SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

# THE IMPORTANCE OF FAMILY THERAPY IN SUBSTANCE USE DISORDER TREATMENT

Involving family members in substance use disorder (SUD) treatment can positively affect client engagement, retention, and outcomes. Positive social/family support is related to long-term abstinence and recovery, whereas negative social/family support (e.g., interpersonal conflict, social pressure to use) is related to increased risk for relapse (Brown et al., 2015; Cavaiola et al., 2015; Moos & Moos, 2007; Worley et al., 2014). In addition, when compared to non-family-based models of counseling, family-based treatments aimed at reducing SUDs are associated with lower delivery costs (Morgan et al., 2013).

This *Advisory* is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocol (TIP) 39, *Substance Use Disorder Treatment and Family Therapy*. It surveys basic factors for programs and providers to consider when implementing family-related therapy approaches, goals and processes for conducting effective family counseling, and resources for further learning about family therapy techniques and models.

### *Key Messages*

- Although family involvement in SUD treatment has been shown to improve outcomes with certain clients, providers should consider client factors, such as withdrawal status, co-occurring disorders, legal involvement, or history of violence in the family, before implementing a family-based approach.
- "Family" is a broad term and can mean different things to different people (i.e., blended families, children living with grandparents, same-sex families, military families, and living with unrelated persons). Providers should allow the client to define whom they consider to be their family.
- Approaches to family counseling need to adapt to scheduling, travel, and/or ambivalence issues that can arise when involving members of a family (as opposed to individual sessions).
- Family counseling should be based on a thorough family assessment that examines patterns of family interaction as well as strengths and challenges in the family dynamic.
- Culture and diversity are vital aspects of effective family counseling. Awareness of these factors will help providers "meet clients where they are" in treatment.

## Goals of Integrated Family Therapy

The overall focus of family counseling in SUD treatment is on the roles, relationships, and communication patterns within the family system (van Wormer & Davis, 2018). Understanding these dynamics and, when necessary, modifying them can help family members both support an individual's SUD recovery, while also altering relational behavior patterns that could trigger future substance use. Specific core objectives include:

- **Leveraging the family to influence change.** Providers should encourage family members to support each other to increase the client's motivation to make important lifestyle changes, including shifting away from substance misuse.
- **Involving families in SUD treatment.** Providers should create inviting, diverse, and easily accessible programs to engage family members in the treatment environment. This might include many families or a single family member attending a psychoeducational activity or participating in a structured family-based counseling intervention. Providers should also consider developing multifamily groups to take advantage of the support, connections, and mutually beneficial effects that can come from families with lived experience interacting.
- **Changing family behaviors that support SUDs.** Providers should help the family recognize behavioral, cognitive, and emotional responses that unintentionally support the client's SUD.
- **Preventing SUDs across generations.** Providers should help families recognize how family patterns that promote SUDs can be passed from generation to generation.

## Assessing the Appropriateness of Integrated Family Counseling

Before beginning family therapy, providers should screen for circumstances in which family-based interventions and counseling approaches would be inadvisable, inappropriate, or counterproductive. Several factors can influence the decision to involve family members in treatment.

- **Domestic violence:** Joint counseling for couples in which intimate partner violence has occurred is generally not recommended (New York State Office for the Prevention of Domestic Violence, 2018). Family members can learn how to express anger appropriately and safely via structured family counseling, but extreme anger or threats of violence rule out family counseling.
- **Abuse:** Do not include children, spouses, or elderly family members in family sessions if there is any current abuse or risk of abuse by family members (see box, "Mandatory Reporting of Abuse").
- **Substance use withdrawal:** Given the intensity of physical and emotional instability experienced by people in withdrawal, it is not practical to attempt integrated family counseling during this process.
- **Co-occurring mental health issues:** Family counseling is generally appropriate for clients with SUDs and mental disorders. Some family-based interventions are particularly effective for specific co-occurring mental disorders, including severe adult anxiety disorders (Gehart, 2018).

### *Mandatory Reporting of Abuse*

If a provider suspects a family member is abusing a child, spouse, or elderly family member, he or she should consult a supervisor immediately and follow agency policy and mandated reporting laws in that state. The State Statutes Search page provided by the Child Welfare Information Gateway can help providers learn about definitions of child abuse and neglect and reporting requirements by state. For information on elder abuse, providers can reference the National Center on Elder Abuse. The National Coalition Against Domestic Violence maintains resources about intimate partner violence, including a link to the national hotline.

