field of alcohol and drug addiction treatment and family counseling. Other professionals also generously contributed their time and commitment to this publication.

The TIP is divided into six chapters so readers can easily find material they need most. Below is a summary of the TIP's main messages, followed by a description of each chapter's key content areas.

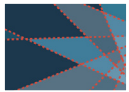
Overall Key Messages

Families affect and are affected by SUDs. In most cases, including family members in a client's treatment or services for substance misuse is beneficial and makes achieving and sustaining long-term recovery more likely.

Family-based SUD interventions are supported by empirical evidence and have been shown to be effective in promoting long-term behavior change, including recovery. A wide variety of family-based treatment models and approaches are available. You can select from these based in part on the family's makeup, needs, readiness for change, treatment setting, and level of care required.

No two families are identical, and as such, the ways in which family members function and interact with one another will vary from family to family. As a clinician, **you should be prepared to adapt SUD treatments and services to each family's unique background, structure, and situation.**

Each family has its own ways of behaving and relating to one another. Those dynamics influence substance misuse and recovery and should be considered when making shared treatment decisions with clients and their family members. **You should be able to identify common family structures and dynamics and understand how they influence substance misuse.** This will help you develop more targeted treatments that directly address a given family's dysfunctions and needs.



Most families are doing their best to adapt to the situation of a family member struggling with substance misuse. In general, families usually are just trying to maintain a steady state (or homeostasis). Sometimes that means engaging in behaviors that actually support the family member's substance misuse. **Avoid blaming, shaming, and using judgmental labels (e.g., referring to family members as "co-dependent" or "enablers") when working with families. Instead, offer them education, empathy, and support.**

There are several ways you can integrate family-based treatments and services into care. Motivational interviewing (MI), family-focused interviews and assessments, genograms, and family-based treatment goals are just a few options.

Families are diverse and may need treatments and services tailored to factors such as their racial/ethnic background, level of acculturation, immigration/nativity status, and history of military service.

It is not enough for clinicians to learn about and offer family-based treatments and services for substance misuse. **Administrators, directors, and clinical supervisors also play a role in delivering family-based SUD treatment and ensuring programs adopt and maintain a family-centered culture.** This means comprehensively addressing a wide range of program development and workforce factors, like hiring and retention, training, clinician and supervisor core competencies, and licensing and credentialing.

Programs that establish and foster close ties to the surrounding community can better help clients and families access resources that meet their needs. Administrators are vital to this process as well.

Content Overview

This TIP is divided into six chapters designed to thoroughly cover all relevant aspects of the ways in which families are touched by SUDs and how providers can offer treatment and services to help meet families' full range of needs.

Chapter 1: Substance Use Disorder Treatment: Working With Families

This chapter lays the groundwork for understanding the treatment concepts and theories of family-based SUD treatment discussed in later parts of this TIP. It is for providers and administrators.

Families are complex entities; no two are the same. To provide effective family-based services for SUDs, one must understand different types of families and the common characteristics families often possess (including their rules, roles, boundaries, and communication styles).

Family counseling can help families facing SUDs in many different ways, including by teaching them to better understand how their interactions and behaviors are contributing to a family member's substance misuse and learning how to adapt their behaviors to support a family member's recovery. Family-based interventions are often centered on helping families learn how to change their behaviors toward and interactions with one another, how they can be a positive influence on recovery, and how to prevent substance misuse in future generations. **There are numerous family-based treatment models, approaches, settings, and formats for SUDs, giving providers (and their client families) a wide range of tools and options from which to choose.**

In Chapter 1, you will learn about:

- The benefits and challenges of offering family counseling for SUDs, including why you should include families in SUD treatment and services and in goal setting for those treatments and services.
- The history of family-based SUD treatment and how the incorporation of families into traditional treatment approaches and settings has changed over time.
- The core objectives of current family-based treatment for SUDs, such as helping the family become a source of strength in their family member's recovery and helping them understand how they influence their family member's substance-related behaviors.

- Common characteristics present in nearly all families (e.g., roles, rules, communication patterns, degree of loyalty, culture) and how those characteristics vary—and subsequently affect a family member’s recovery.
- The various pathways by which family-based SUD treatment and services are delivered, such as parallel, sequential, and integrated approaches. **Different pathways may be more appropriate for certain families depending on their particular structure, way of functioning, and dynamics.**
- The different degrees of family involvement that can occur in SUD treatment across different levels of care and settings (e.g., residential treatment, outpatient care).

Chapter 2: Influence of Substance Misuse on Families

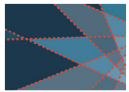
This chapter summarizes the ways in which substance misuse affects family dynamics (the ways in which families behave toward and relate to one another) and family systems and the ways in which those in turn influence substance misuse. This chapter is for providers.

Families operate in their own unique ways. Family dynamics play a large role in both sustaining and reducing/preventing substance misuse. Although all families are different, certain families affect and are affected by SUDs in similar ways. You should be aware of how the dynamics among specific family types—such as families with young or adolescent children, families with adult children, childless couples, and blended families—are affected by and contribute to the risk of substance misuse in the family. This will help you better determine which treatment/services are best suited to the family and their dynamics.

This chapter also presents the latest empirical evidence about common traits of families touched by drug and alcohol addiction. Again, although each family is different, this discussion will help you understand and identify possible targets of intervention, such as poor communication style, high levels of family conflict, ineffective parenting approaches, and lack of family connectedness.

In Chapter 2, you will learn the following:

- **Families with SUDs tend to share certain characteristics, which are often the focus of treatment and services.** These include problems with communication, conflict, parenting skills, family cohesion, and family attitudes about substance use.
- **Most families engage in behaviors to try to maintain homeostasis, or balance.** Family members often try to keep things as “normal” and consistent as possible, and in doing so may behave in ways that actually make substance misuse more likely. Sometimes this is called **enabling**. Rather than criticize or shame families for such behaviors (which are completely normal and, in a way, adaptive), instead work with families to help them learn how to develop healthier behaviors and dynamics.
- There may be gender-specific differences in how family dynamics affect and are affected by SUDs. **These gender differences may need to be taken into consideration when offering treatment and services.** For instance, women are often socialized to be caretakers and to not be confrontational. A mother or daughter may feel that it is not her place to criticize a family member’s substance misuse and may instead engage in caretaking or “enabling” behaviors. These gender beliefs may need to be addressed in treatment if they are contributing to family dysfunction and preventing recovery.
- In couples in which one partner has an SUD, research suggests there is a high risk of interpersonal violence and mistreatment. **Be sure to screen for all forms of abuse.**
- Parents struggling with SUDs may not be able to properly care for their young or adolescent children, possibly leading to negative physical, emotional, economic, and social outcomes for offspring. Neglect and other forms of abuse also may be present. This raises professional and legal issues related to safety, and means loss of child custody may become a factor at some point during treatment/services.



- Children of parents with SUDs may be forced to take on roles inappropriate for their developmental stage. For instance, a teenager may feel that he has to become the “father” of the household because his father has alcohol use disorder and cannot reliably earn a living and help support the family. This can be a significant source of stress for the child.
- It is easy to sympathize with young children living with parents with drug and alcohol addiction, but **do not overlook the effects of SUDs on adult children**. Even when grown, children can be negatively affected by their parents’ substance misuse, including being at risk for substance misuse themselves as well as other unhealthy outcomes (e.g., suicide attempts, higher mortality).
- Just by nature of their structure, blended families often struggle with certain difficult dynamics and situations (like loss of a biological parent or stepparents/stepchildren feeling like “outsiders”). When SUDs are thrown into the mix, this can raise the family stress level even higher. **Be particularly sensitive to the difficulties facing blended families with SUDs**, and understand how helping them strengthen their bonds with one another can be a powerful factor in supporting recovery and preventing substance misuse.
- Adolescent substance misuse can negatively affect parents and siblings and also place the youth at risk for dangerous or unhealthy outcomes (like car accidents, dropping out of school, or continued substance misuse into adulthood). **A family may need help identifying dynamics and functions that are supporting the teen’s SUD and making recovery more difficult.**

Chapter 3: Family Counseling Approaches

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

The numerous family-based SUD treatments that exist differ in the strategies and techniques used to address substance misuse. However,

these treatments share certain features, such as an emphasis on treating the family as a whole rather than focusing only on the individual with an SUD; using a nonblaming, collaborative approach to care; and adapting to the culture and values embraced by each family. Specific family-based treatments that can be used effectively to help families improve their functioning and enhance recovery include psychoeducation, multidimensional family therapy (MDFT), behavioral couples and family therapy, brief strategic family therapy (BSFT), functional family therapy, and solution-focused brief therapy. This chapter discusses each in detail.

In Chapter 3, you will learn the following:

- Family-based treatment guides families in enhancing their thoughts about and reactions to substance misuse. This in turn typically leads to major changes within the family as a whole.
- Regardless of approach, all family-based treatment shares certain core aspects. Aspects include improving the health and well-being of the whole family, not just the person with substance misuse; respecting the value of family and other social relationships as a key part of recovery; and meeting harm-reduction goals other than abstinence, which can still benefit the family and the individual.
- Psychoeducation is a widely used approach to family-based SUD treatment, and many families can improve their functioning and dynamics simply by learning about drug and alcohol addiction and recovery. **Do not underestimate the power of this seemingly simple intervention.**
- MDFT has good empirical support for reducing SUDs, especially among adolescents. It addresses individual behaviors and family processes. It has improved functioning among adolescents, parents, families as a whole, and families’ relationships within their communities.
- Behavioral couples and family counseling approaches help support recovery by teaching clients to improve the quality of their relationships, engage in healthier communication, and build positive relationships with one another.

- BSFT uses a problem-focused, practical approach to reduce or eliminate youth substance misuse and enhance family functioning.
- Functional family therapy also takes a problem-solving approach to engaging, motivating, and creating behavior change among clients. Families are also taught how to apply their newfound skills to future situations.
- Solution-focused brief therapy invites families to build a positive vision of their future and identify interpersonal changes and improvements in target behaviors needed to make that vision a reality.
- Network Therapy uses a combination of individual and group therapy approaches and involves members of the client's network of supportive family members and friends in sessions. The main goal is for members of the supportive network to learn how they can reinforce the client's efforts to achieve and maintain abstinence.
- **In addition to understanding specific treatment approaches, consider offering other family-based skills and services that can support recovery across the continuum of care.** These could include engaging the family in treatment, linking members to community and mutual-aid recovery supports, facilitating behavioral contracts between the person in recovery and his or her family members, and teaching relapse prevention techniques (e.g., family-based problem-solving).
- Case management services can help families address problems within larger systems of care, like healthcare-, education-, legal-, and childcare-related issues. **These commonly occur in individuals and families with SUDs and thus should be a standard part of family-based SUD treatment.**
- Family peer recovery support services offer families the valuable opportunity to learn from others who have walked in their shoes. This can be incredibly powerful and healing, as families touched by drug and alcohol addiction often feel isolated and struggle with stigma, shame, and confusion.

Chapter 4: Integrated Family Counseling To Address Substance Use Disorders

This chapter discusses the advantages and limitations of integrated treatment models and the degree of providers' involvement with families. It offers guidelines on how to deliver family counseling in combination with specific SUD treatment and to match counseling approaches to each family's specific level of recovery. The intended audience is providers.

As a general rule, families should be incorporated into SUD treatment and services to give individuals the best chances at lasting recovery. **Be sure to let the individual in recovery decide who in the family should be invited to participate in treatment.** Barriers to participation may need to be problem solved, such as family members who live far away, have scheduling conflicts, or simply refuse to be a part of treatment. As in individual counseling, screening and assessment are critical components to information gathering, but in this context, **both processes should be family based.** For instance, discuss not only the individual's history of substance misuse but also how substance misuse has occurred historically, throughout the family. Rather than focusing entirely on problems within the family, **be sure to also explore family members' strengths**, including supportive qualities (e.g., warmth, compassion), talents, and goals. This will help you maintain a positive tone throughout treatment and can help keep families motivated and engaged in care.

In Chapter 4, you will learn that:

- **In some instances, certain family members should not be included in SUD treatment and services.** Such situations include when intimate partner violence has occurred, when child abuse or neglect has occurred, when individuals are currently withdrawing from substances, when clients with SUDs are also struggling with psychosis or are suicidal, and when clients have significant cognitive problems (like severe learning or memory problems).



- Mandated family treatment can be difficult because family members are not seeking care willingly. In such cases, **MI can help you build rapport with clients and enhance their willingness and desire to participate in treatment.**
- As with individual treatment, screening and assessments should be conducted to identify current and past problems in need of intervention. **Use a family-based focus that explores the family history of SUDs, mental disorders, abuse, legal problems, work and school issues, and overall health.** Family interviews can help you gather this information and also serve as an opportunity for you to build rapport with families, educate them about treatments and services, and get their “buy-in” to enter and stay engaged in treatment.
- Family-based assessments help you determine the history of the family’s functioning and substance misuse. **Do not forget to also explore the family’s strengths and supports.**
- A **genogram** can help you and your client families visualize their current and history of substance-related problems. It is also a way to depict their strengths and resources.
- Family members may each have different goals for treatment, and that’s okay. **Your job is to help them identify changes they would like to make, teach them how to make those changes, and guide them in becoming sources of support for one another.** You can do this by educating families about SUDs and recovery, facilitating communication between family members, and linking them to community-based resources and support networks.
- It is common to encounter certain challenges in working with families with SUDs, but these can be overcome by helping families build healthier coping skills, educating them to correct myths and misconceptions about SUDs and recovery, offering case management services to help coordinate schedules and service needs, and addressing each family member’s particular stage of change.

Chapter 5: Race/Ethnicity, Sexual Orientation, and Military Status

This chapter discusses family counseling for SUDs among families of diverse racial and ethnic backgrounds; lesbian, gay, bisexual, or transgender (LGBT) families; and military families (including active duty personnel and veterans). Each section discusses the latest empirical evidence for family-based SUD treatment with that population as well as suggestions for how you can tailor family-based interventions to improve outcomes. This chapter is for providers.

Family-based counseling is supported by empirical evidence as a safe and effective option for overcoming drug and alcohol addiction. However, **no SUD treatment is “one size fits all” for all families.** Certain families may benefit more from particular treatment approaches, formats, and settings than from others, based in part on their attitudes, beliefs, and dynamics. These attitudes, beliefs, and dynamics often differ based on a given family’s culture or background. As such, **it is critical that you as a clinician understand how diverse families may affect and are affected by substance misuse and tailor your treatments and services as needed.** For instance, in families of certain racial or ethnic backgrounds, there may be language barriers or cultural beliefs that make treatment seeking less likely. In military families, there may be attitudes that normalize substance misuse and make recovery seem unnecessary. This chapter will guide you through some specific types of families and how their dynamics, functions, attitudes, and values could affect treatment.

In Chapter 5, you will learn that:

- Diversity among families is an important factor to consider when trying to understand how substance misuse fits into a particular family and which treatments and services may be best for them.

- It is not enough to just be culturally sensitive to such issues; rather, **you should provide family-based treatment and services that are culturally responsive.** This includes adopting **cultural humility**, in which you seek to learn from your client families rather than imposing onto them your own beliefs, ideas, and knowledge about a given culture.
- There are several factors to consider when working with diverse family cultures, including their family structure, role of extended family members, spiritual/religious beliefs, immigrant/nativity status, family values, approach to communication, experience with racism or other discrimination, and history of extended separation (especially between parents and children).
- When working with African American families, you should consider tailoring treatments and services by using culturally relevant storytelling techniques, helping parents strengthen the bonds between each other, and addressing racial socialization (that is, the ways in which parents, directly and indirectly, teach their children about race and society).
- Outcomes of family-based SUD treatment for Latino families may be best when you offer treatments and services in their native language, explore the family's history of migration and cultural transition, and understand how substance use is defined and discussed in their country of origin.
- For Asian American families, you can adapt family-based SUD treatment by discussing the concept of collectivism and how that might fit into the family's views, values, and customs; exploring the family's level of acculturation; and learning about help-seeking and coping behaviors common in their country of origin.
- For American Indian/Alaska Native families, a systemwide approach that involves the entire community, tribe, or clan is often needed. Helping families understand their interconnectedness, and how the behavior of one family member can have ripple effects on the rest of the family, is critical and may require clinicians to involve valued others who are outside the family (e.g., community elders, spiritual healers) in the treatment process.
- LGBT families have not been the subject of as much research as families of diverse racial and ethnic backgrounds. Nevertheless, evidence suggests that these families may benefit from strategies such as alliance building among family members, including nontraditional family members, in treatment and having separate counseling sessions with family members nonaccepting of your client.
- If working with military families, you will benefit from learning about military culture, as it is very different from civilian life. This includes understanding power hierarchies, values and expectations for behavior, and attitudes about substance misuse. Military families may benefit from treatment and services that take into account their history of long periods of separation (e.g., deployment) and relocation, both of which are common in military culture and can be significant sources of strain that might make substance misuse by parents, adolescents, or both more likely.

Chapter 6: Administrative and Programmatic Considerations

This chapter outlines family-related aspects of substance misuse that programs should account for when providing alcohol and drug addiction treatment and recovery support services. This chapter is for administrators and clinical supervisors.

The key to developing and implementing family-based SUD treatment and services is to ensure treatment programs adopt a family-centered culture. This means administrators, directors, supervisors, and other leadership should work together to ensure existing treatment and services are family friendly, tailored to families' full range of needs, and based on empirical evidence. A family-centered culture means an organization includes family members and their needs throughout the treatment and service provision process, including as part of engagement and in shaping the physical program environment. **Integrating family counseling and program elements requires education and buy-in among staff as well as the families you serve.** Efforts to enhance workforce development also must be present, such as the hiring and retention of clinicians competent and comfortable in working with families with SUDs.



In Chapter 6, you will learn that:

- **Program policies and procedures should be implemented in ways that make treatment and services accessible and effective for families.**
- Fully integrated family-based programs are those in which all staff understand the ways in which family can influence (and are influenced by) substance misuse. As a reflection of this, administrators, program managers, and clinical supervisors should help create, implement, and document policies that are family friendly. Clinicians should understand how to incorporate these policies into practice.
- **Clinical staff, including supervisors, should possess family-centered counseling competencies.** This includes recruiting and hiring clinicians, supervisors, and administrators who already have the training and knowledge to support a family-based culture in your program setting.
- Core skills for SUD treatment and service providers include having knowledge of family-based interventions and treatment models; diverse cultural factors that affect families with substance misuse; the ways in which family dynamics, relationships, and communication affect recovery; and system concepts, theories, and techniques.
- Administrators and supervisors need to ensure that clinicians engage family members as appropriate throughout all stages of care and that they show families respect, honor their strengths, and recognize their unique needs.
- **One way in which programs demonstrate their commitment to building and maintaining a family-centered culture is by making certain that staff have the necessary training, licensing, and credentialing in family counseling.**
- By providing ongoing opportunities for staff training and education, programs and administrators help ensure clinicians and supervisors possess the latest evidence-based knowledge and practical understanding of working with families with substance misuse.
- **Administrators should develop and maintain ongoing supportive partnerships with community-based organizations to help family members stay integrated within their community and access a wide range of services for all needs** (e.g., those related to child welfare, social services, the legal system, housing, spirituality/faith, education/vocation). Building and maintaining strong relationships with the surrounding community will also help a program stay up to date on available and effective local resources for client families.

Eduardo Lopez
Executive Producer
EVS Communications
Washington, DC

Holly A. Massett, Ph.D.
Academy for Educational Development
Washington, DC

Diane Miller
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse and Alcoholism
Bethesda, Maryland

Harry B. Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Española, New Mexico

Richard K. Ries, M.D.
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, Washington

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
NJ Department of Health and Senior Services
Trenton, New Jersey

Everett Rogers, Ph.D.
Center for Communications Programs
Johns Hopkins University
Baltimore, Maryland

Jean R. Slutsky, P.A., M.S.P.H.
Senior Health Policy Analyst
Agency for Healthcare Research and Quality
Rockville, Maryland

Nedra Klein Weinreich, M.S.
President
Weinreich Communications
Canoga Park, California

Clarissa Wittenberg
Director
Office of Communications and Public Liaison
National Institute of Mental Health
Kensington, Maryland

Consulting Members

Paul Purnell, M.A.
Vice President
Social Solutions, L.L.C.
Potomac, Maryland

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.
Director, Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Alhambra, California

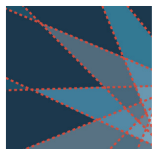
Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, Maryland

Field Reviewers

Field reviewers represent each TIP's intended target audiences. They work in addiction, mental health, primary care, and adjacent fields. Their direct frontline experience related to the TIP's topic allows them to provide valuable input on a TIP's relevance, utility, accuracy, and accessibility. Additional advisors to this TIP include members of a resource panel and an editorial advisory board.

Stephanie Abbott, M.A.
Adjunct Professor
Marymount University
Arlington, Virginia

Raymond P. Adams, M.P.S., CAP
Drug Court Substance Abuse Counselor
Florida 16th Judicial Circuit Court
Marathon, Florida



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.

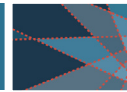


EXHIBIT 1.1. TIP Organization

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.

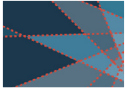


EXHIBIT 1.2. Key Terms

- **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.)

Continued on next page

Continued

- **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

Continued on next page

Continued

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).

Continued on next page



Continued

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).

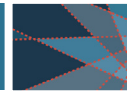
Flexibility in treatment planning. Integrated models enable counselors to tailor treatment plans to reflect individual and family factors. Early in treatment, families may need education about substance misuse and its effects. Families in later stages of treatment may need help as they address such issues 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

Continued on next page



Continued

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 World War 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.

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.

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>).



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.

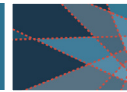


EXHIBIT 1.7. Understanding Client Reluctance Toward Family Involvement

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.

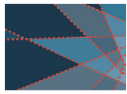
Sequential

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.

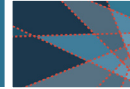
EXHIBIT 1.8. Multifamily Groups

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.

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 America: 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).

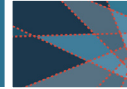


Exhibit 2.3 gives examples of ways in which certain substances commonly affect families.

EXHIBIT 2.3. Effects of Different Substances on Families

SUBSTANCE	EFFECTS ON THE FAMILY
Alcohol	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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



Continued

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, Włodarczyk, 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

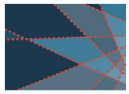
Parental SUDs can negatively affect both young children and grown children. Compared with research on young children affected by parental SUDs, comparatively less research has examined the effects in adulthood. And much of the available literature concerns adult children of parents with AUD, so less 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.

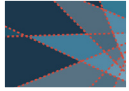
Substance misuse in blended families can lead to additional strain that can weaken family bonds and cause unhealthy patterns of behavior.

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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?

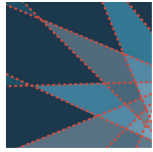
In “The Forgotten Ones: Siblings of Substance Abusers,” Smith-Genthôs, Logue, Low, and Hendrick (2017, p. 130) asked siblings of people who misuse substances about problematic experiences and difficulties they endured. Not surprisingly, many of the siblings reported being exposed to substances at earlier 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):

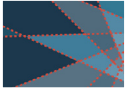


EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3

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

Continued on next page

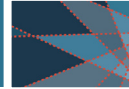


EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3 (continued)

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: <ul style="list-style-type: none"> • 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 <p>MDFT occurs in three stages:</p> <ul style="list-style-type: none"> • 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

Continued on next page

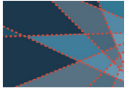


EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3 (continued)

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: <ul style="list-style-type: none"> • 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

Continued on next page

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

Continued on next page

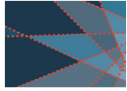


EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3 (continued)

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: <ul style="list-style-type: none"> • 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.

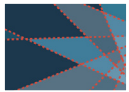
Psychoeducation

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 (McCrary 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 reinforce positive 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 (McCrary 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	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>

Continued on next page

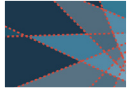


EXHIBIT 3.2. BCT Interventions (*continued*)

FOCUS	INTERVENTIONS
<p>Relationship Concerns</p>	<p><i>Increase positive activities.</i></p> <ul style="list-style-type: none"> • “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. <p><i>Teach communication skills.</i></p> <ul style="list-style-type: none"> • 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.
<p>Relapse Prevention</p>	<p><i>Create a continuing recovery plan.</i> The counselor and couple create a continuing recovery plan before treatment ends; the plan lists behaviors and activities the couple would like to continue.</p> <p><i>Anticipate high-risk situations.</i> 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.</p> <p><i>Create a written relapse prevention plan.</i> 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.</p>

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.

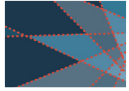
During the course of treatment, Darius was able to stop drinking and reevaluate his belief system against the backdrop of his family and the larger judicial system in which he had been so chronically involved. He came to be able to express anger more appropriately and to recognize and process his many 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.

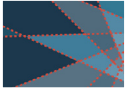
Research shows lower levels of adolescent substance use and risk for SUD diagnosis when parents complete the FCU intervention (Hernandez et al., 2015). A systematic review and meta-analysis found that FCU as part of a larger school-based approach reduced marijuana use among adolescents (Stormshak et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

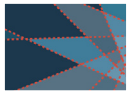
Asking the miracle question: This is perhaps the most representative of the solution-focused therapy techniques. It elicits each family member's vision of life without substance misuse. The miracle question traditionally takes this form (De Jong & Berg, 1998):

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 (McCullum & 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 (McCullum & 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



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)

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.

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

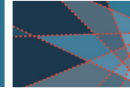
<https://facesandvoicesofrecovery.org/resources/mutual-aid-resources/>

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.

Chapter 4—Integrated Family Counseling To Address Substance Use Disorders

KEY MESSAGES

- Consider the family from the client's point of view—that is, whom the client would describe as a family member or a significant other.
- Many families or family members may be hesitant to participate in treatment at first. However, some family members are willing to attend at least an initial session.
- Integrating family-based counseling techniques into substance use disorder (SUD) treatment is possible along a continuum of care, from assessment through the various stages of family counseling.

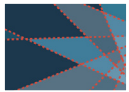
Chapter 4 discusses common issues you may face as an SUD treatment provider using an integrated family counseling approach. It also presents family-centered counseling strategies you can use to overcome these challenges. This chapter will help you determine when to use family-based interventions across the continuum of care, whom to involve in those interventions, and what to consider when providing screening and assessment in a family context. It also summarizes the goals of family involvement in a client's SUD treatment and identifies your role in providing integrated family counseling, along with the stages of family counseling.

Family involvement can positively affect SUD treatment engagement and retention. Whether you provide individual or group treatment, family

member psychoeducation, or counseling for couples or families as part of your organization's treatment program, it is important to keep a family-centered focus. Because most SUD treatment services and reimbursement are geared toward individuals who initially present for treatment, the first step in providing integrated family counseling for SUD treatment is to ask the individual client whom he or she considers to be family. Who are the significant people in the client's life who can support the client's recovery and also benefit from family-based interventions?

The size, norms, and values of a person's social network and the quality of social and family support affect the recovery of the individual with an SUD. Positive social/family support (especially support for recovery) is related to long-term abstinence and recovery, and negative social/family support (e.g., interpersonal conflict, social pressure to use) is related to increased risk for returning to substance misuse (Brown, Tracy, Jun, Park, & Min, 2015; Cavaola, Fulmer, & Stout, 2015; Moos & Moos, 2007; Worley et al., 2014). These associations occur in diverse populations with people who use various substances. Social support, bonding with family members, goal direction, and monitoring by families help clients' recovery efforts (Moos, 2011; Moos & Moos, 2007).

Engaging family members in treatment is the key to decreasing interpersonal conflict among family members and increasing family bonding and other elements of recovery support for the client.



Appropriateness of Integrated Family Counseling for SUDs

It is your responsibility to provide a safe, supportive environment for all participants in family counseling. Generally, you can use integrated family counseling to treat SUDs when there are no health or legal constraints and no current risk of intimate partner violence in the family or couple with whom you are working. However, engaging clients and their families in family-based interventions without first carefully assessing for such constraints, and particularly for violence in the family, can result in less effective treatment and increased risk of physical or other forms of abuse.

Only in rare situations are family-based interventions and counseling inadvisable, inappropriate, or counterproductive. Integrated family counseling is often an excellent way to approach the treatment of SUDs, but you may sometimes need to rule it out because of safety, health, or legal constraints. Several factors, including the presence of violence in the family, can influence your decisions about involving family members in treatment. The following sections discuss these factors.

History of Family Violence

Intimate Partner Violence

Domestic violence is a serious issue among people with SUDs. Before considering couples or family counseling, evaluate the client's history of violence, particularly in family contexts.

Ask about current violence and criminal justice involvement and adjust your counseling approach accordingly. For example, if a restraining or protection from abuse order prohibits spouses from seeing each other, make sure that the spouse who has been violent does not have direct contact in your treatment program with the protected partner. To the extent possible, arrange for separate treatment for the client who is violent, such as in a Batterer's Intervention Program, and individual counseling focused on safety planning for the partner who has been a victim of violence.

Experts in the field of domestic violence generally do not recommend joint counseling

for couples in which intimate partner violence has occurred (National Domestic Violence Hotline, 2014) because:

- It is not effective.
- It is unsound practice if based on the assumption that both people are responsible for the violence.
- It is unsound practice if sessions focus on improving communication instead of the abusive behavior.
- It can be dangerous; the nonabusing partner may be punished after being honest during sessions.

Violence is often a behavioral expression of anger, but anger does not always result in violence. Family members can learn how to express anger appropriately and safely via structured family counseling. **Extreme anger or threats of violence, however, rule out family counseling.**

When screening and treating families in which violence occurs, do not practice outside the scope of your training. **Consult your clinical supervisor to determine the appropriate course of action if you believe that any family member is in danger of domestic violence.**

Child Abuse

Child abuse and neglect are serious considerations in the delivery of SUD treatment. Children in violent households have more physical, mental, and emotional problems than do those in nonviolent homes. Substance misuse and child maltreatment must be addressed at the same time to ensure children's safety—but do not include children in family sessions if there is current risk of child abuse by family members.

Once you have addressed safety issues, you may still be able to engage parents in couples counseling that focuses on parenting issues. Refer all family members for appropriate counseling, including children. **If you suspect a parental figure in the family is abusing a child, consult your supervisor immediately and follow agency policy and mandated reporting laws in your state to report the abuse.**

COUNSELOR NOTE: INTERVENING WITH A DOMINEERING FAMILY MEMBER

A systems approach to SUD treatment assumes that all family members contribute roughly equally to the process and have similar degrees of power and control. A domineering member disrupts this balance. If there is a dominant family member, but no violence, integrated family counseling for SUDs is likely still appropriate.

When a family member dominates the conversation and blocks exploration of sensitive topics, reframe the domineering behavior. For example, acknowledge that this family member has considerable responsibility for protecting the family and that his or her intention is to take care of the family. This will help you work together with the dominant family member (Szapocznik, Hervis, & Schwartz, 2003). You then can begin to question the family about how the behavior is working or not working for the family.

All participants in couples and family counseling should have a voice and a safe place to raise important issues, even if a domineering family member does not want to discuss those issues. Another strategy is to **block interruptions by the domineering family member and create pauses in the conversation to encourage other family members to speak** (Gehart, 2018). Doing so begins to shift the power dynamics in the family system.

Severity of Health Issues

Substance Withdrawal

Given the intensity of physical and emotional instability people in withdrawal experience, it is not practical to attempt integrated family counseling during this process. Until the person stabilizes after withdrawal, provide the family with psychoeducation about SUDs and the effects of substance misuse on the family system. Continue to assess the physical and emotional stability of the client with the SUD over time; protracted withdrawal symptoms can affect the ability to participate in family counseling.

In addition, a parent in withdrawal may experience intense feelings, which can increase the risk of child maltreatment. During this time, provide additional support to the family and make sure that children know how to find safe adults to help and protect them when needed.

Serious Mental Illness

Clients with SUDs often have co-occurring mental disorders. Family counseling is generally appropriate for clients with SUDs and mental disorders—and in fact, some family-based

interventions are particularly effective for specific co-occurring mental disorders, including severe adult anxiety disorders (Gehart, 2018). A review of the evidence found that any kind of brief psychoeducation, including family-based interventions, reduces relapse, increases medication adherence, and improves social functioning of people with serious mental illness (SMI; Zhao, Sampson, Xia, & Jayaram, 2015).



SMI is a diagnosable mental, behavioral, or emotional disorder that an adult has experienced in the past year that causes . . . serious functional impairment that substantially interferes with or limits at least one major life activity. Examples include schizophrenia, bipolar disorder, and major depression.” (www.samhsa.gov/dbhis-collections/smi)



Family counseling may not be helpful for clients who are actively suicidal or psychotic. Families of clients in these states may have other goals they would like to address in family counseling. However, your primary goal in cases of active suicidality or psychosis is to provide treatment to stabilize clients. **Family-based interventions with clients who have co-occurring disorders should focus on education about the mental disorder, the effects of SUDs and co-occurring mental disorders on families, and development of coping skills to manage those effects.** For example, address medication nonadherence as a risk behavior, like substance misuse, and help the family engage in positive reinforcement strategies. (See Chapter 3 for more information about positive reinforcement strategies).

Significant Cognitive Impairment

Cognitive impairment can include short- and long-term memory problems as well as difficulties in learning, concentration, and decision making (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011). It may be linked to extensive substance misuse or head trauma and may cause disruptive behavior.

Family counseling is not as effective with clients who have significant cognitive impairment.

However, you can still consider integrated family counseling and family-based SUD interventions for clients with such impairments. Family counseling can be helpful if the client is not overly disruptive, is also involved in individual counseling or other rehabilitation treatment, and is stabilized on appropriate medications as needed. Your goals in this situation are to help all family members understand how to cope with behavioral disruptions and support the client to remain abstinent from alcohol and drugs.

Mandated Family Counseling

Another factor that can complicate any counseling process is external coercion. One or more family members, particularly those with SUDs, can be mandated to treatment by the criminal justice system, Child Protective Services, or an

employer. In these circumstances, the person who has been mandated is likely to be angry and to try to get you, as well as family members, to focus on how unfair the situation is.

Your first priority should be to form an alliance with the mandated client without “taking sides” with the client regarding the need for treatment.

Motivational interviewing (MI) strategies can help you build a therapeutic alliance and help the client and family members resolve their ambivalence about participating in family counseling (Lloyd-Hazlett, Honderich, & Heyward, 2016).

MI is an evidence-based counseling approach that has demonstrated effectiveness with clients who are mandated to treatment and has been used as an intervention to help enhance client motivation to participate in formal treatment (Miller & Rollnick, 2013). Although MI is used primarily in individual and group counseling, you can adapt MI principles and counseling strategies in family sessions with a focus on changing substance use that negatively affects family functioning (Lloyd-Hazlett et al., 2016). See TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (Substance Abuse and Mental Health Services Administration [SAMHSA], 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 MI.

Address the issue of communicating with the referring organization. Clarify that your primary concern is the family’s well-being, and share with them any requirements you must follow regarding release of information or progress to the referring organization. Inform all family members about agency policies, their rights and responsibilities as clients, and your legal/ethical responsibilities as a counselor. Have family members sign all pertinent releases as part of this informed consent process.

