SUBSTANCE USE DISORDER TREATMENT: FAMILY COUNSELING APPROACHES

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

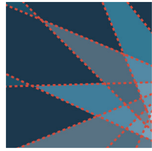
Substance use disorders (SUDs) within families not only change the life of the individual with the SUD, but they may also create issues for the entire family system. There are specific family-based treatments that can effectively help families improve their functioning and support individuals with SUDs in their recovery. This learning material uses Chapter 3 (Family Counseling Approaches) and Chapter 4 (Integrated Family Counseling to Address Substance Use Disorder) 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 present clinicians with the different family counseling approaches available for SUD treatment and how to integrate these family-based counseling techniques into SUD treatment. Chapter 3 reviews the multiple forms of family-based treatment models that are currently available, while Chapter 4 discusses how to integrate treatment models based on families' and clients' needs, readiness for change, treatment setting, and other factors. In this learning material, clinicians will learn how to determine the most appropriate course of treatment and family involvement to help develop more targeted treatments that directly address families' and clients' challenges for improved outcomes.

LEARNING OBJECTIVES

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

1. Identify methodologies specific to different family-based SUD intervention models.
2. Explain the appropriate family-based SUD intervention for specific clients and families based on the intervention's goals and outcomes.
3. Explain when integrated family counseling approaches are contraindicated and when they are appropriate.
4. Apply tools and methodologies necessary for effective family counseling for SUDs.



Chapter 3—Family Counseling Approaches

KEY MESSAGES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Overview of Family-Based SUD Treatment Methods

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

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

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

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

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

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

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

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

MST

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

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

Systemic–Motivational Therapy

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

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

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

Psychoeducation

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

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

Psychoeducation helps family members:

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

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

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

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

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

MDFT

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

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

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

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

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

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

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

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

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

Behavioral Couples and Family Counseling

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

BCT

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

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

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

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

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

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

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

(Klostermann, Kelley, Mignone, Pusateri, & Wills, 2011, p. 1503)

RESOURCE ALERT: MDFT ONLINE

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

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

Benefits of BCT in Relapse Prevention and Recovery Promotion

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

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

BCT Interventions

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

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

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

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

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

EXHIBIT 3.2. BCT Interventions

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

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EXHIBIT 3.2. BCT Interventions *(continued)*

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

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

CLINICAL SCENARIO: COUPLES COMMUNICATION SKILLS

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

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

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

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

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

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

Parenting Skills Training in BCT

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

BCT for Family Counseling

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

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

BFT

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

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

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

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

Family Behavior Loop Mapping

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

CLINICAL SCENARIO: INDIVIDUAL COUNSELING WITH A FAMILY FOCUS

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

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

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

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

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

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

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

Family Check-Up

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

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

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

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

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

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

CLINICAL SCENARIO: COGNITIVE RESTRUCTURING AND PROBLEM-SOLVING

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

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

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

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

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

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

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

BSFT

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

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

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

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

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

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

EXHIBIT 3.3. Concepts Underlying BSFT

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

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

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

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

Functional Family Therapy

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

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

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

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

COUNSELOR NOTE: CULTURAL CONSIDERATIONS

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

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

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

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

CLINICAL SCENARIO: JOINING AND ESTABLISHING BOUNDARIES

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

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

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

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

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

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

Solution-Focused Brief Therapy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNSELOR NOTE: ASKING THE MIRACLE QUESTION

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

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

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

CRAFT

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

Community Reinforcement

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

A Less Structured Approach

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

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

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

Network Therapy

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

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

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

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

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

Family Approaches To Support Ongoing Recovery

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

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

Engagement of Families in Treatment

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

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

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

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

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

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

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

Family Recovery Support Groups

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

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

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

12-Step Groups

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

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

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

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

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

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

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

Case Management

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

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

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

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

Family Peer Recovery Support Services

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

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

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

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

(Werner, Young, Dennis, & Amatetti, 2007, p. 13)

RESOURCE ALERT: FAMILY-FOCUSED RECOVERY SUPPORT GROUP ONLINE RESOURCES

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

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

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

CLINICAL SCENARIO: DEBBIE'S CASE MANAGEMENT

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

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

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

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

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

Relapse Prevention for Families

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

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

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

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

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

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

Where Do We Go From Here?