- **Significant cognitive impairment:** For clients who have significant cognitive impairment, 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.

### *Mandated participation*

One or more family members, particularly those with SUDs, may be mandated to treatment by the criminal justice system, Child Protective Services, or an employer. A provider's 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 strategies can help providers build a therapeutic alliance and help the client and family members resolve their ambivalence about participating in family counseling (Lloyd-Hazlett et al., 2016).

In mandated counseling, providers should clarify that the primary concern is the family's well-being, and share any requirements that must be followed regarding release of information to the referring organization. Providers should inform all family members about their rights and responsibilities as clients, and the provider's legal and ethical responsibilities. Providers also should have family members sign all pertinent releases as part of the informed consent process.

## Who Participates: Defining "Family"

It is up to clients to identify whom they would like to include in family counseling. Providers should make their best efforts to include anyone the client thinks is significant: relatives or nonrelatives, extended family (e.g., grandparents, a cousin), friends, significant others, or "family of choice" (i.e., supportive members of a community the client identifies with). Providers can offer ideas about why it might be important or helpful to include specific family members, but they should always honor the clients' autonomy and right to decide for themselves what constitutes their family and decide which family members to include in treatment. Once family is identified, providers should be prepared to address obstacles that can hinder family participation:

- **Geographic constraints:** Some clients have no significant family members close enough to attend family sessions in person. Using secure teleconferencing or videoconferencing technology is one strategy for including family members in important conversations with the client. Another is 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:** Overcoming work and scheduling obstacles can necessitate holding multiple sessions outside of normal work hours or offering phone or video consultation.
- **Disruptive behavior:** Providers may need to exclude a family member who is continually angry, blaming, or disruptive. Address this issue with the family and the individual separately, and explore options for addressing that family member's needs (e.g., individual counseling, referral to other support services). Reinvolve the individual in family sessions when the needs have been addressed.
- **Family subsystems:** All families include subsystems—the interpersonal relationships among clusters of people within the family system. Providers may need to work with individuals or different subsets of family members before the whole family can address its overall treatment goals.

> ***Address the Impact of Stigma***
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> When working with families in SUD treatment, it is important to recognize that feelings of stigma can affect willingness to participate in therapy. Families affected by SUDs often feel isolated and struggle with stigma, shame, and confusion. Providers should be aware of this and work to educate family members about the nature of addiction (Lancaster et al., 2017).

- **Refusal to attend counseling sessions:** 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, or calling the family member who is not present during the family session (after securing his or her permission) to enlist his or her help in answering a question that has come up in the session.

## Conducting Appropriate Screening and Assessment

Assessment is an important component of any SUD treatment program. Assessment moves through several stages that are designed to identify the client's family resources and strengths to best position the client and family to achieve positive treatment outcomes.

### *Individual assessment*

Comprehensive assessments are usually conducted at intake and are often required for an individual entering SUD treatment. To ensure effective family involvement, the assessment should:

- Yield a thorough and accurate family history.
- Confirm and clarify information about the client.
- Establish the context in which substance misuse most often occurs and in which it may have started or accelerated.
- Set a tone for a continuing focus on the family.
- Identify family resources to help plan long-term care.
- Document specific information that can determine treatment goals.
- Help the counselor determine which family members should be involved.

If the client agrees to family involvement in treatment, providers should obtain privacy/confidentiality releases and then schedule an initial family interview.

### *Family interview*

Although family members may feel ambivalent about becoming involved in treatment, they are often willing to attend at least an initial interview either individually or as a group. The primary focus is to engage the family and begin to develop an alliance with each family member. Providers can also use this initial interview to determine how the family functions, identify major family problems, and identify the family's perception of how the client's SUD has affected the family and each member (Schumm & O'Farrell, 2013). Because safety is paramount, providers should also make a preliminary determination of any current family violence and physical or sexual abuse or abuse history.

### *Family and strengths assessment*

Once the family is actively involved in treatment sessions, the provider has an opportunity to assess current family functioning, the history of SUDs over time and across generations, and the role of SUDs in the development of family problems (Schumm & O'Farrell, 2013). Providers can also explore the history of the individual's SUD over time, but they should always link this history to the development of family system

dynamics and functioning over time (Schumm & O'Farrell, 2013). The primary assessment task is to observe family interactions during sessions to determine alliances and conflicts among family members, interpersonal boundaries, and communication styles.