COUNSELOR NOTE: THINK OUTSIDE THE BOX

If you are an SUD treatment provider who is not familiar with family work, it can be helpful for you to think “outside the box” when working with clients in groups. Remember to think about clients not as separate isolated individuals, but as part of a family system that can be a potentially important source of recovery support for the client. Conflict in a family system is not necessarily a threat to the client’s recovery. Family-based interventions can help families resolve conflicts and find ways to positively reinforce the client’s treatment and recovery goals. Encouraging clients to participate in family-based interventions can improve family relations and support the client’s recovery. Encourage clients to invite family members to family-centered treatment activities at your agency. If your agency does not provide family counseling, refer clients, when appropriate, to family counselors who are knowledgeable about the impact of SUDs on the family system. Communicate and collaborate with family counselors in your community and coordinate with them to ensure that the client and family are receiving the best possible care.

Whom To Involve in Integrated Family Counseling for SUDs

From individual to multiple family counseling formats, family-based interventions can include a combination of family members (e.g., couples or siblings), the entire family, an individual family member, or several family groups at one time. In family counseling, the units of treatment are the family and the individual within the context of the family system.

It is up to clients to identify whom they would like to include in family counseling. Make your best efforts to include anyone the client thinks is significant—anyone who provides emotional or financial support, maintains the household, or has a strong, enduring social or emotional bond with the client. The term “family” can mean people living in the client’s household, immediate family members (e.g., a parent, spouse, intimate partner, siblings, children), and extended family members (e.g., grandparents). Some clients want no family involved in treatment or may include or exclude some family members.

Explore the client’s ambivalence and reasons for excluding family members. You can offer your ideas about why you think it might be important or helpful to include specific family members, but honor the client’s autonomy and right to give or not give permission to include family members in treatment.

Once the client gives permission, there are **several factors you should consider in determining whether and how to involve family members in family sessions.** These considerations include:

- **Geographic constraints:** Some clients have no significant family members close enough to attend family sessions in person. Using secure teleconferencing and videoconferencing technology is one strategy for including family members in important conversations with the client. Another strategy might be to hold longer family sessions (e.g., 2 hours) or multiple sessions over consecutive days with family members who are able to travel and attend family counseling.
- **Work and scheduling conflicts:** Work or other scheduling conflicts of family members can be obstacles to their attendance at family sessions. Sometimes these are legitimate concerns and sometimes they are expressions of ambivalence about participating in family counseling. Strategies for overcoming these obstacles include providing multiple session times outside of normal work hours and exploring family members’ reluctance to participate in family counseling via an individual session or phone consultation.
- **Disruptive behavior:** You may need to exclude from family sessions a family member who is continually angry, blaming, or disruptive. Address this issue with the family and the individual separately, explore options for



addressing that family member's needs (e.g., individual counseling, referral to other support services), and then reinvolve the individual in family sessions when his or her needs have been addressed.

- **Family subsystems:** One helpful strategy for managing the family counseling process is to do individual or subsystem work with different constellations of family members, when needed. For example, if parents have overly rigid or loose boundaries, help them reestablish appropriate boundaries and authority in the parental subsystem before including children in family sessions. Do not include children in family sessions if the focus of the work is solely the couple's relationship.
- **Refusal to attend counseling:** Strategies to include relatives who refuse to attend sessions include:
 - Arranging an empty chair in the room to represent that family member and addressing the absent family member metaphorically.
 - Calling the family member who is not present during the family session to enlist his or her help in answering a question that has come up in the session.

Decisions about which and how family members participate in family counseling depend on the client's wishes, family members' willingness, and your judgment of what is most helpful for the entire family.

Screening and Assessment in Integrated Family Counseling

Individual Assessment With a Family Focus

Assessment is one of the most important components of any SUD treatment program. Individual assessment should be family focused. Gathering information about the client's family:

- Yields a more thorough, and perhaps more accurate, family history.
 - Presents an opportunity to confirm and clarify information on the client.
 - Provides insight into the context where substance misuse most often occurs and where it may have started or accelerated.
 - Sets the tone for a continuing focus on the family.
 - Identifies family resources to help plan long-term care.
 - Documents specific information that can determine treatment goals.
- Conduct a comprehensive psychosocial assessment with the individual who is identified as the primary client with the SUD as part of your standard assessment procedures. Assessments in SUD treatment programs focus on the individual's current and history of substance use. Other information gathered during an individual assessment that is helpful to understanding current family functioning includes the client's:
- History of mental disorders.
 - History of family-of-origin SUDs or mental disorders.
 - History of domestic violence.
 - History of trauma.
 - History of physical, emotional, verbal, or sexual abuse.
 - History of criminal justice involvement, including arrests for driving under the influence and periods of incarceration.
 - Occupational and work history, including periods of unemployment or underemployment.
 - Sexual and reproductive health history, including HIV status, safe sex practices, sexual or gender identity, and sexual practices.
- During individual assessment, emphasize the importance of including family members in treatment,** encourage discussion about who might be involved in family treatment, and explore the current family situation from the client's perspective. Including family members at the start of SUD treatment gives you an opportunity to provide education about the biological and psychosocial aspects of SUDs. It also helps uncover client and family strengths and begins the process of preparing family members for changes to the family system that will happen as the client initiates recovery (van Wormer & Davis, 2018).

Here are some questions that can start the conversation:

- Who can support you while you are in treatment?
- Who in the past has been the most helpful to you?
- Who is taking care of your children while you are in treatment?
- Does anyone in your family use substances?
- Is anyone in your family recovering from a substance use disorder?
- How would your family react to your recovery from the substance use disorder?
- What does your family think about your being here? Did you tell them? Why or why not?
- How is substance use an important part of your family life?
- Who in your family or support system would you like to be involved in your treatment?
- Is it okay if we talk about the ways that your family can be involved in treatment?

This conversation sets the stage for the initial family interview. If the client agrees to family involvement in treatment, get signed privacy/confidentiality releases and then schedule an initial family interview.

Family Interview

Before determining whether to use family-based interventions, you should conduct a family interview. The family interview is part of the assessment process. **Although family members may feel ambivalent about getting involved in treatment, they are often willing to attend at least an initial interview.**

The primary focus is to engage the family and begin to develop an alliance with each family member. You can also use the initial interview to determine how the family functions, identify major family problems, and identify the family's perception of how the SUD has affected their family and each member (Schumm & O'Farrell, 2013b). You should also make a preliminary determination of any current or history of family violence and physical or sexual abuse because safety is paramount.

Other tasks for the family interview include:

- Determining the need for further screenings and assessments of SUDs and mental disorders for individual family members.
- Determining whether an immediate intervention or referral is needed or whether the family can return for a more thorough assessment later.
- Telling the family what will be involved in a more extensive assessment.
- Evaluating the appropriateness of including children in family sessions and when it would be most effective to include them.
- Providing information about the treatment process including schedules, treatment activities, staff involvement, and program expectations.
- Suggesting an out-of-session assignment for each relative present (if he or she agrees to further counseling) as a way for them to take a small step toward change (van Wormer & Davis, 2018).
- Scheduling an initial family counseling session for a more comprehensive family-based assessment.

Family-Based Assessment

A family-based assessment differs from an individual assessment. The focus of a family assessment is not the history of substance misuse of the identified client, but an evaluation of current family functioning, the history of substance misuse over time and across generations, and the role of substance misuse in the development of family problems (Schumm & O'Farrell, 2013b). You can also explore the history of the individual's SUD over time, but always link this history to the development of family system dynamics and functioning over time (Schumm & O'Farrell, 2013b). Family counseling assessments focus on family interactions and family strengths.

The primary assessment task is to observe family interactions during sessions to determine alliances, conflicts, interpersonal boundaries, and communication and meaning. In a family systems approach to assessment, the counselor identifies the interactional behavior sequences that contribute to the problem (i.e., substance misuse),



including the actions and reactions of everyone in the system and the associated meanings (Gehart, 2018; see the “Family Behavior Loop Mapping” section of Chapter 3).

Ask each family member to describe his or her theory about the client’s substance use behavior.

Their input will help you understand how the family system is organized around and reacts to the behavior (Gehart, 2018). The next task is to explore the family’s strengths and positive ways they have managed the disruptions to family life caused by substance misuse. Exhibit 4.1 offers an alternative approach.

EXHIBIT 4.1. A Narrative Approach to Family Assessment

One family assessment strategy that might be particularly useful in SUD treatment comes from narrative therapy, a nonpathologizing approach to family and community practice originally developed by Michael White and David Epston (1990). It involves a two-step process, which includes (1) mapping the influence of the identified problem on family life and (2) mapping the influence of family members on the problem (Gehart, 2018). When you engage in this process, use externalizing language (e.g., say “the drinking” instead of “Dad’s drinking”). This puts the **problem** instead of the **person** with the problem in the center of the conversation, where family members can work as a team to lessen the problem’s effects on family functioning.

Some issues you can ask family members about during this mapping process (Gehart, 2018) include:

- **Mapping the effects of substance misuse on the family by asking questions like:**

- How does substance misuse affect your mood, eating, sleeping, feelings of panic, worry or obsessive thinking, thoughts about hurting yourself or others, or hurtful behavior toward yourself or others?
- How does substance misuse affect your relationships at home, work, or school, or with your extended family or social network?
- How does substance misuse affect your social and recreational activities?
- How does substance misuse affect your daily functioning and ability to meet your responsibilities at home, work, or school?
- How does substance misuse affect your spiritual life, beliefs, or sense of purpose in life?

- **Mapping the effects of family members on substance misuse by asking questions like:**

- What are some ways that you have used to lessen the negative impact of substance misuse on yourself or other family members?
- Are there times when you can keep substance misuse from negatively affecting your thoughts, feelings, eating, sleeping, or other daily activities?
- What are some ways that you were able to do this?
- Are there times when you can protect your relationships from the negative effects of substance misuse?
- What are some ways that you were able to do this?
- Are there ways that you can maintain a sense of meaning and purpose, despite the negative influence of substance misuse?

Use a white board, easel with newsprint, or paper to list the influence of the problem and the influence of family members on the problem. Doing so creates a map of how the family system organizes around substance misuse, and also how the family’s strengths and expertise defy, stand up to, or take power away from substance misuse.

Strengths Assessment

Conduct a strengths assessment with the client and all family members involved in treatment. The goal of this assessment is to identify their current coping skills and abilities; family, social, and recovery supports; motivation and commitments to change; self-efficacy; and other sources of recovery capital. This will give you a baseline of family coping skills and client-centered knowledge, values, and resources to build on in helping the family develop a treatment and recovery plan. Recognizing different strengths available to clients is an important element of conducting an effective strengths assessment.

The term “recovery capital” refers to the internal and external resources that a person draws on to begin and sustain recovery. Internal resources include client values, knowledge, skills, self-efficacy, and hope. External resources include employment; safe housing; financial resources; access to health care; as well as social, family, spiritual, cultural, and community supports (White & Cloud, 2008).

A strengths-based assessment is more than simply asking clients to name their strengths at initial intake (White & Cloud, 2008). Some clients will have difficulty identifying their strengths or say that they don't have any. As part of the family history, conduct a careful and thorough exploration of family members' internal and external resources, how they have overcome adversity in the past, and how they have previously managed problems like SUDs, physical illness, or mental illness.

Uncovering exceptions or unique outcomes when SUDs and mental disorders have overwhelmed family functioning is key to helping the family expand awareness of their values, strengths, competencies, and abilities. View strengths broadly to include family members' values, interpersonal skills, talents, and knowledge gained from previous efforts to overcome SUDs or adversity (including trauma). Also consider the family members':

- Spirituality and faith.
- Personal hopes, dreams, and goals.
- Family, friend, and community connections.
- Cultural and family narratives of resilience.
- Ability to heal.
- General skills in daily living.

There are four broad categories of strengths to explore in this assessment (Rapp & Goscha, 2012):

- **Personal attributes** are personal qualities associated with identity, such as honesty, assertiveness, warmth, compassion, and caring.
- **Talents and skills** are abilities and competencies a person has developed, such as being good at managing money, fixing cars, or using a computer.
- **Environmental strengths** are external resources that can help a person achieve his or her recovery goals. External resources can include a safe living environment, supportive family and friends, affiliation with a spiritual or faith-based community, and participation in recovery support groups.
- **Interests and aspirations** are activities that enrich a person's life (e.g., hiking, dancing, traveling), along with goals and dreams that motivate forward movement in life (e.g., wanting to get a high school equivalency degree, learn to play the guitar, or get a job helping others).

In addition to doing an initial strengths assessment, maintain a strengths-focused lens throughout counseling to set a positive tone for family sessions and enhance family members' motivation to address challenging problems (Tuerk, McCart, & Henggeler, 2012).

Genograms

Initially conceptualized by Murray Bowen (1978) as part of an intergenerational family model, a genogram is a comprehensive pictorial map of a family's health, communication, relationship, vocational, and other psychosocial patterns within and across three or more generations of the family. It provides information about marriages, divorces, births, geographical locations, deaths, and illness over the generations. It also depicts family patterns, events, and relationships, including emotional closeness, enmeshment, conflict, and emotional cutoffs (Platt & Skowron, 2013). Genograms are useful to discuss in psychoeducational sessions, family interviews, and assessments (Platt & Skowron, 2013). The genogram is both an assessment instrument and a counseling intervention (Gehart, 2018). As an assessment tool, it can help identify intergenerational dynamics. As an intervention, it



can help family members see how they are living out dysfunctional family patterns, roles, and rules (Gehart, 2018).

A genogram can also help family members see their current problems from a wider perspective and identify strengths and resources. You can also use a genogram as a project the family works on together to enhance communication and bonding. A genogram can help you identify intergenerational relationship patterns and generate hypotheses about counseling interventions (Shellenberger, 2007).

The genogram is flexible. Tailor it to the needs and current challenges of the family. Some of the themes you can highlight in a genogram include:

- Substance misuse across generations.
- Mental illness and trauma across generations.
- Individual and family strengths across generations.
- The roles of culture and spirituality across generations.
- The impact of substance misuse, mental illness, trauma, and family strengths on relationship patterns (e.g., enmeshment, conflict, emotional cutoffs, or emotional support and closeness).

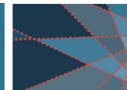
Strategies for creating a genogram with a family include the following:

- Beginning the process at the initial family interview. Ask family members about their understanding of SUDs and how their family member's substance misuse has affected family relationships. Then trace the history of the problem and family dynamics to prior generations. Also ask about important events like births, graduations, marriages, and deaths and how those events may be linked to the current substance misuse (Shellenberger, 2007).
- Asking about family members with SUDs who are or were in recovery and any information family members have about their recovery efforts.
- Filling in as much genogram information as possible about current and extended family members. Start with the identified client and his or her current spouse or intimate partner. Work up to include parents, stepparents, and siblings. Then work down to the children.

- Spending time gathering information about the child's relationships with parents and siblings—if the identified client is one of the children (e.g., a teenage son)—before moving on to extended family.
- Giving family members between-session assignments to gather more family history to bring back to the next family session. This can help family members gain further insight into how intergenerational family dynamics affect current family functioning.
- Asking young children to draw themselves and other relatives, including extended family (e.g., aunt, uncle, grandparent) during the session or at home and to bring the drawing to a family meeting.
- Continually adding to the genogram for a fuller, richer understanding of family history, relationship dynamics, and the role of substance misuse and recovery efforts in family life across generations.

Genograms are not intended for an initial assessment only. Work on the genogram at different points in the treatment process to see how counseling may have affected family relationships. For example, a couple's relationship might be represented as conflicted initially, but after some couples work, the genogram might include the symbol for a closer, less conflicted relationship. Genograms are a tool to assess family progress throughout treatment. Exhibit 4.2 shows common symbols used in genograms.

The genogram in Exhibit 4.3 shows five generations in American playwright Eugene O'Neill's family, depicted by Monica McGoldrick (1995). The key to symbols depicts a slightly different version of how to identify family members with SUDs, mental disorders, physical illnesses, emotional closeness, conflict, and cutoffs than shown in the key in Exhibit 4.2. It is a good example of how a genogram can uncover a family history of substance misuse. The Counselor Note on how to have meaningful conversations about genograms also gives important guidance on what clients and their families need to know about this helpful tool, including how it relates to SUD treatment and recovery. For more information about the heritability of addictions and the role of genetics and family history in SUD treatment and recovery, also see Chapter 2 (pp. 24-25).



COUNSELOR NOTE: TALKING TO CLIENTS ABOUT GENOGRAMS IN A MEANINGFUL WAY

Most clients and families will not have heard of a genogram before, and genograms can be confusing without an explanation of their appearance and purpose. To get the best use of the genogram, you need to have a meaningful, productive discussion with clients and their families about its role and value as well as the process of developing a genogram.

When talking about genograms with clients and families, be sure to discuss with them:

- **What a genogram is.** For instance, you can say something like:
 - “A genogram is a way of recording and interpreting your family’s history so you can better understand the genetic, medical, social, and cultural aspects of your family.”
 - “A genogram is a lot like a family tree in that it is a picture that uses shapes and figures to represent the people, relationships, and events in your family.”
- **How the genogram process works.** Tell them things like:
 - “To develop your genogram, I’ll ask you a series of questions going back to your great grandparents. If you do not know some of the answers now, perhaps you can look into them between our sessions, and we can discuss how this family history is important to your current efforts in recovery.”
 - “Here is an example of what we will create.” (*Show the example genogram in Exhibit 4.3.*) “We will use standard symbols representing individual family members and their physical and mental health history and specifics on their history of substance use.”
 - “You will see me using various symbols and shapes on this genogram. Each symbol or shape has a specific meaning. For instance, males are represented by a square, and females are represented by a circle. A pregnancy is represented by a triangle. A divorce is depicted by two lines crossing through this line connecting the two spouses.” (*Be sure to point to the symbols and shapes on the genogram as you are explaining them.*)
- **What types of questions you will ask.** For instance, let them know you will ask things like:
 - “To whom was your grandfather married?”
 - “How many siblings does your mother have?”
 - “Tell me about any history of alcoholism in your family.”
 - “Has anyone in your family attempted or completed suicide?”
 - “Who in your family is widowed, divorced, or unmarried?”
 - “Who in your family has experienced mental health issues? What about anyone who received treatment for a psychiatric disorder?”
 - “What was your aunt and uncle’s marriage like?”
 - “Has anyone in your family ever been arrested or incarcerated?”
- **Why you are creating the genogram and how it can help them.** You can say something like:
 - “A genogram can give you insight into the many different things that have happened in your family, such as negative family dynamics and family struggles, like divorce, death, and broken relationships. It also can help you understand why these things might have happened.”
 - “Many people are not fully aware of their family history. By recording it in a genogram, you might learn new information about your past and your loved ones.”
 - “A genogram is a good way to see repetitive patterns of behavior that have occurred in your family—especially patterns of behavior you want to stop, like abuse, conflict, legal problems, or addiction.”

Continued on next page



COUNSELOR NOTE: TALKING TO CLIENTS ABOUT GENOGRAMS IN A MEANINGFUL WAY (*continued*)

- **How the genogram can help specifically with substance misuse.** You can mention things like:
 - “Many people do not realize the extent to which their family has experienced substance-related problems. A genogram can help you uncover such information and show you that you are not alone in your struggles.”
 - “Seeing how your family has been affected by substance misuse can be a powerful reminder of the importance of treatment and recovery.”
 - “It is not unusual for people with substance misuse to blame themselves. But addiction has nothing to do with weak character or personality flaws. A genogram can show you the biological roots, or ‘genetic loading,’ of substance misuse and why some individuals are more vulnerable to the effects of drinking and/or drug use than others.”
 - “The family environment—like your culture—plays a critical role in development and is an important influence on how we learn to relate with others, communicate, and respond to both positive and negative experiences. Understanding your immediate and closest family members’ experiences with using substances can help reduce self-blame and shame and instead motivate you to break these generational cycles.”
 - “This genogram can show you how your immediate family can have both positive and negative effects on your current efforts toward recovery.”
 - “Understanding the influence of your family relationships is a helpful tool for clients and their involved family members seeking a path toward recovery.”
- **Any feelings of discomfort that may develop as they work through the genogram.** For instance:
 - “It is not uncommon for people to feel overwhelmed when looking at their completed genogram, especially if you see a lot of mental health or addiction issues in your family. Remember that we can talk through any of those feelings as needed.”
 - “Many clients find this to be a useful way of gaining knowledge and insight into the ways their family history has shaped their lives and behavior. But some people find the creation of their genogram to be emotionally difficult. We will take things slow, and if at any time you need to stop and talk about how you are feeling or if you just need a break, let me know. Does that sound okay?”

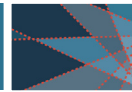
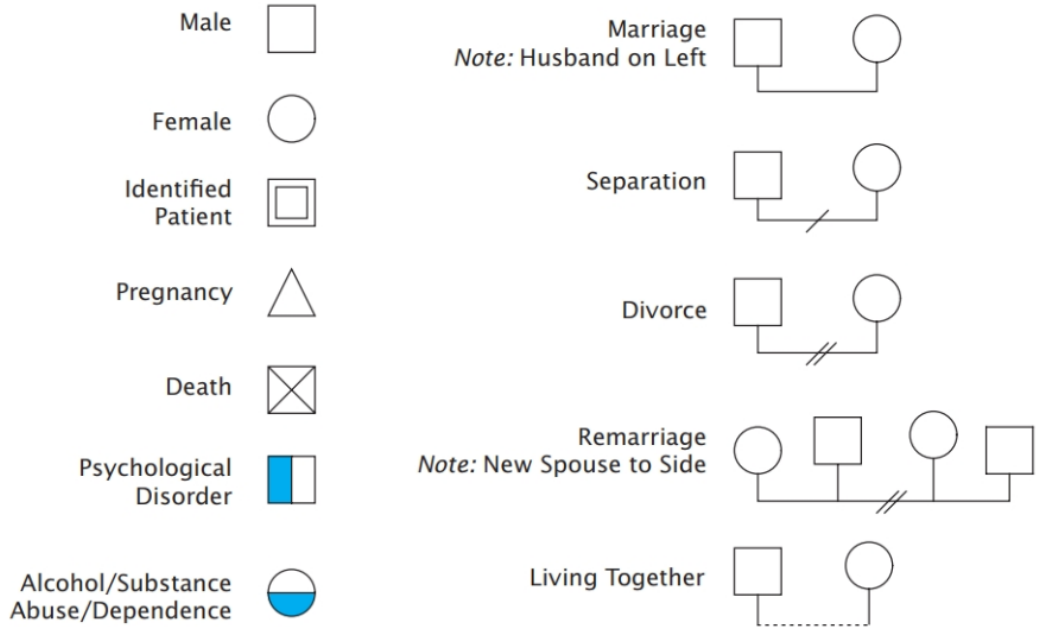
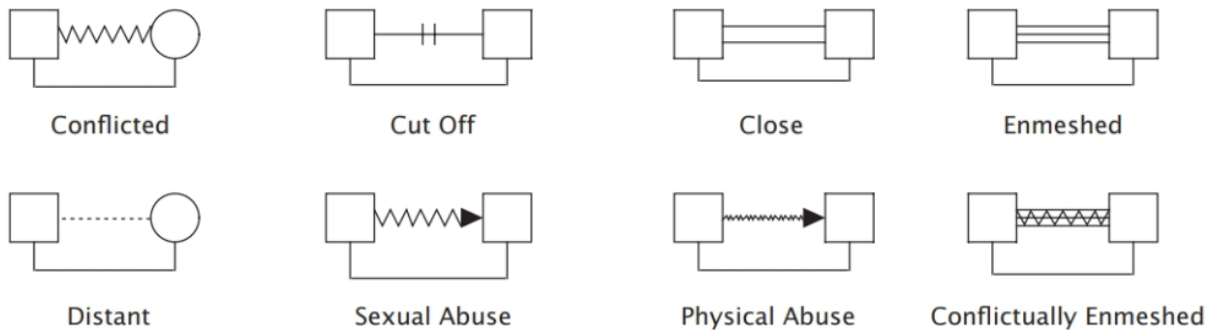


EXHIBIT 4.2. Genogram Symbols

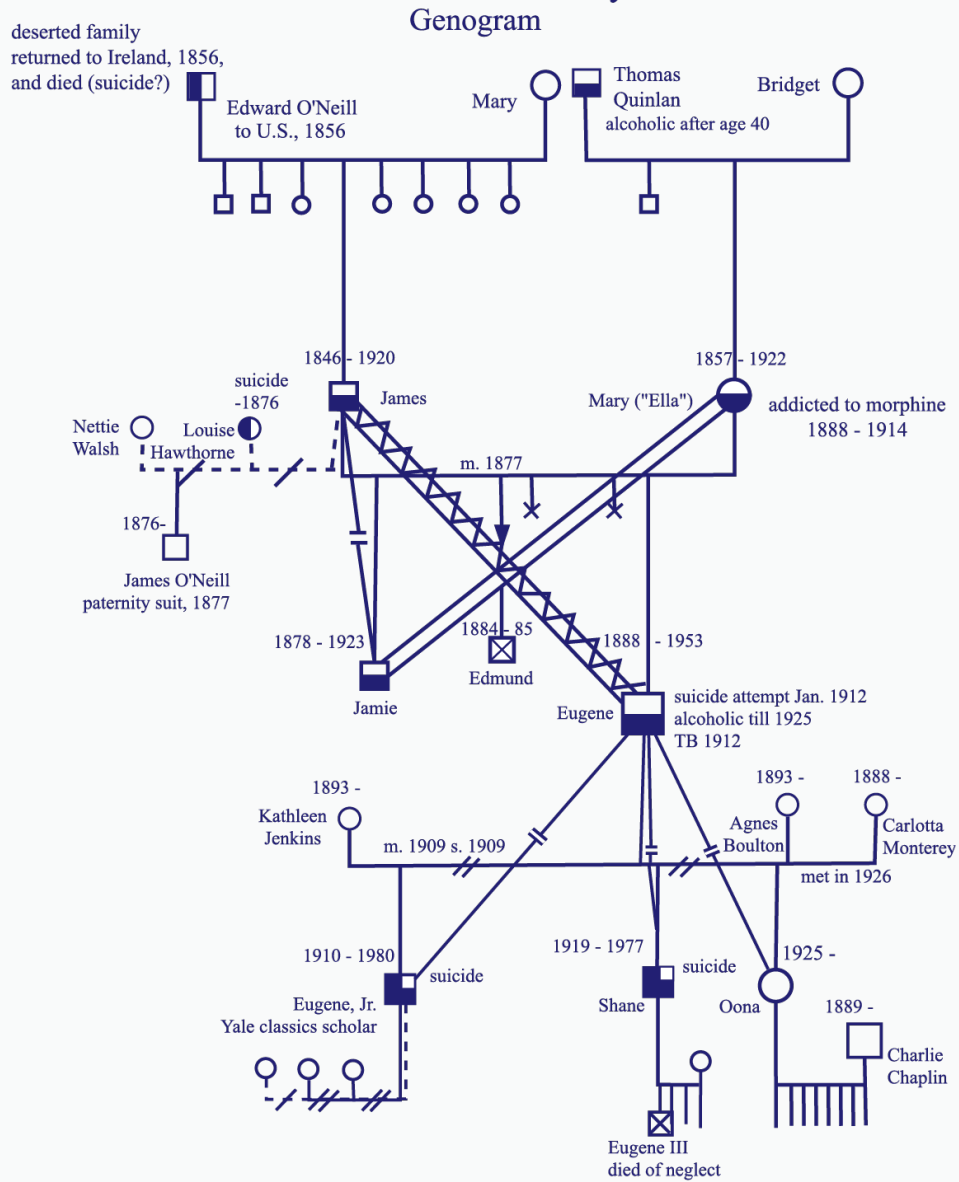


Symbols for Interactional Patterns

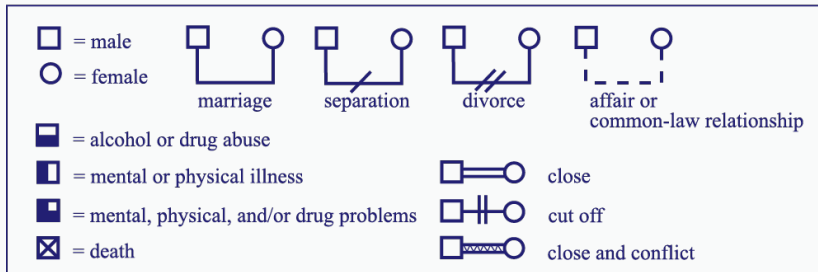


Source: From Gehart. eBook: *Mastering Competencies in Family Therapy: A Practical Approach to Theory and Clinical Case Documentation, 3E.* © 2018 South-Western, a part of Cengage, Inc. Reproduced by permission. www.cengage.com/permissions.

EXHIBIT 4.3. O'Neill Genogram



Key to Symbols



Source: McGoldrick (1995). Reprinted with permission of the author.

Goals of Integrated Family Counseling for SUDs

In person-centered SUD treatment, the clients' desire, ability, reasons, and need to change drive counseling goals. The same is true for integrated family counseling to address SUDs. Yet each family member may have different ideas about what he or she can gain from participating in family counseling. For example, parents may want their son to stop drinking with friends. The son may participate in family sessions to get his parents to stop fighting. The goal of each family member may differ, but the overarching goal is to engage the family in changing communication patterns that support the son's substance use.

Your overall focus in family counseling is on the roles, relationships, and communication patterns of the family system (van Wormer & Davis, 2018). Be aware of the core objectives of family-based interventions as you work with family systems to identify their specific treatment goals.

There are several core objectives of family-based interventions in SUD treatment:

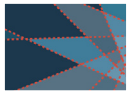
- Leverage the family to influence change—Encourage family members to support and enhance each other's desire, abilities, reasons, and need to make important lifestyle changes, including shifts away from substance misuse. Your goal is to help families develop effective coping and communication skills that promote recovery and prevent returns to substance use.
- Involve families in SUD treatment—Get family members involved in treatment in some way. This might include family members attending a family psychoeducational activity or participating in a structured family-based counseling intervention, as described in Chapter 3. Your goal is to help families recognize their strengths, address family dynamics, and build effective relationship skills.
- Change family behaviors that support substance misuse—Help the family recognize behavioral, cognitive, and emotional responses that unintentionally support the client's continued substance misuse. Address negative effects of substance misuse on family systems to improve functioning.
- Prevent SUDs across generations—Help families recognize the intergenerational transmission of family patterns that promote substance misuse. Your goal is to help families prevent SUDs in current and future generations by encouraging parenting practices that help prevent SUDs in children, improve SUD treatment outcomes in adolescents, and enhance the family recovery process.

The following sections describe ways to meet these objectives by focusing on certain goals in your provision of integrated family counseling for SUDs.

Understand Your Role as an SUD Treatment Provider

Your role in family-based interventions depends, to some extent, on your level of training, education, licensing, and scope of practice. For example, if you are leading a family psychoeducation group, your primary role is as a guide or educator. In couples counseling, your role is to facilitate the couple's interactions. Whatever family-based intervention you provide, your role also includes:

- Approaching the family on their own terms.
- Working together with the family.
- Facilitating communication among all family members.
- Facilitating family member interactions (avoid being an arbiter of right and wrong).
- Educating family members about how families work.
- Educating family members about the effects of substance misuse on the family.
- Educating family members about the recovery process.
- Facilitating the development of a relapse prevention plan.
- Actively linking family members to community-based recovery support and other services.



The key to successful family work is to maintain a focus on engagement and collaboration with the family throughout treatment.

Optimize Initial Sessions

After the family interview and assessment process, initial family counseling sessions should focus on building a relationship with the entire family. The identified client should always be part of family sessions. The only times to exclude someone are if he or she is intoxicated or under the influence of drugs (“high”), has severe psychiatric symptoms (e.g., hallucinations, delusions, severe mania), has threatened violence, or a combination of these.

To engage family members’ support for a client with SUD as he or she initiates and sustains recovery, you can:

- Welcome and thank family members for coming.
- Use reflective listening to understand family members’ frustrations and concerns.
- Use externalizing language (e.g., “the drinking,” not “her drinking”) to help the client and family members disengage substance use from negative identity conclusions. Making the SUD an external focus of attention allows everyone to work as a team to defeat it.
- Explore how family members have been helpful in the past.
- Explain ways that family members can support the client’s recovery.
- Ask the client whether he or she is willing to have family members help in this way.
- Ask whether family members have any questions.
- Ask whether the client has any questions about family members’ participation.
- Summarize the important points of the session and recovery commitments anyone has made.
- Actively link family members to community-based family recovery supports (e.g., Al-Anon) and additional behavioral health or social services, when appropriate.
- Assess the willingness of family members to participate in ongoing family counseling if appropriate.

Initial sessions should focus on:

- Working together with the family.
- Orienting them to the family counseling process.
- Continuing the assessment of how substance misuse has affected each family member.
- Reframing substance misuse from a character flaw to a biochemical and behavioral problem they can work together to remove from their lives.
- Continuing the assessment of family strengths and strategies they have already used to lessen the impact of substance misuse on the family.
- Exploring family hopes for the future and each family member’s ideas on how counseling can help.

Key opening strategies include building relationships and giving each family member time to share his or her frustrations and hopes for the future. Avoid jumping too quickly into goal consensus.

Acknowledge Stages of Change

The process of recovery from SUDs is complex and multifaceted. A useful framework for understanding this process involves the stages of change (SOC) model, a transtheoretical approach to behavior change, originally developed by Prochaska and DiClemente (1984). The SOC model was developed for use with individuals, but it can be a helpful approach to assessing family members’ readiness to discuss a problem that they often view as something so shameful they can’t talk about it. The SOC approach can help you guide families through the process of change.

The five stages of change and the counseling focus for each stage adapted for family work (DiClemente, 2018; van Wormer & Davis, 2018) are:

1. **Precontemplation:** Client or family doesn’t perceive a problem or need for behavior change. Counseling focus: Engage the family. Establish a working alliance with each family member. Help family members identify their core values, hopes, and dreams and how substance misuse or other disruptive behaviors are blocking them from achieving their goals.

Remember, each family member might be in a different stage of change around specific behavioral change goals.

2. **Contemplation:** Client or family is ambivalent about behavior change and begins to identify reasons for change. Counseling focus: Elicit from each family member his or her own reasons for wanting or needing to change certain behaviors, including substance misuse, to help the family reach their goals. Reinforce family members' strengths and their capacity to take action toward desired solutions to family problems.
3. **Preparation:** Client or family is motivated to change behavior and starts taking steps toward change. Counseling focus: Help family members clarify their own goals and strategies for change, offer some options and advice, if asked for, and encourage them to engage in recovery and social support resources outside of family counseling.
4. **Action:** Client or family is actively engaged in behavior change. Counseling focus: Help the family develop a change plan that includes tasks for each family member. Invite one family member to write out the plan. Then make a copy for each family member. At the next family session, review the plan and how each family member did with achieving change goals. Tweak the plan if needed and continue to evaluate the plan's effectiveness.
5. **Maintenance:** Client or family has changed behavior and is actively engaged in sustaining change. Counseling focus: Help the family anticipate potential stressors that could

destabilize family functioning again. As behavioral changes are made, substance misuse decreases or the client becomes abstinent, and family function shifts to supporting the family to maintain those behavioral changes outside of treatment.