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

Chapter 4—Integrated Family Counseling To Address Substance Use Disorders

KEY MESSAGES

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

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

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

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

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

Appropriateness of Integrated Family Counseling for SUDs

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

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

History of Family Violence

Intimate Partner Violence

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

Experts in the field of domestic violence generally do not recommend joint counseling for couples in which intimate partner violence has occurred (National Domestic Violence Hotline, 2014) because:

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

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

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

Child Abuse

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

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

COUNSELOR NOTE: INTERVENING WITH A DOMINEERING FAMILY MEMBER

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

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

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

Severity of Health Issues

Substance Withdrawal

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

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

Serious Mental Illness

Clients with SUDs often have co-occurring mental disorders. Family counseling is generally appropriate for clients with SUDs and mental disorders—and in fact, some family-based interventions are particularly effective for specific co-occurring mental disorders, including severe adult anxiety disorders (Gehart, 2018). A review of the evidence found that any kind of brief psychoeducation, including family-based interventions, reduces relapse, increases medication adherence, and improves social functioning of people with serious mental illness (SMI; Zhao, Sampson, Xia, & Jayaram, 2015).

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

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

Significant Cognitive Impairment

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

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

Mandated Family Counseling

Another factor that can complicate any counseling process is external coercion. One or more family members, particularly those with SUDs, can be mandated to treatment by the criminal justice system, Child Protective Services, or an employer. In these circumstances, the person who has been mandated is likely to be angry and to try to get you, as well as family members, to focus on how unfair the situation is.

Your first priority should be to form an alliance with the mandated client without "taking sides" with the client regarding the need for treatment. Motivational interviewing (MI) strategies can help you build a therapeutic alliance and help the client and family members resolve their ambivalence about participating in family counseling (Lloyd-Hazlett, Honderich, & Heyward, 2016).

MI is an evidence-based counseling approach that has demonstrated effectiveness with clients who are mandated to treatment and has been used as an intervention to help enhance client motivation to participate in formal treatment (Miller & Rollnick, 2013). Although MI is used primarily in individual and group counseling, you can adapt MI principles and counseling strategies in family sessions with a focus on changing substance use that negatively affects family functioning (Lloyd-Hazlett et al., 2016). See TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019a; https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003) for more information about MI.

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

COUNSELOR NOTE: THINK OUTSIDE THE BOX

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

Whom To Involve in Integrated Family Counseling for SUDs

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

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

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

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

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

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

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

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

Screening and Assessment in Integrated Family Counseling

Individual Assessment With a Family Focus

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

- Yields a more thorough, and perhaps more accurate, family history.
- Presents an opportunity to confirm and clarify information on the client.
- Provides insight into the context where substance misuse most often occurs and where it may have started or accelerated.
- Sets the tone for a continuing focus on the family.
- Identifies family resources to help plan long-term care.
- Documents specific information that can determine treatment goals.

Conduct a comprehensive psychosocial assessment with the individual who is identified as the primary client with the SUD as part of your standard assessment procedures. Assessments in SUD treatment programs focus on the individual's current and history of substance use. Other information gathered during an individual assessment that is helpful to understanding current family functioning includes the client's:

- History of mental disorders.
- History of family-of-origin SUDs or mental disorders.
- History of domestic violence.
- History of trauma.
- History of physical, emotional, verbal, or sexual abuse.
- History of criminal justice involvement, including arrests for driving under the influence and periods of incarceration.
- Occupational and work history, including periods of unemployment or underemployment.
- Sexual and reproductive health history, including HIV status, safe sex practices, sexual or gender identity, and sexual practices.

During individual assessment, emphasize the importance of including family members in treatment, encourage discussion about who might be involved in family treatment, and explore the current family situation from the client's perspective. Including family members at the start of SUD treatment gives you an opportunity to provide education about the biological and psychosocial aspects of SUDs. It also helps uncover client and family strengths and begins the process of preparing family members for changes to the family system that will happen as the client initiates recovery (van Wormer & Davis, 2018).

Here are some questions that can start the conversation:

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

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

Family Interview

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

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

Other tasks for the family interview include:

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

Family-Based Assessment

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

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

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

Ask each family member to describe his or her theory about the client's substance use behavior. Their input will help you understand how the family system is organized around and reacts to the behavior (Gehart, 2018). The next task is to explore the family's strengths and positive ways they have managed the disruptions to family life caused by substance misuse. Exhibit 4.1 offers an alternative approach.

