SUBSTANCE USE DISORDER TREATMENT: WORKING WITH FAMILIES

Series Overview: This course is part of a 3-course series on Substance Use Disorder Treatment and Family Therapy

Substance use disorders (SUDs) are complex and far reaching, affecting not only the individual with SUD, but also their family. This series provides information that clinicians can use to provide SUD treatments, services, and programs that best meet the needs of those seeking addiction treatment as well as those supporting recovery. The courses in this SUD Treatment and Family Therapy series are:

Substance Use Disorder Treatment: Working with Families
Substance Use Disorder Treatment: Family Counseling Approaches
Substance Use Disorder Treatment: Family and Organizational Cultures

Families affect—and are affected by—substance use disorders (SUDs). As such, it is beneficial to include family members in clients' treatments and/or services for SUDs. Appropriate family inclusion often increases the likelihood of achieving and maintaining long-term recovery. This learning material uses Chapter 1 (Substance Use Disorder Treatment: Working with Families) and Chapter 2 (Influence of Substance Misuse on Families) of the Substance Abuse and Mental Health Services Administration's (SAMHSA) publication *TIP 39 Substance Use Disorder Treatment and Family Therapy.*

The purpose of this learning material is to prepare clinicians to adapt SUD treatments and services to each family's individual makeup and needs, including background, structure, and situation. Chapter 1 discusses different types of families and gives an overview of different approaches of family-based SUD treatment. Chapter 2 delves deeper into family systems and the role of substance misuse on family dynamics. In this learning material, clinicians will learn how to identify common family structures and dynamics and determine how these may influence substance use.

LEARNING OBJECTIVES

Upon completion of this course, the learner will be able to:

1. Describe the importance of integrating family counseling into SUD treatment.
2. Identify common concepts of family structure related to SUDs.
3. Discuss current models and treatment approaches to family counseling for SUD treatment.
4. Recognize common family features and dynamics associated with substance misuse and SUDs.
5. Describe how a parent's SUD affects children both in childhood and adulthood.

Chapter 1—Substance Use Disorder Treatment: Working With Families

KEY MESSAGES

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

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

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

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

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

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

Scope of This TIP

Audience

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

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

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

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

Organization

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

EXHIBIT 1.1. TIP Organization

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

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

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

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

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

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

Goals

This TIP will help SUD treatment providers and administrators:

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

EXHIBIT 1.2. Key Terms

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

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

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

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

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

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

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

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

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

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

Family counseling helps each family member understand:

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

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

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

Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Challenges

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

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

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

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

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

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

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

Family Counseling Objectives

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

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

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

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

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

Understanding Families

What Is a Family?

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

Family Types

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

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

Common Characteristics of All Families

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

Subsystems

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

EXHIBIT 1.4. Treatment Issues According to Family Type

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

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

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

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

EXHIBIT 1.5. Homeostasis

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

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

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

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

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

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

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

Rules

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

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

Shared Values, History, and Narratives

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

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

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

Roles

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

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

Boundaries

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

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

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

Power Structures

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

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

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

Communication Patterns

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

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

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

Durability and Loyalty

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

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

Developmental Stage

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

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

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

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

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

Context and Culture

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

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

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

History of Family-Based Interventions in SUD Treatment

Family Theory—Initial Research

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

Incorporating the Concept of Systems Into Family Models

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

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

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

Initial Integration of Families Into SUD Treatment

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

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

Specialized Family SUD Treatment Programs

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

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

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

Current Models for Including Families in SUD Treatment

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

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

EXHIBIT 1.6. The Matrix Intensive Outpatient Approach

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

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

Different Pathways in Working With Families

Parallel, Integrated, and Sequential Approaches

Parallel

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

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

RESOURCE ALERT: SAMHSA'S ROSC RESOURCE GUIDE

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

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

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

Integrated

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

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

EXHIBIT 1.7. Understanding Client Reluctance Toward Family Involvement

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

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

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

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

Sequential

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

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

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

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

Settings and Formats

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

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

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

EXHIBIT 1.8. Multifamily Groups

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

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

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

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

Levels of Family Involvement

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

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

Where Do We Go From Here?

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

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Chapter 2—Influence of Substance Misuse on Families

KEY MESSAGES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Common Characteristics of Families With SUDs

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

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

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

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

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

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

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

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

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

EXHIBIT 2.3. Effects of Different Substances on Families

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

Source: Mathew et al. (2018).

MINI-CASE EXAMPLE

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

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

Homeostasis

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

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

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

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

Traditional Gender Roles, SUDs, and Family Dynamics

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

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

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

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

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

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

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

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

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

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

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

Family Types: SUDs and Family Dynamics

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

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

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

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

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

Couples in Which a Partner Has an SUD

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

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

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

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

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

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

COUNSELOR NOTE: WHAT IS CODEPENDENCE?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Continued on next page

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, Wlodarczyk, Schwarze, Rumpf, Metzner, and Pawils (2017) identify some positive developments, including resiliency and reduced risk of substance misuse. These were especially likely in children who had certain protective factors, such as:

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

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

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

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

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

Parents Who Have SUDs and Adult Children

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

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

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

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

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

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

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

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

Blended Families in Which a Family Member Has an SUD

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

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

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

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

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

EXHIBIT 2.4. Family Roles When a Parent Has an SUD

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

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

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

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

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

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

Families With Adolescents Who Have SUDs

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

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

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

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

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

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

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

- Parental substance misuse.
- Parental mental disorder.

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

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

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

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

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

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

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

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

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

Where Do We Go From Here?

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

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:10.1177/0011128711420110

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/agv023

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/s11121-018-0914-5

Jensen, M. R., Wong, J. J., Gonzales, N. A., Dumka, L. E., Millsap, R., & Coxe, 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%2Falcohol-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:10.1080/10826084.2016.1253747

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

McCollum, E. E., & Trepper, T. S. (2013). *Family solutions for substance abuse: Clinical and counseling approaches.* New York, NY: Routledge Publishers.

McCrady, 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

McCrady, 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

Roozen, 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-Martinez, A., Díaz-Martinez, 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=ACSST1Y2018.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=ACSST1Y2018.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=ACSDT1Y2018.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:10.3109/10826084.2010.501676

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.