Apply the SOC approach to a behavior each family member can change to support recovery and enhance family functioning. For example, when one partner's drinking is interfering with a couple's relationship, the drinking partner needs to change the drinking behavior. At the same time, the nondrinking partner may need to change his or her negative communication pattern of blaming and judging the drinking partner and shift to a positive communication pattern that reinforces nondrinking behavior. Please note that each family member may be at a different stage of change or level of motivation regarding the behavior change that he or she needs to make to improve family functioning.

Educating families about the SOC framework can help them identify where they each are in the stages and support each other to move toward positive change. The SOC approach provides an overarching model for behavior change from an SUD treatment perspective. See TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 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 the SOC model.



COUNSELOR NOTE: THE ROLE OF FAMILY IN RELAPSE PREVENTION

Factors that protect against relapse for people with SUDs (SAMHSA, 2015a) include:

- Family support for recovery.
- Involvement in peer recovery support groups and recovery-oriented social experiences.
- Positive coping skills.
- High motivation to change risk behaviors.
- Self-efficacy.
- High levels of confidence in managing high-risk situations.
- Active engagement in spiritual or religious practices or community events.
- Beliefs that enhance hope and resilience.

Because family members often can identify early warning signs that the client may not be aware of, involve them in identifying early signs of a potential return to use. Family members can also provide positive emotional and instrumental support (e.g., transportation to Alcoholics Anonymous meetings or help with monitoring medications) for the client's recovery. This support can help prevent a return to substance misuse.

If the client relapses (i.e., returns to previous levels of substance use), the family also is likely to return to old patterns of behavior. A key strategy to help the client and family get back on track right away is to create an emergency plan so the family knows what to do if the client returns to substance misuse. Work with family members and the client to create the plan. Write it out and give each family member a copy.

The plan should:

- Explain that a return to drinking or drug use is not inevitable but also is not unusual. The longer a person can abstain, the greater the likelihood that he or she will not return to use.
- Make it clear that the client is responsible for his or her own behavior.
- Identify the steps family members are willing to take to support the client's reengagement in his or her recovery (e.g., call the treatment agency's crisis number and talk to the on-call counselor if the client is intoxicated, transport the client to a recovery support meeting).
- Explore the family's options for dealing with the client's return to substance misuse, including self-care (e.g., get help from an Al-Anon, Alateen, or other family recovery support; talk to a friend).
- Give a responsible family member your number and available hours to contact you for support and help with next steps for the family and the client.

Another useful framework for understanding the stages of change that the family system undergoes in family counseling comes from Virginia Satir (Satir, Banmen, Gerber, & Gomori, 1991). These six stages (Gehart, 2018) are:

1. **Status quo:** This is a state of family homeostasis in which at least one family member has symptoms of a mental disorder or SUD; the family organizes interactions and functioning around the symptom.
2. **Foreign element:** A foreign element moves the system off balance. The foreign element could be a life crisis like substance misuse or a counseling intervention like offering the family a new perspective on or information about substance misuse.
3. **Chaos:** The counseling intervention throws the family system into a temporary state of chaos. The family most often experiences discomfort and tries to get back to the stage 1 status quo.

4. **Integration:** Eventually, the family system interprets the new information in a meaningful way, which opens up new possibilities for change.
5. **Practice:** The family system develops new ways to interact/communicate based on new information.
6. **New status quo:** This is a new state of homeostasis that supports all family members to grow and contribute to enhanced family functioning.

Families often undergo the stages several times until the system gets used to change (Gehart, 2018). This framework is based on the idea that the family system is resilient and will find its way to a new and healthier level of functioning. Your task is to be respectful of how the family uses and responds to your introduction of a “foreign element” and honor the family system’s autonomy (Gehart, 2018).

Address Common Challenges

You will encounter challenges, myths, and obstacles that hinder engagement and treatment of families dealing with SUDs. Some challenges are related to attitudes and myths about offering family counseling in SUD treatment settings. Others may be related to integrating family work into SUD treatment settings. Still others are related to family issues such as low motivation to change and power dynamics within the family. The next sections describe some challenges and strategies to overcome them.

Family Counseling Is Secondary

SUD treatment has historically been viewed through the lens of an individual approach. Integrated family-based interventions should be as much of a priority in your treatment program as any other treatment activity. When family counseling is viewed as an adjunct to individual or group counseling, it sends the message to clients and family members that family counseling is simply not that important. Evaluate your attitudes about family involvement in treatment and be a champion for integrating family-based interventions as an important and primary part of SUD treatment.

Family Counseling Is Too Painful

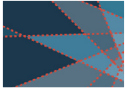
The SUD treatment field has promoted the myth that family counseling that includes the client with SUD may bring up painful feelings for the client that will somehow lead to a return to use or jeopardize the client’s recovery. Although family counseling may temporarily shake up the family system and activate intense feelings, these feelings are a normal part of any counseling experience. Your task is to help the client and family members discover new ways of coping with intense emotions instead of reverting to old behaviors like substance misuse or blaming and shaming the family member with the SUD.

Coordination of Family Services

It is challenging to provide family-oriented case management or referral and coordination of services while doing family counseling. You are working with a family system made up potentially of many family members, who may each require other treatment or social services. This requires an appreciation for each family member’s needs and a concerted effort to coordinate other agencies’ services to satisfy multiple needs. Actively link individual family members to case management services or peer providers who can work collaboratively with you to coordinate the multiple service needs of the family.

Keeping Family Secrets

Secretiveness is often a hallmark of family behavior where there is an SUD. When family members become involved in counseling, they may want to tell you secrets outside a family session. Different family counseling models approach this differently. However, in the context of SUD treatment, it is important to avoid being the holder of family secrets. Holding a secret puts you in an ethically untenable position and will interfere with the family counseling process. Let everyone know during the initial family interview that you will bring up information a family member brings to you outside of family sessions, and you will do so during the next family session. The only exception to this boundary is if a family member tells you privately of violence or abusive behavior that needs to be addressed separately.



SUD Client or Family Member Is in Precontemplation

Historically, the term “denial” has described clients or family members who do not see substance misuse as a problem. This label is judgmental, so avoid using it and let family members know that using labels to confront each other leads to conflict or an emotional cutoff. As with name calling, using labels like “denial” is often an attempt to establish power in a relationship, which is damaging to that relationship. Set boundaries in early family sessions by establishing some rules for interactions, including no “labels” or name calling. You can also reframe “denial” as precontemplation, one of the stages of the SOC model and simply an indication that the family member is ambivalent and not quite ready to change.

Family’s Adjustment to Abstinence

Just as the family system organizes itself around the client’s substance misuse to maintain a level of homeostasis, you can expect family members to act differently (and not always positively) when the client with the SUD enters recovery. For example, family members may express resentment and anger more directly to the recovering person because of the disruption of the family’s homeostasis. Children and adolescents may engage in more externalizing behaviors like aggression, violence, lying, or stealing. An adolescent or intimate partner who has taken on major responsibilities for family functioning given up by the adult client with the SUD may resent and unintendedly sabotage the client’s efforts to resume a position of responsibility and authority in the family system. Or the family may experience a period of relative harmony that is disrupted if other family issues begin to surface. Your task is to help family members adjust to these changes in lifestyle, find ways to support the client’s recovery, learn new relationship and coping skills, and find healthier levels of functioning and family homeostasis.

The Client on Medication

Clients with co-occurring mental disorders or those who are prescribed medications for alcohol use disorder or opioid use disorder often are uncertain about adhering to medication routines. Some of the reasons clients stop taking medications include

cost, negative side effects, the belief that they are not in recovery because they are substituting one drug for another, or systemic barriers (e.g., having to go to a clinic every day to receive a methadone dose). When clients stop taking medications, symptoms of mental disorders or old substance use behaviors reemerge, and families return to previous patterns of dysfunction. The issue of medication adherence is a common theme in the families you serve. Your task is to raise this issue, when applicable, in family sessions.

Before jumping to educating family members about medications and how important medication adherence is for individual and family stability, explore both the client’s and the family’s perspective about medication and its role in family functioning. As you explore multiple perspectives, use some motivational counseling tools like elicit-provide-elicit; that is, eliciting what family members already know about medication, asking permission to offer information, providing brief chunks of information, and then eliciting the family members’ reactions to the information (Miller & Rollnick, 2013). Once the topic is raised and all family members have accurate information about the medication and the importance of medication adherence in family stability, the conversation can shift to the family working as a team to support the client to adhere to medication as prescribed or safely taper off medication under medical supervision if and when it is no longer needed for the client to maintain stable recovery.

Where Do We Go From Here?

Integrating family-based counseling techniques into SUD treatment is possible along a continuum of care, from initial assessment through the various stages of family counseling. This chapter examined some of the common issues you may face and family-centered strategies you can use along that continuum of care, including when to use family counseling, who can be involved, the goals of family-based interventions, and your role as a counselor. Chapter 5 examines your role in delivering culturally responsive family-based SUD treatment. It also explores the diversity of family cultures you will encounter in your work.

Chapter 5—Race/Ethnicity, Sexual Orientation, and Military Status

KEY MESSAGES

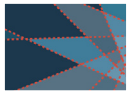
- Family cultures often have specific practices, structures, values, and belief systems that can affect substance use and substance-related outcomes (e.g., achieving recovery).
- Understanding the ways in which diverse family cultures function is critical to identifying and addressing family-related factors—like communication patterns, parenting practices, and level of acculturation—that increase the risk for substance misuse.
- Family separation (e.g., because of immigration or military deployment) and lack of communication about substance misuse may be present across many family cultures. Similarly, racial discrimination, stigma, shame, and prejudice may exert influence across multiple generations, influencing families' substance use and help-seeking behaviors. Family characteristics and feelings related to these factors should be addressed as a part of family counseling for substance use disorders (SUDs).
- Much of the empirical literature is silent on how best to adapt family-based counseling interventions for SUDs to the specific needs of the diverse family cultures discussed here. However, to the extent possible, you should still try to use family-based treatment/services that meet families where they are—that is, services matched to the family's level of motivation to change and responsive to their unique change goals.

Chapter 5 of this Treatment Improvement Protocol (TIP) will guide providers in delivering family-based SUD treatment that is culturally responsive and evidence based. It addresses:

- **General information about diverse family cultures** and why you, as a provider, need to be aware of their specific treatment/service needs and challenges.
- **Culturally responsive family counseling.**
- **Background issues and aspects of family structure and functioning in specific populations**, which will help guide your approach to meeting the needs of families from a cultural perspective.
- **Specific family cultures** (e.g., families of diverse racial and ethnic backgrounds; families with lesbian, gay, bisexual, or transgender [LGBT] members; military families), with summaries of recent scientific evidence on the use of family-based interventions for SUDs with each population as well as suggestions for how to culturally tailor interventions to get the best outcomes.

This chapter is not a comprehensive summary of all family cultures. The literature on the effectiveness of family counseling for SUDs in specific cultures is often limited but is discussed when available. Populations this chapter discusses are among those commonly seen in SUD treatment settings, and they often have specific cultural practices.

Family-based interventions for SUDs are evidence-based, effective approaches to achieving and sustaining long-term recovery, particularly for adolescents (Hartnett, Carr, Hamilton, & O'Reilly, 2017; Horigian, Anderson, & Szapocznik, 2016; Ventura & Bagley, 2017). But the diverse makeup and culture of a family can affect the degree to which individuals and families facing substance misuse can successfully access, engage



in, and benefit from SUD treatment. That partly may be because of culture-related barriers that can make achieving recovery difficult for some families (e.g., language barriers, stigma, or negative attitudes about help seeking).

To successfully use family-based interventions, you must be aware of and pay attention to the unique features of certain family cultures. These features include, for example, the family's structure, communication style, immigration history, experience of individual and historical trauma, and interrelationships with one another.

Scope of This Chapter

The topic of culture and cultural competency in SUD treatment (and in behavioral health services in general) is beyond the scope of this chapter. **The focus of this chapter is on families and the ways in which family-based interventions can be adapted to, and thus more effective for, specific family cultures** discussed here (i.e., those of diverse racial/ethnic backgrounds, LGBT families, military families).

COUNSELOR NOTE: AFFILIATION WITH MULTIPLE CULTURES AND CULTURES WITHIN A CULTURE

People often affiliate with multiple cultures to varying degrees—cultures centered on race/ethnicity, gender, profession, age, economic class, geographic location, education level, and so on. For example, a married heterosexual African American couple from a rural parish in Louisiana might view their cultural identity very differently than a single gay African American father living in Manhattan. All may identify with aspects of African American culture; this facet of their cultural identities may figure more or less prominently than being part of married versus single culture, rural versus urban culture, straight versus gay culture, and so forth. Additionally, there are often cultures within a culture—one may, for example, be part of Korean culture, and within that culture, affiliate strongly with the subculture of Korean Catholicism.

To learn more about culture and diversity issues in behavioral health services, SUD treatment, and ongoing recovery support, review these publications from the Substance Abuse and Mental Health Services Administration (SAMHSA):

- ***Advancing Best Practices in Behavioral Health for Asian American, Native Hawaiian, and Pacific Islander Boys and Men:*** This report offers tools and best practice guidance for working with Asian American, Native Hawaiian, and Pacific Islander boys and young men (<https://store.samhsa.gov/product/advancing-best-practices-behavioral-health-asian-american-native-hawaiian-pacific-islander/SMA17-5032>).
- ***A Provider's Introduction to Substance Abuse Treatment for LGBT Individuals:*** This manual informs clinicians and administrators about SUD treatment approaches that are culturally responsive to LGBT individuals. It covers cultural, clinical, health, administrative, and legal issues as well as alliance building (<https://store.samhsa.gov/product/A-Provider-s-Introduction-to-Substance-Abuse-Treatment-for-Lesbian-Gay-Bisexual-and-Transgender-Individuals/SMA12-4104>).
- ***Continuity of Offender Treatment for Substance Use Disorders from Institution to Community—Quick Guide for Clinicians Based on TIP 30:*** This publication guides SUD treatment providers in helping offenders transition from the criminal justice system to life after release, including adaptation to community and work cultures and the culture of recovery. It discusses assessment, transition plans, special populations, family involvement in treatment and transition where appropriate, and confidentiality (<https://store.samhsa.gov/product/Continuity-of-Offender-Treatment-for-Substance-Use-Disorder-from-Institution-to-Community/sma15-3594>).
- ***TIP 51, Substance Abuse Treatment: Addressing the Specific Needs of Women:*** This guide assists providers in offering treatment to women living with SUDs. It reviews gender-specific research and best practices, such as common patterns of initial use and specific treatment issues and strategies (<https://store.samhsa.gov/product/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA15-4426>).

- **TIP 55, Behavioral Health Services for People Who Are Homeless:** This manual emphasizes that SUD treatment and mental health service providers can improve their service delivery by understanding the cultural context of clients and having the skills to adapt to a variety of cultures of people who are homeless. It also describes intervention methods to address SUDs during a variety of stages of homelessness rehabilitation and discusses methods providers can use to support recovery from mental illness and substance misuse among people and families who are homeless (<https://store.samhsa.gov/product/TIP-55-Behavioral-Health-Services-for-People-Who-Are-Homeless/SMA15-4734>).
- **TIP 56, Addressing the Specific Behavioral Health Needs of Men:** This guide addresses specific treatment needs of adult men living with SUDs. It reviews gender-specific research and best practices, such as common patterns of substance use among men and specific treatment issues and strategies (<https://store.samhsa.gov/product/TIP-56-Addressing-the-Specific-Behavioral-Health-Needs-of-Men/SMA14-4736>).
- **TIP 57, Trauma-Informed Care in Behavioral Health Services:** Trauma can affect individuals, families, groups, communities, specific cultures, and generations. This manual helps behavioral health professionals understand the impact of trauma on those who experience it. The manual discusses trauma-informed, culturally responsive assessment and treatment planning strategies, and it highlights the importance of context and culture in people's response to trauma and SUD recovery (<https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>).
- **TIP 59, Improving Cultural Competence:** This manual provides more information on working with people from various cultures and providing culturally competent treatment (<https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849>).
- **TIP 61, Behavioral Health Services for American Indians and Alaska Natives:** This publication offers practical guidance for

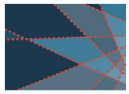
addressing the social challenges and behavioral health needs of Native American populations in culturally responsive ways (<https://store.samhsa.gov/product/tip-61-behavioral-health-services-for-american-indians-and-alaska-natives/sma18-5070>).

Terminology is important. The term **specific populations** refers to the features of families based on specific, common groupings that influence the process of therapy. The term **culture** often brings to mind concepts related to race and ethnicity but is used more broadly here. In this chapter, **culture** refers to the thoughts, interactions, beliefs, and values of a family that shape the way that family feels, thinks, and talks about and reacts to substance use issues. Indeed, the family cultures described here are known to have their own attitudes, ideas, customs and, in some cases, language that shapes the family and the ways in which its members relate to one another.

Why Focus on Diverse Family Cultures?

Why should SUD counselors learn about diversity among families? Family-based interventions for substance use are not “one-size-fits-all” approaches. Different families will have different needs, and in many cases, those needs are affected by the culture of that family. **You cannot offer truly comprehensive, evidence-based SUD treatment if you ignore the culture of the family with whom you are working.** Think about the following when working with diverse family cultures:

- **A supportive family is a key protective factor in relapse prevention and recovery promotion, and family support can be heavily influenced by culture.** Cultural differences exist in the way families understand, feel about, and respond to mental illness or SUDs (particularly, perceived shame about these conditions). Cultural shame about SUDs and mental disorders can be a relapse risk factor or barrier to treatment engagement. Thus, family ties may affect treatment engagement, adherence, and completion. Psychoeducation about the nature of SUDs and mental disorders as medical issues that can be treated, like many other chronic conditions, may help reduce shame and increase family support and acceptance.



- **Diversity may be a factor in family-based SUD treatment outcomes.** For instance, in some research, ethnicity has been shown to be an influential factor in outcomes from multidimensional family therapy (MDFT) for SUDs. One study that looked at findings from five MDFT clinical trials for adolescent substance use found that MDFT was effective only for men, African Americans, and European Americans, whereas women and Latino individuals did not benefit significantly (Greenbaum et al., 2015).
- **Cultural background can shape attitudes about factors like “proper” family behavior, family hierarchy, acceptable levels of substance use, and methods of dealing with shame and guilt.** Forcing families or individuals to follow the customs of the dominant culture can create mistrust and lower the effectiveness of counseling. A competent treatment provider, however, can work with a culture’s customs and beliefs to improve treatment rather than cause resistance to treatment.
- **Some families may prefer alternative interventions in place of or along with family counseling.** In cultures that place a high value on indigenous healing practices and spirituality, such as in some Latino, Asian American, African American, and American Indian/Alaska Native (AI/AN) communities, you can actively support clients with SUDs or mental disorders in using traditional healing approaches, faith-based community resources, and spirituality as supports in their efforts to lower the likelihood of relapse. The key is for you to keep your clients in the center of the conversation about what will be the most effective relapse prevention and recovery strategies for them based on cultural considerations and to adapt approaches to fit the needs of each individual and family.
- **Behavioral health disparities are real and, if unaddressed, can keep people from achieving and maintaining recovery.** Some racial and ethnic groups have higher rates of poverty (which can be intergenerational), domestic violence, childhood and historical trauma, and involvement in the criminal justice system than the general population. These

risk factors can increase the chances of relapse or recurrence of SUDs and mental disorders. Levels of education and of health literacy can also influence awareness of and access to treatment and recovery supports. These and other gaps in treatment access and retention exist for a number of populations, including the groups described in this chapter. Your organization can help reduce disparities in SUD treatment and recovery support by improving outreach and sharing of information, promoting active linkages to culturally diverse community resources, and implementing relapse prevention treatment and recovery promotion initiatives that specifically serve these populations.

Culturally Responsive Family Counseling

Cultural competence is an important feature in family counseling because family counselors must work with families from many cultures. Integrated family counseling for SUD treatment works for people from many races, ethnicities, faiths, and educational backgrounds. In many cultures, it is important to include families in treatment. However, a culture’s high regard for families does not always equate to healthy family functioning. People may hide substance misuse in the family because revealing it would lead to prejudice and shame.

RESOURCE ALERT: SOCIAL DETERMINANTS OF HEALTH

The Office of Disease Prevention and Health Promotion maintains a website with summaries of many social determinants of health, as well as data and other evidence-based information regarding these determinants (www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health). The site also provides many links to additional educational resources on this topic.

Furthermore, **using culturally competent, family-based services may help clients reach better SUD outcomes.** A meta-analysis of seven studies looking at culturally responsive SUD interventions for racial and ethnic minority youth (including studies that used family-based approaches like MDFT, brief strategic family therapy [BSFT], and

the Culturally Informed and Flexible Family-Based Treatment for Adolescents [CIFTA] Program) showed, on average, that these treatments resulted in greater reductions in substance use than nonculturally adapted treatments (Steinka-Fry, Tanner-Smith, Dakof, & Henderson, 2017).

COUNSELOR NOTE: CULTURAL HUMILITY AND WILLINGNESS TO BE THE STUDENT—NOT THE TEACHER

More and more, the concept of cultural humility is being embraced in primary care and behavioral health services (Allwright, Goldie, Almost, & Wilson, 2019; Watkins et al., 2019). **Cultural humility can help you not just work better with diverse family cultures but also become a better clinician in general. It can help you become more open and willing to learn from your clients rather than always playing the role of “the expert.”**

What is cultural humility, and how does it differ from cultural sensitivity, cultural awareness, and cultural competency? According to research (Allwright et al., 2019; Barksy, 2018; Danso, 2018):

- **Cultural competency** is “the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, spiritual traditions, immigration status, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each” (National Association of Social Workers, 2015, p. 13). In other words, cultural competency is about your clinical practices and making sure you have the knowledge, skills, and training to work appropriately with different cultures.
- **Cultural awareness** and **cultural sensitivity** are about consciousness and self-reflection. How conscious are you of other cultures and their unique needs? How mindful are you of your own cultural beliefs and how those affect the way you care for clients from other cultures?
- **Cultural humility** goes a step further and asks you to release your own beliefs, ideas, and doubts about a given culture and treat clients as “the experts.” Cultural humility means:
 - Being willing to admit to understanding less about clients’ cultural experiences than they do.
 - Having an open heart and listening to your clients share their stories—especially when they tell you things that do not match what you thought you already knew about their culture.
 - Being humble and learning from your clients rather than just using what you read in textbooks or were taught in training sessions.
 - Questioning culture-related differences in power that can be present in working relationships, organizations, and systems.
 - Engaging in a lifelong process of self-reflection and self-critique, especially to identify any prejudices.



To add culture into your SUD treatment approaches:

- **Engage aspects of the family's culture or religion that promote healing.**
- **Consider the role that drugs and alcohol play in the culture.**
- **Be flexible** and meet families where they are.
- **Be continuously aware of and sensitive to the differences between yourself and the members of the group you are counseling.** Is the family a homogeneous group or one that represents different backgrounds? What is the significance that family members assign to their own identities and to the identity of the counselor? Does the family live in one community or several different communities? Are those communities the same as or different from the one in which you live? These considerations and responsiveness to the specific cultural norms of the family in treatment must be respected from the start of counseling. Differences within the family also should be explored. If these factors are not apparent or explicit, ask.
- **Be aware of and sensitive to your own family culture.** Counselors bring their own cultural issues to treatment. Your age, gender, ethnicity, local community, and levels of health literacy and education, as well as other traits, may affect therapeutic processes.

You can be culturally competent even if you don't belong to the same cultural groups as the families you serve. You can develop the cultural competence to work with families who affiliate with cultures other than your own. Cultural competence means you pay attention to cultural nuances, learning from diverse clients. Even if you identify with the same culture as a family you treat, don't assume you understand all their cultural views and beliefs. The ways and extent to which culture influences them may differ from your experience.

General Considerations When Working With Diverse Family Cultures

Families and family cultures will differ in their structures, values, and beliefs; they also will differ in their SUD treatment needs. However, certain common family features may be present across many family cultures, such as their immigration status and history, level of acculturation (that is, the degree to which individuals or groups adopt the practices of the dominant culture), communication style, and hierarchical structure. **Be aware of these general features, but also remember that each family is different and will operate in its own unique way** (Exhibit 5.1).

EXHIBIT 5.1. Eight Questions To Consider When Offering SUD Treatment for Families of Diverse Racial/Ethnic Backgrounds

To help lay the groundwork for better understanding a particular family's response to and treatment/service needs for substance use, here are eight questions to ask yourself:

1. How is this family structured?
2. What is the role of the extended family?
3. What is the role of religion or spirituality within this family?
4. What is the family's immigration/nativity status? How does this affect family members' level of acculturation?
5. Are there culture-specific family values to be aware of?
6. How does the family's culture affect their communication style?
7. How does this family experience racism and discrimination? How do those experiences, along with historical trauma, affect the family?
8. Has the family experienced any periods of separation (particularly between parent and child)?

For more specific information on common characteristics of families, see Chapter 1 of this TIP.

1. How Is This Family Structured?

The ways families are organized can affect the relationships family members have with each other. These, in turn, can directly affect their communication style, expectations for behavior, and more.

- For instance, White, Latino, Hmong, and Somali students living with nuclear families (i.e., families made up of only the parents and their children) have a significantly lower rate of exposure to substance-related risk behaviors and substance use than students living in single-parent or cohabitating households (Areba, Eisenberg, & McMorris, 2018).
- **Hierarchical family structures (i.e., the order/rank of power and authority within the family, such as patriarchal versus matriarchal) are prevalent in some cultures**, including Latino populations (Santisteban, Mena, & Abalo, 2013) and Asian populations (Chuang, Glozman, Green, & Rasmi, 2018). For example, military families often adopt the same core values and principles that define military culture in general, like respect for authority and adherence to chains of command. The focus on hierarchies and parents as authority figures can affect parent–child conflict and resolution, especially as children age into adolescence and potentially begin to challenge parental authority.
- **A related aspect of a family’s hierarchy and power structure is the way in which the family views and uses child discipline.** For instance, many African American households value child discipline as a critical part of childrearing that can effectively shape children’s behavior and help them make good life choices (Adkison-Johnson, 2015). **Understanding the intent and use of specific disciplinary strategies, as well as whether discipline is carried out primarily by male or female adult relatives, can help you better work with families** to improve parenting practices and reduce negative child behavior (like substance use) in a way that matches their cultural values.

2. What Is the Role of the Extended Family?

Extended family members within the household are typical in many cultures, especially those of diverse racial and ethnic backgrounds. For example, some families consist of grandparents raising their grandchildren; other families have multiple family groups dwelling together (e.g., two sisters and their spouses and children share a single-family home). Still others may include multiple generations—perhaps a single parent, grandparent, and adult sibling—all sharing the responsibility of raising a child. **But how does extended family relate to substance misuse?**

- **In a nationally representative survey (Cross, 2018), 35 percent of children reported ever living in an extended family unit.** Responses differed significantly by race and ethnicity, with only 20 percent of White children reporting having lived with an extended family versus 57 percent of African American children, 35 percent of Latino children, and 34 percent of “other race” children (“other race” was not defined by the study authors).
- **When it comes to substance misuse, extended families can be both positive and negative.**
 - Findings from the Los Angeles Family and Neighborhood Study and the decennial census (Kang, 2019) suggest that children living with extended family members are at an 18-percent increased risk of internalizing disorders and a 22-percent increased risk of externalizing disorders compared with children living in nuclear families. Extended families may exacerbate child misbehavior by increasing strain on family resources (e.g., leaving less time and money for the child), interfamily conflicts, and ineffective collective monitoring of children by multiple family members (Kang, 2019). In some research, extended family members introduced youth to substance use (Gilliard-Matthews, Stevens, Nilsen, & Dunaev, 2015).
 - Other studies suggest extended families can be protective against child/adolescent misbehavior and maladjustment (Bai, Leon, Garbarino, & Fuller, 2016), including



substance use (Areba et al., 2018) and can be an effective part of family counseling for SUDs (Zweben et al., 2015). For example, in a qualitative study of Mexican youth (Strunin et al., 2015), extended family members acted as mentors who provided guidance about safe and acceptable alcohol consumption and modeled negative effects of alcohol misuse, positively shaping youth behavior.

3. What Is the Role of Religion or Spirituality Within This Family?

Many diverse family cultures find strength and support from their spiritual or religious beliefs and activities, including prayer and attending services at faith-based institutions.

- **Religious or spiritual beliefs or activities may influence the family's engagement and participation in counseling.** For instance, African American individuals may seek help for SUDs from spiritual or religious leaders (Wong, Derose, Litt, & Miles, 2018) or may view mental illness through a spiritual or religious lens. In Latino communities, church leaders, such as priests, may be sources of help seeking or referrals for formal SUD treatment (Cuadrado, 2018). SUD treatment providers should understand that cultural beliefs and practices may influence help-seeking behaviors. Thus, some families may be reluctant to accept services or may decline them altogether.
- **Family encouragement of faith-based activities can help people seeking recovery.** In the National Longitudinal Study of Adolescent Health, Latino emerging adults engaged in public religious activities (e.g., attending church services, participating in church-related social activities) were less likely to binge drink or use cannabis than youth who were not "publicly religious" (Escobar & Vaughan, 2014).

4. What Is the Family's Immigration/Nativity Status? How Does This Affect Family Members' Level of Acculturation?

To understand family cultures and their subgroups, you must learn about their immigration history, because this may be

connected to their substance misuse (Marsiglia, Nagoshi, Parsai, & Castro, 2014). Family-based SUD interventions, including prevention programming, also may have different effects depending on nativity (Cordova, Huang, Pantin, & Prado, 2012).

- **Some people leave their home country voluntarily to pursue opportunities or escape poverty. Refugees, on the other hand, may flee persecution, fear for their safety, and have much more pain and anger associated with their migration.** Those who come from war-torn countries may show symptoms of posttraumatic stress disorder (PTSD) and other associated trauma; symptoms might include substance misuse.
- **Immigration status can affect parent-child relationships when one or both parents immigrate before the child. Parent-child separation can cause major stress and dysfunction in family relationships** (e.g., poor attachments, feelings of abandonment). When people immigrate to the United States, it is not uncommon for them to feel family-, work-, and money-related stressors, which can increase the chances of substance misuse.
- **Degree of acculturation is linked to substance use behaviors and SUD treatment outcomes.**
 - Among Latinos and Asians, greater acculturation may increase the risk of alcohol use, whereas lower acculturation and more recent immigration status may lower the risk of substance misuse because of the presence of protective factors like stronger family cohesion (Vaeth, Wang-Schweig, & Caetano, 2017). Differences in acculturation may be particularly relevant in cases where a person is using substances to cope with stress related to parent-child differences in acculturation.
 - A study of SUD treatment outcomes from motivational enhancement provided to Latino individuals found differences among subgroups (e.g., Cuban Americans, Mexican Americans, Puerto Ricans, and other Latino Americans) and among levels of acculturation, including differences in treatment retention and percentage of days abstinent (Chartier et al., 2015).

- In the National Latino and Asian American Study (Savage & Mezuk, 2014), higher acculturation increased the risk of lifetime alcohol use disorder (AUD) and drug use disorder by 1.67 to 1.8 times.

5. Are There Culture-Specific Family Values To Be Aware Of?

Strong and stable cultural values may be protective against substance misuse in racially and ethnically diverse families, such as Latino families (Cruz, King, Cauce, Conger, & Robins, 2017):

- *Familism* or *familismo* may be present in Latino families (Santisteban et al., 2013). These terms refer to the primary values, structures, and expectations of the family, which shape each family member's behavior. *Familism* may lead family members to make decisions that are best for the family as a whole as opposed to the individual. It has three components: (1) perceived duties related to helping family members; (2) dependence on family members' support; and (3) use of family members as behavioral and attitudinal referents. *Familism* emphasizes enmeshment within the family, high family loyalty, and pride in the family as a cohesive unit.
- High *familism* may be beneficial in shaping healthy behaviors (like not misusing substances) if that is what is valued by the family. Yet if substance misuse happens within the family, especially across generations, *familism* may reinforce these negative behaviors by normalizing them. In one study of Latino adolescents, 3-month substance misuse was significantly correlated with lower levels of *familism* (Ma et al., 2017).

6. How Does the Family's Culture Affect Their Communication Style?

Understanding the culture-specific ways in which family members talk with one another will help you better understand the context for how the family functions, the dynamics between family members, and what contributes to the family's dysfunction. This in turn can inform the person's chances of achieving and sustaining recovery from substance misuse.

- For instance, in a study of Asian and Pacific Islander individuals, family openness about communicating about substance use was a positive factor in SUD treatment seeking, whereas family noncommunication about substance use was seen as discriminating and a barrier to treatment success (Chang et al., 2017).
- **Communication style also can shape the way families resolve conflicts.**
 - The concept of *respeto* refers to Latino values of respect in the family, which can influence communication and dealing with conflict between parents and children. Openly disagreeing with parents or voicing one's opinion goes against the concept of *respeto* and is considered negative behavior (Santisteban et al., 2013). Thus, counseling techniques that fail to account for *respeto* and that urge adolescents to "speak out" against their parents may be counterproductive.
 - *Simpatía*, a focus on interpersonal relationship harmony, is another aspect of traditional communication styles in many Latino families. Greater *respeto* and *simpatía* have been linked to lower levels of Latino youth drug and alcohol use over 3 months and to abstinence from substances (Ma et al., 2017).

7. How Does This Family Experience Racism and Discrimination? How Do Those Experiences, Along With Historical Trauma, Affect the Family?

Feelings of racism and discrimination can increase the risk for substance misuse among people of diverse races and ethnicities.

- In the National Latino and Asian American Study (Savage & Mezuk, 2014), discrimination increased the risk of lifetime AUD and drug use disorder by 1.4 to 1.54 times.
- Structural racism has led to multiple systemic effects on African American families in many forms, such as socioeconomic disparities, voter suppression, educational disadvantages, and racial discrimination (Kelly, Maynigo, Wesley, &



Durham, 2013). These challenges are significant stressors and may increase the changes seen in individuals misusing substances as a coping mechanism.

Also be sure to acknowledge the significance of historical trauma, and consider whether it is playing a role in the family's substance use problems. Certain cultures, like African American and AI/AN populations, have suffered for decades from social injustices, extreme physical and emotional trauma, and ongoing discrimination and prejudice. These experiences have had lasting effects on individuals and families. For instance, there is a widely held belief in AI/AN cultures that loss of culture because of historical trauma and ongoing mistreatment is a primary cause of mental disorders and SUDs in this population today (SAMHSA, 2018). It may be important to address such issues with families before families with substance misuse can fully recover.

8. Has the Family Experienced Any Periods of Separation (Particularly Between Parent and Child)?

In certain family cultures, parent-child separations may happen, sometimes repeatedly. Notable examples include families in which parents and children have immigrated separately and military

families in which a parent has been deployed. In some of these cases, one parent may take over parenting responsibilities alone, grandparents may take over the duties of raising children, or children may stay with other members of their extended family or with family friends.

- **Parental separation from children is a strong independent risk factor for early substance use in children.** In a sample of more than 3,000 adolescent and adult children (about 26 percent of whom were African American and 8 percent of whom were of unspecified race or ethnicity), parental separation happening between ages 12 and 17 was as strong a predictor of initiating alcohol use before age 13 and of initiating cigarette and cannabis use before age 16 as living in a household with two parents with AUD (McCutcheon et al., 2018).
- **Youth in military families are at an increased risk of substance misuse compared with adolescents from civilian families.** In one study, military family youth were 50 percent more likely than civilian youth to report both current and lifetime substance use (Sullivan et al., 2015). Long deployments are particularly stressful to children and parents and increase the odds of psychological maladjustment (Nicosia, Wong, Shier, Massachi, & Datar, 2017).