EXHIBIT 4.1. A Narrative Approach to Family Assessment

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

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

- **Mapping the effects of substance misuse on the family by asking questions like:**
  - How does substance misuse affect your mood, eating, sleeping, feelings of panic, worry or obsessive thinking, thoughts about hurting yourself or others, or hurtful behavior toward yourself or others?
  - How does substance misuse affect your relationships at home, work, or school, or with your extended family or social network?
  - How does substance misuse affect your social and recreational activities?
  - How does substance misuse affect your daily functioning and ability to meet your responsibilities at home, work, or school?
  - How does substance misuse affect your spiritual life, beliefs, or sense of purpose in life?
- **Mapping the effects of family members on substance misuse by asking questions like:**
  - What are some ways that you have used to lessen the negative impact of substance misuse on yourself or other family members?
  - Are there times when you can keep substance misuse from negatively affecting your thoughts, feelings, eating, sleeping, or other daily activities?
  - What are some ways that you were able to do this?
  - Are there times when you can protect your relationships from the negative effects of substance misuse?
  - What are some ways that you were able to do this?
  - Are there ways that you can maintain a sense of meaning and purpose, despite the negative influence of substance misuse?

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

Strengths Assessment

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

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

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

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

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

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

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

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

Genograms

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

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

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

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

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

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

- Beginning the process at the initial family interview. Ask family members about their understanding of SUDs and how their family member's substance misuse has affected family relationships. Then trace the history of the problem and family dynamics to prior generations. Also ask about important events like births, graduations, marriages, and deaths and how those events may be linked to the current substance misuse (Shellenberger, 2007).
- Asking about family members with SUDs who are or were in recovery and any information family members have about their recovery efforts.
- Filling in as much genogram information as possible about current and extended family members. Start with the identified client and his or her current spouse or intimate partner. Work up to include parents, stepparents, and siblings. Then work down to the children.
- Spending time gathering information about the child's relationships with parents and siblings—if the identified client is one of the children (e.g., a teenage son)—before moving on to extended family.
- Giving family members between-session assignments to gather more family history to bring back to the next family session. This can help family members gain further insight into how intergenerational family dynamics affect current family functioning.
- Asking young children to draw themselves and other relatives, including extended family (e.g., aunt, uncle, grandparent) during the session or at home and to bring the drawing to a family meeting.
- Continually adding to the genogram for a fuller, richer understanding of family history, relationship dynamics, and the role of substance misuse and recovery efforts in family life across generations.

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

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

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

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

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

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

Continued on next page

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

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

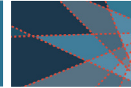
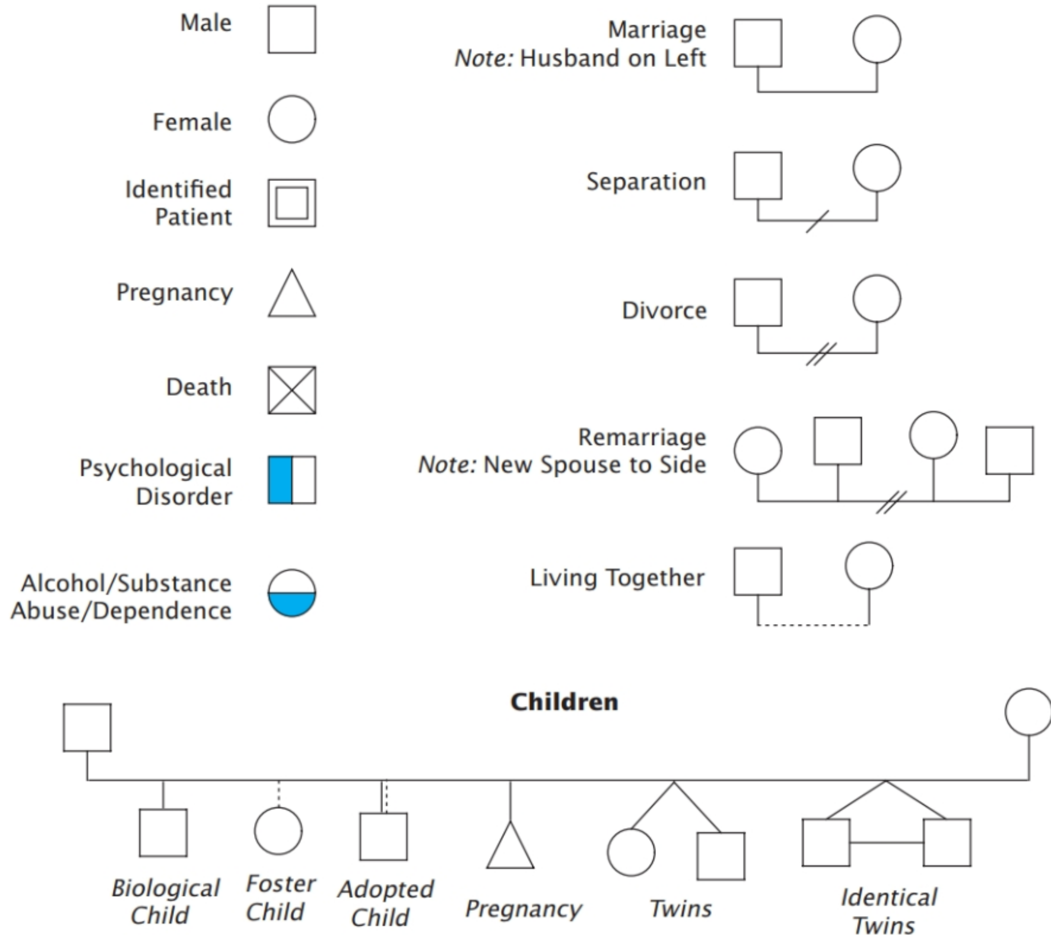