Providers can also assess the strengths of the client and all family members involved in treatment. The goal is to identify: the family's current coping skills and abilities; family, social, and recovery supports; motivation and commitments to change; and self-efficacy. In other words, providers are assessing **recovery capital**—the internal and external resources that the client can draw on to begin and sustain recovery. Doing so will give providers 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. It is also critical to maintain a strengths-focused lens throughout counseling to set a positive tone and enhance family members' motivation to address challenging problems (Tuerk et al., 2012).

### *Optimizing initial family counseling sessions*

After the family interview and assessment process, initial family counseling sessions should focus on building relationships with all family members and giving each member time to share his or her frustrations, challenges, and hopes. 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, has severe psychiatric symptoms (e.g., hallucinations, suicidality, delusions, severe mania), has threatened violence, or a combination of these.

Initial sessions should focus on:

- Establishing a working relationship with members of the family.
- Orienting participants to the family counseling process.
- Continuing the assessment of how the SUD has affected each family member.
- Reframing SUDs from a character flaw or moral failing to a biochemical and behavioral problem they can work on together to remove from their lives.
- Continuing the assessment of family strengths and strategies they have previously used to lessen the impact of the SUD on the family.
- Exploring family goals and expectations for the future and each family member's ideas on how counseling can help.

## Addressing Common Challenges

The following approaches can help overcome common challenges, myths, and obstacles hindering engagement and treatment of families.

- **"Family counseling is secondary."** When a provider views family therapy as an add-on to individual or group counseling, it sends a message to clients and family members that family counseling is not important. Providers should evaluate their attitudes about family involvement and be champions for integrating family-based interventions as an important part of SUD treatment.
- **"Family counseling is too painful."** Although family counseling may temporarily shake up the family system and activate intense feelings, these feelings are a normal part of counseling. A provider's task is to help the client and family members discover new ways of coping with intense emotions instead of reverting to old behaviors (e.g., blaming and shaming the family member with the SUD).

| *Two Family-Based Models for Treating SUD: An Overview* | |
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| ***Behavioral Couples Therapy (BCT)*** is designed for married or cohabiting individuals seeking help for an SUD (O'Farrell & Fals-Stewart, 2006). BCT is a structured approach that focuses on improving partners' patterns of interaction, building more cohesive relationships to reduce risk of return to use for the partner with an SUD, supporting abstinence, and improving relationship functioning. BCT has also been adapted for use with families (O'Farrell et al., 2010).<br><br>Appropriate participants are generally couples, with the following characteristics:<br>• Partners are married or living together.<br>• Neither partner has a significant co-occurring mental disorder.<br>• Only one member has an SUD.<br>• There is no indication of risk of any intimate partner violence.<br><br>Interventions in BCT focus on reducing substance misuse and (in some cases) promoting abstinence in support of recovery from an SUD (e.g., developing a recovery contract), addressing relationship concerns (e.g., increasing positive activities and improving communication), and preventing relapse (e.g., developing plans for continued recovery and relapse prevention).<br><br>BCT can yield desirable treatment outcomes, including reductions in substance use, legal and family problems, and hospitalizations. It is also linked with increased abstinence and treatment adherence (O'Farrell & Clements, 2012; Rowe, 2012). | ***Risk Reduction through Family Therapy (RRFT)*** is an integrative approach that addresses co-occurring posttraumatic stress disorder (PTSD) symptoms (or other mental health problems), SUDs, and other risk behaviors in trauma-exposed adolescents. In RRFT, clients intentionally recall specific feelings, thoughts, cues, and memories of traumatic experiences.<br><br>Appropriate participants are trauma-exposed adolescents ages 13–18 who experience co-occurring trauma-related mental health problems (e.g., PTSD, depression), substance use problems, and other risk behaviors (e.g., risky sexual behavior, nonsuicidal self-injury) and parents/caregivers. RRFT is individualized to each family and adolescent.<br><br>The goals of RRFT include reducing symptoms of trauma-related mental health issues, reducing substance use and substance use risk factors, increasing protective factors, improving family communication and cohesion, and reducing risk factors for revictimization.<br><br>RRFT can lead to reductions in drug use, drug use-related risks, PTSD symptoms, and sexual behaviors that increase risk for HIV and other sexually transmitted infections (Danielson et al., 2010; Danielson et al., 2012; Hahn et al., 2020).<br><br>For more information on RRFT, a link is provided in the "Resources" section. |
| *See Chapter 3 of TIP 39 for a more detailed discussion of evidence-based family therapy models for addressing SUDs.* | |

- **Coordination of family services.** It is challenging to provide family-oriented case management or referral and coordination of services while doing family counseling, but providers can actively link individual family members to case management services or peer providers who can collaborate with them to coordinate the multiple service needs of the family. It can also be helpful to connect a family with other persons with lived experience of recovery to help them navigate coordinated care.