COUNSELOR NOTE: ARE PARENTING INTERVENTIONS FOR SUDs AMONG RACIALLY/ETHNICALLY DIVERSE ADOLESCENTS EFFECTIVE?

SUD prevention programs that target parent training appear to be effective, but comparatively less research has looked at racially and ethnically diverse families versus White families. What does the available research say? A review from Garcia-Huidobro, Doty, Davis, Borowsky, and Allen (2018) found the following:

- Of 38 studies examined, 9 (23.7 percent) included a majority of White/European families, 5 (13.2 percent) included Black/African American families, 4 (10.5 percent) included Latino families, and 1 (2.6 percent) included Asian families, whereas 19 (50 percent) included diverse populations.
- Among adolescents from multiple races or ethnicities, parent training was associated with improved scores on all substance use outcomes except for polysubstance use.
- Among the five studies investigating Black/African American families, parent training was linked to lowered tobacco, alcohol, and polysubstance use but not illicit substance use.
- Three interventions among Latino families were efficacious across all substance use outcomes.
- The one study focusing on Asian families found parent training to be efficacious for alcohol and illicit substance use but not tobacco use.

SUD Treatment for Specific Family Cultures

This section presents brief summaries of the empirical evidence (Exhibit 5.2) on family-based SUD interventions for family cultures likely to be seen in your service setting, including families of diverse racial and ethnic backgrounds, LGBT families, and military families. This information is not meant to cover everything you need to know about offering SUD treatment to these family cultures; instead, it is designed to give you a broad overview of what evidence-based treatments exist and how you can tailor existing treatments and services to a family's unique needs.

SUD Treatment for African American Families

Family-based interventions for SUDs that have support for use with African American families include MST, MDFT, and BSFT (Huey & Polo, 2017; Pina, Polo, & Huey, 2019; Rowe, 2012). BSFT has been accepted by SAMHSA as a model program for reducing or eliminating adolescent substance use behaviors and is effective for minority youth (particularly African American and Latino youth) (U.S. Department of Health and Human Services, Office of Minority Health, 2018).

In a sample of runaway youth in which 66 percent of participants were African American, ecologically based family therapy led to a decrease in percentage of days with substance use. Non-White adolescents showed significantly greater reductions than White youth (Slesnick, Erdem, Bartle-Haring, & Brigham, 2013). Treatment nonattendance was lower in the family therapy condition (12 percent) than in a motivational interviewing treatment group (34 percent) and a community reinforcement approach intervention group (26 percent); however, proportionally, there were no differences in the number of sessions attended across the three groups.

Over the past decade, increasing evidence has emerged in support of a family-based intervention designed for rural African American families—the Strong African American Families (SAAF) Program. Developed at the University of Georgia, SAAF focuses on the primary prevention or elimination of conduct problems and negative health behaviors (including substance use) in rural African American early adolescents. SAAF has been shown to be effective in improving targeted parenting practices, adolescent self-regulation, and youth vulnerability to problem behaviors (Kogan et al., 2016). Brody, Chen, Kogan, Yu, and colleagues (2012) examined SAAF for reduction of

EXHIBIT 5.2. Family-Based SUD Services for Youth of Diverse Races/Ethnicities

Pina and colleagues (2019) recently reviewed the empirical evidence in support of psychosocial interventions for adolescents from diverse ethnic and racial backgrounds. Many of the studies included samples of multiple racial and ethnic groups. How did family-focused services fare in these studies of diverse groups of children? Among their findings were the following:

- In a sample of African American, Asian American, European American, and AI teens, multisystemic therapy (MST) led to lower alcohol, cannabis, and other drug use versus usual care.
- In a sample of Latino, African American, Haitian or Jamaican, and European American youth, MDFT was associated with lower alcohol and cannabis use than peer group therapy.
- In a sample of African American, Latino, European American, and AI adolescents, ecologically based family therapy and functional family therapy led to lower alcohol and drug use versus usual care.
- In a sample of African American, Latino, and European American youth, BSFT was associated with greater decreases in days of self-reported drug use versus usual care.
- In a sample of Latino teens, CIFFTA was associated with less cannabis and cocaine use than traditional family therapy.



substance use, conduct problems, and depressive symptoms. Techniques included teen and caregiver skill building, prevention programming, health promotion education and skills, and adaptive racial socialization (i.e., helping youth develop racial pride and teaching them how to deal with racism and discrimination). Over 22 months, the intervention was associated with a 32-percent decrease in substance use and a 47-percent decrease in related problems.

An offshoot of the original SAAF Program, called Protecting Strong African American Families (PSAAF), is similarly focused on reducing problem behaviors and health risks in rural African American adolescents but is specifically for two-parent African American households (Barton et al., 2018; Beach et al., 2016). Components of the intervention include (Beach et al., 2016):

- Delivery of services in the home to foster greater participation by fathers.
- A heavy focus on effective coparenting, including monitoring children's behavior, enforcing family rules, and instilling in children a sense of racial pride (racial socialization).
- Techniques to improve communication and problem-solving between couples.
- An emphasis on addressing specific domains of stress for African American families, including work, racism, finances, and extended family issues.

Compared with control families, families in PSAAF showed better improvements in parental monitoring; racial socialization (improved but nonsignificant versus controls); and adolescent conduct problems, self-concept, and substance use initiation at follow-up (Beach et al., 2016).

Adapting Family-Based SUD Interventions for African American Families

When working with African American families, it may be helpful to tailor treatments and services by:

- **Including racial socialization promotion strategies.** Helping African American adolescents develop a sense of pride about

their race and ethnicity and effectively manage discrimination are considered protective practices that can improve self-regulation and promote healthy behaviors, like choosing not to misuse substances (Beach et al., 2016). SUD counselors should incorporate techniques that address racial pride and discrimination into family-based SUD interventions.

- **Helping parents strengthen their bonds with one another.** In African American families with two parents, interventions focused on coparenting and reducing couple strain may be critical to preventing and improving children's health-risk behavior, including substance use (Beach et al., 2016). Family counseling that includes techniques specifically for parents may help enhance family communication and instill in children strength and resiliency.
- **Using culturally relevant storytelling.** Cunningham, Foster, and Warner (2010) note how counselor use of personal narratives during MST for adolescent substance use was particularly effective for African American parents by helping support and reinforce decision making. Other counselor behaviors and core skills they report as beneficial for engaging African American families in MST for substance use and other externalizing disorders include:
 - **Offering instrumental support** (i.e., support for practical, everyday needs such as transportation and finances).
 - **Being willing to accept gifts** from families and invitations to attend special family events.
 - Using a **strengths-based approach** and **positive reinforcement**.
 - **Validating and empathizing** with the family member's point of view.
 - Helping families build skills by **directly educating** them (versus using indirect instruction).
 - Being **open and honest** in admitting to families when you make a mistake or do not have information or knowledge about a particular topic, question, or problem.

COUNSELOR NOTE: BOOSTING AFRICAN AMERICANS' ATTENDANCE AT FAMILY COUNSELING

A small qualitative study (Awosan, Sandberg, & Hall, 2011, p. 159) asked African American clients who previously attended family counseling about perceived obstacles to engaging in services. Common concerns included:

- The **mismatch between the ethnicity of the clients and the counselor**, which some respondents felt created a sense of mistrust.
- The **high cost** of therapy.
- The **lack of support for counseling** within the African American community at large (e.g., the belief that you shouldn't be talking about your problems with a counselor, feeling that counseling will be unhelpful).

When asked about what advice they would give clinicians to improve African American engagement and participation in family counseling, responses included:

- "Create a program/campaign to attract people of **all** cultures to become therapists."
- "I would encourage those who can to try to place themselves where they can experience the disparity... take up residence in a Black neighborhood.... To remove obstacles, educate yourselves as much as you can about race and cultural issues in America."
- "Connect with others [in the] Black community. [Be] open to Afro-centric approaches in therapy and the need to understand Black culture."

SUD Treatment for Latino Families

Substantial research documents underuse of services by Latino families, but **family counseling can effectively reduce substance misuse in Latino individuals**, especially adolescents (Henderson, Hogue, & Dauber, 2019; Hogue et al., 2015; Pina et al., 2019). For example:

- A meta-analysis examined the **effectiveness of seven culturally responsive SUD studies for diverse racial and ethnic adolescents—six of which targeted Latino populations** in part or entirely (Steinka-Fry et al., 2017). Across all studies, there were significant reductions in youth substance use via interventions like Conjoint Family Therapy, BSFT, MDFT, and the CIFFTA Program.
- Another meta-analysis focused solely on culturally responsive interventions for Latino youth with SUDs (Hernandez Robles, Maynard, Salas-Wright, & Todric, 2018) reported **small but positive effects of culturally responsive interventions on improving substance use outcomes**.
- Of the 10 studies examined, 2 used BSFT or structured family therapy, and 4 included parents as part of the intervention.
- The authors note that 90 percent of the studies integrated cultural values into services, with *familism* and *respeto* being among the most common. (See "General Considerations When Working With Diverse Family Cultures" for a brief explanation of these concepts.)
- An analysis of the Bridges to High School Program—a culturally adapted, family-based intervention to prevent future SUDs and mental disorders in middle-school youth—found the program was associated with lowered substance use at 5-year follow-up (Jensen et al., 2014). Analyses indicate **the intervention's effects on reducing substance use stemmed in part from improvements in mother-adolescent conflict**. Additionally, higher levels of acculturation were associated with greater number of substances used.



- **Culturally adapted cognitive-behavioral therapy (CBT) for Latino adolescents and their parents** (Burrow-Sánchez, Minami, & Hops, 2015) **is associated with improvements** in the number of days of youth substance use, with ethnic identity and parental levels of *familism* moderating this effect. Specifically:
 - Adolescents receiving adapted CBT who displayed greater exploration of and commitment to their ethnic identity showed a lower mean number of days of substance use at posttreatment and 3-month follow-up than did adolescents in the adapted-CBT group with low exploration of and commitment to ethnic identity.
 - Higher parent *familism* in the adapted-CBT group was associated with lower mean number of days of substance use at 3-month follow-up than lower *familism* in the adapted-CBT group.
- Two prospective studies of **family-based interventions for SUDs among Latino individuals** (Sparks, Tisch, & Gardner, 2013) reported **significant improvements in substance use after the intervention** compared with baseline measurements. Enhancements in Latino families were often on par with, and in some cases better than, improvements among non-Latino families, including improvements in:
 - Parenting skills.
 - Drug and alcohol use.
 - Family strengths/resilience.
 - Parent observations of children's activities.
 - Parents' social/cognitive skills.
- In a randomized clinical trial of **MDFT in juvenile drug court**, Dakof et al. (2015) found treatment **resulted in significant reductions in substance use**, although reductions were no different from those in a control condition of adolescent group therapy. The study sample was 59 percent Latino and 35 percent African American.
- **Collaborating with community faith leaders may help behavioral health service providers target Latino families in need of mental disorder and substance use-related treatment** (Villatoro, Morales, & Mays, 2014).

Adapting Family-Based SUD Interventions for Latino Families

In Steinka-Fry et al.'s (2017) meta-analysis of culturally responsive SUD interventions for adolescents, culturally responsive treatment components among Latino families included:

- The provision of **racially and ethnically diverse clinicians** (though not necessarily matched to the race or ethnicity of clients/families).
- Use of written materials for parents that were delivered **in their native language**.
- **Spanish-speaking counselors**.
- **Easily accessible** treatment locations.
- **Convenient scheduling**.
- **Culture-informed assessments and treatment planning**.
- Treatment planning and delivery **tailored to families who have trouble engaging in services**.

COUNSELOR NOTE: FAITH, LATINO FAMILY CULTURE, AND SEEKING HELP FOR MENTAL ILLNESS AND SUBSTANCE MISUSE

Findings from the National Latino and Asian American Study (Villatoro et al., 2014) suggest that family culture plays a role in whether Latino families seek mental health services or SUD treatment. Specifically, families with high levels of behavioral *familismo* (defined as level of perceived family support) were significantly more likely to seek informal or religious services (e.g., folk healers, mutual-help groups, online support groups, religious leaders) for mental and substance use-related needs than to seek mental health services. The authors suggest that these types of services may be more culturally aligned with Latino families or may be deemed more "acceptable" because of the prejudice associated with attending formal mental health services.

Why does this finding matter? Because Latino populations are known to underuse mental health services.

Other suggested approaches when working with Latino families include the following:

- **Have a working knowledge of how substance use is defined in the family's country of origin.** Many countries of origin, such as Mexico, have a culture that is more permissive toward substance use. Immigration and acculturation into the United States may alter family members' attitudes toward substance use. Such changes must be addressed, given their immediate effect on family relations.
- **Be aware of regional and national differences** (e.g., North, Central, and South American cultural diversity in the Hispanic diaspora; Spanish as spoken in Mexico versus as spoken in Argentina or Spain or the Dominican Republic).
- **Explore family members' experiences of migration, cultural transition, and ethnic-minority status.** Hold an open discussion about these experiences, which will help you analyze family stories and lead directly to issues affecting substance misuse. For instance, a discussion concerning how family members reconcile their culture of origin and American culture will reveal differing acculturation levels within the family. Also explore the issue through the simple exercise of having family members rate how close they feel to their culture of origin on a scale from 1 to 10. Counselors must make arrangements so that language does not impede a family member's participation.
- **If you plan to work with Latino families with origins in Mexico, be familiar with spiritual healers, the *curandero* or *curandera*** (i.e., folk healer). These healers can help resolve intrapsychic and interpersonal problems. *Curanderismo*, or the art of folk healing, is a particular treatment modality used primarily in Latino/Southwestern rural communities, although it is also prevalent in metropolitan areas with a large Latino population. *Curanderos* earn their trust from the community; the community validates their "practice." This modality contains a mix of psychological, spiritual, and personal belief factors. Because the *curanderos* are considered to be holy, they invoke God's and the saints' blessings on people seeking their help.

- Rather than using a businesslike approach to treatment, which will not appeal to many Latino families, **take a personable tack**, which will yield much more effective results.
- **Be attentive to family conflict, which could affect substance use.** One study of SUD treatment among Latino adults found that people who had a decrease in family conflict from pretreatment to posttreatment showed less alcohol and drug use at posttreatment than individuals who had an increase in family conflict from pretreatment to posttreatment (Fish, Maier, & Priest, 2015).

For more guidance about family counseling with Latino families, see "Resource Alert: Recovery and Mental Health Services for Latino Families."

RESOURCE ALERT: RECOVERY AND MENTAL HEALTH SERVICES FOR LATINO FAMILIES

The National Resource Center for Healthy Marriage and Families offers a toolkit for stakeholders serving the mental health needs of Latino individuals, couples, and families. The guide includes:

- A brief summary of cultures and values common in Latino families.
- A discussion of immigration and acculturation and how these factors influence families.
- Ways to improve engagement and retention of Latino families in services.
- Resources for integrating marriage and relationship education into services.

Access the toolkit at www.healthymarriageandfamilies.org/library-resource/working-latino-individuals-couples-and-families-toolkit-stakeholders.



SUD Treatment for Asian American Families

Family-based drug and alcohol use interventions for Asian American families have not been rigorously studied, but **the small amount of evidence seems positive**. Culturally appropriate treatment models include CBT, strategic and structural family therapy, and solution-focused brief therapy (Cheung, 2014). Specific study findings include the following:

- **Family counseling for Asian individuals with SUDs has been linked to decreased substance use as well as improved family relationships** (Fang & Schinke, 2014).
- In a meta-analysis of parenting interventions for adolescent substance use, one study was focused on Asian American youth; it found the **parenting intervention was associated with significant reductions in teen alcohol and illicit substance use** (Garcia-Huidobro et al., 2018).
- In a small investigation of Asian American mother–daughter dyads (Fang & Schinke, 2013), **a family-based, Internet-delivered intervention for SUDs that focused on mother–daughter relationships**, conflict resolution, substance use risk, body image, mood and stress management, problem-solving, social relationships, and self-efficacy **resulted in many positive outcomes** versus a control condition. These included:
 - Higher levels of mother–daughter closeness.
 - Improved mother–daughter communication.
 - Increased maternal monitoring.
 - Enhanced parental rules against substance use.
 - Higher self-efficacy.
 - Greater youth substance refusal skills.
 - Less intention to use substances in the future.
 - Reduced 30-day alcohol, cannabis, and nonmedical prescription drug use by daughters.

Adapting Family-Based SUD Interventions for Asian American Families

To help address cultural barriers and ensure treatment/service delivery meets the unique needs of this population, consider the following guidance:

- **To ensure you are offering appropriate and effective family-based interventions for Asian families, consider taking the following steps** (Cheung, 2014):
 - Strive toward multicultural competency.
 - Acknowledge and respect Asian collectivist worldviews, values, and customs, and understand how collectivism affects family functioning.
 - **Learn the family’s immigration history** and any resulting disruptions in the family structure.
 - **Understand that Asian American families are often complex** in structure and can differ in how traditional versus modern they are, their biculturalism, and their degree of “Americanization.”
 - **Use strategies that Asian American families are comfortable with**, like hypothesizing, perspective taking, gift giving, and balancing “problem talk” with “solution talk.”
 - **Share** personal anecdotes or personal information with families, as appropriate.
 - **Conceptualize your role from multiple views** rather than just seeing yourself as the family’s counselor—for instance, view yourself as a teacher and community liaison for the family.
 - **Avoid thinking of all Asian American families as belonging to one single ethnic group**. Rather, clinical programming, approaches, and treatment/service materials should be congruent with and adapted to the unique languages, values, family structure, and life circumstances (e.g., immigration status, history of discrimination) of the many heterogeneous subgroups that Asian American families comprise (Chang et al., 2017; Cheung, 2014), such as Chinese, Korean, Japanese, Vietnamese, and Thai populations. This is particularly important because adolescent substance use and risk factors for misuse can vary across Asian subgroups, which are discussed further below (Shih et al., 2015).
- **Include family members in treatment, with an emphasis on educating them about the recovery process and why recovery**

is important. Research on Asian American and Pacific Islander individuals suggests these groups have problems with or have been reluctant to enter SUD treatment in part because of certain family factors. Family misunderstandings or misperceptions about SUDs and the need for treatment can cause recoverees shame and embarrassment about seeking help.

- **Explore families' level of acculturation and acculturation stress** (Cheung, 2014), which have been linked to substance use and misuse across subgroups of Asians immigrating to the United States (Park, Anastas, Shibusawa, & Nguyen, 2014). (Subgroups—or cultures within a culture, as discussed previously—are secondary cultures within the Asian culture at large, such as Chinese people, Japanese people, Korean people, Vietnamese people, and so forth. Subgroups often have separate languages, customs, beliefs, and value systems.)
 - **Asian subgroups are deeply heterogenous** in the social, cultural, historical, and contextual factors surrounding their immigration and acculturation experiences. Take time to educate yourself about a family's specific background.
 - **Also be mindful that acculturation and immigration among Asian immigrants can vary by generation.** The life experiences of newly immigrated individuals and those not yet proficient in English can affect risk of alcohol use differently than immigrants with a longer residency and greater acculturation into U.S. society (Park et al., 2014).
- **When possible, match counselors of similar race, ethnicity, or cultural background, similar language, or both to Asian American families** (Chang et al., 2017).
- **Know and incorporate into treatment the unique help-seeking and coping behaviors** often present in Asian Americans, including use of religion, meditation, and family support (Lei & Pellitteri, 2017).

SUD Treatment for AI/AN Families

Although family-based SUD programs for AI/AN populations are understudied, they appear to be

effective, particularly for youth (Pina et al., 2019). Liddell and Burnette's (2017) review of culturally informed SUD interventions for indigenous youth found that all included studies reported some degree of improvement in alcohol or drug use and that community or family involvement was a key component in many studies. There were also improvements in family support and relationships, and the inclusion of family or community into service/interventions was well accepted.

In another review, Rowan et al. (2014) examined interventions offered to indigenous clients (and often their families), which included some aspect of Western-based SUD services (e.g., assessment, education, counseling, treatment, continuing care services) as well as traditional cultural services. The following **positive outcomes were reported among the studies that included families in their interventions:**

- Abstinence was maintained for 1 year in one-third to one-half of participants.
- Perceived level of family support was high among intervention recipients (94 percent).
- Percentage of days abstinent across 12 months ranged from 80 percent to 100 percent (but was not statistically different from a treatment-as-usual group).
- 30-day alcohol or drug use declined from 24 percent to 5 percent.
- Past-month substance-related stress/emotions/activities decreased from 47 percent to 23 percent.
- Part- or full-time employment increased from 11 percent to 20 percent.
- Enrollment in school or occupational training programs increased from 7 percent to 17 percent.
- Arrests and acts of criminal behavior decreased from 31 percent to 5 percent.
- Significant improvements were seen in self-reported depression, anxiety, problems concentrating, hallucinations, problems controlling violent behavior, and suicide attempt.

Other family-based substance use reduction or prevention programs have been adapted to the



needs of AI/AN families (Belone et al., 2017; Ivanich, Mousseau, Walls, Whitbeck, & Whitesell, 2020), but findings on substance use outcomes specifically are either currently unavailable (e.g., programs still being pilot tested) or have yet to show significant improvement. Further research will be needed to identify any potential substance-related benefits of such family-based programs.

SUD treatment for AI/AN families has been successfully provided via home visiting programs (Barlow et al., 2015). For instance, tribal home visiting programs funded through the federal Tribal Maternal, Infant, and Early Childhood Home Visiting Program have shown success in identifying and providing referrals for treatment of family-based substance use problems in AI/AN families (Novins, Ferron, Abramson, & Barlow, 2018). Programs offered include the:

- Parents as Teachers Program (<https://parentsasteachers.org>).
- Family Spirit Home Visiting Program (<http://caih.jhu.edu/programs/family-spirit>).
- Nurse-Family Partnership Program (www.nursefamilypartnership.org).
- Parent-Child Assistance Program (<http://depts.washington.edu/pcapu>).
- SafeCare Program (<http://safecare.publichealth.gsu.edu>).

Of nine programs surveyed (Novins et al., 2018), all implemented SUD screening and monitoring at intake and during in-home visits. All screened pregnant women and mothers; five also screened fathers. Eight offered referral for community-based SUD treatment, and six offered home-based SUD services. Eight made referrals to treatment programs with cultural elements or access to traditional providers.

Adapting Family-Based SUD Interventions for AI/AN Families

Family counseling techniques for AI/AN populations should take a systems approach that incorporates not just the family but the community, tribe, or clan. The following strategies can help you maintain such an approach and maximize positive substance-related outcomes for AI/AN families (SAMHSA, 2018):

- **Understand and acknowledge the interconnectedness of AI/AN families.** Family counseling with this population requires an approach wherein each member of the family is understood to be interconnected with one another as well as with the surrounding community, tribe, or clan. Thus, when change happens in an individual, it has ripple effects on the group or population at large. Nothing happens in isolation.
- **Help families build strong relationships between parents and children.** A review of protective factors against negative health outcomes in AI/AN youth found positive family bonds, including those between parent and child, were correlated with low substance use (Henson, Sabo, Trujillo, & Teufel-Shone, 2017).
- **Learn how the family defines itself:** Who is considered “family,” and what is each person’s role?
- Discuss with family members their **thoughts and feelings about participating in family counseling.**
- Discuss with family members their **thoughts and feelings about substance use.** Parent and grandparent norms have been shown to influence AI youth substance use. The presence of family members who discourage substance use is linked to lower intent to use (particularly alcohol, nicotine, and cannabis) in this population (Martinez, Ayers, Kulis, & Brown, 2015). Thus, open expression of antisubstance use messaging from parents and grandparents may be useful during family counseling in shaping adolescent behavior.
- Where appropriate, **include valued others** (e.g., community elders, spiritual healers) into service/treatments.
- **Use family genograms** to understand the family’s history, structure, values, and strengths.
- **Consider including family sculpting**—a family counseling technique that involves role-playing and acting out dramatic representations of past family events.
- Seek out information about and be willing to include **traditional healing practices.**

- Build relationships and connections with spiritual advisors, traditional healers, elders, and others in the AI/AN community.

Using Trauma-Informed Family Counseling in SUD Treatment for AI/AN Families

Another key aspect of culturally informed SUD treatment and services for AI/AN families is using **trauma-informed care** (Lucero & Bussey, 2015). This requires acknowledging and addressing trauma in three areas:

1. The historical trauma inflicted on AI/AN cultures as a whole (e.g., discrimination, forced relocation).
2. Intergenerational trauma passed down among family members (e.g., impact of suicides, adverse childhood experiences, and violence within the family and community).
3. Trauma felt by the individual misusing substances.

A trauma-informed approach means using (Lucero & Bussey, 2015):

- Trauma-informed screening and assessment tools.
- Treatment/service delivery that fosters feelings of safety.
- Staff training in recognizing and responding to trauma symptoms.
- Referrals to trauma-informed behavioral health services with providers who have worked with AI/AN clients.
- An interaction style that establishes trust and fosters mutually respectful relationships with families.

Myhra, Wieling, and Grant (2015) describe specific family dynamics of AI/AN families affected by SUDs. These dynamics may serve as important targets of clinical intervention or otherwise help inform effective service delivery. They include:

- The presence of **grandparents as a source of stability, safety, and security for grandchildren**, particularly when parents with SUDs are unable to care for their children.

- The need for **open communication about substance misuse** among family members, especially among parents/grandparents and children.
- The **importance of forgiveness** as a part of recovery and of healing broken family relationships.
- The use of **cultural and spiritual practices in promoting recovery** (e.g., sweat lodge practices, cultural ceremonies, passing down cultural and ancestral knowledge to children/grandchildren).

RESOURCE ALERT: TIP 61, BEHAVIORAL HEALTH SERVICES FOR AMERICAN INDIANS AND ALASKA NATIVES

SAMHSA recently developed an indepth guide for mental health service and SUD treatment provision for AI/AN clients. Download TIP 61, *Behavioral Health Services for American Indians and Alaska Natives*, from <https://store.samhsa.gov/product/tip-61-behavioral-health-services-for-american-indians-and-alaska-natives/sma18-5070>.

SUD Treatment for LGBT Families

Research is insufficient to suggest the efficacy of any one type of family counseling over another for use with LGBT families. In fact, little or no empirical research has been published investigating the use of family counseling in SUD treatment for these families. However, a review of SUD treatments for LGBT youth (Aromin, 2016) notes that **family therapy is often an effective and critical addition to individual treatment**. Specific benefits cited in the review include:

- Addressing substance use from a systems approach rather than solely as an individual problem.
- Identifying and repairing dysfunctional family dynamics, especially those influencing substance use.
- Teaching assertiveness training.
- Improving overall family functioning.



Notably, for youth who are nondisclosed and feel that discussions about their sexual orientation cannot be separated from discussions about their substance use, you should **weigh the pros and cons of including family in treatment/services** (Aromin, 2016). If family members are included, issues about confidentiality and treatment alliance may need to be addressed.

Strong, positive family relationships may buffer against substance misuse among LGBT individuals, as is the case among heterosexual individuals.

- For instance, findings from Waves I and III of the National Longitudinal Study of Adolescent to Adult Health (Magette, Durtschi, & Love, 2018) showed that emerging adults who reported close relationships with their mothers in adolescence were less likely to use cannabis, and a strong relationship with fathers during adolescence predicted significantly lower past-year illicit drug use.
- In a national survey of 12- to 17-year-olds (Padilla, Crisp, & Rew, 2010), parental acceptance of sexual orientation among LGBT youth (and particularly acceptance by mothers) was protective against future substance use. Specifically, parents' acceptance lowered the risk of substance use by 35 percent to 39 percent compared with adolescents who were not out to their parents or whose parents were nonaccepting of their sexual orientation.

These findings underscore the influence of parent-child relationships as possible risk factors for substance use later in life. They also suggest **the critical role of family counseling in supporting and strengthening bonds among LGBT families**, particularly during adolescence.

Adapting Family-Based SUD Interventions for LGBT Families

There is a significant lack of empirically validated research about family-based SUD counseling for LGBT families. Thus, identifying effective changes for this population is difficult. However, it can be useful to consider research on family and couples therapy with LGBT populations in general to learn

which adaptations may be useful when applied in the context of SUD treatment.

For instance, **guidance on how to adapt attachment-based family therapy to gay and lesbian adults with nonaccepting family members includes** the following (Diamond & Shpigel, 2014):

- **Focus on alliance building, including getting to know clients and their perceptions of the problem.** Many LGBT individuals have had problems with developing and sustaining healthy attachments with their family. Thus, rapport building is an important goal of counseling and helps build trust, empathy, and confidence.
- **Help clients prepare to invite family into treatment.** Work with them on the possibility that family will reject their invitation. Use individual sessions to discuss and role-play conversations with family members, or have clients express their thoughts and feelings to family by writing a letter.
- As needed, **have a separate session with nonaccepting family members**, such as parents, alone. If family members are not accepting of your client's sexual orientation, they may feel avoidant or resentful of engaging in family counseling. You may need to gently challenge their false beliefs about their family member's sexuality while remaining compassionate and empathetic.

Other general guiding principles include:

- **Address your own potential biases about LGBT couples and families.** Most communities have some sort of visible LGBT organizations, and countless Internet resources are readily available.
- Family can be a very sensitive issue for LGBT clients. **Use the client's definition of family rather than relying on a heterosexual-based model.** For example, an LGBT client may define family as same-sex parents and their children, rather than a mother and father with children.
- Likewise, **be accepting of whatever identification an individual chooses for himself or herself and be responsive to the need to be inclusive and nonjudgmental** in word choice.

For example, gender-neutral words and phrases may be preferred, such as *partner* rather than *husband* or *wife*. Such an approach will ensure a greater likelihood that people will continue with therapy.

- **Do not overpathologize issues of boundaries and fusion.** Many LGBT couples appear to have more permeable boundaries than are commonly seen among heterosexual couples. For example, a lesbian may seek support from an expartner to help with troubles with a current partner more often than would typically be seen in a heterosexual woman. When violence between partners is a treatment issue, safety must be the counselor's main concern.
- Many LGBT clients may be reluctant to include other members of their families of origin in therapy because they fear rejection and further distancing. **Be open to including nontraditional family members or using nontraditional family models,** such as one-person family counseling, which incorporates a family focus without treating the whole family of origin. Be alert to possible substance misuse or mental illness among LGBT clients' nontraditional family members as well.
- **LGBT individuals should not be urged to come out when they are not ready.**

SUD Treatment for Military Families

Active duty and veteran military personnel are at an increased risk for substance misuse, including AUD, drug use disorders, past-month heavy episodic drinking, daily cigarette use, and prescription drug misuse (Hoggatt, Lehavot, Krenek, Schweizer, & Simpson, 2017; Teeters, Lancaster, Brown, & Back, 2017). Additionally, **spouses and children of military members are vulnerable to substance misuse** (Sullivan et al., 2015; Trone et al., 2018). Thus, family-based approaches in SUD treatment for military personnel can be key.

Nearly all of the empirical research on SUD treatment in military populations has been focused on individual treatment effects rather than the effects of family-based interventions. Furthermore, an abundance of family-based research in military populations concerns topics like deployment,

suicide/violence, or PTSD, not SUDs. Thus, **it is difficult to know the degree to which family counseling for substance misuse has been successfully used with military families.** Examples of available evidence-based findings include the following:

- In a very small study of male military veterans and female spouses, behavioral couples therapy for AUD combined with cognitive-behavioral conjoint therapy was associated with a reduction in percentage of days of heavy alcohol use and PTSD symptoms (Schumm, Monson, O'Farrell, Gustin, & Chard, 2015).
- A web-based adaptation of Community Reinforcement and Family Training was efficacious in improving social support, relationship quality, family conflict, and spouse perceptions of partner drinking rates (Osilla et al., 2018).

The Department of Defense has made concerted efforts to better address family-wide problems felt by military personnel, including marital issues, child behavioral problems, and adjustment problems, through programs such as Military and Family Life Counseling (MFLC) and Military OneSource. These programs provide services like couples counseling, psychotherapy, suicide prevention, screening, pharmacotherapy, telehealth, inpatient psychiatric care, residential treatment, and SUD treatment (Trail et al., 2017). Unfortunately, little peer-reviewed research has been conducted to assess the efficacy and cost-effectiveness of these programs (Trail et al., 2017), especially regarding SUD services and outcomes. However, **recent analyses from the RAND Corporation suggest these programs can be effective at** (Trail et al., 2017):

- Reducing short- and long-term **problem severity.**
- Reducing interference with **work and daily functioning.**
- Providing **needed referrals** for outside services (including mental health services).
- Improving **stress (work-related and life stress) and anxiety.**
- Meeting clients' **treatment expectations.** Specifically, over 90 percent of participants reported feeling satisfied with the speed with



which care was accessed, the confidentiality of the care, and continuity of services.

- **Responding to military-specific needs.** Specifically, 25 percent of MFLC participants agreed, and 69 percent strongly agreed, that the counselor understood military culture. For Military OneSource participants, 34 percent agreed and 44 percent strongly agreed that the counselor understood military culture.

Adapting Family-Based SUD Interventions for Military Families

Because of the lack of empirical data on family-based SUD treatment for military populations, our understanding of how to adapt traditional family-based SUD interventions for the needs of military families is limited. However, you can draw guidance from research on family counseling for military families in general. Consider the following when working with these families:

- **For adolescents with or at risk for SUDs, ensure parent involvement in services/treatment.**
 - A study of data from the 2004 to 2013 National Surveys on Drug Use and Health revealed that adolescent children of veteran fathers were more likely than children of nonveteran fathers to report lifetime, past-year, and past-month use of tobacco and nonmedical use of psychotropic medication as well as lifetime cannabis use (Lipari et al., 2017). Lower father involvement predicted greater chances of youth substance use in this study.
 - The authors suggest that **parent involvement and communication with children about substance use can be valuable, especially for prevention efforts.** They note that “formal support from programs serving veterans’ families may be necessary to address prevention or intervention for adolescents’ substance use. In addition, effectively supporting families requires the active participation of a network of stakeholders, including extended family members, schools, health and mental health care providers, community leaders and groups, private associations, and faith-based and civic organizations” (p. 705).

- **Educate yourself about military culture, including what life is like for military families.** The RAND assessment of MFLC and Military OneSource (Trail et al., 2017) indicates that, although most participants felt counselors understood military culture, many did not, and that was considered a barrier to successful treatment.
- **Consider stressors related to military life that may exacerbate or increase the risk for substance misuse.** Military family life can be very difficult for families, and children especially, in large part because of parent/spouse deployment and repeated household relocations. These events can be a strain on children (Lester et al., 2016) because of:
 - Having to take over household responsibilities while a parent is deployed.
 - Fears about parent safety while deployed.
 - Reunification and readjusting to life with the returning parent back in the home.
 - Helping care for a parent who returns with combat-related injuries or trauma.
 - Adjustment problems with fitting into new schools and communities.
 - Having to form new bonds with teachers.
 - Having to build new friendships and integrate into new peer groups.

When working with military families on substance use-related issues, it may be helpful to consider the overall context of military family life and related burdens placed on service members, spouses, and children because of deployment, relocation, or other military-related events and factors. It is possible that recovery will not be successfully achieved and maintained without also addressing such stressors if present, as they could make return to substance use more likely.