EXHIBIT 4.2. Genogram Symbols



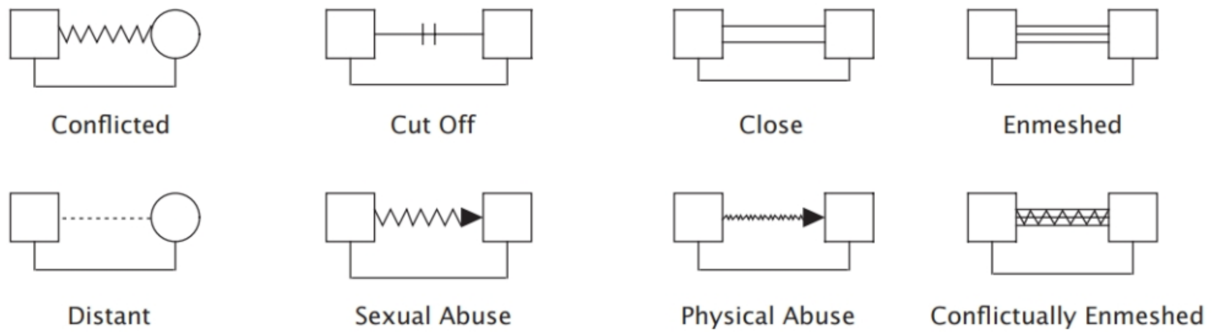


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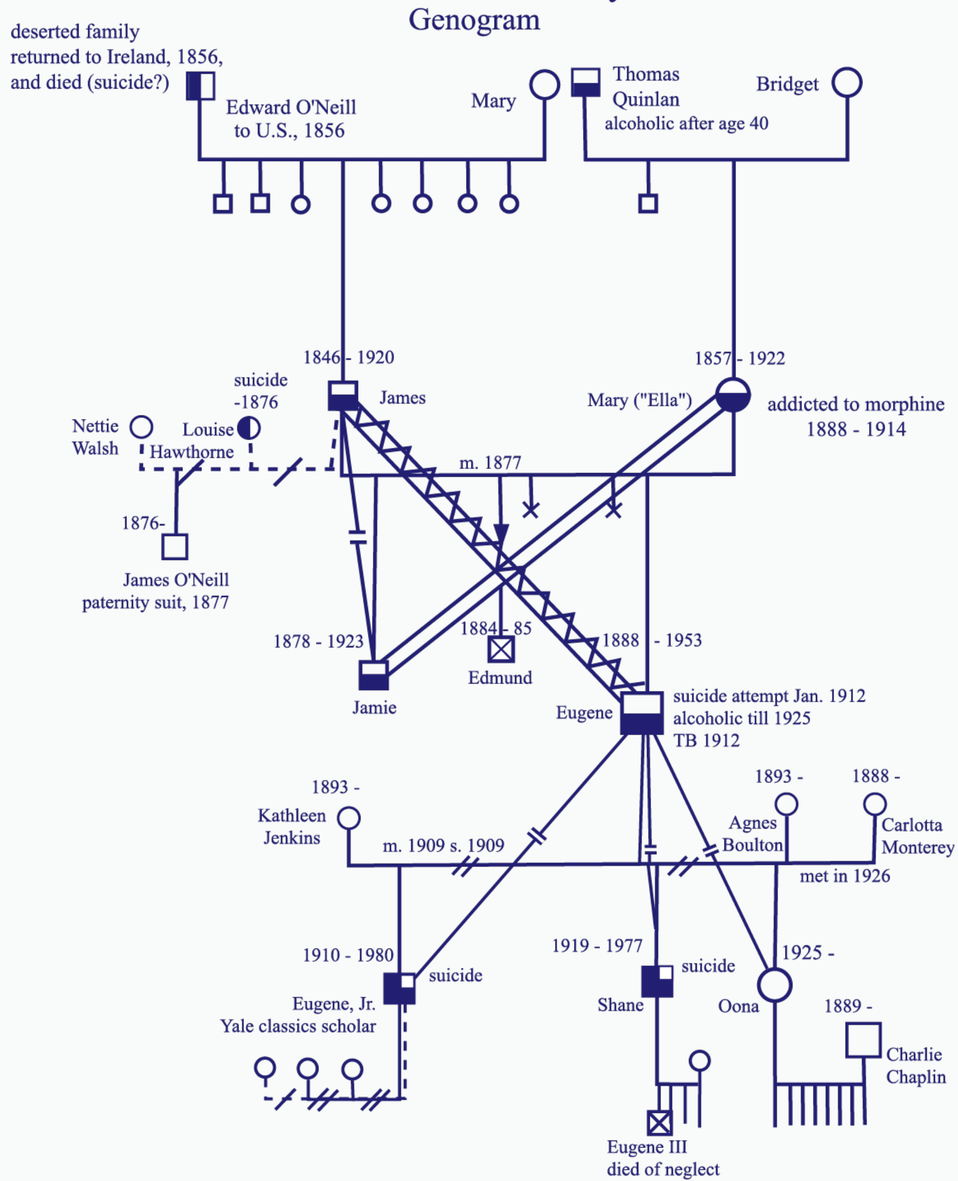
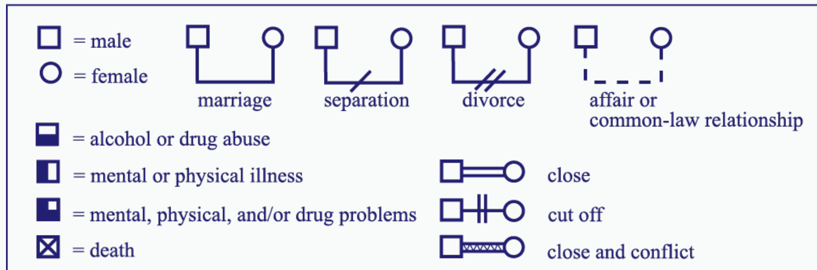
EXHIBIT 4.3. O'Neill Genogram



Key to Symbols



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

Goals of Integrated Family Counseling for SUDs

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

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

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

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

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

Understand Your Role as an SUD Treatment Provider

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

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

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

Optimize Initial Sessions

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

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

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

Initial sessions should focus on:

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

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

Acknowledge Stages of Change

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

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

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

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

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

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

Educating families about the SOC framework can help them identify where they each are in the stages and support each other to move toward positive change. The SOC approach provides an overarching model for behavior change from an SUD treatment perspective. See TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 2019a; https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003), for more information about the SOC model.

COUNSELOR NOTE: THE ROLE OF FAMILY IN RELAPSE PREVENTION

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

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

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

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

The plan should:

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

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

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

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

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

Address Common Challenges

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

Family Counseling Is Secondary

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

Family Counseling Is Too Painful

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

Coordination of Family Services

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

Keeping Family Secrets

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

SUD Client or Family Member Is in Precontemplation

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

Family's Adjustment to Abstinence

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

The Client on Medication

Clients with co-occurring mental disorders or those who are prescribed medications for alcohol use disorder or opioid use disorder often are uncertain about adhering to medication routines. Some of the reasons clients stop taking medications include cost, negative side effects, the belief that they are not in recovery because they are substituting one drug for another, or systemic barriers (e.g., having to go to a clinic every day to receive a methadone dose). When clients stop taking medications, symptoms of mental disorders or old substance use behaviors reemerge, and families return to previous patterns of dysfunction. The issue of medication adherence is a common theme in the families you serve. Your task is to raise this issue, when applicable, in family sessions.

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

Where Do We Go From Here?

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

Appendix—Bibliography

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