- **Keeping family secrets.** A provider should not hold family secrets. The provider should let everyone know during the initial family interview that he or she will bring up information a family member reveals outside of family sessions and will do so during the next family session. The only exception is if a family member tells the provider privately of violence or abuse that needs to be addressed separately.
- **SUD client or family member is in precontemplation.** The term "denial" has been used to describe people who do not see an SUD as a problem. This label is judgmental; avoid using it and let family members know that using labels to confront each other can lead to conflict or family members closing down emotionally. Providers can also reframe "denial" as precontemplation, an indication that the family member is not quite ready to change.
- **Family's adjustment to abstinence.** Families tend to adjust to SUDs, and family members may act differently (and not always positively) when the client with the SUD enters recovery, as long-standing problems finally come to light and roles within the family realign. The provider's task is to help family members adapt to these changes, find ways to support the client's recovery, learn new relationship and coping skills, and find healthier ways to function as a family.
- **The client being treated for opioid use disorder (OUD) with buprenorphine and methadone.** Common myths of medication treatment for OUD include the false belief that people taking it are simply replacing one addiction with another, and that people cannot truly be in recovery while taking these medications. Family members need to be educated about what medication treatment for OUD is, as well as its effectiveness and safety, so they can be a source of emotional and practical support for clients.
- **The client on other medication.** When clients stop taking medications, symptoms of mental disorders or previous substance use behaviors can reemerge, causing families to return to patterns of dysfunction. The provider's task is to raise this issue in family sessions. Once all family members have accurate information about the importance of medication adherence, the conversation can shift to the family's working as a team to support the client in taking medication as prescribed or safely tapering off (under medical supervision and when appropriate).
- **Financial/logistical barriers.** For many families or family members, financial and/or travel resources may be limited. Offering bus tokens, transit cards, or similar transportation incentives can help increase the ability of the family (or other members) to participate.

## Responding to Cultural Differences

Truly comprehensive, evidence-based SUD treatment cannot be offered if the culture of the family with whom the provider is working is not considered. Although a comprehensive discussion of culture and diversity in family-based treatment is beyond the scope of this *Advisory,* providers can consider the following steps to embrace cultural differences:

- Engage aspects of the family's culture or religion that promote healing.
- Consider the role that drugs and alcohol may play in the culture.
- Be flexible and meet families where they are.
- Be continuously aware of and sensitive to the differences between the provider and the members of the group he or she is counseling.
- Is the family a homogeneous group or one that represents different backgrounds? Does the family live in one community or several different communities? Are those communities different from the one in which the provider lives? These considerations and responsiveness to the specific cultural norms of the family in treatment must be respected from the start of counseling. Family members may also identify or affiliate

with multiple cultures (e.g., ethnic origin but also religion or sexual identity). If these factors are not apparent or explicitly explained by the clients and families, the provider should ask.

- Providers should be aware of and sensitive to their own family culture. Providers may bring their own cultural issues to treatment. A provider's age, gender, ethnicity, local community, and levels of health literacy and education, as well as other traits, may affect therapeutic processes.

See Chapter 5 of TIP 39 for a more detailed discussion of diversity and culture and the important role they can play in the treatment process. For more information about gaining cultural competence, also see TIP 59, *Improving Cultural Competence*.

***Eight Cultural Questions To Consider When Offering SUD Treatment for Families***

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

See TIP 39, Chapter 5, pages 100–105, for a detailed discussion of how differing answers to these questions can influence the family therapy process.

## Resources

- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
  - Practitioner Training Resources
  - *Recovery-Oriented Systems of Care (ROSC) Resource Guide*
  - Resources for Families Coping with Mental and Substance Use Disorders
  - TIP 39, *Substance Use Disorder Treatment and Family Therapy*
  - TIP 59, *Improving Cultural Competence*
- **American Association for Marriage and Family Therapy (AAMFT)**
- **Faces & Voices of Recovery**
  - Mutual Aid Resources
- **Friends of Recovery**
  - Family Resources
- **Multidimensional Family Therapy (MDFT)**
- **Risk Reduction through Family Therapy (RRFT)**
- **Self-Management and Recovery Training (SMART) Recovery Family and Friends**

## Bibliography


Brown, S., Tracy, E. M., Jun, M., Park, H., & Min, M. O. (2015). Personal network recovery enablers and relapse risks for women with substance dependence. *Qualitative Health Research, 25*(3), 371–385.