- **Accept that being in the military is extremely demanding and all encompassing; it is not “just a job.”** Military life is “24/7.” Working effectively with military families means understanding that the person serving in the military (and his or her family) has made an extraordinary sacrifice and commitment. In a way, the military as an institution almost operates as a third person in the marriage,

RESOURCE ALERT: PROVIDING SUD SERVICES FOR MILITARY FAMILIES

- The National Child Traumatic Stress Network supports interventions to help lower substance use and other unhealthy behaviors in military-family youth. They offer multiple resources specifically for active duty and veteran families to help them cope with the stress (and trauma) of military family life.
 - A listing of resources can be found here: www.nctsn.org/what-is-child-trauma/populations-at-risk/military-and-veteran-families/nctsn-resources.
 - Online courses about evidence-based military-informed care for families can be found here: <https://learn.nctsn.org/course/index.php?categoryid=28>.
- SAMHSA's Service Members, Veterans, and their Families Technical Assistance Center provides training, technical assistance, and consultation to address the behavioral health needs of service members, veterans, and their families. Visit the center's website for more information (www.samhsa.gov/smvf-ta-center).

creating a relational triangle (as reflected in the common remark from spouses, "My husband is married to the military") that may need to be addressed (Moon, 2016, p. 130).

- **Because military service is often transgenerational, explore whether substance use patterns in military personnel were present in other generations of the family who served** (Moon, 2016). For instance, a father in the Army who drinks heavily may have grown up with a father who, like him, served in the Army and drank heavily, perhaps to cope with stress or trauma. This normalizes the substance misuse and, if unaddressed, can become a barrier to recovery.
- **Explore your own thoughts, beliefs, and biases about the military and military culture.** Do this preparation before interacting with military families. The goal is to avoid any reactions you might have that could negatively influence your work with these families (Moon, 2016).

Where Do We Go From Here?

You will encounter many diverse types of families in your clinical setting, but no two families are the same. Understanding why you may need to make adaptations to treatment for certain family cultures and how to make those adaptations will increase your chances of success in helping them achieve good outcomes. But it is not enough for just counselors to develop this knowledge. Service delivery that is responsive to families and their cultural needs requires the integration of appropriate staff training, competency, and supervision throughout the entire program. In the next chapter, readers will learn how administrators and supervisors can collaborate with providers to accomplish comprehensive, integrated family counseling for SUD treatment. The goal is to develop SUD programs that successfully provide high-quality, evidence-based care, including referrals, outreach, community linkage, SUD services, and SUD treatments for all families with substance misuse.

Chapter 6—Administrative and Programmatic Considerations

KEY MESSAGES

- The key to integrating family-based interventions into substance use disorder (SUD) treatment programs is to create a family-centered culture throughout the organization.
- Cross-training and ongoing supervision are essential for SUD treatment providers to achieve competency in family-based interventions.
- Clinical supervisors overseeing integration efforts should have experience and training in family counseling as well as SUD treatment.
- Provider collaboration supports greater service access and a “no wrong door” approach to treatment by facilitating successful referrals, effective engagement, and meaningful partnerships with community resources.

Helping individuals and families initiate and sustain long-term recovery contributes to the overall health of communities and lowers societal healthcare costs. Many programs already involve families in the SUD treatment process in some way, such as through family psychoeducation groups. Even so, integrating family counseling into SUD treatment may require administrators to make significant investments of time and resources—but the benefits to clients, families, and communities make such investments worthwhile.

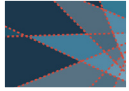
As a program administrator, director, or clinical supervisor, you can lead your SUD treatment program in making changes to incorporate family-based interventions into existing services.

Doing so will help:

- Improve long-term recovery outcomes for your program’s clients and their families.
- Harness the support of family members as a source of recovery capital for clients with SUDs.
- Improve clients’ family functioning.
- Protect against substance misuse among family members who are children or adolescents.

Including family-based interventions in SUD treatment settings at any level of intensity requires a systematic, continual administrative effort. This chapter provides guidance that will help you initiate and maintain integration efforts by exploring how to:

- Develop a family-centered culture in your organization.
- Incorporate and improve the quality of family counseling and family-based interventions.
- Facilitate workforce development that will support integrated family counseling for SUDs (e.g., providing ongoing staff education about family counseling; hiring new staff members with family and marriage counseling credentials to provide more intensive family counseling).
- Establish or expand collaboration with community-based family therapists and other family-centered social service providers and programs.
- Address programmatic issues related to the integration of family counseling and SUD treatment, such as reimbursement, regulations, and outcomes monitoring.



Developing a Family-Centered Organizational Culture as an Administrator

A family-centered organizational culture fosters SUD treatment practices that promote dignity and respect, reflect cultural responsiveness, and focus on family strengths and resources. It creates a welcoming atmosphere and invites family members of all ages into treatment and recovery activities. A family-centered organizational culture also encourages development of program activities that leverage the power of family systems and acknowledge the potential of family members—including those with SUDs—to be positive influences and resources for each other and for other families.

The key to integrating family-based interventions into SUD treatment programs is to create a family-centered culture throughout the organization.

With your clients' permission, try to involve family members in all aspects of SUD treatment programming. Ideally, clients' families will have a voice in developing and running activities. Even program evaluations and outcomes research should reflect families' perspectives. By prioritizing the inclusion of families in SUD treatment, you can identify counseling interventions and family-centered program activities that best address the needs of the clients and families you serve.

Engagement

Ensure that all staff members understand how your agency will engage families throughout SUD treatment and family counseling processes and activities. Well-integrated family counseling for SUD treatment reflects a family-centered organizational culture across a range of programming, such as:

- Screening and assessment for substance misuse and family issues.

- SUD treatment.
- Family counseling and family-based interventions (e.g., to address intergenerational substance misuse issues).
- Education and engagement (e.g., parent education; web-based psychoeducation about SUDs).
- Community partnerships.
- Home-based counseling and family case management services.
- Process and outcome evaluations.

Promote respectful, nonjudgmental interactions between clients and agency staff at all levels to enhance and maintain engagement. Engagement begins at first contact with clients or family members, so it is essential that your staff members reflect a family-centered program culture from the outset.

At an administrative level, you can **foster family-based SUD engagement by:**

- **Informing clients of your services and family-oriented SUD treatment philosophy** via brief, easy-to-read materials (e.g., plain jargon-free language; text big enough for older clients and those with vision difficulties to read). Consider having a client/family "bill of rights" in these materials.
- **Using family-oriented language** in client and family interactions and in all written materials.
- **Adapting all client-related materials into diverse languages** reflecting the cultural/ethnic groups in your community. (See also TIP 60, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* [Substance Abuse and Mental Health Services Administration (SAMHSA), 2015].)
- **Providing free self-assessment tools**, such as the Alcohol Use Disorders Identification Test.
- **Informing clients at intake or first contact about the benefits of family involvement in treatment** and addressing their ambivalence or anxiety about including family members.
- **Linking clients and their families with community services** that address critical needs, such as housing, employment, or health care.

- **Reaching out to families of people with SUDs or mental disorders** by offering information about your services in nontraditional settings.
- **Providing transportation** to your facility for clients and their family members through recovery volunteers, peer recovery support specialists, or case managers.
- **Conducting brief interventions over the phone** when potential clients or family members call, such as with a motivational interviewing (MI) script that trained support staff can administer (Loveland, 2014).
- **Promoting reengagement with clients who have returned to substance use** or have had recovery setbacks by welcoming them and their families back into treatment with respect and optimism.
- **Keeping demands on family schedules in mind** when arranging interviews.
- Adaptations to make navigating the facility easier for clients with mobility issues (e.g., older clients).
- Age-appropriate materials (e.g., coloring books to occupy younger children; large-print handouts to provide information for older family members who may have impaired vision).
- Educational programming for family members of all ages, complete with age-appropriate information and educational activities to help them understand the effects of substance misuse on their families.

Incorporating Family Counseling and Family Programming

Integration helps avoid duplication of services, lessen the artificial split between counseling for family problems versus SUDs, and increase treatment efficiency and effectiveness for clients and families. Most SUD treatment agencies serve diverse clients with a range of substance misuse profiles. The array of client needs, multiple family influences, and differences in providers' training and priorities can compound the challenges of addressing substance misuse. To offset these challenges, professionals—including administrators—in family counseling and SUD treatment should work together. The resources, insights, and strategies each field can bring to programming will enhance treatment.

Understand the various degrees to which family counseling can be incorporated into SUD treatment. There are many ways to provide family-based interventions along the continuum of SUD treatment and recovery support services. You may opt for full integration in your program, offering both family counseling and SUD treatment in the same facility (whether the same or different counselors provide each service). Alternatively, you can build partnerships with other agencies to create a comprehensive referral network for SUD treatment and family counseling services. Exhibit 6.1 provides a framework for levels of integration of family-based interventions in SUD treatment programs.

To improve access and engagement, consider an open-access model for initial engagement with clients and family members. In this model, programs set a certain number of hours a day during which clients can walk into one or more access points (e.g., outpatient counseling program or primary care office) without an appointment for an initial intake and admission to available treatment services.

Environment

To foster family-based SUD treatment engagement, create a warm, inviting treatment environment that feels safe and accessible for family members of all ages. Such an environment may have:

- Large counseling rooms or spaces that can accommodate a family or multiple families.
- Child-sized furniture and colorfully painted walls in designated family treatment spaces.
- Free or low-cost child care at the facility, active linkage to childcare providers near the facility, or linkages to financial resources to pay for child care.



EXHIBIT 6.1. Levels of Program Integration

The consensus panel of this TIP developed a framework for administrators to determine the extent to which their programs integrate family-based interventions with SUD treatment. The framework has four levels:

1. **Staff awareness and education.** At this level, resources are almost completely informational in nature. Staff members generally understand that clients require support systems to maintain recovery and avoid relapse. Staff members develop awareness of and participate in training to enhance their understanding of the family as a strength and a potentially positive resource in SUD treatment and ongoing recovery support.
2. **Family education.** At this level, the organization offers high-quality referral lists and active linkage to family services to interested parties for follow-up. However, the program generally lacks the financial and human resources to provide direct services to family members. The focus is on providing information to clients and families about the role of the family in SUD treatment and making informal referrals for the general public. Although the program may offer some educational seminars, they are not mandatory for clients and families as part of the formal SUD treatment program.
3. **Family collaboration.** At this level, the program actively involves clients' families and understands their importance as a potential resource in SUD treatment. The program refers clients for family counseling services through coordinated SUD treatment efforts that maintain collaborative ties.
4. **Family counseling integration.** At this level, all components of the program and its policies support full integration of family counseling into SUD treatment. Systemwide, strengths-based, family-friendly approaches are operational and culturally responsive, providing "one-stop assistance" for clients and families. A family-centered culture is apparent in all levels of the program and is supported by program infrastructure: specifically, human and financial resources.

Encourage open communication about family counseling and family-based interventions, as well as mutual respect between SUD treatment providers and family counselors. Whatever your program's current level of integration, it is essential for you to encourage an organizational culture that values both types of services. SUD treatment providers and family counselors should know when to refer clients and when to consult with counselors or clinical supervisors in the other field. To deliver effective services, providers in each field should coordinate and tailor their approaches so that clients and families who receive family counseling get the most benefit from family-based SUD treatment.

Facilitate cross-training and clear procedures for referral and follow-up. As an administrator, you can foster ongoing communication by creating specific procedures for referral and follow-up with providers from other organizations. You can also invite providers from other agencies to participate in cross-training (Exhibit 6.2) on family-based interventions and SUD treatment.

Understand what makes a fully integrated SUD treatment and family counseling program work. Full integration means that services at all levels reflect fully functional operations, policies, procedures, and philosophical approaches to providing family-based SUD interventions. The following paragraphs describe some characteristics of fully integrated programs:

- All staff—from support staff to the executive director—understand the important role of the family as a potentially positive influence on clients in the treatment and recovery process. They have resolved any ambivalence they may have had about making clinical, administrative, and structural changes to integrate family services into the program. They are ready to take action.
- Administrators, program managers, and clinical supervisors reinforce written policies and procedures for including families in program activities. A manual describing how to manage issues specific to family counseling is in place and available to all clinical and nonclinical staff (Exhibit 6.3).

EXHIBIT 6.2. Cross-Training

Cross-training helps SUD treatment providers and family counselors work together effectively by learning about each other's profession. There is a shortage of SUD treatment providers who are well trained in family issues. Likewise, there is a shortage of family counselors with practical knowledge of SUD treatment techniques. Administrators can help address these shortages through cross-training.

All providers should receive cross-training in family-based counseling approaches and SUD treatment strategies. SUD treatment providers should be trained in family counseling and family-based SUD interventions. Family counselors should be trained in SUD treatment approaches, including screening, assessment, MI, cognitive-behavioral therapy, and relapse prevention.

The consensus panel also recommends ongoing training in other topics, such as domestic violence, child abuse and neglect, elder abuse and neglect, posttraumatic stress disorder, and cardiopulmonary resuscitation.

EXHIBIT 6.3. Sample Policies and Procedures To Support Integrated Family Counseling for SUD Treatment

Consult state and federal laws to ensure your policies and procedures comply with relevant regulations and licensing requirements. The following administrative processes should be considered when developing policies and procedures to support full integration of family counseling into your SUD treatment program:

- **Intake calls and scheduling.** Who is responsible for first contact with clients? Who handles the scheduling of appointments? Are there specific policies for scheduling initial appointments with individuals who have SUDs versus scheduling initial appointments with the individual's family members?
- **Fees and procedures for handling money.** Are there specific program fees related to family-based SUD treatment? What are the procedures for collecting co-pays or fees? Who is responsible for collection?
- **Intake process.** Who gathers initial intake information?
- **Case assignments.** Who is responsible for family case assignments? How are family cases assigned?
- **Referral sources.** What procedures are in place to ensure that clients and family members have an opportunity to sign releases allowing providers to communicate with referral sources?
- **Initial interview.** Do procedures to conduct an initial family counseling interview include a consent process?
- **Case management.** Do policies and procedures address the following topics?
 - Professional and legal duty to warn/duty to maintain confidentiality
 - Consent for treatment
 - Special releases for video or audio recording of counseling sessions
 - Case progress notes
 - Referral and other professional interaction
 - Paperwork responsibilities
 - Case recordkeeping
 - Case transfers

Continued on next page



EXHIBIT 6.3. Sample Policies and Procedures To Support Integrated Family Counseling for SUD Treatment (*continued*)

- **Assignment of family treatment rooms.** How do clinical staff members reserve rooms specifically used for family psychoeducation or family counseling?
- **Video recording sessions.** Which policies and procedures guide video or audio recordings of family sessions? Do guidelines recommend that all family members sign a release form that details the purpose of the recordings? Who will have access to the recordings, and when and how will the recordings be destroyed?
- **Observation of sessions.** Do policies about other counselors, supervisors, or clinical staff observing family sessions (either behind a one-way mirror or in the session) include informing clients and family members about the purpose of live observation and the role of observers in a session?
- **Confidentiality issues.** Do reporting and testimony policies and procedures address the following topics?
 - Child abuse
 - Elder abuse
 - Danger to self and others: Duty to warn
 - Court- and subpoena-related situations
- **Alternative communication with family members.** Are there policies to guide communication between clinical staff and family members through the following ways?
 - Home phone
 - Cell phone
 - Email
 - Text message
- **Managing crisis situations.** Do policies and procedures for managing high-risk situations address the following topics?
 - Suicide or other risk of injury
 - Imminent hospitalization
 - In-house emergency
 - Domestic violence
 - Notification of supervisor

These examples are adapted with permission from The Ohio State University's *Policies and Procedures Manual for the Ph.D. Specialization in Couple and Family Therapy* (Bartle-Haring, Pratt, & Knerr, 2019). The full manual is available online (<https://ehe.osu.edu/sites/ehe.osu.edu/files/files/couple-and-family-therapy-policies-and-procedures.pdf>).

- **All clinical staff receive cross-training** in and are comfortable with and competent in providing family-based interventions, SUD treatment approaches, and family case management within their licensing and scope of practice. They are knowledgeable about community social services and recovery resources.
- **Culturally and linguistically responsive, age-appropriate practices are implemented throughout the organization and inform all policies and procedures.** Staff members:
 - Have cultural competence training.
 - Use treatment strategies that promote dignity and respect for clients.
 - Can discuss issues without inhibition or fear of termination.
 - Where possible, reflect the cultures and native language of the clients and families the program serves.
- **Financing and human resources are adequate** to implement and sustain family counseling and family-based interventions and recovery activities.
- **Social, individual, and family supports are in place** to improve family relationships and involve family members in relapse prevention and recovery maintenance efforts. **Established linkages exist with social service agencies** to provide assistance with transportation, housing, medical care, food, and childcare services.
- **Program infrastructure is robust** (e.g., physical space is sufficient and accessible; there are supports for Internet, video, and other multimedia; multilingual program materials are available).

Additional considerations may include policies for nonclients on the treatment premises, security of the building, liability insurance, and service reimbursement.

Supporting Workforce Development

Workforce development plays a key role in delivering quality SUD treatment services to individuals and families affected by substance

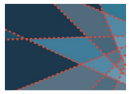
misuse. Per a family-centered SUD treatment philosophy and mission, workforce development efforts should orient all staff to the importance of engaging family members in the treatment process and providing family-centered services.

Differing philosophies, education, training, and licensing requirements among SUD treatment providers and family counselors can complicate administrative issues in family-centered SUD treatment programs. For example, SUD counselor training focuses mostly on individuals with SUDs, yet family-based SUD interventions require SUD counselors to have training in family-based psychoeducational and counseling approaches. Licensed family and marriage therapists, clinical social workers, mental health counselors, psychiatric nurses, and clinical psychologists may have more education in family systems theory but less in SUD treatment approaches. These providers will not be able to make appropriate referrals for screening, assessment, diagnosis, and treatment of SUDs—unless they also receive the necessary training to conduct these aspects of service themselves.

All clinical staff need training in how substance misuse affects family systems, family dynamics, and initiation and maintenance of family recovery. SUD counselors who provide family-based interventions need family-centered counseling competencies, which often require intensive training to develop. Their clinical supervisors should be trained in family counseling or licensed as marriage and family therapists.

Hiring and Retention

Recruit counselors who are interested in and comfortable with working with families; prioritize candidates with specific education, training, lived experience, or professional history in working with families. SUD treatment counselors have specialized knowledge of addiction and recovery but may be unfamiliar with the theories and techniques of family systems interventions. They may realize the influence a family exerts on one's use of substances, but some may see family issues as a threat to their clients' recovery, particularly when clients feel overwhelmed and unable to cope with their families' reactions to treatment and the intense emotions that can be evoked in treatment.



Nevertheless, addiction counselors who are enthusiastic about working with families can be as effective as family counselors who are well acquainted with the operation of family systems but may not fully understand the needs and stresses of people with SUDs. Peer recovery support specialists and recovery coaches, including those who have lived experience as a family member of someone with an SUD, can also be valuable members of the clinical team.

Match staff members' family-centered duties and responsibilities with their educational background, certification or license, training, and scope of practice. Staff members interested in working with families need ongoing training, in-house mentoring, and sufficient resources. For example, addiction counselors may be qualified to provide family intake, family psychoeducation, family recovery support groups, or family consultations, but providing ongoing family counseling may be outside their current scope of licensure and practice. However, with administrative support that facilitates proper training and ongoing supervision, bachelor's- and master's-level addiction counselors can provide evidence-based family interventions like behavioral couples therapy (Rowe, 2012) or manualized approaches like the family education component in the *Counselor's Treatment Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders* (Center for Substance Abuse Treatment [CSAT], 2006b, 2006c).

Provide incentives for staff members to further their understanding of and training in family-based counseling for SUDs. SUD treatment providers may need motivation to acquire more intensive training and coaching in family-centered, evidence-based practices that ensure fidelity and quality service. They are more likely to find this motivation in programs that reward ongoing professional development with opportunities to move up the career ladder with commensurate job title changes and salary increases.

Core Competencies

Counselors need specific knowledge, attitudes, and skills to shift from an individual to a family systems focus in their approach. Level of family

involvement in treatment falls on a continuum. It may be as simple as providing collateral information to counseling staff during assessment and treatment, or it may be as intensive as attending psychoeducational sessions and participating in family counseling.

Core competencies for working with families differ among professions, but **all providers and administrators across the continuum of care should be able to understand the complexity of the clients' family networks and interactions with their families** (Gehart, 2018). How counselors apply that knowledge varies by level of family involvement and complexity of the family-based intervention.

Acknowledge core competencies for family counseling as a framework for training, supervision, performance evaluation, and professional development. Across the continuum of care, SUD treatment providers who offer family-based interventions should understand (CSAT, 2006a; Gehart, 2018):

- How counselors' own family histories and issues affect their interactions with and perceptions of the dynamics of families in SUD treatment.
- Systems concepts, theories, and techniques foundational to family-based interventions.
- The diverse cultural factors that influence the characteristics and dynamics of families and couples.
- Risks and benefits of couples- and family-based interventions.
- How, when, and why to involve clients' families and significant others in treatment and recovery.
- The effects of substance misuse on family communication, roles, and dynamics.
- The characteristics of families, couples, and significant others affected by substance use.

SUD treatment providers who offer family-based interventions should also demonstrate the ability to:

- Show genuine care and concern for clients' family members and significant others.
- Respect the contributions of significant others to the treatment and recovery process.

- Engage family members and significant others throughout the treatment and recovery process.
- Identify systemic interactions likely to affect recovery (e.g., by recognizing the roles of significant others in clients' social systems; by knowing the potential signs of domestic violence).
- Determine who should attend family counseling and in what configuration (e.g., individual family members, couples, entire family, extrafamilial recovery supports).
- Identify treatment goals based on both individual and systemic concerns.
- Communicate with families and significant others about confidentiality rules, regulations, and boundaries.
- Obtain consent to treatment from all individuals involved in family-based interventions.
- Apply assessment tools for use with couples, families, and significant others.
- Identify couples' and families' strengths, resilience, and resources.
- Recognize issues beyond their own license and scope of practice that require referral for specialized evaluation, assessment, or treatment.
- Apply appropriate models of assessment and intervention for families, couples, and significant others, regardless of their extended, kinship, or tribal family structures.
- Provide culturally appropriate intervention strategies for couples and families.
- Help couples, families, and significant others adopt strategies and behaviors that sustain recovery and maintain healthy relationships.
- Manage session interactions with couples, families, and groups.
- Follow the procedures, processes, and counseling methods of manualized or structured family-based interventions with fidelity and within their scope of practice and license.
- Use family-centered supervision and consultation effectively.

Certification and Licensure

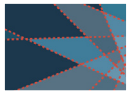
Programs with diverse professional staff have greater depth and richness in clinical teams. Even so, administrators can find it challenging to provide the training, supervision, performance evaluation, and professional development required by different state and national certification and licensing authorities.

Know the certification and licensing requirements of all clinical staff who currently provide or will provide family-based interventions or family counseling in your program. Check with your state licensing board for rules and regulations related to these requirements. Having this knowledge will better enable you to hire clinical staff from diverse educational backgrounds, such as licensed drug and alcohol counselors, marriage and family therapists, clinical social workers, mental health counselors, psychiatric nurses, and other behavioral health service professionals who have training and experience working with families.

Develop training programs that help counselors meet initial or recertification requirements to maintain their licenses. Two examples of licensing and certification authorities you should be familiar with are the American Association for Marriage and Family Therapy (AAMFT) and the International Certification and Reciprocity Consortium (IC&RC).

AAMFT

Fifty states and the District of Columbia require licenses for people practicing as family therapists (AAMFT, n.d.-b). Although the specific educational requirements vary from state to state, all require at least a master's degree. AAMFT's Commission on Accreditation for Marriage and Family Therapy Education requires an educational component on the assessment, diagnosis, and treatment of addiction in their accreditation standards. More information on state licensing and certification requirements is available online (www.aamft.org/Directories/MFT_Licensing_Boards.aspx?hkey=c0f838ad-2672-4b4e-8b51-b9578fe5c28a).



AAMFT also offers a designation as an approved marriage and family therapy supervisor. This designation requires completion of additional training and an examination offered by AAMFT. (See www.aamft.org/AAMFT/Membership/Approved_Supervisors/Supervision/Supervision.aspx?hkey=79f01af6-6412-4eb5-9d75-9909aca18b1a for more information.)

IC&RC

IC&RC provides credentials in SUD prevention and counseling in 46 states and the District of Columbia, three branches of the military, some foreign countries, and the Indian Health Service. Each member board determines its own standards for certification or licensing based on IC&RC standards, which include knowledge of substance misuse, counseling, and ethics, as well as assessment, treatment planning, clinical evaluation, and family services. More information is available online (www.internationalcredentialing.org; <https://internationalcredentialing.org/memberboards>). IC&RC and many member boards also offer a clinical supervisor certification (see <https://internationalcredentialing.org/creds/cs>).

Professional Development

Involving families in SUD treatment heightens counselors' responsibilities. For example, counselors need to understand the varied effects of substance misuse on family systems well enough to describe them to clients and family members. They must also incorporate new family-based interventions and activities into their general counseling style and treatment approach. **Proper training and consistent clinical supervision are essential to support counselors in handling these additional responsibilities.**

Staff Training

Family-based interventions and family counseling require special training and skills uncommon among staff in many SUD treatment programs. Workshops and self-study may increase counselor knowledge, but **the key to integrating evidence-based, family-centered counseling approaches into SUD treatment programs is provision of specialized training and ongoing supervision** (Olmstead, Abraham, Martino, & Roman, 2012).

Extensive training and supervision in family-based interventions will help counselors develop skills in and maintain fidelity to these counseling approaches. Ideally, training and supervision prepares SUD counselors to work with families by tapping into their existing knowledge of how substance misuse affects families.

Educate staff about family counseling and family issues to increase staff (and therefore client) awareness of the role families can play in SUD treatment, recovery, and relapse. Effective staff education should increase provider knowledge of the family as a unit and the influence of the ecological setting in which substance misuse occurs. Administrative and supervisory staff are the starting point for supporting providers in becoming knowledgeable about family counseling issues and for initiating program changes that integrate or enhance the delivery of such services to clients and their families.

Commit the necessary resources to provide ongoing family-centered training for counselors. Some strategies to train your program's providers in the delivery of family-based interventions include:

- **Gathering input from current counseling staff about training opportunities** available from their professional organizations. For example, state branches of the National Association of Social Workers (NASW) often offer low-cost training for members and nonmembers.
- Partnering with local college or university programs that offer courses on family counseling topics.
- **Providing internship or field placement opportunities** for students in family counseling programs. In some such arrangements, your agency field instructor or supervisor receives free training from the students' social work, mental health counseling, or marriage and family counseling program.
- **Contacting professional organizations** like AAMFT, NAADAC (The Association for Addiction Professionals), the American Psychiatric Association, or local branches of NASW for information on members qualified to offer training on family counseling at your organization.

- **Vetting all trainers' educational backgrounds and training experience** and making sure their approach is consistent with your program's philosophy and training needs.
- **Sending clinical supervisors and experienced counselors to family counseling workshops** that offer group discounts; partnering with other agencies to increase group size for better discounts.
- **Devoting time, attention, and resources to help staff integrate their family counseling training** and get comfortable with how the training may change some of their counseling practices. Ongoing family-centered clinical supervision is crucial to this integration process.
- **Creating small learning communities dedicated to advancing competence and professional development in family-based SUD interventions and family counseling** among counselors, supervisors, and peer providers in your organization. Provide space for meetings and paid time away from regular clinical duties to participate in these communities and in training opportunities. Invite clinical staff from other programs to participate as well.
- **Investigating online training and ongoing consultation resources** to reduce program costs for travel and overnight accommodations. (See "Resource Alert: Online Learning Opportunities and Resources.")

Clinical Supervision

Clinical supervision is a primary resource for counselors for gaining the practical skills and knowledge that will help them become ethical and effective service providers (Boyle & McDowell-Burns, 2016). Training in family-based theory and interventions is a good focus for supervision, which should be ongoing.

Ensure that clinical supervisors have experience and training in family counseling or licensure as marriage and family therapists. These qualifications are essential to help SUD treatment providers gain sufficient competency to provide family counseling. Supervisors should also have a range of knowledge on other issues such as child care, confidentiality and liability concerns related to providing services to children and adolescents, and the documentation and billing related to family counseling sessions.

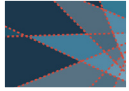
Direct session observation by supervisors helps counselors develop and maintain competency in common evidence-based SUD interventions (e.g., supervisor in session, behind a one-way mirror, or video recording review; Olmstead et al., 2012). This is especially important for professional development of family counselors, given the higher level of complexity in delivering family-based SUD interventions. Yet one study found that only 2 percent of SUD treatment programs that offered brief strategic family therapy provided supervisor review of audio- or video-recorded family sessions (Olmstead et al., 2012).

RESOURCE ALERT: ONLINE LEARNING OPPORTUNITIES AND RESOURCES

AAMFT (www.aamft.org) offers low-cost online learning opportunities on family counseling topics for members and nonmembers.

The **Addiction Technology Transfer Center (ATTC) Network** (<https://attcnetwork.org>) offers free and low-cost webinars, videoconferencing consultation groups, and other online learning opportunities. To stay informed of upcoming opportunities, subscribe to the *ATTC Messenger* (<https://attcnetwork.org/subscribe-messenger>), a monthly electronic newsletter that provides information about best practices, professional development events, funding, research literature, and other resources related to SUD treatment.

NAADAC (www.naadac.org) offers free and low-cost webinars, publications, and other online learning opportunities. To stay informed of upcoming opportunities, subscribe to NAADAC's weekly e-newsletter (www.naadac.org/professional-eupdate), which provides news from NAADAC and partner organizations, as well as information about educational events, trainings, and resources.



Collaborate with other administrators, program managers, and clinical supervisors to integrate live supervision approaches into the training, supervision, and professional development of family counselors. (See “Resource Alert: Clinical Supervision and Professional Development of SUD Treatment Providers” for guidance on conducting live observation supervision.)

Supervisor Competencies

Regardless of the education or professional licensure of the providers clinical supervisors oversee, their supervisory responsibilities in integrated family counseling for SUDs include (Rigazio-DiGilio, 2016):

- Facilitating counselors’ development of self-awareness, cultural and social responsiveness, and theoretical, technical, and cultural competence.
- Monitoring the quality of counselor service provision.
- Assessing counselors’ current areas of competence and those that need development.
- Serving as gatekeepers for a variety of counselor specialties. This requires familiarity with various professional codes of ethics, state licensing requirements, scope of practice boundaries, and state agency licensing requirements (e.g., fulfilling the hours of clinical supervision required by state mental health and SUD treatment departments).

RESOURCE ALERT: CLINICAL SUPERVISION AND PROFESSIONAL DEVELOPMENT OF SUD TREATMENT PROVIDERS

SAMHSA’s TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (<https://store.samhsa.gov/product/TIP-52-Clinical-Supervision-and-Professional-Development-of-the-Substance-Abuse-Counselor/SMA14-4435.html>), details supervision models, offers guidelines for direct observation and parallel process supervision, and addresses transference/countertransference in supervision.

For family counseling supervisors to carry out these responsibilities, they must have the knowledge and skills necessary to (Rigazio-DiGilio, 2016):

- Apply different supervision models, methods, and interventions.
- Attend to ethical, legal, and professional concerns of clinical staff in different areas of practice.
- Manage supervisory relationships.
- Conduct counselor assessments and performance reviews.
- Address cultural diversity and responsiveness issues in counseling and supervisory relationships.
- Maintain a self-reflective stance in supervision.

The Association for Counselor Education and Supervision (ACES) provides specific competency standards for clinical supervisors that apply across a range of educational and professional backgrounds, including family counseling and SUD treatment. Standards include (ACES, 2011):

- Setting goals (e.g., developing specific goals for supervision, in collaboration with the counselor).
- Giving feedback (e.g., balancing feedback that is challenging and supportive).
- Conducting supervision (e.g., providing a safe, supportive, structured supervision context).
- Engaging in the supervisory relationship (e.g., building trust and developing a solid working alliance).
- Using various supervisor models and formats to address counselor needs.
- Attending to cultural diversity and advocacy considerations (e.g., integrating multicultural awareness and responsiveness into your supervision).
- Attending to ethical considerations in the supervisory relationship (e.g., providing counselor with a professional disclosure statement, including information about your professional background, clinical experience, and supervision approach).
- Documenting supervision (e.g., to support counselor development and protect client welfare).

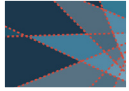
- Evaluating counselor proficiency and performance (e.g., communicating about supervisory evaluation tools and processes).
- Fulfilling educational and work experience requirements for providing competent supervision.
- Engaging in supervision training and supervision of one's own supervision as part of supervisor professional development.
- Initiating supervision, such as by establishing a contract with the counselor (Exhibit 6.4).

EXHIBIT 6.4. Developing a Supervision Contract With a Family Counselor

Supervision contracts describe how you, as a supervisor, will provide supervision to a family counselor. Here are key topics that you and the counselor should discuss and document in a supervision contract:

- The logistics of supervision (e.g., length, frequency, and location of supervision sessions)
- Your educational background, credentials, and preferred counseling method
- Your preferred supervision philosophy and approach
- Your roles and responsibilities as a family counseling supervisor—including an explanation of how your role differs from an administrative supervisor
- The conditions under which you and another supervisor may discuss the counselor's professional development progress and performance
- The counselor's own supervision goals (e.g., what the counselor wants to learn or accomplish; how supervision hours count toward certification or licensure)
- Your expectations and logistics of how to review client and family sessions (e.g., live supervision sitting in on a session, one-way mirror, audio or video recording review, counselor formulation or process notes)
- Exploration of the counselor's experience with, comfort or discomfort with, and ideas about ways to adapt different supervision methods (e.g., reviewing audio/video recordings so the counselor can identify portions of the session that were or were not successful)
- Schedule and documentation processes, as well as criteria, for formal counselor evaluations
- Issues, rules, and regulations specific to your organization and state licensing board regarding how supervision is conducted (e.g., rules about video recording or removing client notes from the premises)
- Reporting requirements and emergency procedures for high-risk clients (e.g., clients who are intoxicated or engaging in violence, suicidal, or suspected of child maltreatment)
- Information about how your supervisee can reach you in cases of emergency
- Professional ethics and confidentiality guidelines:
 - Review codes of ethics for counselors and your professional association; clarify/resolve discrepancies.
 - Negotiate an agreement about adherence to ethical guidelines.
 - Clarify confidentiality and the limits to confidentiality in the supervisor–counselor relationship.
 - Clarify how supervision session notes and logs will be kept and who has access to that information.
 - Discuss how the counselor should notify clients and family members about your supervision, including the potential for live supervision.
 - Review how disagreements between you and the counselor will be discussed and resolved.
 - Clarify the conditions under which the supervisory relationship will end.
- How the contract will be periodically reviewed and renewed (e.g., every 6 months or year or when the counselor has achieved professional development goals and needs to discuss new goals)

Source: AAMFT (2019).



As a supervisor, your focus with counselors is on client issues and concerns. Yet the quality of your relationship with the counselor is a primary factor that will determine each counselor's sense of achievement and professional satisfaction, similar to the quality of the counselor's therapeutic relationship influencing the effectiveness of work with clients and family members (Rigazio-DiGilio, 2016). To develop a strong working alliance with family counselors, engage in self-reflection and multilayered self-evaluation (Rigazio-DiGilio, 2016) about:

- Your own cultural, family, and contextual histories and experiences.
- The main theories and models that shaped your education and training in family counseling.
- Ways in which your participation in family, professional, and cultural experiences shape the worldview you bring to every supervision session (see Exhibit 6.5).

Family counseling supervision differs from individual counseling supervision. Instead of only reviewing individual client–counselor interactions in supervision, the supervisor also gives guidance to the counselor on the couple's or family members' interactions with each other and the counselor's interactions with the couple, a single family system, or multiple family systems. For example, in evaluating a counselor's reflective listening skills, a supervisor might assess the counselor's skill in paraphrasing multiple perspectives and feelings of relatives and summarizing interaction patterns in the couple or family (Lambie, Mullen, Swank, & Blount, 2018). The focus on systems, not individuals, adds complexity to supervision.

Systemic–Developmental Supervision

This model of supervision is widely used in SUD treatment settings. It holds that **counselors undergo stages of professional development; it is the clinical supervisor's role to match his or her relational stance and supervision strategies to counselors' developmental stages.** For example, a new counselor might require more structure and encouragement in supervision than an experienced counselor.

Similarly, in the developmental model for supervising family counselors (Carlson & Lambie, 2012), supervisors of beginning family counselors use live observation, model family counseling techniques, and engage in role-plays to facilitate the counselor's development. As the counselor becomes more confident, the supervisor can invite the counselor to develop a family genogram (see Chapter 4) and use it in supervision to help counselors identify transference feelings of family members toward the counselor and countertransference feelings of the counselor linked to the counselor's family of origin.

EXHIBIT 6.5. Multicultural Supervision

Supervisors are inherently in a more powerful position in relationship to supervisees. This power differential may be compounded by differences in race, ethnicity, gender, sexual orientation, gender identity, socioeconomic status, and disability. Multicultural supervision involves bringing the awareness of individual, family, and societal cultural differences and considerations into the supervisory relationship (Gutierrez, 2018). Your responsibilities as a supervisor include recognizing different cultural values and perspectives on family and substance misuse; exploring your own worldview, privileges, and biases; and maintaining an open and safe space in which supervisees can raise issues about their own cultural identities (Gutierrez, 2018). If you understand and acknowledge your own biases and raise the issue of cultural identity differences that might exist between you and the supervisee, you can help supervisees enhance their own cultural knowledge and be a role model for how to have these conversations with clients and families.

A genogram depicts a person's family tree through use of symbols. Symbols of different colors or shapes represent individuals in the person's family across several generations. Initially conceptualized by Murray Bowen (Goldenberg, Stanton, & Goldenberg, 2017) as a part of his intergenerational family model, a genogram is more than just a family tree: it is an important counseling tool. Using the information that family members provide, **a genogram can visibly demonstrate family patterns, events, and relationships.** Across health fields, the genogram offers a map of a family's known health, communication, relationship (e.g., marriage, divorce), vocational, and other psychosocial patterns in each generation. It can aid clinical interviews, psychoeducational sessions, or assessments (e.g., the Family Genogram Interview by Platt & Skowron [2013]).

The genogram is flexible and can be tailored to the needs and current challenges of a family. For example, a counselor may create a genogram and have family members identify those relatives with a history of substance misuse and related health issues. Family members can also use the genogram exercise to identify specific individual strengths and inherent strengths across generations. **By illustrating substance use, cultural characteristics, and family dynamics, the genogram can reveal certain influential patterns.**

In the context of SUD treatment supervision, a genogram can help supervisors link SUD counselors' family patterns back to their counseling practice and raise counselor self-awareness of countertransference issues that may result, in part, from these family patterns (Carlson & Lambie, 2012). See also Chapter 4 of this TIP.

The supervisor may also introduce and explore parallel process—that is, how the supervisory relationship mirrors the counseling relationship—and focus on relationship dynamics in the couple's or family's sessions. Supervision of experienced family counselors is more reciprocal, so the supervisor becomes more of a consultant than a teacher. As counselors move through stages, they develop higher levels of self-awareness and differentiation from the supervisor (Carlson & Lambie, 2012).

Exhibit 6.6 lists the stages and samples of supervision strategies in systemic–developmental supervision.

A counselor may be in one stage of professional growth as an addiction counselor and another stage in developing competencies for providing family-based interventions. **The systemic–developmental model of clinical supervision offers a framework for matching supervision strategies to counselor competency levels in delivering family-based SUD interventions.**

Encouraging Collaboration as an Administrator

One of your most important roles as an administrator is to develop ongoing connections between your program and others that provide a range of services to families. Such relationships should encourage family participation in both SUD and family-based services. Yet collaborating with other behavioral health and community-based services involves more than maintaining a list of other agencies where staff can refer clients and family members. If your program does not offer in-house, integrated family counseling services, develop and maintain partnerships with other programs that provide family counseling and family-centered services.

Provider collaboration ensures high-quality referrals, effective outreach, and meaningful partnerships with community resources.

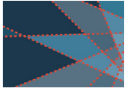


EXHIBIT 6.6. Systemic–Developmental Supervision

COUNSELOR LEVEL	BEGINNING	INTERMEDIATE	EXPERIENCED
Counselor Description	High anxiety Low self-confidence Low autonomy	Some anxiety Some self-confidence Desires autonomy	Minimal anxiety Self-confident Autonomous
Supervision Environment	Encouraging Structured Prescriptive	Encouraging Reflective Insight oriented	Reciprocal or mutual Supervisor as consultant
Supervisor Strategies	Psychoeducation Direct observation Modeling Role-plays	Create counselor genogram to explore family-of-origin issues related to professional growth Explore counselor recall of sessions to foster counselor reflection & awareness Explore transference/countertransference	Parallel process Active listening
Supervisor Considerations	Introduce supervision style Assess level of counselor anxiety	Maintain process-oriented approach Focus supervision on counselor	Consider using self-disclosure Use supportive and validating statements

Level of self-awareness/differentiation from supervisor



Low

High

Source: Carlson & Lambie (2012). Republished with permission of Sage Publications Inc. Permission conveyed through Copyright Clearance Center, Inc.

Clinical and nonclinical staff should be familiar with community services and resources for families. Counselors should match the resources of various local programs with a family's needs. They should then provide the family with information, including the pros and cons, of particular programs to facilitate the family's selection of those with resources that will work best for them.

Supporting an informed, family-centered referral process requires a strong community perspective and resource commitment at the administrative level. Such support will allow staff members across the family services spectrum to expand their knowledge of community-based SUD education resources and family services. Staff should know about family-based treatment models and provide information using collateral resources to build trust with family members. Supervisors can help staff adjust to the changes and new information generated by collaboration with other providers.

Partnerships

Partnerships with community-based organizations require intensive collaboration. You will need to identify stakeholders in the community, bring them together, and work toward common goals (Partnership for Drug-Free Kids, 2015). Collaborations with other agencies from which families seek services can help reduce fragmentation, duplication, and isolation of services.

SUD treatment program administrators can be a catalyst for SUD treatment–community partnership with the combined goals of reducing substance misuse and helping families initiate and sustain recovery, achieve improved health and wellness, and become integral members of the community.

Community stakeholders whose goals include prevention and treatment of SUDs with a focus on family-based interventions and recovery may include:

- Other SUD treatment professionals.
- Family counseling professionals.
- School administrators and school personnel.

- Youth and family organizations.
- Family and drug court providers.
- Probation and parole services providers.
- Churches and other faith-based organizations.
- Family and child welfare agencies.
- Eldercare agencies and service providers who work with older adults.
- Primary care providers.
- Family members (including parents, youth, and extended family members).

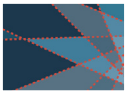
Family members are clearly key stakeholders in the partnership-building process. Including their perspectives can heighten their commitment as stakeholders, invest them in their own care, and reduce misconceptions about substance misuse and ambivalence about involvement in SUD treatment.

Include consumer voices in the development of family-centered services to anchor your program in the community. Provide a mechanism to gather input from SUD providers, including those who work with families, and other key stakeholders. Doing so can support consumer-led movements that will encourage policy shifts related to community-based SUD treatment and family involvement.

Adequate Resources

Provide adequate resources to monitor and ensure that high-quality referrals, outreach, and partnership components are in place. Examples of such resources include:

- A comprehensive referral system that can facilitate the participation of families and clients in family counseling activities not provided by your program.
- Expanded privacy/disclosure, consent, and referral procedures, which may include multiple release of information forms, active linkage to other services, and follow-up from your counseling staff.
- Client and family education on benefits and challenges of participating in other programs/services.



- Client and family information on your relationship to other service providers, potential conflicts of interest, and limits of your program's responsibility for the family's treatment at another program.
- Allocation of staff resources for a variety of tasks, including:
 - Documenting referrals.
 - Monitoring ongoing relationships with other agencies.
 - Coordinating information exchange about clients and families in accordance with Health Insurance Portability and Accountability Act (HIPAA) requirements and state law (for more information on HIPAA, see www.hhs.gov/hipaa).

Develop memorandums of understanding (MOUs) with other agencies to clarify and guide the referral process and interagency coordination of services. Coordination efforts can include active involvement of SUD counseling staff in the therapeutic process and continual contact with the family counselor at the other agency. MOUs can provide a detailed understanding of the other agency's process and procedures, which helps both organizations improve quality and avoid redundancies. For example, if each program screens for mental disorders, coordinated screening processes lessen duplication and client confusion, especially if different screening approaches provide different results. MOUs can also establish each program's responsibilities for on-call services and procedures for responding to family crises.

Monitor and improve referral services by involving families in evaluating the partnership component of your program. A follow-up survey to family members you have referred to another agency may ask:

- Which members of your family are participating in the services of the agency we referred you to?
- On a scale of 1 to 5 (1 being easy and 5 being difficult), how easy was the referral process for you?
- Can you provide examples of what was easy and what was hard about the referral process?

- What can we do to improve the referral process going forward?

Addressing Other Programmatic Considerations

There are other issues you should address in your administrative efforts to integrate family counseling and family-based interventions into your program. These issues include cultural competence, federal and state regulations, consent related to privacy and disclosure, confidentiality, funding, counselor caseloads, treatment outcome evaluations, provider collaboration, and adequate resources for staff.

Organizational Cultural Competence

An organizational culture that is infused with the values of cultural competence and diversity on every level will highlight and implement such values concretely in staffing patterns, language, and cultural issues related to families and substance misuse. **Hire staff and build an organizational culture that reflects the diversity of the client populations your organization serves.** Programmatic cultural responsiveness assessments explore institutional assumptions regarding services for specific racial and ethnic communities. Use this information to reduce bias based on institutional misperceptions. (See "Resource Alert: Developing Organizational Cultural Competence" for a link to more information.)

RESOURCE ALERT: DEVELOPING ORGANIZATIONAL CULTURAL COMPETENCE

SAMHSA's TIP 59, *Improving Cultural Competence* (<https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849>), provides information, strategies, and tools for administrators and clinical supervisors to promote and improve cultural competence for the entire organization.

Regulations

Different regulations created by government agencies and third-party payers affect the SUD treatment and family counseling fields.

Regulations influence confidentiality, training, and licensing requirements. For example, federal regulations specifically guarantee confidentiality for people who seek SUD assessment and treatment.

Your program needs policies and procedures in place that allow clients to give or revoke consent to disclose information to other providers.

These policies should be consistent with federal laws and regulations, such as HIPAA 42 CFR Part 2 (SAMHSA, 2019b), and any state laws that apply (www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs).

A consumer has the right to self-disclose anything he or she wants to disclose about his or her substance use history in group counseling sessions. If family-based group SUD counseling occurs in a HIPAA CFR Part 2 program, as defined by 42 CFR §2.11 and §2.12, then program staff are bound by Part 2 regulations in sharing any information a client self-discloses during such a group.

As an administrator, you should be familiar with laws and regulations in your state that affect confidentiality, training and licensing requirements for counselors, delivery of family counseling services, duty to warn, and mandated reporting requirements for child and elder abuse and neglect.

Privacy and Disclosure

Consent issues require careful consideration by program administrators. All family members receiving services in your program should receive and have the opportunity to sign consent forms acknowledging the organization's policies around confidentiality and the potential risks and benefits of family program activities. Parents or legal guardians can usually sign for children and adolescents (unless the adolescent has reached the age of majority defined by state law or if state law permits minors to consent to SUD

treatment or mental health services). Forms asking clients' permission to share or disclose personal information (e.g., so a provider can discuss a treatment course with family members) should describe in detail, for example, the program or staff responsibilities regarding the reporting of information that is required by law (such as elder abuse, child abuse or neglect, infectious disease, or duty to warn).

Local, state, and federal laws sometimes conflict. Consult with your in-house or local legal services agency to help you reconcile those conflicts.

Inform clients about the limits of confidentiality in family group activities so that all participants understand the benefits and potential risks of family group participation. For example, providers are bound by confidentiality laws, but family therapy group members and others in similar settings may not be. Each family member should receive clear, accurate information about what will happen when they engage in SUD treatment, family counseling, and family program activities. Consent for information-sharing protects clients before, during, and after treatment. Although many laws may not apply to group members, program staff may wish to stress to family group participants the importance of respecting one another's privacy and what is shared in group settings as a facilitator of candid discussion.

Confidentiality

Confidentiality policies should extend to everyone in treatment. Maintaining confidentiality in family and couples counseling is complicated, because many individuals may be involved. Programs need written policies about when family counselors can refrain from disclosing information to family members not present at the time of a client's disclosure and when they are justified in disclosing that information (Mignone, Klostermann, Mahadeo, Papagni, & Jankie, 2017). For example, policies should guide when or if it is okay for a counselor seeing a couple or family to "keep a secret" for a family member who is also in individual counseling from other family members and when that information should be disclosed (e.g., when a family member is suicidal or has relapsed). Duty to warn may apply in some cases,



too (www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx)—for instance, if clear and explicit threats are made to other participants, providers, or third parties. **At intake, inform all family members involved in treatment, at whatever level, about disclosure policies during the privacy, disclosure, and consent process.**

Confidentiality issues for family counselors working with adolescents and their families can be complex. Family counseling practices often reflect the idea of restoring parental authority in the family, but adolescents' developmental stage prompts movement toward independence from parents. **You should have clear policies regarding adolescents' right to and limits of confidentiality based on state and federal laws and professional ethics codes regarding treating adolescents.**

In general, all staff (clinical and nonclinical) should adhere to confidentiality laws and organizational policies. Nonclinical staff members may not be bound by confidentiality laws that apply to counselors, but they should **be familiar with HIPAA and other applicable privacy laws and the importance of keeping client identifying information (and even clients' presence in treatment) confidential.** For example, family members and clients participating in group activities should not be required to sign a login sheet that other clients can see. One strategy is to create an agency procedure and physical space at reception where clients can discreetly sign in or inform staff of their arrival for a family group activity. These issues become especially complicated when a client identifies as "family" people who are not related by blood or law and wishes to include friends or coworkers in family treatment activities.

The consensus panel recommends that all clients and family members involved in treatment sign consent forms conforming to 42 CFR Part 2 and that program staff discuss confidentiality and its limits with everyone as part of the process by which clients can choose to consent to the sharing or disclosing of certain private/personal information.

RESOURCE ALERT: SAMHSA Q&A ABOUT 42 CFR PART 2

SAMHSA's Substance Abuse Confidentiality Regulations webpage (www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs) answers questions about 42 CFR Part 2 in plain language and provides helpful fact sheets for determining whether Part 2 applies to an organization and how to exchange information with other providers.

The federal regulations at 42 CFR Part 2 (SAMHSA, 2019b) are stricter than many state requirements regarding the privacy of individuals in SUD treatment. Participant patient-identifying information must not be disclosed either to other participants (including family members) or to other service providers without a specific release form that complies with regulations or unless other Part 2 exceptions apply. Program staff may disclose confidential information to other staff members in the same program to provide treatment.

Funding and Reimbursement for Family-Based Interventions

There is considerable evidence to support the clinical effectiveness as well as the cost-effectiveness of family-based interventions in SUD treatment (Akram & Copello, 2013; Morgan & Crane, 2010; Wells, Kristman-Valente, Peavy, & Jackson, 2013). However, like the SUD treatment system, both private and federally funded health insurance still emphasize individual treatment. For example, the average state Medicaid reimbursement of SUD treatment providers for couples or family counseling is less than for individual counseling (Beck, Buche, Page, Rittman, & Gaiser, 2018).

Insurance providers are moving toward reimbursing providers with a wider range of licenses for couples and family counseling services. A survey of all states and the District of Columbia found that Medicaid reimbursed addiction counselors for couples and family counseling at a higher rate when they worked in an SUD treatment program

versus private practice (Beck et al., 2018). About 40 state Medicaid programs now have some reimbursement or recognition of licensed marriage and family therapists (AAMFT, n.d.-a). Check your state's Medicaid provider manual for information about recognized licenses and reimbursement codes for family counseling.

Some strategies for expanding the types of behavioral health service providers who can be reimbursed for family counseling services and increasing reimbursement rates include:

- Identifying ways to partner with professional associations to encourage reimbursement for family counseling and family-based interventions.
- Developing relationships with key staff at your Single State Agency for substance use disorder treatment services. (See SAMHSA's *Directory of Single State Agencies for Substance Abuse Services* at www.samhsa.gov/sites/default/files/ssa-directory-01212020.pdf).
- Partnering with other agencies to seek increased Medicaid reimbursement for family counseling.
- Sharing the evidence that family-based SUD interventions are effective and reduce healthcare costs by improving treatment outcomes and long-term recovery.

Counselor Caseloads

Working with families increases the amount of clinical time and nonclinical work that counselors perform. Family counselors must not only manage more clinical complexity than those doing individual work, but also meet more documentation requirements, collaborate with more referral sources and multiple providers involved with the family, and satisfy greater training and clinical supervision needs. At an administrative level, you will need to **adjust counselors' caseloads to account for these additional work requirements** (Association for Family Therapy and Systemic Practice, n.d.).

Incorporate burnout prevention strategies in staff training and supervision activities. Depending on the level of family involvement in your treatment program and the complexity of

the family's needs, counselors may experience higher levels of stress. Ensure that counselors are not doing family work beyond their level of professional development—even when no other staff is available. (See the "Clinical Supervision" section of this chapter.) When counselors attempt to function at a level that is beyond their training, their interventions are typically ineffective, and they can begin to feel demoralized. This is likely to affect the family negatively and be a contributing factor to counselor burnout.

Clinical supervisors should monitor the development of counselors doing family work and slowly introduce new family counseling cases into counselors' caseload when they are ready. Balancing cases involving families with cases involving only individual clients or couples can help lessen counselor stress.

Outcomes

Evaluating client outcomes can improve counselor delivery of family-based services and provide evidence you can share with potential funders on the effectiveness of your program's family-based SUD treatment approach (Boswell, Kraus, Miller, & Lambert, 2013; Moran, 2017). Strong evidence suggests that using a routine outcome monitoring (ROM) system in behavioral health service settings improves clinically significant client outcomes and enhances counselors' abilities to predict and prevent client deterioration (Boswell et al., 2013). However, ROM measures are not universally applied in treatment programs. Counselors may view ROM requirements as intrusions into their client relationships, feel anxious about use of ROM information to assess their performance, and worry about client privacy; some administrators see ROM as time-consuming and costly (Boswell et al., 2013; Moran, 2017).

Strategies to address concerns related to ROM system implementation include (Boswell et al., 2013):

- **Inviting counselor input about which outcome measures to use** and what feedback would be most helpful to them to enhance their work with clients and families.



- **Being transparent about benefits and potential time burdens** that counselors may encounter and how ROM data will be used to evaluate counselor performance.
- **Making ROM measures as simple as possible** so they are less disruptive to counselors, clients, and family members. For example, use self-report measures that take less than 10 minutes to complete.
- **Using electronic or online outcomes assessment, tracking, and feedback systems** that are simple for clients and counselors to use and are HIPAA compliant in addressing confidentiality concerns.
- **Automating reminders for counselors and support staff** to initiate periodic follow-up outcome assessments with clients and family members.
- **Incentivizing ROM engagement** (e.g., allow time outside regular duties for training on ROM processes and assessment instruments or reimburse fee-for-service counselors for ROM training).
- **Identifying one or two “local champions”** who are well respected in your organization; have had positive experiences with ROM; are enthusiastic about ROM; and who take responsibility for helping you adopt, integrate, and sustain the ROM system in your program.

Measuring outcomes of family counseling is complex—more so than, for example, measuring

whether an individual client has stopped or reduced substance misuse or is attending recovery support groups. Before instituting a ROM process for family-based interventions, **consider which family outcomes to assess and which family members to engage in the process.** Some questions to ask yourself include:

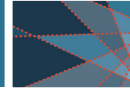
- Are you interested in knowing how your family-based interventions are affecting the functioning of the entire family or how the family-based interventions are affecting the client’s substance use?
- If you treat younger children in your program, will they or one of their parents fill out ROM surveys?
- If children or adolescents fill out outcome assessment instruments as part of ROM, are there different versions of a single instrument? Are instruments designed to be age appropriate?
- Are the ROM instruments you are using culturally responsive and available in multiple languages?

There is no single instrument to address all of these concerns, but the SCORE-15 Index of Family Functioning and Change (Exhibit 6.7) is specifically designed to measure outcomes of family counseling. Consider adding it to other measures of substance misuse outcomes you may already use as part of ROM.

EXHIBIT 6.7. SCORE-15 Index of Family Functioning and Change

SCORE-15 is a brief, validated self-report outcome measure designed to be sensitive to systemic family changes that can take place in couples and family counseling (Carr & Stratton, 2017). SCORE-15 measures overall family functioning and has subscale scores to measure a family’s strengths and adaptability, sense of being overwhelmed by difficulties, and experience of disrupted communication.

Administer the instrument at the outset of family counseling and at intervals throughout treatment to measure changes in family functioning. An adaptation of the SCORE-15 can be used by children as young as 8 (Jewell, Carr, Stratton, Lask, & Eisler, 2013). SCORE-15 has been translated into many different languages, including Spanish, and is free for download and use (with administration and scoring instructions) from the Association for Family Therapy and Systemic Practice website (www.aft.org.uk/view/score.html?tzcheck=1).



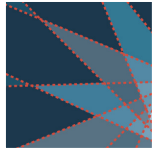
Engage clinical staff in a process that dispels misgivings about the ROM process and encourages buy-in. Doing so will enhance staff members' motivation to improve the quality of the family-based interventions they provide. Involve them in the planning and implementation process right up front. This will increase their motivation and demonstrate your administrative commitment to transparency.

Where Do We Go From Here?

Administrators must balance the potential for better client and family treatment outcomes with the challenge and costs of program development, the additional training and professional development of counselors from different backgrounds, and nonreimbursable activities like developing partnerships with other organizations.

In your decision-making process, remember that you cannot measure the value of adding family-based interventions to your treatment program only in terms of better substance misuse outcomes for specific clients or enhanced functioning of specific families.

Families, however defined, are the cornerstone of our cultural life and the backbone of society's structure. When you shift SUD treatment programs from a solely individual focus to a family-centered focus, you not only improve individual treatment outcomes but also contribute to SUD prevention efforts and enhance protective factors that can improve the health and wellness of **future generations**. Remember your agency's mission statement and let that guide you to next steps.



Appendix—Bibliography

- Adkison-Johnson, C. (2015). Child discipline and African American parents with adolescent children: A psychoeducational approach to clinical mental health counseling. *Journal of Mental Health Counseling, 37*(3), 221–233. doi:10.17744/mehc.37.3.03
- Akram, Y., & Copello, A. (2013). Family-based interventions for substance misuse: A systematic review of reviews. *The Lancet, 382*, S24. doi:10.1016/S0140-6736(13)62449-6
- Al-Anon Family Group Headquarters, Inc. (n.d.). The Legacies. Retrieved August 13, 2019, from <https://al-anon.org/for-members/the-legacies/>
- Al-Anon Family Group Headquarters, Inc. (2016). *Al-Anon: Then and now: A brief history* [Brochure].
- Alexander, J., & Parsons, B. V. (1982). *Functional family therapy*. Monterey, CA: Brooks/Cole Publishing Company.
- Ali, M. M., Dean, D., Jr., & Hedden, S. L. (2016). The relationship between parental mental illness and/or substance use disorder on adolescent substance use disorder: Results from a nationally representative survey. *Addictive Behaviors, 59*, 35–41. doi:10.1016/j.addbeh.2016.03.019
- Allwright, K., Goldie, C., Almost, J., & Wilson, R. (2019). Fostering positive spaces in public health using a cultural humility approach. *Public Health Nursing, 64*(4), 551–556. doi:10.1111/phn.12613
- Alonzo, D., Thompson, R. G., Stohl, M., & Hasin, D. (2014). The influence of parental divorce and alcohol abuse on adult offspring risk of lifetime suicide attempt in the United States. *American Journal of Orthopsychiatry, 84*(3), 316–320. doi:10.1037/h0099804
- Amato, P. R., King, V., & Thorsen, M. L. (2016). Parent-child relationships in stepfather families and adolescent adjustment: A latent class analysis. *Journal of Marriage and Family, 78*(2), 482–497. doi:10.1111/jomf.12267
- American Association for Marriage and Family Therapy. (n.d.-a). Medicaid. Retrieved April 6, 2020, from www.aamft.org/Advocacy/Medicaid.aspx
- Association for Marriage and Family Therapy. (n.a.-b). *MFT Licensing Boards*. Retrieved August 13, 2019, from www.aamft.org/Directories/MFT_Licensing_Boards.aspx?WebsiteKey=8e8c9bd6-0b71-4cd1-a5ab-013b5f855b01
- American Association for Marriage and Family Therapy. (2019). *Approved supervision designation: Standards handbook*. Version 5. Retrieved March 30, 2020, from www.aamft.org/documents/Supervision/2020_AS_Documents/ASHandbook02-2020edits.pdf
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
- Areba, E. M., Eisenberg, M. E., & McMorris, B. J. (2018). Relationships between family structure, adolescent health status and substance use: Does ethnicity matter? *Journal of Community Psychology, 46*(1), 44–57. doi:10.1002/jcop.21915
- Aromin, R. A., Jr. (2016). Substance abuse prevention, assessment, and treatment for lesbian, gay, bisexual, and transgender youth. *Pediatric Clinics of North America, 63*(6), 1057–1077. doi:10.1016/j.pcl.2016.07.007
- Association for Counselor Education and Supervision. (2011, January 18). *Best practices in clinical supervision: ACES task force report*. Retrieved April 7, 2020, from www.apsu.edu/mscounseling/pdfs/ACES_Best_Practices_Supervision.pdf
- Association for Family Therapy and Systemic Practice. (n.d.). *Guidance on caseload and clinical activity for family and systemic psychotherapists in the NHS*. Retrieved March 30, 2020, from www.aft.org.uk/SpringboardWebApp/userfiles/aft/file/Members/GuidanceonCaseloadandClinicalActivityforFamilySystemicPsychotherapists.pdf
- Ast, L. (2018). Developing alternative stories with partners of illicit substance users. *Journal of Family Psychotherapy, 29*(3), 201–222. doi:10.1080/08975353.2017.1410768
- Awosan, C. I., Sandberg, J. G., & Hall, C. A. (2011). Understanding the experience of Black clients in marriage and family therapy. *Journal of Marital and Family Therapy, 37*(2), 153–168. doi:10.1111/j.1752-0606.2009.00166.x
- Bai, G. J., Leon, S. C., Garbarino, J., & Fuller, A. K. (2016). The protective effect of kinship involvement on the adjustment of youth in foster care. *Child Maltreatment, 21*(4), 288–297. doi:10.1177/1077559516669043
- Baldwin, S. A., Christian, S., Berkeljon, A., & Shadish, W. R. (2012). The effects of family therapies for adolescent delinquency and substance abuse: A meta-analysis. *Journal of Marital and Family Therapy, 38*(1), 281–304. doi:10.1111/j.1752-0606.2011.00248.x
- Barfield-Cottledge, T. (2015). The triangulation effects of family structure and attachment on adolescent substance use. *Crime and Delinquency, 61*(2), 297–320. doi:10.1177/001128711420110



- Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., . . . Walkup, J. T. (2015). Paraprofessional-delivered home-visiting intervention for American Indian teen mothers and children: 3-year outcomes from a randomized controlled trial. *American Journal of Psychiatry, 172*(2), 154–162. doi:10.1176/appi.ajp.2014.14030332
- Barsky, A. (2018). Cultural competence, awareness, sensitivity, humility, and responsiveness: What's the difference? *New Social Worker, 25*(4), 4–5.
- Bartle-Haring, S., Pratt, K., & Knerr, M. C. (2019). *Policies and procedures manual for the Ph.D. specialization in couple and family therapy*. Retrieved August 9, 2019, from <https://ehe.osu.edu/sites/ehe.osu.edu/files/files/couple-and-family-therapy-policies-and-procedures.pdf>
- Bartle-Haring, S., Slesnick, N., & Murnan, A. (2018). Benefits to children who participate in family therapy with their substance-using mother. *Journal of Marital and Family Therapy, 44*(4), 671–686. doi:10.1111/jmft.12280
- Barton, A. W., Beach, S. R. H., Wells, A. C., Ingels, J. B., Corso, P. S., Sperr, M. C., . . . Brody, G. H. (2018). The Protecting Strong African American Families Program: A randomized controlled trial with rural African American couples. *Prevention Science, 19*(7), 904–913. doi:10.1007/s11121-018-0895-4
- Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment, 63*, 1–9. doi:10.1016/j.jsat.2016.01.003
- Beach, S. R., Barton, A. W., Lei, M. K., Mandara, J., Wells, A. C., Kogan, S. M., & Brody, G. H. (2016). Decreasing substance use risk among African American youth: Parent-based mechanisms of change. *Prevention Science, 17*(5), 572–583. doi:10.1007/s11121-016-0651-6
- Beck, A., Buche, J., Page, C., Rittman, D. & Gaiser, M. (2018). *Scopes of practice and reimbursement patterns of addiction counselors, community health workers, and peer recovery specialists in the behavioral health workforce*. Ann Arbor: University of Michigan School of Public Health, Behavioral Workforce Research Center.
- Becvar, R. J., & Becvar, D. S. (2018). *Systems theory and family therapy: A primer* (3rd ed.). Lanham, MD: Hamilton Books.
- Belone, L., Orosco, A., Damon, E., Smith-McNeal, W., Rae, R., Sherpa, M. L., . . . Wallerstein, N. (2017). The piloting of a culturally centered American Indian family prevention program: A CBPR partnership between Mescalero Apache and the University of New Mexico. *Public Health Reviews, 38*, 30. doi:10.1186/s40985-017-0076-1
- Berg, I. K., & Miller, S. D. (1992). *Working with the problem drinker: A solution-focused approach*. New York, NY: Norton & Co.
- Birkeland, B., Foster, K., Selbekk, A. S., Høie, M. M., Ruud, T., & Weimand, B. (2018). The quality of life when a partner has substance use problems: A scoping review. *Health and Quality of Life Outcomes, 16*(1), 219. doi:10.1186/s12955-018-1042-4
- Bischof, G., Iwen, J., Freyer-Adam, J., & Rumpf, H. J. (2016). Efficacy of the community reinforcement and family training for concerned significant others of treatment-refusing individuals with alcohol dependence: A randomized controlled trial. *Drug and Alcohol Dependence, 163*, 179–185. doi:10.1016/j.drugalcdep.2016.04.015
- Black, C. (2018). *Unspoken legacy: Addressing the impact of trauma and addiction within the family*. Las Vegas, NV: Central Recovery Press.
- Blum, K., Febo, M., Badgaiyan, R. D., Demetrovics, Z., Simpatico, T., Fahlke, C., . . . Gold, M. S. (2017). Common neurogenetic diagnosis and meso-limbic manipulation of hypodopaminergic function in reward deficiency syndrome (RDS): Changing the recovery landscape. *Current Neuropharmacology, 15*(1), 184–194. doi:10.2174/1570159X13666160512150918
- Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2013). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research, 25*(1), 6–19. doi:10.1080/10503307.2013.817696
- Bowen, M. (1978). *Family therapy in clinical practice*. New York, NY: Jason Aronson, Inc.
- Boyle, R., & McDowell-Burns, M. (2016). Modalities of marriage and family therapy supervision. In J. Karin (Ed.) *Couple, marriage, and family therapy supervision* (pp. 51–69). New York, NY: Springer Publishing Co.
- Bradshaw, S. D., Shumway, S. T., Wang, E. W., Harris, K. S., Smith, D. B., & Austin-Robillard, H. (2016). Family functioning and readiness in family recovery from addiction. *Journal of Groups in Addiction and Recovery, 11*(1), 21–41. doi:10.1080/1556035X.2015.1104644
- Braitman, A. L., & Kelley, M. L. (2016). Initiation and retention in couples outpatient treatment for parents with drug and alcohol use disorders. *Experimental and Clinical Psychopharmacology, 24*(3), 174–184. doi:10.1037/pha0000072
- Bregman, O. C., & White, C. M. (2011). *Bringing systems thinking to life: Expanding the horizons for Bowen family systems theory*. New York, NY: Brunner-Routledge.
- Brody, G. H., Chen, Y. F., Kogan, S. M., Murry, V. M., & Brown, A. C. (2010). Long-term effects of the Strong African American Families Program on youths' alcohol use. *Journal of Consulting and Clinical Psychology, 78*(2), 281–285. doi:10.1037/a0018552

- Brody, G. H., Chen, Y. F., Kogan, S. M., Yu, T., Molgaard, V. K., DiClemente, R. J., & Wingood, G. M. (2012). Family-centered program deters substance use, conduct problems, and depressive symptoms in Black adolescents. *Pediatrics, 129*(1), 108–115. doi:10.1542/peds.2011-0623
- Brown, S., Tracy, E. M., Jun, M., Park, H., & Min, M. O. (2015). Personal network recovery enablers and relapse risks for women with substance dependence. *Qualitative Health Research, 25*(3), 371–385. doi:10.1177/1049732314551055
- Burrow-Sánchez, J. J., Minami, T., & Hops, H. (2015). Cultural accommodation of group substance abuse treatment for Latino adolescents: Results of an RCT. *Cultural Diversity and Ethnic Minority Psychology, 21*(4), 571–583. doi:10.1037/cdp0000023
- Burstein, M., Stanger, C., & Dumenci, L. (2012). Relations between parent psychopathology, family functioning, and adolescent problems in substance-abusing families: Disaggregating the effects of parent gender. *Child Psychiatry and Human Development, 43*(4), 631–647. doi:10.1007/s10578-012-0288-z
- Calhoun, S., Conner, E., Miller, M., & Messina, N. (2015). Improving the outcomes of children affected by parental substance abuse: A review of randomized controlled trials. *Substance Abuse and Rehabilitation, 6*, 15–24. doi:10.2147/sar.s46439
- Canfield, M., Radcliffe, P., Marlow, S., Boreham, M., & Gilchrist, G. (2017). Maternal substance use and child protection: A rapid evidence assessment of factors associated with loss of child care. *Child Abuse and Neglect, 70*, 11–27. doi:10.1016/j.chiabu.2017.05.005
- Carlson, R. G., & Lambie, G. W. (2012). Systemic-developmental supervision: Clinical supervisory approach for family counseling student interns. *Family Journal, 20*(1), 29–36. doi:10.1177/1066480711419809
- Carr, A., & Stratton, P. (2017). The SCORE family assessment questionnaire: A decade of progress. *Family Process, 56*(2), 285–301. doi:10.1111/famp.12280
- Cavaiola, A. A., Fulmer, B. A., & Stout, D. (2015). The impact of social support and attachment style on quality of life and readiness to change in a sample of individuals receiving medication-assisted treatment for opioid dependence. *Substance Abuse, 36*(2), 183–191. doi:10.1080/08897077.2015.1019662
- Center for Behavioral Health Statistics and Quality. (2020). *Results from the 2019 National Survey on Drug Use and Health: Detailed tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved September 14, 2020, from <https://www.samhsa.gov/data/>
- Center for Substance Abuse Treatment. (2006a). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice*. Technical Assistance Publication (TAP) Series 21. HHS Publication No. (SMA) 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2006b). *Counselor's family education manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders*. HHS Publication No. (SMA) 13-4153. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2006c). *Counselor's treatment manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders*. HHS Publication No. (SMA) 13-4152. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Chang, J. S., Sorensen, J. L., Masson, C. L., Shopshire, M. S., Hoffman, K., McCarty, D., & Iguchi, M. (2017). Structural factors affecting Asians and Pacific Islanders in community-based substance use treatment: Treatment provider perspectives. *Journal of Ethnicity in Substance Abuse, 16*(4), 479–494.
- Chartier, K. G., Carmody, T., Akhtar, M., Stebbins, M. B., Walters, S. T., & Warden, D. (2015). Hispanic subgroups, acculturation, and substance abuse treatment outcomes. *Journal of Substance Abuse Treatment, 59*, 74–82. doi:10.1016/j.jsat.2015.07.008
- Cheung, S. (2014, October). *Family therapy with Asian Americans: Principles and practice*. Paper presented at the 20th Annual Asian American Mental Health Training Conference, Alhambra, CA.
- Chuang, S. S., Glozman, J., Green, D. S., & Rasmi, S. (2018). Parenting and family relationships in Chinese families: A critical ecological approach. *Journal of Family Theory and Review, 10*(2), 367–383. doi:10.1111/jftr.12257
- Commission on Accreditation for Marriage and Family Therapy Education. (2014, July 15). *Accreditation standards: Graduate & post-graduate marriage and family therapy training programs (Version 12.0)*. Retrieved April 7, 2020, from www.coamfte.org/documents/COAMFTE/Accreditation%20Resources/2018%20COAMFTE%20Accreditation%20Standards%20Version%2012%20May.pdf
- Cordova, D., Heinze, J., Mistry, R., Hsieh, H. F., Stoddard, S., Salas-Wright, C. P., & Zimmerman, M. A. (2014). Family functioning and parent support trajectories and substance use and misuse among minority urban adolescents: A latent class growth analysis. *Substance Use and Misuse, 49*(14), 1908–1919. doi:10.3109/10826084.2014.935792
- Cordova, D., Huang, S., Pantin, H., & Prado, G. (2012). Do the effects of a family intervention on alcohol and drug use vary by nativity status? *Psychology of Addictive Behaviors, 26*(3), 655–660. doi:10.1037/a0026438
- Corless, J., Mirza, K. A. H., & Steinglass, P. (2009). Family therapy for substance misuse: The maturation of a field. *Journal of Family Therapy, 31*(2), 109–114. doi:10.1111/j.1467-6427.2009.00457.x
- Cosden, M., & Koch, L. M. (2015). Changes in adult, child, and family functioning among participants in a family treatment drug court. *Child Welfare, 94*(5), 89–106.