Cavaiola, A. A., Fulmer, B. A., & Stout, D. (2015). The impact of social support and attachment style on quality of life and readiness to change in a sample of individuals receiving medication-assisted treatment for opioid dependence. *Substance Abuse, 36*(2), 183–191.

Danielson, C. K., McCart, M., de Arellano, M. A., Macdonald, A., Silcott, L., & Resnick, H. (2010). Risk reduction for substance use and trauma-related psychopathology in adolescent sexual assault victims: Findings from an open trial. *Child Maltreatment, 15,* 261–268.

Danielson, C. K., McCart, M., Walsh, K., de Arellano, M. A., White, D., & Resnick, H. S. (2012). Reducing substance use risk and mental health problems among sexually assaulted adolescents: A pilot randomized controlled trial. *Journal of Family Psychology, 26,* 628–635.

Gehart, D. R. (2018). *Mastering competencies in family therapy: A practical approach to theories and clinical case documentation* (3rd ed.). Cengage Learning.

Hahn, A. M., Adams, Z. A., Chapman, J., McCart, M. R., Sheidow, A. J., de Arellano, M. A., & Danielson, C. K. (2020). Risk reduction through family therapy (RRFT): Protocol of a randomized controlled efficacy trial of an integrative treatment for co-occurring substance use problems and posttraumatic stress disorder symptoms in adolescents who have experienced interpersonal violence and other traumatic events. *Contemporary Clinical Trials, 93,* 106012. Retrieved October 22, 2020, from www.ncbi.nlm.nih.gov/pmc/articles/PMC7194734/

Lancaster, K., Seear, K., & Ritter, A. (2017). *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use.* Queensland Mental Health Commission.

Lloyd-Hazlett, J., Honderich, E. M., & Heyward, K. J. (2016). Fa-MI-ly: Experiential techniques to integrate motivational interviewing and family counseling. *Family Journal, 24*(1), 31–37.

Moos, R. H., & Moos, B. S. (2007). Protective resources and long-term recovery from alcohol use disorders. *Drug and Alcohol Dependence, 86*(1), 46–54.

Morgan, T. B., Crane, D. R., Moore, A. M., & Eggett, D. L. (2013). The cost of treating substance use disorders: Individual versus family therapy. *Journal of Family Therapy, 35*(1), 2–23.

O'Farrell, T. J., & Clements, K. (2012). Review of outcome research on marital and family therapy in treatment for alcoholism. *Journal of Marital and Family Therapy, 38*(1), 122–144.

O'Farrell, T. J., & Fals-Stewart, W. (2006). *Behavioral couples therapy for alcoholism and drug abuse.* Guilford Press.

O'Farrell, T. J., Murphy, M., Alter, J., & Fals-Stewart, W. (2010). Behavioral family counseling for substance abuse: A treatment development pilot study. *Addictive Behaviors, 35*(1), 1–6.

New York State Office for the Prevention of Domestic Violence. (2018). *Domestic violence: Finding safety and support.* https://opdv.ny.gov/help/fss/fss.pdf

Rowe, C. L. (2012). Family therapy for drug abuse: Review and updates 2003–2010. *Journal of Marital and Family Therapy, 38*(1), 59–81.

Schumm, J. A., & O'Farrell, T. J. (2013). Families and addiction. In P. M. Miller et al. (Eds.), *Comprehensive addictive behaviors and disorders: Vol. 1. Principles of addiction* (pp. 303–312). Elsevier Academic Press.

Tuerk, E. H., McCart, M. R., & Henggeler, S. W. (2012). Collaboration in family therapy. *Journal of Clinical Psychology, 68*(2), 168–178.

van Wormer, K. S., & Davis, D. R. (2018). *Addiction treatment: A strengths perspective.* Cengage Learning.

Worley, M. J., Trim, R. S., Tate, S. R., Roesch, S. C., Myers, M. G., & Brown, S. A. (2014). Self-efficacy and social networks after treatment for alcohol or drug dependence and major depression: Disentangling person and time-level effects. *Psychology of Addictive Behaviors, 28*(4), 1220–1229.

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