- Cranford, J. A. (2014). DSM-IV alcohol dependence and marital dissolution: Evidence from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Studies on Alcohol and Drugs, 75*(3), 520–529. doi:10.15288/jsad.2014.75.520
- Cross, C. J. (2018). Extended family households among children in the United States: Differences by race/ethnicity and socio-economic status. *Population Studies, 72*(2), 235–251. doi:10.1080/00324728.2018.1468476
- Cruz, R. A., King, K. M., Cauce, A. M., Conger, R. D., & Robins, R. W. (2017). Cultural orientation trajectories and substance use: Findings from a longitudinal study of Mexican-origin youth. *Child Development, 88*(2), 555–572. doi:10.1111/cdev.12586
- Cuadrado, M. (2018). Roman Catholic priests as referral sources and treatment aides for Hispanics with substance misuse/abuse problems. *Journal of Religion and Health, 57*(2), 609–621. doi:10.1007/s10943-017-0464-3
- Cunningham, P. B., Foster, S. L., & Warner, S. E. (2010). Culturally relevant family-based treatment for adolescent delinquency and substance abuse: Understanding within-session processes. *Journal of Clinical Psychology, 66*(8), 830–846. doi:10.1002/jclp.20709
- Dahlgren, A., Wargelius, H. L., Berglund, K. J., Fahlke, C., Blennow, K., Zetterberg, H., . . . Balldin, J. (2011). Do alcohol-dependent individuals with DRD2 A1 allele have an increased risk of relapse? A pilot study. *Alcohol and Alcoholism, 46*(5), 509–513. doi:10.1093/alcalc/agr045
- Dakof, G. A., Henderson, C. E., Rowe, C. L., Boustani, M., Greenbaum, P. E., Wang, W., . . . Liddle, H. A. (2015). A randomized clinical trial of family therapy in juvenile drug court. *Journal of Family Psychology, 29*(2), 232–241. doi:10.1037/fam0000053
- Danso, R. (2018). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work, 18*(4), 410–430. doi:10.1177/1468017316654341
- De Jong, P., & Berg, I. K. (1998). *Interviewing for solutions*. Pacific Grove, CA: Brooks/Cole Publishing Company.
- de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York, NY: Norton & Co.
- Diamond, G. M., & Shpigel, M. S. (2014). Attachment-based family therapy for lesbian and gay young adults and their persistently nonaccepting parents. *Professional Psychology: Research and Practice, 45*(4), 258–268. doi:10.1037/a0035394
- DiClemente, C. C. (2018). *Addiction and change: How addictions develop and addicted people recover* (2nd ed.). New York, NY: Guilford Press.
- Drapkin, M. L., Eddie, D., Buffington, A. J., & McCrady, B. S. (2015). Alcohol-specific coping styles of adult children of individuals with alcohol use disorders and associations with psychosocial functioning. *Alcohol and Alcoholism, 50*(4), 463–469. doi:10.1093/alcalc/agn023
- Eddie, D., Epstein, E. E., & Cohn, A. M. (2015). Pathways to vulnerability for alcohol problem severity in a treatment-seeking sample. *Addictive Disorders and Their Treatment, 14*(2), 82–94. doi:10.1097/adt.0000000000000045
- Elam, K. K., Chassin, L., & Pandika, D. (2018). Polygenic risk, family cohesion, and adolescent aggression in Mexican American and European American families: Developmental pathways to alcohol use. *Development and Psychopathology, 30*(5), 1715–1728. doi:10.1017/s0954579418000901
- Escobar, O. S., & Vaughan, E. L. (2014). Public religiosity, religious importance, and substance use among Latino emerging adults. *Substance Use and Misuse, 49*(10), 1317–1325. doi:10.3109/10826084.2014.901384
- Fang, L., & Schinke, S. P. (2013). Two-year outcomes of a randomized, family-based substance use prevention trial for Asian American adolescent girls. *Psychology of Addictive Behaviors, 27*(3), 788–798. doi:10.1037/a0030925
- Fang, L., & Schinke, S. P. (2014). Mediation effects of a culturally generic substance use prevention program for Asian American adolescents. *Asian American Journal of Psychology, 5*(2), 116–125. doi:10.1037/a0035928
- Fang, L., Schinke, S. P., & Cole, K. C. (2010). Preventing substance use among early Asian-American adolescent girls: Initial evaluation of a web-based, mother-daughter program. *Journal of Adolescent Health, 47*(5), 529–532. doi:10.1016/j.jadohealth.2010.03.011
- Finan, L. J., Schulz, J., Gordon, M. S., & Ohannessian, C. M. (2015). Parental problem drinking and adolescent externalizing behaviors: The mediating role of family functioning. *Journal of Adolescence, 43*, 100–110. doi:10.1016/j.adolescence.2015.05.001
- Fish, J. N., Maier, C. A., & Priest, J. B. (2015). Substance abuse treatment response in a Latino sample: The influence of family conflict. *Journal of Substance Abuse Treatment, 49*, 27–34. doi:10.1016/j.jsat.2014.07.011
- Fletcher, K. (2013). Couple therapy treatments for substance use disorders: A systematic review. *Journal of Social Work Practice in the Addictions, 13*(4), 327–352. doi:10.1080/1533256X.2013.840213
- Frank, L. E., & Nagel, S. K. (2017). Addiction and moralization: The role of the underlying model of addiction. *Neuroethics, 10*(1), 129–139. doi:10.1007/s12152-017-9307-x
- Galanter, M. (2014). Network therapy for substance use disorders. In G. O. Gabbard (Ed.), *Gabbard's treatments of psychiatric disorders* (5th ed., pp. 919–922). Arlington, VA: American Psychiatric Publishing, Inc.
- Galanter, M. (2015). Network therapy. In M. Galanter, H. D. Kleber, & K. T. Brady (Eds.), *The American Psychiatric Publishing textbook of substance abuse treatment* (5th ed., pp. 441–461). Arlington, VA: American Psychiatric Publishing, Inc.

- Galanter, M., Dermatis, H., Glickman, L., Maslansky, R., Sellers, M. B., Neumann, E., & Rahman-Dujarric, C. (2004). Network therapy: Decreased secondary opioid use during buprenorphine maintenance. *Journal of Substance Abuse Treatment, 26*(4), 313–318.
- Galanter, M., Dermatis, H., Keller, D., & Trujillo, M. (2002). Network therapy for cocaine abuse: Use of family and peer supports. *American Journal on Addictions, 11*(2), 161–166.
- Garcia-Huidobro, D., Doty, J. L., Davis, L., Borowsky, I. W., & Allen, M. L. (2018). For whom do parenting interventions to prevent adolescent substance use work? *Prevention Science, 19*(4), 570–578. doi:10.1007/s11121-017-0853-6
- Gehart, D. R. (2018). *Mastering competencies in family therapy: A practical approach to theories and clinical case documentation* (3rd ed.). Boston, MA: Cengage Learning.
- Gerra, G., Somaini, L., Manfredini, M., Raggi, M. A., Saracino, M. A., Amore, M., . . . Donnini, C. (2014). Dysregulated responses to emotions among abstinent heroin users: Correlation with childhood neglect and addiction severity. *Progress in Neuro-Psychopharmacology and Biological Psychiatry, 48*, 220–228. doi:10.1016/j.pnpbp.2013.10.011
- Gilliard-Matthews, S., Stevens, R., Nilsen, M., & Dunaev, J. (2015). “You see it everywhere. It’s just natural.”: Contextualizing the role of peers, family, and neighborhood in initial substance use. *Deviant Behavior, 36*(6), 492–509. doi:10.1080/01639625.2014.944068
- Gingerich, W. J., & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice, 23*(3), 266–283. doi:10.1177/1049731512470859
- Gladding, S. T. (2019). *Family therapy: History, theory, and practice* (7th ed.). Boston, MA: Pearson.
- Glazer, S. S., Galanter, M., Megwinoff, O., Dermatis, H., & Keller, D. S. (2003). The role of therapeutic alliance in network therapy: A family and peer support-based treatment for cocaine abuse. *Substance Abuse, 24*(2), 93–100.
- Goldenberg, I., Stanton, M., & Goldenberg, H. (2017). *Family therapy: An overview* (9th ed.). Boston, MA: Cengage Learning.
- Goorden, M., Schawo, S. J., Bouwmans-Frijters, C. A., van der Schee, E., Hendriks, V. M., & Hakkaart-van Roijen, L. (2016). The cost-effectiveness of family/family-based therapy for treatment of externalizing disorders, substance use disorders and delinquency: A systematic review. *BMC Psychiatry, 16*, 237. doi:10.1186/s12888-016-0949-8
- Greenbaum, P. E., Wang, W., Henderson, C. E., Kan, L., Hall, K., Dakof, G. A., & Liddle, H. A. (2015). Gender and ethnicity as moderators: Integrative data analysis of multidimensional family therapy randomized clinical trials. *Journal of Family Psychology, 29*(6), 919–930. doi:10.1037/fam0000127
- Gustavsen, G. W., Nayga, R. M., Jr., & Wu, X. (2016). Effects of parental divorce on teenage children’s risk behaviors: Incidence and persistence. *Journal of Family and Economic Issues, 37*(3), 474–487. doi:10.1007/s10834-015-9460-5
- Gutierrez, A., & Sher, L. (2015). Alcohol and drug use among adolescents: An educational overview. *International Journal of Adolescent Medicine and Health, 27*(2), 207–212. doi:10.1515/ijamh-2015-5013
- Gutierrez, D. (2018). The role of intersectionality in marriage and family therapy multicultural supervision. *American Journal of Family Therapy, 46*(1), 14–26. doi:10.1080/01926187.2018.1437573
- Harford, T. C., Chen, C. M., Kerridge, B. T., & Grant, B. F. (2018). Self- and other-directed forms of violence and their relationship with lifetime DSM-5 psychiatric disorders: Results from the National Epidemiologic Survey on Alcohol Related Conditions-III (NESARC-III). *Psychiatry Research, 262*, 384–392. doi:10.1016/j.psychres.2017.09.012
- Harford, T. C., Yi, H. Y., Chen, C. M., & Grant, B. F. (2018). Substance use disorders and self- and other-directed violence among adults: Results from the National Survey on Drug Use And Health. *Journal of Affective Disorders, 225*, 365–373. doi:10.1016/j.jad.2017.08.021
- Harp, K. L. H., & Oser, C. B. (2018). A longitudinal analysis of the impact of child custody loss on drug use and crime among a sample of African American mothers. *Child Abuse and Neglect, 77*, 1–12. doi:10.1016/j.chiabu.2017.12.017
- Hartnett, D., Carr, A., Hamilton, E., & O’Reilly, G. (2017). The effectiveness of functional family therapy for adolescent behavioral and substance misuse problems: A meta-analysis. *Family Process, 56*(3), 607–619. doi:10.1111/famp.12256
- Haverfield, M. C., & Theiss, J. A. (2016). Parent’s alcoholism severity and family topic avoidance about alcohol as predictors of perceived stigma among adult children of alcoholics: Implications for emotional and psychological resilience. *Health Communication, 31*(5), 606–616. doi:10.1080/10410236.2014.981665
- Henderson, C. E., Hogue, A., & Dauber, S. (2019). Family therapy techniques and one-year clinical outcomes among adolescents in usual care for behavior problems. *Journal of Consulting and Clinical Psychology, 87*(3), 308–312. doi:10.1037/ccp0000376
- Henderson, C. E., Rowe, C. L., Dakof, G. A., Hawes, S. W., & Liddle, H. A. (2009). Parenting practices as mediators of treatment effects in an early-intervention trial of multidimensional family therapy. *American Journal of Drug and Alcohol Abuse, 35*(4), 220–226. doi:10.1080/00952990903005890
- Henggeler, S. W., & Schaeffer, C. M. (2016). Multisystemic therapy: Clinical overview, outcomes, and implementation research. *Family Process, 55*, 514–528. doi:10.1111/famp.12232



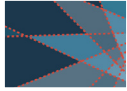
- Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *Journal of Primary Prevention, 38*(1–2), 5–26. doi:10.1007/s10935-016-0455-2
- Hernandez, L., Rodriguez, A. M., & Spirito, A. (2015). Brief family-based intervention for substance abusing adolescents. *Child and Adolescent Psychiatric Clinics of North America, 24*(3), 585–599. doi:10.1016/j.chc.2015.02.010
- Hernandez Robles, E., Maynard, B. R., Salas-Wright, C. P., & Todic, J. (2018). Culturally adapted substance use interventions for Latino adolescents: A systematic review and meta-analysis. *Research on Social Work Practice, 28*(7), 789–801. doi:10.1177/1049731516676601
- Hinrichs, J., Defife, J., & Westen, D. (2011). Personality subtypes in adolescent and adult children of alcoholics: A two-part study. *Journal of Nervous and Mental Disease, 199*(7), 487–498. doi:10.1097/NMD.0b013e3182214268
- Hoggatt, K. J., Lehavot, K., Krenek, M., Schweizer, C. A., & Simpson, T. (2017). Prevalence of substance misuse among US veterans in the general population. *American Journal on Addictions, 26*(4), 357–365. doi:10.1111/ajad.12534
- Hogue, A., Bobek, M., Dauber, S., Henderson, C. E., McLeod, B. D., & Southam-Gerow, M. A. (2017). Distilling the core elements of family therapy for adolescent substance use: Conceptual and empirical solutions. *Journal of Child and Adolescent Substance Abuse, 26*(6), 437–453. doi:10.1080/1067828X.2017.1322020
- Hogue, A., Dauber, S., Henderson, C. E., Bobek, M., Johnson, C., Lichvar, E., & Morgenstern, J. (2015). Randomized trial of family therapy versus nonfamily treatment for adolescent behavior problems in usual care. *Journal of Clinical Child and Adolescent Psychology, 44*(6), 954–969. doi:10.1080/15374416.2014.963857
- Horigian, V. E., Anderson, A. R., & Szapocznik, J. (2016). Family-based treatments for adolescent substance use. *Child and Adolescent Psychiatric Clinics of North America, 25*(4), 603–628. doi:10.1016/j.chc.2016.06.001
- Horigian, V. E., Feaster, D. J., Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2015). The effects of Brief Strategic Family Therapy (BSFT) on parent substance use and the association between parent and adolescent substance use. *Addictive Behaviors, 42*, 44–50. doi:10.1016/j.addbeh.2014.10.024
- Horigian, V. E., Feaster, D. J., Robbins, M. S., Brincks, A., Perez, M. A., & Szapocznik, J. (2014). Long-term effects of brief strategic family therapy for adolescent substance users. *Drug and Alcohol Dependence, 140*, e91. doi:10.1016/j.drugalcdep.2014.02.265
- Horigian, V. E., Feaster, D. J., Robbins, M. S., Brincks, A. M., Ucha, J., Rohrbaugh, M. J., . . . Szapocznik, J. (2015). A cross-sectional assessment of the long term effects of brief strategic family therapy for adolescent substance use. *American Journal on Addictions, 24*(7), 637–645. doi:10.1111/ajad.12278
- Huey S. J., Jr., & Polo, A. J. (2017). Evidence-based psychotherapies with ethnic minority children and adolescents. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (3rd ed., pp. 361–378). New York, NY: Guilford Press.
- Huibregtse, B. M., Corley, R. P., Wadsworth, S. J., Vandever, J. M., DeFries, J. C., & Stallings, M. C. (2016). A longitudinal adoption study of substance use behavior in adolescence. *Twin Research and Human Genetics, 19*(4), 330–340. doi:10.1017/thg.2016.35
- Hummel, A., Shelton, K. H., Heron, J., Moore, L., & van den Bree, M. B. (2013). A systematic review of the relationships between family functioning, pubertal timing and adolescent substance use. *Addiction, 108*(3), 487–496. doi:10.1111/add.12055
- Ivanich, J. D., Mousseau, A. C., Walls, M., Whitbeck, L., & Whitesell, N. R. (2020). Pathways of adaptation: Two case studies with one evidence-based substance use prevention program tailored for indigenous youth. *Prevention Science, 21*(Suppl. 1), 43–53. doi:10.1007/s1121-018-0914-5
- Jensen, M. R., Wong, J. J., Gonzales, N. A., Dumka, L. E., Millsap, R., & Cox, S. (2014). Long-term effects of a universal family intervention: Mediation through parent-adolescent conflict. *Journal of Clinical Child and Adolescent Psychology, 43*(3), 415–427. doi:10.1080/15374416.2014.891228
- Jessup, M. A., Ross, T. B., Jones, A. L., Satre, D. D., Weisner, C. M., Chi, F. W., & Mertens, J. R. (2014). Significant life events and their impact on alcohol and drug use: A qualitative study. *Journal of Psychoactive Drugs, 46*(5), 450–459. doi:10.1080/02791072.2014.962715
- Jewell, T., Carr, A., Stratton, P., Lask, J., & Eisler, I. (2013). Development of a children's version of the SCORE Index of Family Function and Change. *Family Process, 52*(4), 673–684. doi:10.1111/famp.12044
- Kaiser Permanente. (2019). Alcohol use in older adults. Retrieved April 7, 2020, from <https://wa.kaiserpermanente.org/healthAndWellness/index.jhtml?item=%2Fcommon%2FhealthAndWellness%2FhealthyLiving%2Flifestyle%2Falc-hol-seniors.html>
- Kalb, F. M., Vincent, V., Herzog, T., & Austin, J. (2017). Genetic counseling for alcohol addiction: Assessing perceptions and potential utility in individuals with lived experience and their family members. *Journal of Genetic Counseling, 26*(5), 963–970. doi:10.1007/s10897-017-0075-x

- Kang, J. (2019). Do extended family members protect children from disadvantaged neighborhoods? Focusing on behavioral problems of children. *Child and Youth Care Forum, 48*(3), 427–447. doi:10.1007/s10566-019-09489-6
- Kelly, S., Maynigo, P., Wesley, K., & Durham, J. (2013). African American communities and family systems: Relevance and challenges. *Couple and Family Psychology: Research and Practice, 2*(4), 264–277. doi:10.1037/cfp0000014
- Kepple, N. J. (2017). The complex nature of parental substance use: Examining past year and prior use behaviors as correlates of child maltreatment frequency. *Substance Use and Misuse, 52*(6), 811–821. doi:10.1080/0826084.2016.1253747
- Kepple, N. J. (2018). Does parental substance use always engender risk for children? Comparing incidence rate ratios of abusive and neglectful behaviors across substance use behavior patterns. *Child Abuse and Neglect, 76*, 44–55. doi:10.1016/j.chiabu.2017.09.015
- Kidorf, M., Latkin, C., & Brooner, R. K. (2016). Presence of drug-free family and friends in the personal social networks of people receiving treatment for opioid use disorder. *Journal of Substance Abuse Treatment, 70*, 87–92. doi:10.1016/j.jsat.2016.08.013
- Kim, J. S., Brook, J., & Akin, B. A. (2018). Solution-focused brief therapy with substance-using individuals: A randomized controlled trial study. *Research on Social Work Practice, 28*(4), 452–462. doi:10.1177/1049731516650517
- Kim-Spoon, J., Lauharatanahirun, N., Peviani, K., Brieant, A., Deater-Deckard, K., Bickel, W. K., & King-Casas, B. (2019). Longitudinal pathways linking family risk, neural risk processing, delay discounting, and adolescent substance use. *Journal of Child Psychology and Psychiatry, 60*(6), 655–664. doi:10.1111/jcpp.13015
- Klostermann, K., Chen, R., Kelley, M. L., Schroeder, V. M., Braitman, A. L., & Mignone, T. (2011). Coping behavior and depressive symptoms in adult children of alcoholics. *Substance Use and Misuse, 46*(9), 1162–1168. doi:10.3109/10826080903452546
- Klostermann, K., Kelley, M. L., Mignone, T., Pusateri, L., & Wills, K. (2011). Behavioral couples therapy for substance abusers: Where do we go from here? *Substance Use and Misuse, 46*(12), 1502–1509. doi:10.3109/10826084.2011.576447
- Klostermann, K., & O'Farrell, T. J. (2013). Treating substance abuse: Partner and family approaches. *Social Work in Public Health, 28*(3–4), 234–247. doi:10.1080/19371918.2013.759014
- Kogan, S. M., Lei, M. K., Brody, G. H., Futris, T. G., Sperr, M., & Anderson, T. (2016). Implementing family-centered prevention in rural African American communities: A randomized effectiveness trial of the Strong African American Families Program. *Prevention Science, 17*(2), 248–258. doi:10.1007/s11121-015-0614-3
- Korcha, R. A., Polcin, D. L., & Bond, J. C. (2016). Interaction of motivation and social support on abstinence among recovery home residents. *Journal of Drug Issues, 46*(3), 164–177. doi:10.1177/0022042616629514
- Kuhn, C. (2015). Emergence of sex differences in the development of substance use and abuse during adolescence. *Pharmacology and Therapeutics, 153*, 55–78. doi:10.1016/j.pharmthera.2015.06.003
- Kuntsche, S., & Kuntsche, E. (2016). Parent-based interventions for preventing or reducing adolescent substance use—A systematic literature review. *Clinical Psychology Review, 45*, 89–101. doi:10.1016/j.cpr.2016.02.004
- Lam, W. K., Fals-Stewart, W., & Kelley, M. L. (2008). Effects of parent skills training with behavioral couples therapy for alcoholism on children: A randomized clinical pilot trial. *Addictive Behaviors, 33*(8), 1076–1080. doi:10.1016/j.addbeh.2008.04.002
- Lam, W. K., Fals-Stewart, W., & Kelley, M. L. (2009). Parent training with behavioral couples therapy for fathers' alcohol abuse: Effects on substance use, parental relationship, parenting, and CPS involvement. *Child Maltreatment, 14*(3), 243–254. doi:10.1177/1077559509334091
- Lam, W. K. K., O'Farrell, T. J., & Birchler, G. R. (2012). Family therapy techniques for substance abuse treatment. In S. T. Walters & F. Rotgers (Eds.), *Treating substance abuse: Theory and technique* (3rd ed., pp. 256–280). New York, NY: Guilford Press.
- Lambie, G. W., Mullen, P. R., Swank, J. M., & Blount, A. (2018). The counseling competencies scale: Validation and refinement. *Measurement and Evaluation in Counseling and Development, 51*(1), 1–15. doi:10.1080/07481756.2017.1358964
- Lander, L., Howsare, J., & Byrne, M. (2013). The impact of substance use disorders on families and children: From theory to practice. *Social Work in Public Health, 28*(3–4), 194–205. doi:10.1080/19371918.2013.759005
- Laqueur, H. P., Laburt, H. A., & Morong, E. (1964). Multiple family therapy. *Current Psychiatric Therapies, 4*, 150–154.
- Lassiter, P. S., Czerny, A. B., & Williams, K. S. (2015). Working with addictions in family therapy. In D. Capuzzi & M. D. Stauffer (Eds.), *Foundations of couples, marriage, and family counseling* (pp. 389–417). Hoboken, NJ: Wiley.
- Lebensohn-Chialvo, F., Rohrbaugh, M. J., & Hasler, B. P. (2019). Fidelity failures in brief strategic family therapy for adolescent drug abuse: A clinical analysis. *Family Process, 58*(2), 305–317. doi:10.1111/famp.12366
- Lee, J. O., Cho, J., Yoon, Y., Bello, M. S., Khoddam, R., & Leventhal, A. M. (2018). Developmental pathways from parental socioeconomic status to adolescent substance use: Alternative and complementary reinforcement. *Journal of Youth and Adolescence, 47*(2), 334–348. doi:10.1007/s10964-017-0790-5



- Lei, N., & Pellitteri, J. (2017). Help-seeking and coping behaviors among Asian Americans: The roles of Asian values, emotional intelligence, and optimism. *Asian American Journal of Psychology, 8*(3), 224–234. doi:10.1037/aap0000086
- Lent, J., P., & Otto, A. (2018). Grandparents, grandchildren, and caregiving: The impacts of America's substance use crisis. *Generations, 42*(3), 15–22.
- Lester, P., Aralis, H., Sinclair, M., Kiff, C., Lee, K. H., Mustillo, S., & Wadsworth, S. M.. (2016). The impact of deployment on parental, family and child adjustment in military families. *Child Psychiatry and Human Development, 47*(6), 938–949. doi:10.1007/s10578-016-0624-9
- Leventhal, A. M., Lee, W., Bergen, A. W., Swan, G. E., Tyndale, R. F., Lerman, C., & Conti, D. V. (2014). Nicotine dependence as a moderator of genetic influences on smoking cessation treatment outcome. *Drug and Alcohol Dependence, 138*, 109–117. doi:10.1016/j.drugalcdep.2014.02.016
- Liddell, J., & Burnette, C. E. (2017). Culturally-informed interventions for substance abuse among indigenous youth in the United States: A review. *Journal of Evidence-Informed Social Work, 14*(5), 329–359. doi:10.1080/23761407.2017.1335631
- Liddle, H. A. (2010). Multidimensional family therapy: A science-based treatment system. *Australian and New Zealand Journal of Family Therapy, 31*(2), 133–148. doi:10.1375/anft.31.2.133
- Liddle, H. A., Dakof, G. A., Henderson, C., & Rowe, C. (2011). Implementation outcomes of Multidimensional Family Therapy-Detention to Community: A reintegration program for drug-using juvenile detainees. *International Journal of Offender Therapy and Comparative Criminology, 55*(4), 587–604. doi:10.1177/0306624x10366960
- Liddle, H. A., Dakof, G. A., Rowe, C. L., Henderson, C., Greenbaum, P., Wang, W., & Alberga, L. (2018). Multidimensional Family Therapy as a community-based alternative to residential treatment for adolescents with substance use and co-occurring mental health disorders. *Journal of Substance Abuse Treatment, 90*, 47–56. doi:10.1016/j.jsat.2018.04.011
- Liddle, H. A., Dakof, G. A., Turner, R. M., Henderson, C. E., & Greenbaum, P. E. (2008). Treating adolescent drug abuse: A randomized trial comparing multidimensional family therapy and cognitive behavior therapy. *Addiction, 103*(10), 1660–1670. doi:10.1111/j.1360-0443.2008.02274.x
- Liddle, H. A., Rowe, C. L., Dakof, G. A., Henderson, C. E., & Greenbaum, P. E. (2009). Multidimensional family therapy for young adolescent substance abuse: Twelve-month outcomes of a randomized controlled trial. *Journal of Consulting and Clinical Psychology, 77*(1), 12–25. doi:10.1037/a0014160
- Liddle, H. A., Rowe, C. L., Dakof, G. A., Ungaro, R. A., & Henderson, C. E. (2004). Early intervention for adolescent substance abuse: Pretreatment to posttreatment outcomes of a randomized clinical trial comparing Multidimensional Family Therapy and peer group treatment. *Journal of Psychoactive Drugs, 36*(1), 49–63. doi:10.1080/02791072.2004.10399723
- Liepman, M. R., Flachier, R., & Tareen, R. S. (2008). Family behavior loop mapping: A technique to analyze the grip addictive disorders have on families and to help them recover. *Alcoholism Treatment Quarterly, 26*(1–2), 59–80. doi:10.1300/J020v26n01_04
- Lipari, R., Palen, L. A., Ashley, O. S., Penne, M., Kan, M., & Pemberton, M. (2017). Examination of veteran fathers' parenting and their adolescent children's substance use in the United States. *Substance Use and Misuse, 52*(6), 698–708. doi:10.1080/10826084.2016.1253748
- Lipari, R. N., & Van Horn, S. L. (2017, August 24). *Children living with parents who have a substance use disorder: The CBHSQ Report*. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
- Lloyd-Hazlett, J., Honderich, E. M., & Heyward, K. J. (2016). Fa-MI-ly: Experiential techniques to integrate motivational interviewing and family counseling. *Family Journal, 24*(1), 31–37. doi:10.1177/1066480715615666
- Loveland, D. (2014, June). Creating a front door to engage and retain individuals with a SUD. In *Engagement strategies: Supporting wellness and recovery conference*. Presentation at the Meeting of Community Care and Western Psychiatric Institute & Clinic. State College, PA.
- Lucero, N. M., & Bussey, M. (2015). Practice-informed approaches to addressing substance abuse and trauma exposure in urban native families involved with child welfare. *Child Welfare, 94*(4), 97–117.
- Ma, M., Malcolm, L. R., Díaz-Albertini, K., Sánchez, J. C., Simpson, B., Cortes, L., & Kibler, J. L. (2017). Cultural assets and substance use among Hispanic adolescents. *Health Education and Behavior, 44*(2), 326–331. doi:10.1177/1090198116659440
- MacNicol, B. (2017). The biology of addiction. *Canadian Journal of Anesthesia, 64*(2), 141–148. doi:10.1007/s12630-016-0771-2
- Magette, A. L., Durtschi, J. A., & Love, H. A. (2018). Lesbian, gay, and bisexual substance use in emerging adulthood moderated by parent-child relationships in adolescence. *American Journal of Family Therapy, 46*(3), 272–286. doi:10.1080/01926187.2018.1493958
- Mahalik, J. R., Lombardi, C. M., Sims, J., Coley, R. L., & Lynch, A. D. (2015). Gender, male-typicality, and social norms predicting adolescent alcohol intoxication and marijuana use. *Social Science and Medicine, 143*, 71–80. doi:10.1016/j.socscimed.2015.08.013

- Marmorstein, N. R., Iacono, W. G., & McGue, M. (2012). Associations between substance use disorders and major depression in parents and late adolescent-emerging adult offspring: An adoption study. *Addiction, 107*(11), 1965–1973. doi:10.1111/j.1360-0443.2012.03934.x
- Marsiglia, F. F., Nagoshi, J. L., Parsai, M., & Castro, F. G. (2014). The effects of parental acculturation and parenting practices on the substance use of Mexican-heritage adolescents from southwestern Mexican neighborhoods. *Journal of Ethnicity in Substance Abuse, 13*(3), 288–311. doi:10.1080/15332640.2014.905215
- Martinez, M. J., Ayers, S. L., Kulis, S., & Brown, E. (2015). The relationship between peer, parent, and grandparent norms and intentions to use substances for urban American Indian youths. *Journal of Child and Adolescent Substance Abuse, 24*(4), 220–227. doi:10.1080/1067828X.2013.812529
- Mathew, K. J., Regmi, B., & Lama, L. D. (2018). Role of family in addictive disorders. *International Journal of Psychosocial Rehabilitation, 22*(1), 65–75.
- McCollister, K. E., French, M. T., Sheidow, A. J., Henggeler, S. W., & Halliday-Boykins, C. A. (2009). Estimating the differential costs of criminal activity for juvenile drug court participants: Challenges and recommendations. *Journal of Behavioral Health Services and Research, 36*(1), 111–126. doi:10.1007/s11414-007-9094-y
- McCullum, E. E., & Trepper, T. S. (2013). *Family solutions for substance abuse: Clinical and counseling approaches*. New York, NY: Routledge Publishers.
- McCrary, B. S., Tonigan, J. S., Ladd, B. O., Hallgren, K. A., Pearson, M. R., Owens, M. D., & Epstein, E. E. (2019). Alcohol behavioral couple therapy: In-session behavior, active ingredients and mechanisms of behavior change. *Journal of Substance Abuse Treatment, 99*, 139–148. doi:10.1016/j.jsat.2019.01.018
- McCrary, B. S., Wilson, A. D., Muñoz, R. E., Fink, B. C., Fokas, K., & Borders, A. (2016). Alcohol-focused behavioral couple therapy. *Family Process, 55*(3), 443–459. doi:10.1111/famp.12231
- McCutcheon, V. V., Agrawal, A., Kuo, S. I., Su, J., Dick, D. M., Meyers, J. L., . . . Bucholz, K. K. (2018). Associations of parental alcohol use disorders and parental separation with offspring initiation of alcohol, cigarette and cannabis use and sexual debut in high-risk families. *Addiction, 113*(2), 336–345. doi:10.1111/add.14003
- McFarlane, W. R., Dixon, L., Lukens, E., & Lucksted, A. (2003). Family psychoeducation and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy, 29*(2), 223–245. doi:10.1111/j.1752-0606.2003.tb01202.x
- McGoldrick, M. (1995). *You can go home again: Reconnecting with your family*. New York, NY: Norton.
- McHugh, R. K., Votaw, V. R., Sugarman, D. E., & Greenfield, S. F. (2018). Sex and gender differences in substance use disorders. *Clinical Psychology Review, 66*, 12–23. doi:10.1016/j.cpr.2017.10.012
- McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2010). Childhood adversities and adult psychiatric disorders in the National Comorbidity Survey Replication II: Associations with persistence of DSM-IV disorders. *Archives of General Psychiatry, 67*(2), 124–132. doi:10.1001/archgenpsychiatry.2009.187
- Menon, J., & Kandasamy, A. (2018). Relapse prevention. *Indian Journal of Psychiatry, 60*(Suppl. 4), S473–S478. doi:10.4103/psychiatry.IndianJPsychiatry_36_18
- Mignon, S. I., & Holmes, W. M. (2013). Substance abuse and mental health issues within Native American grandparenting families. *Journal of Ethnicity in Substance Abuse, 12*(3), 210–227. doi:10.1080/15332640.2013.798751
- Mignone, T., Klostermann, K., Mahadeo, M., Papagni, E., & Jankie, J. (2017). Confidentiality and family therapy: Cultural considerations. *ARC Journal of Psychiatry, 2*(1), 9–16.
- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.
- Milne, B. J., Caspi, A., Harrington, H., Poulton, R., Rutter, M., & Moffitt, T. E. (2009). Predictive value of family history on severity of illness: The case for depression, anxiety, alcohol dependence, and drug dependence. *Archives of General Psychiatry, 66*(7), 738–747. doi:10.1001/archgenpsychiatry.2009.55
- Mojtabai, R., Stuart, E. A., Hwang, I., Eaton, W. W., Sampson, N., & Kessler, R. C. (2017). Long-term effects of mental disorders on marital outcomes in the National Comorbidity Survey ten-year follow-up. *Social Psychiatry and Psychiatric Epidemiology, 52*(10), 1217–1226. doi:10.1007/s00127-017-1373-1
- Moon, Z. (2016). Pastoral care and counseling with military families. *Journal of Pastoral Care Counseling, 70*(2), 128–135. doi:10.1177/1542305016633663
- Moos, R. H. (2011). Processes that promote recovery from addictive disorders. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, research, and practice* (pp. 45–66). New York, NY: Humana Press.
- Moos, R. H., & Moos, B. S. (2007). Protective resources and long-term recovery from alcohol use disorders. *Drug and Alcohol Dependence, 86*(1), 46–54. doi:10.1016/j.drugalcdep.2006.04.015
- Moran, P. (2017). Selecting self-report outcome measures for use in family and systemic therapy. *Journal of Family Therapy, 39*(1), 41–56. doi:10.1111/1467-6427.12082



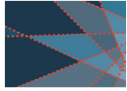
- Morgan, T. B., & Crane, D. R. (2010). Cost-effectiveness of family-based substance abuse treatment. *Journal of Marital and Family Therapy, 36*(4), 486–498. doi:10.1111/j.1752-0606.2010.00195.x
- Morgan, T. B., Crane, D. R., Moore, A. M., & Eggett, D. L. (2013). The cost of treating substance use disorders: Individual versus family therapy. *Journal of Family Therapy, 35*(1), 2–23. doi:10.1111/j.1467-6427.2012.00589.x
- Myhra, L. L., Wieling, E., & Grant, H. (2015). Substance use in American Indian family relationships: Linking past, present, and future. *American Journal of Family Therapy, 43*(5), 413–424. doi:10.1080/01926187.2015.1069133
- Nadel, E. L., & Thornberry, T. P. (2017). Intergenerational consequences of adolescent substance use: Patterns of homotypic and heterotypic continuity. *Psychology of Addictive Behaviors, 31*(2), 200–211. doi:10.1037/adb0000248
- National Academies of Sciences, Engineering, and Medicine. (2016). *Families caring for an aging America*. Washington, DC: National Academies Press.
- National Alliance on Mental Illness. (2019). NAMI family support group. Retrieved from <https://www.nami.org/Support-Education/Support-Groups/NAMI-Family-Support-Group>
- National Association of Social Workers. (2015). *Standards and indicators for cultural competence in social work practice*. Retrieved April 7, 2020, from www.socialworkers.org/LinkClick.aspx?fileticket=7dVckZAYUmk%3d&portalid=0
- National Domestic Violence Hotline. (2014, August 1). Why we don't recommend couples counseling for abusive relationships. Retrieved April 6, 2020, from www.thehotline.org/2014/08/01/why-we-dont-recommend-couples-counseling-for-abusive-relationships/
- National Institute on Alcohol Abuse and Alcoholism. (n.d.). Drinking levels defined. Retrieved from www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking
- National Institute on Drug Abuse. (2018). *Is drug addiction treatment worth its cost?* Retrieved April 6, 2020, from www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost
- Nichols, M. P., & Davis, S. (2017). *Family therapy: Concepts and methods* (11th ed.). Boston, MA: Pearson.
- Nicosia, N., Wong, E., Shier, V., Massachi, S., & Datar, A. (2017). Parental deployment, adolescent academic and social-behavioral maladjustment, and parental psychological well-being in military families. *Public Health Reports, 132*(1), 93–105. doi:10.1177/0033354916679995
- Novins, D. K., Ferron, C., Abramson, L., & Barlow, A. (2018). Addressing substance-use problems in tribal home visiting. *Infant Mental Health Journal, 39*(3), 287–294. doi:10.1002/imhj.21706
- O'Farrell, T. J., & Clements, K. (2012). Review of outcome research on marital and family therapy in treatment for alcoholism. *Journal of Marital and Family Therapy, 38*(1), 122–144. doi:10.1111/j.1752-0606.2011.00242.
- O'Farrell, T. J., Murphy, M., Alter, J., & Fals-Stewart, W. (2010). Behavioral family counseling for substance abuse: A treatment development pilot study. *Addictive Behaviors, 35*(1), 1–6. doi:10.1016/j.addbeh.2009.07.003
- O'Farrell, T. J., & Schein, A. Z. (2011). Behavioral couples therapy for alcoholism and drug abuse. *Journal of Family Psychotherapy, 22*(3), 193–215. doi:10.1080/08975353.2011.602615
- O'Farrell, T. J., Schreiner, A., Schumm, J., & Murphy, M. (2016). Do outcomes after behavioral couples therapy differ based on the gender of the alcohol use disorder patient? *Addictive Behaviors, 54*, 46–51.
- O'Farrell, T. J., Schumm, J. A., Murphy, M. M., & Muchowski, P. M. (2017). A randomized clinical trial of behavioral couples therapy versus individually-based treatment for drug-abusing women. *Journal of Consulting and Clinical Psychology, 85*(4), 309–322.
- Ohannessian, C. M., Flannery, K. M., Simpson, E., & Russell, B. S. (2016). Family functioning and adolescent alcohol use: A moderated mediation analysis. *Journal of Adolescence, 49*, 19–27. doi:10.1016/j.adolescence.2016.02.009
- Olmstead, T. A., Abraham, A. J., Martino, S., & Roman, P. M. (2012). Counselor training in several evidence-based psychosocial addiction treatments in private US substance abuse treatment centers. *Drug and Alcohol Dependence, 120*(1–3), 149–154. doi:10.1016/j.drugalcdep.2011.07.017
- Orford, J., Hodgson, R., Copello, A., Wilton, S., Slegg, G., & UKATT Research Team. (2009). To what factors do clients attribute change? Content analysis of follow-up interviews with clients of the UK Alcohol Treatment Trial. *Journal of Substance Abuse Treatment, 36*(1), 49–58.
- Osilla, K. C., Trail, T. E., Pedersen, E. R., Gore, K. L., Tolpadi, A., & Rodriguez, L. M. (2018). Efficacy of a web-based intervention for concerned spouses of service members and veterans with alcohol misuse. *Journal of Marital and Family Therapy, 44*(2), 292–306. doi:10.1111/jmft.12279
- Padilla, Y. C., Crisp, C., & Rew, D. L. (2010). Parental acceptance and illegal drug use among gay, lesbian, and bisexual adolescents: Results from a national survey. *Social Work, 55*(3), 265–275. doi:10.1093/sw/55.3.265
- Papernow, P. L. (2018). Clinical guidelines for working with stepfamilies: What family, couple, individual, and child therapists need to know. *Family Process, 57*(1), 25–51. doi:10.1111/famp.12321

- Park, S. Y., Anastas, J., Shibusawa, T., & Nguyen, D. (2014). The impact of acculturation and acculturative stress on alcohol use across Asian immigrant subgroups. *Substance Use and Misuse, 49*(8), 922–931. doi:10.3109/10826084.2013.855232
- Partnership for Drug-Free Kids. (2015). *How to build effective community partnerships to prevent teen substance abuse: Implementing PACT360 in your community*. Washington, DC: Office of Community Oriented Policing Services.
- Pina, A. A., Polo, A. J., & Huey, S. J. (2019). Evidence-based psychosocial interventions for ethnic minority youth: The 10-year update. *Journal of Clinical Child and Adolescent Psychology, 48*(2), 179–202. doi:10.1080/15374416.2019.1567350
- Platt, L. F., & Skowron, E. A. (2013). The family genogram interview: Reliability and validity of a new interview protocol. *Family Journal, 21*(1), 35–45. doi:10.1177/1066480712456817
- Prado, G., Cordova, D., Huang, S., Estrada, Y., Rosen, A., Bacio, G. A., . . . McCollister, K. (2012). The efficacy of Familias Unidas on drug and alcohol outcomes for Hispanic delinquent youth: Main effects and interaction effects by parental stress and social support. *Drug and Alcohol Dependence, 125*(Suppl. 1), S18–S25. doi:10.1016/j.drugalcdep.2012.06.011
- Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy*. Homewood, IL: Dow Jones-Irwin.
- Prom-Wormley, E. C., Ebejer, J., Dick, D. M., & Bowers, M. S. (2017). The genetic epidemiology of substance use disorder: A review. *Drug and Alcohol Dependence, 180*, 241–259. doi:10.1016/j.drugalcdep.2017.06.040
- Rambo, A., & Hibel, J. (2013). What is family therapy? Underlying premises. In A. Rambo, C. West, A. Schooley, & T. V. Boyd (Eds.), *Family therapy review: Contrasting contemporary models* (pp. 3–8). New York, NY: Routledge, Taylor & Francis Group.
- Rapp, C. A., & Goscha, R. J. (2012). *The strengths model: A recovery-oriented approach to mental health services* (3rd ed.). New York, NY: Oxford University Press.
- Rapp, R. C., Van Den Noortgate, W., Broekaert, E., & Vanderplasschen, W. (2014). The efficacy of case management with persons who have substance abuse problems: A three-level meta-analysis of outcomes. *Journal of Consulting and Clinical Psychology, 82*(4), 605–618. doi:10.1037/a0036750
- Reczek, C., Thomeer, M. B., Kissling, A., & Liu, H. (2017). Relationships with parents and adult children's substance use. *Addictive Behaviors, 65*, 198–206. doi:10.1016/j.addbeh.2016.10.014
- Reilly, M. T., Noronha, A., Goldman, D., & Koob, G. F. (2017). Genetic studies of alcohol dependence in the context of the addiction cycle. *Neuropharmacology, 122*, 3–21. doi:10.1016/j.neuropharm.2017.01.017
- Reiter, M. D. (2015). *Substance abuse and the family*. New York, NY: Routledge.
- Reyes, H. L., Foshee, V. A., Tharp, A. T., Ennett, S. T., & Bauer, D. J. (2015). Substance use and physical dating violence: The role of contextual moderators. *American Journal of Preventive Medicine, 49*(3), 467–475. doi:10.1016/j.amepre.2015.05.018
- Rigazio-DiGilio, S. A. (2016). MFT supervision: An overview. In K. Jordan (Ed.), *Couple, marriage, and family therapy supervision* (pp. 25–49). New York, NY: Springer Publishing.
- Robbins, M. S., Feaster, D. J., Horigian, V. E., Rohrbaugh, M., Shoham, V., Bachrach, K., . . . Szapocznik, J. (2011). Brief strategic family therapy versus treatment as usual: Results of a multisite randomized trial for substance using adolescents. *Journal of Consulting and Clinical Psychology, 79*(6), 713–727. doi:10.1037/a0025477
- Rogers, R. G., Lawrence, E. M., & Montez, J. K. (2016). Alcohol's collateral damage: Childhood exposure to problem drinkers and subsequent adult mortality risk. *Social Forces, 95*(2), 809–836. doi:10.1093/sf/sow074
- Roizen, H. G., de Waart, R., & van der Kroft, P. (2010). Community reinforcement and family training: An effective option to engage treatment-resistant substance-abusing individuals in treatment. *Addiction, 105*(10), 1729–1738. doi:10.1111/j.1360-0443.2010.03016.x
- Rothenberg, J. L., Sullivan, M. A., Church, S. H., Seracini, A., Collins, E., Kleber, H. D., & Nunes, E. V. (2002). Behavioral naltrexone therapy: An integrated treatment for opiate dependence. *Journal of Substance Abuse Treatment, 23*(4), 351–360.
- Rowan, M., Poole, N., Shea, B., Gone, J. P., Mykota, D., Farag, M., . . . Dell, C. (2014). Cultural interventions to treat addictions in indigenous populations: Findings from a scoping study. *Substance Abuse Treatment, Prevention, and Policy, 9*, 34. doi:10.1186/1747-597x-9-34
- Rowe, C., Rigter, H., Henderson, C., Gantner, A., Mos, K., Nielsen, P., & Phan, O. (2013). Implementation fidelity of Multidimensional Family Therapy in an international trial. *Journal of Substance Abuse Treatment, 44*(4), 391–399. doi:10.1016/j.jsat.2012.08.225
- Rowe, C. L. (2012). Family therapy for drug abuse: Review and updates 2003-2010. *Journal of Marital and Family Therapy, 38*(1), 59–81. doi:10.1111/j.1752-0606.2011.00280.x
- Russell, B. S., Simpson, E., Flannery, K. M., & Ohannessian, C. M. (2019). The impact of adolescent substance use on family functioning: The mediating role of internalizing symptoms. *Youth and Society, 51*(4), 504–528. doi:10.1177/0044118X16688708
- Santisteban, D. A., Mena, M. P., & Abalo, C. (2013). Bridging diversity and family systems: Culturally informed and flexible family-based treatment for Hispanic adolescents. *Couple and Family Psychology: Research and Practice, 2*(4), 246–263. doi:10.1037/cfp0000013



- Satir, V. (1988). *The new peoplemaking*. Mountain View, CA: Science and Behavior Books.
- Satir, V., Banmen, J., Gerber, J., & Gomori, M. (1991). *The Satir model: Family therapy and beyond*. Palo Alto, CA: Science and Behavior Books.
- Savage, J. E., & Mezuk, B. (2014). Psychosocial and contextual determinants of alcohol and drug use disorders in the National Latino and Asian American Study. *Drug and Alcohol Dependence, 139*, 71–78. doi:10.1016/j.drugalcdep.2014.03.011
- Schaeffer, C. M., Swenson, C. C., Tuerk, E. H., & Henggeler, S. W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families Program. *Child Abuse and Neglect, 37*(8), 596–607. doi:10.1016/j.chiabu.2013.04.004
- Schinke, S. P., Fang, L., Cole, K. C., & Cohen-Cutler, S. (2011). Preventing substance use among Black and Hispanic adolescent girls: Results from a computer-delivered, mother-daughter intervention approach. *Substance Use and Misuse, 46*(1), 35–45. doi:10.3109/10826084.2011.521074
- Schuckit, M. A. (2014). A brief history of research on the genetics of alcohol and other drug use disorders. *Journal of Studies on Alcohol and Drugs, 75*(Suppl. 17), 59–67.
- Schumm, J. A., Monson, C. M., O'Farrell, T. J., Gustin, N. G., & Chard, K. M. (2015). Couple treatment for alcohol use disorder and posttraumatic stress disorder: Pilot results from U.S. military veterans and their partners. *Journal of Traumatic Stress, 28*(3), 247–252. doi:10.1002/jts.22007
- Schumm, J. A., & O'Farrell, T. J. (2013a). Behavioral couples therapy for alcoholism. In P. M. Miller et al. (Eds.), *Comprehensive addictive behaviors and disorders: Vol. 3. Interventions for addiction* (pp. 57–65). San Diego, CA: Elsevier Academic Press.
- Schumm, J. A., & O'Farrell, T. J. (2013b). Families and addiction. In P. M. Miller et al. (Eds.), *Comprehensive addictive behaviors and disorders: Vol. 1. Principles of addiction* (pp. 303–312). San Diego, CA: Elsevier Academic Press.
- Schumm, J. A., O'Farrell, T. J., & Andreas, J. B. (2012). Behavioral couples therapy when both partners have a current alcohol use disorder. *Alcoholism Treatment Quarterly, 30*(4), 407–421. doi:10.1080/07347324.2012.718963
- Schumm, J. A., O'Farrell, T. J., Kahler, C. W., Murphy, M. M., & Muchowski, P. (2014). A randomized clinical trial of behavioral couples therapy versus individually based treatment for women with alcohol dependence. *Journal of Consulting and Clinical Psychology, 82*(6), 993–1004. doi:10.1037/a0037497
- Shaw, D. J., Warren, T. B., & Johnson, M. E. (2019). Family structure and past-30 day opioid misuse among justice-involved children. *Substance Use and Misuse, 54*(7), 1226–1235. doi:10.1080/10826084.2019.1573839
- Sheidow, A. J., & Henggeler, S. W. (2008). Multisystemic therapy for alcohol and other drug abuse in delinquent adolescents. *Alcoholism Treatment Quarterly, 26*(1–2), 125–145. doi:10.1300/J020v26n01_07
- Sheidow, A. J., McCart, M. R., & Davis, M. (2016). Multisystemic therapy for emerging adults with serious mental illness and justice involvement. *Cognitive Behavioral Practice, 23*(3), 356–367. doi:10.1016/j.cbpra.2015.09.003
- Shellenberger, S. (2007). Use of the genogram with families for assessment and treatment. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and family therapy processes* (pp. 76–94). Hoboken, NJ: Wiley.
- Shih, R. A., Tucker, J. S., Miles, J. N., Ewing, B. A., Pedersen, E. R., & D'Amico, E. J. (2015). Differences in substance use and substance use risk factors by Asian subgroups. *Asian American Journal of Psychology, 6*(1), 38–46. doi:10.1037/a0036251
- Slesnick, N., Erdem, G., Bartle-Haring, S., & Brigham, G. S. (2013). Intervention with substance-abusing runaway adolescents and their families: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 81*(4), 600–614. doi:10.1037/a0033463
- Smith, J. M., & Estefan, A. (2014). Families parenting adolescents with substance abuse—Recovering the mother's voice: A narrative literature review. *Journal of Family Nursing, 20*(4), 415–441. doi:10.1177/1074840714554397
- Smith, T. E., Malespin, T. S., Pereira, M. G., & Richards, K. V. (2016). Factors relating to the use of family therapy with adolescent marijuana abusers. *Child and Adolescent Social Work Journal, 33*(3), 237–243. doi:10.1007/s10560-015-0417-1
- Smith, V. C., Wilson, C. R., & Committee on Substance Use and Prevention. (2016). Families affected by parental substance use. *Pediatrics, 138*(2), e20161575. doi:10.1542/peds.2016-1575
- Smith-Genthôs, K. R., Logue, E. M., Low, B. E., & Hendrick, S. S. (2017). The forgotten ones: Siblings of substance abusers. *Journal of Loss and Trauma, 22*(2), 120–134. doi:10.1080/15325024.2016.1202005
- Soper, R. G. (2014, October 6). Intimate partner violence and co-occurring substance abuse/addiction. *ASAM Magazine, 1–9*.
- Sparks, S. N., Tisch, R., & Gardner, M. (2013). Family-centered interventions for substance abuse in Hispanic communities. *Journal of Ethnicity in Substance Abuse, 12*(1), 68–81. doi:10.1080/15332640.2013.759785

- Stanton, M., & Welsh, R. (2012). Systemic thinking in couple and family psychology research and practice. *Couple and Family Psychology: Research and Practice*, 1(1), 14–30. doi:10.1037/a0027461
- Steinglass, P. (2009). Systemic-motivational therapy for substance abuse disorders: An integrative model. *Journal of Family Therapy*, 31(2), 155–174. doi:10.1111/j.1467-6427.2009.00460.x
- Steinglass, P., Sanders, C., & Wells, F. (2019). Multiple family group therapy. In B. H. Fiese, M. Celano, K. Deater-Deckard, E. N. Jouriles, & M. A. Whisman (Eds.), *APA handbook of contemporary family psychology: Family therapy and training* (Vol. 3, pp. 155–169). Washington, DC: American Psychological Association.
- Steinka-Fry, K. T., Tanner-Smith, E. E., Dakof, G. A., & Henderson, C. (2017). Culturally sensitive substance use treatment for racial/ethnic minority youth: A meta-analytic review. *Journal of Substance Abuse Treatment*, 75, 22–37. doi:10.1016/j.jsat.2017.01.006
- Stormshak, E. A., Connell, A. M., Véronneau, M. H., Myers, M. W., Dishion, T. J., Kavanagh, K., & Caruthers, A. S. (2011). An ecological approach to promoting early adolescent mental health and social adaptation: Family-centered intervention in public middle schools. *Child Development*, 82(1), 209–225. doi:10.1111/j.1467-8624.2010.01551.x
- Strunin, L., Díaz-Martínez, A., Díaz-Martínez, L. R., Kuranz, S., Hernández-Ávila, C. A., Pantridge, C. E., & Fernández-Varela, H. (2015). Natural mentors and youth drinking: A qualitative study of Mexican youths. *Health Education Research*, 30(4), 660–670. doi:10.1093/her/cyv030
- Substance Abuse and Mental Health Services Administration. (2010). Recovery-oriented systems of care (ROSC) resource guide – Working draft.
- Substance Abuse and Mental Health Services Administration. (2013). *Substance abuse treatment: Addressing the specific needs of women*. Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. (SMA)13-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2015). *Using technology-based therapeutic tools in behavioral health services*. Treatment Improvement Protocol (TIP) Series 60. HHS Publication No. (SMA) 15-4924. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2017, August 1). *Complex connections: Intimate partner violence and women's substance abuse and recovery*. PowerPoint slides presented as part of Relationships Matter, a webinar series on women's behavioral health. Rockville, MD: Substance Abuse and Mental Health Services Administration and Administration for Children and Families. Retrieved September 10, 2020, from <https://www.youtube.com/watch?v=IE13p5GgW0E>
- Substance Abuse and Mental Health Services Administration. (2018). *Behavioral health services for American Indians and Alaska Natives*. Treatment Improvement Protocol (TIP) Series 61. HHS Publication No. (SMA) 18-5070. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2019a). *Enhancing motivation for change in substance use disorder treatment*. Treatment Improvement Protocol (TIP) Series 35. HHS Publication No. PEP19-02-01-003. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2019b). Substance abuse confidentiality regulations. Retrieved April 6, 2020, from www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs
- Substance Abuse and Mental Health Services Administration. (2020). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2019. Data on substance abuse treatment facilities*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved September 10, 2020, from <https://www.samhsa.gov/data/sites/default/files/reports/rpt29389/NSSATS-2019.pdf>
- Sudhir, P. M. (2018). Cognitive behavioural interventions in addictive disorders. *Indian Journal of Psychiatry*, 60(Suppl. 4), S479–S484. doi:10.4103/psychiatry.IndianJPsychiatry_15_18
- Sullivan, K., Capp, G., Gilreath, T. D., Benbenishty, R., Roziner, I., & Astor, R. A. (2015). Substance abuse and other adverse outcomes for military-connected youth in California: Results from a large-scale normative population survey. *JAMA Pediatrics*, 169(10), 922–928. doi:10.1001/jamapediatrics.2015.1413
- Szapocznik, J., Hervis, O., & Schwartz, S. (2003). *Brief strategic family therapy for adolescent drug abuse. Therapy Manuals for Drug Addiction*. Bethesda, MD: National Institute on Drug Abuse.
- Szapocznik, J., Muir, J. A., Duff, J. H., Schwartz, S. J., & Brown, C. H. (2015). Brief strategic family therapy: Implementing evidence-based models in community settings. *Psychotherapy Research*, 25(1), 121–133.
- Tanner-Smith, E. E., Wilson, S. J., & Lipsey, M. W. (2013). The comparative effectiveness of outpatient treatment for adolescent substance abuse: A meta-analysis. *Journal of Substance Abuse Treatment*, 44(2), 145–158. doi:10.1016/j.jsat.2012.05.006
- Teeters, J. B., Lancaster, C. L., Brown, D. G., & Back, S. E. (2017). Substance use disorders in military veterans: Prevalence and treatment challenges. *Substance Abuse and Rehabilitation*, 8, 69–77. doi:10.2147/sar.S116720



- Thapa, S., Selya, A. S., & Jonk, Y. (2017). Time-varying effects of parental alcoholism on depression. *Preventing Chronic Disease, 14*, E136. doi:10.5888/pcd14.170100
- Trail, T. E., Martin, L. T., Burgette, L. F., May, L. W., Mahmud, A., Nanda, N., & Chandra, A. (2017). *An evaluation of U.S. military non-medical counseling programs*. Santa Monica, CA: RAND.
- Trone, D. W., Powell, T. M., Bauer, L. M., Seelig, A. D., Peterson, A. V., Littman, A. J., . . . Boyko, E. J. (2018). Smoking and drinking behaviors of military spouses: Findings from the Millennium Cohort Family Study. *Addictive Behaviors, 77*, 121–130. doi:10.1016/j.addbeh.2017.09.015
- Tucker, J. S., Edelen, M. O., & Huang, W. (2017). Effectiveness of parent-child mediation in improving family functioning and reducing adolescent problem behavior: Results from a pilot randomized controlled trial. *Journal of Youth and Adolescence, 46*(3), 505–515. doi:10.1007/s10964-015-0412-z
- Tuerk, E. H., McCart, M. R., & Henggeler, S. W. (2012). Collaboration in family therapy. *Journal of Clinical Psychology, 68*(2), 168–178. doi:10.1002/jclp.21833
- U.S. Census Bureau. (2017a). *Grandchildren under 18 years living with a grandparent householder by age of grandchild, 2013-2017. American Community Survey 5-year estimates*. Retrieved August 13, 2019.
- U.S. Census Bureau. (2017b). *Grandparents, 2013-2017. American Community Survey 5-year estimates*. Retrieved August 13, 2019.
- U.S. Census Bureau. (2019a). *Grandchildren characteristics. 2018 American Community Survey 1-year estimates*. Retrieved April 6, 2020, from <https://data.census.gov/cedsci/table?q=S10&d=ACS%201-Year%20Estimates%20Subject%20Tables&tid=ACSS1Y2018.S1001&vintage=2018>
- U.S. Census Bureau. (2019b). *Grandparents. 2018 American Community Survey 1-year estimates*. Retrieved April 6, 2020, from <https://data.census.gov/cedsci/table?q=S10&d=ACS%201-Year%20Estimates%20Subject%20Tables&tid=ACSS1Y2018.S1002&vintage=2018>
- U.S. Census Bureau. (2019c). *Relationship to householder for children under 18 years in households. 2018 American Community Survey 1-year estimates*. Retrieved April 6, 2020, from <https://data.census.gov/cedsci/table?hidePreview=true&tid=ACSD1Y2018.B09018&vintage=2018>
- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2011). *Cognitive impairment: A call for action now*. Retrieved April 7, 2020, from www.cdc.gov/aging/pdf/cognitive_impairment/cogimp_poilicy_final.pdf
- U.S. Department of Health and Human Services, Office of Minority Health. (2018). Brief strategic family therapy. Retrieved April 6, 2020, from <https://minorityhealth.hhs.gov/npa/materials/briefstrategyfamilytherapy.pdf>
- U.S. Department of Health and Human Services, Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. Washington, DC: Author.
- Vaeth, P. A., Wang-Schweig, M., & Caetano, R. (2017). Drinking, alcohol use disorder, and treatment access and utilization among U.S. racial/ethnic groups. *Alcoholism: Clinical and Experimental Research, 41*(1), 6–19. doi:10.1111/acer.13285
- van Eeden-Moorefield, B., & Pasley, B. K. (2013). Remarriage and stepfamily life. In G. W. Peterson & K. R. Bush (Eds.), *Handbook of marriage and the family* (3rd ed., pp. 517–546). New York, NY: Springer Science + Business Media.
- van Wormer, K. S., & Davis, D. R. (2018). *Addiction treatment: A strengths perspective*. Boston, MA: Cengage Learning.
- Ventura, A. S., & Bagley, S. M. (2017). To improve substance use disorder prevention, treatment and recovery: Engage the family. *Journal of Addiction Medicine, 11*(5), 339–341. doi:10.1097/adm.0000000000000331
- Vermeulen-Smit, E., Verdurmen, J. E., & Engels, R. C. (2015). The effectiveness of family interventions in preventing adolescent illicit drug use: A systematic review and meta-analysis of randomized controlled trials. *Clinical Child and Family Psychology Review, 18*(3), 218–239. doi:10.1007/s10567-015-0185-7
- Vernig, P. M. (2011). Family roles in homes with alcohol-dependent parents: An evidence-based review. *Substance Use and Misuse, 46*(4), 535–542. doi:10.3109/0826084.2010.501676
- Villatoro, A. P., Morales, E. S., & Mays, V. M. (2014). Family culture in mental health help-seeking and utilization in a nationally representative sample of Latinos in the United States: The NLAAS. *American Journal of Orthopsychiatry, 84*(4), 353–363. doi:10.1037/h0099844
- Ward, K. P., Dennis, C. B., & Limb, G. E. (2018). The impact of stepfamily relationship quality on emerging adult non-medical use of prescription drugs. *American Journal of Drug and Alcohol Abuse, 44*(4), 463–471. doi:10.1080/00952990.2017.1405010
- Watkins, C. E., Hook, J. N., Jr., Owen, J., DeBlaere, C., Davis, D. E., & Van Tongeren, D. R. (2019). Multicultural orientation in psychotherapy supervision: Cultural humility, cultural comfort, and cultural opportunities. *American Journal of Psychotherapy, 72*(2), 38–46. doi:10.1176/appi.psychotherapy.20180040

- Wegscheider-Cruse, S. (1989). *Another chance: Hope and health for the alcoholic family* (2nd ed.). Palo Alto, CA: Science and Behavior Books.
- Wells, E. A., Kristman-Valente, A. N., Peavy, K. M., & Jackson, T. R. (2013). Social workers and delivery of evidence-based psychosocial treatments for substance use disorders. *Social Work in Public Health, 28*(3–4), 279–301. doi:10.1080/19371918.2013.759033
- Welsh, J. W., Knight, J. R., Hou, S. S., Malowney, M., Schram, P., Sherritt, L., & Boyd, J. W. (2017). Association between substance use diagnoses and psychiatric disorders in an adolescent and young adult clinic-based population. *Journal of Adolescent Health, 60*(6), 648–652. doi:10.1016/j.jadohealth.2016.12.018
- Werner, D., Young, N. K., Dennis, K., & Amatetti, S. (2007). *Family-centered treatment for women with substance use disorders: History, key elements and challenges*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends* (1st ed.). New York, NY: Norton.
- White, W., & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor, 9*(5), 22–27.
- White, W. L. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America* (2nd ed.). Bloomington, IL: Chestnut Health Systems.
- White, W. L., & Sanders, M. (2006). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. In W. L. White, E. Kurtz, & M. Sanders (Eds.), *Recovery management* (pp. 58–86). Chicago, IL: Great Lakes Addiction Technology Transfer Center.
- Whiteman, S. D., Jensen, A. C., Mustillo, S. A., & Maggs, J. L. (2016). Understanding sibling influence on adolescents' alcohol use: Social and cognitive pathways. *Addictive Behaviors, 53*, 1–6.
- Wilkinson, A. L., Fleming, P. J., Halpern, C. T., Herring, A. H., & Harris, K. M. (2018). Adherence to gender-typical behavior and high frequency substance use from adolescence into young adulthood. *Psychology of Men and Masculinity, 19*(1), 145–155. doi:10.1037/men0000088
- Williamson, E., Smith, M., Orford, J., Copello, A., & Day, E. (2007). Social Behavior and Network Therapy for drug problems: Evidence of benefits and challenges. *Addictive Disorders and Their Treatment, 6*, 167–179.
- Wlodarczyk, O., Schwarze, M., Rumpf, H. J., Metzner, F., & Pawils, S. (2017). Protective mental health factors in children of parents with alcohol and drug use disorders: A systematic review. *PloS One, 12*(6), e0179140. doi:10.1371/journal.pone.0179140
- Wong, E. C., Derose, K. P., Litt, P., & Miles, J. N. V. (2018). Sources of care for alcohol and other drug problems: The role of the African American church. *Journal of Religion and Health, 57*(4), 1200–1210. doi:10.1007/s10943-017-0412-2
- Worley, M. J., Trim, R. S., Tate, S. R., Roesch, S. C., Myers, M. G., & Brown, S. A. (2014). Self-efficacy and social networks after treatment for alcohol or drug dependence and major depression: Disentangling person and time-level effects. *Psychology of Addictive Behaviors, 28*(4), 1220–1229. doi:10.1037/a0037901
- Yap, M. B. H., Cheong, T. W. K., Zaravinos-Tsakos, F., Lubman, D. I., & Jorm, A. F. (2017). Modifiable parenting factors associated with adolescent alcohol misuse: A systematic review and meta-analysis of longitudinal studies. *Addiction, 112*(7), 1142–1162. doi:10.1111/add.13785
- Yoon, G., Westermeyer, J., Kuskowski, M. A., & Nesheim, L. (2013). Impact of the number of parents with alcohol use disorder on alcohol use disorder in offspring: A population-based study. *Journal of Clinical Psychiatry, 74*(8), 795–801. doi:10.4088/JCP.13m08350
- Zhao, S., Sampson, S., Xia, J., & Jayaram, M. B. (2015). Psychoeducation (brief) for people with serious mental illness. *Cochrane Database of Systematic Reviews, 4*, CD010823. doi:10.1002/14651858.CD010823.pub2
- Zweben, J. E., Moses, Y., Cohen, J. B., Price, G., Chapman, W., & Lamb, J. (2015). Enhancing family protective factors in residential treatment for substance use disorders. *Child Welfare, 94*(5), 145–166.

Substance Abuse and Mental Health Services Administration. Substance Use Disorder Treatment and Family Therapy. Treatment Improvement Protocol (TIP) Series, No. 39. SAMHSA Publication No. PEP20-02-02-012. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

As part of its coursework, Quantum Units Education uses the above-referenced article published by the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA). HHS and SAMHSA have no affiliation with Quantum Units Education and have not endorsed Quantum Units Education's course or business in any way.

Quantum Units Education

Affordable. Dependable. Accredited.

www.quantumunitsed.com