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The Impact of Substance Use Disorders on Families and Children: From Theory to Practice

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Abstract

The effects of a substance use disorder (SUD) are felt by the whole family. The family context holds information about how SUDs develop, are maintained, and what can positively or negatively influence the treatment of the disorder. Family systems theory and attachment theory are theoretical models that provide a framework for understanding how SUDs affect the family. In addition, understanding the current developmental stage a family is in helps inform assessment of impairment and determination of appropriate interventions. SUDs negatively affect emotional and behavioral patterns from the inception of the family, resulting in poor outcomes for the children and adults with SUDs. Social workers can help address SUDs in multiple ways, which are summarized in this article.

Keywords

Substance use disorder; attachment theory; family systems theory; impact; treatment

INTRODUCTION AND THEORETICAL FRAMEWORK

The family remains the primary source of attachment, nurturing, and socialization for humans in our current society. Therefore, the impact of substance use disorders (SUDs) on the family and individual family members merits attention. Each family and each family member is uniquely affected by the individual using substances including but not limited to having unmet developmental needs, impaired attachment, economic hardship, legal problems, emotional distress, and sometimes violence being perpetrated against him or her. For children there is also an increased risk of developing an SUD themselves (Zimic & Jakic, 2012). Thus, treating only the individual with the active disease of addiction is limited in effectiveness. The social work profession more than any other health care profession has historically recognized the importance of assessing the individual in the context of his or her family environment. Social work education and training emphasizes the significant impact the environment has on the individual and vice versa. This topic was chosen to illustrate how involving the family in the treatment of an SUD in an individual is an effective way to help the family and the individual. The utilization of evidence-based family approaches has demonstrated superiority over individual or group-based treatments (Baldwin, Christian,

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Berkeljon, & Shandish, 2012). Treating the individual without family involvement may limit the effectiveness of treatment for two main reasons: it ignores the devastating impact of SUDs on the family system leaving family members untreated, and it does not recognize the family as a potential system of support for change. Two theories important to understanding how and why SUDs impact the family are attachment theory and systems theory.

Attachment Theory

It is estimated that more than eight million children younger than age 18 live with at least one adult who has a SUD that is a rate of more than one in 10 children. The majority of these children are younger than age 5 (U.S. Department of Health and Human Services [USDHHS], 2010). The studies of families with SUDs reveal patterns that significantly influence child development and the likelihood that a child will struggle with emotional, behavioral, or substance use problems (Substance Abuse and Mental Health Services Administration [SAMHSA], 2003). The negative impacts of parental SUDs on the family include disruption of attachment, rituals, roles, routines, communication, social life, and finances. Families in which there is a parental SUD are characterized by an environment of secrecy, loss, conflict, violence or abuse, emotional chaos, role reversal, and fear.

Relationships serve as the communication conduits that connect family members to each other. Attachment theory provides a way of understanding the development and quality of relationships between family members. John Bowlby (1988) developed attachment theory through the clinical study of mammalian species and humans. He postulated that at the time of an infant's birth, the primary relationship, usually with the mother but not always, serves as the template for all subsequent relationships throughout the life cycle. This relationship forms a subsystem within the larger family system. It is through this relationship, at a prelanguage level, that infants learn to communicate and relate to their environment. They do this through crying, cooing, rooting, and clinging. The way in which the primary caretaker responds to these cues will establish the quality of the attachment. Generally, if the child experiences the primary caretaker as responsive and nurturing, a secure attachment will form. If the child experiences the primary caretaker as unresponsive or inconsistently responsive, an insecure attachment may form that can result in a variety of problems including anxiety, depression, and failure to thrive.

A parent with a SUD, who is mood altered, preoccupied with getting high or spending significant amounts of time recovering from the effects of substances, may miss the opportunities to foster healthy attachment. Consequently, the intricate attachment system that is built on hundreds of thousands of reciprocal and implicit interactions between infant and attachment figure will be affected. Eye contact, tone, volume and rhythm of voice, soothing touch, and the ability to read the needs of the infant are all intricate building blocks of attachment. Healthy attachment is a psychological immune system of sorts. Just as humans need a physiological immune system to fight off disease and illness, likewise, the relational attachment system provides protection against psychological problems and illness. Without a healthy attachment system, a child is much more vulnerable to stress and therefore more susceptible to having problems with trauma, anxiety, depression, and other mental illness. Attachment theory posits that the quality of the parents' attachment system that developed in infancy will affect their ability to form healthy attachments to their own children and with other adults.

Family Systems Theory

Family systems theory grew out of the biologically based general systems theory. General systems theory focuses on how the parts of a system interact with one another. In general systems theory an individual cell is one example of a system, and in family systems theory

the family is essentially its own system. Key concepts in both theories are feedback, homeostasis and boundaries that are defined and operationalized in this section. Family systems theory was developed in the late 1960s and early 1970s. Nathan Ackerman, Jay Haley, Murray Bowen, Salvadore Minuchin, Virginia Satir, and Carl Witaker, among others were highly influential figures in this movement and developed its applications to psychiatric treatment. Out of this theory multiple models of family therapy developed including but not limited to strategic, structural, experiential, and more recently the multisystemic family systems therapy (MFT) model. All the family therapy models share the basic principal of family systems theory that is that the individual cannot be fully understood or successfully treated without first understanding how that individual functions in his or her family system. Individuals who present in our clinical settings can be seen as "symptomatic," and their pathology can be viewed as an attempt adapt to their family system so as to maintain homeostasis.

Homeostasis refers to the idea that it is the tendency of a system to seek stability and equilibrium (Brown & Christensen, 1986). The idea of homeostasis is key to understanding the effect of SUDs on the family in that each family member tends to function in such a way that keeps the whole system in balance even if it is not healthy for specific individuals. For example, a latency-age child may cover up her father's drinking by cleaning up after him if he is sick, getting him into bed after he passes out, and minimizing his drinking to her mother. Her efforts allow his SUD to continue with limited consequence and keep the family system at relative equilibrium by reducing fighting between the mother and father. Although that adaptation may keep the family system in a state of equilibrium, it also serves to maintain the problem. *Feedback* refers to the circular way in which parts of a system communicate with each other. The process of feedback is how the parent–child attachment relationship is formed. In a family system, a wife may identify that she abuses pain pills because her husband ignores her and she is depressed. The husband may in turn state that he avoids his wife because she is always morose and high on pain pills. Each person's behavior becomes reinforcing feedback for the other. *Boundaries* define internal and external limits of a system and are established to conserve energy by creating a protective barrier around a system. In a family they regulate interpersonal contact. In a healthy family, boundaries surround the parental subsystem and the child subsystem by keeping them separate. In a family with a parent who has a SUD, boundaries around the parental and child subsystems are typically permeable as the parental subsystem does not function well as a cohesive unit. Boundaries around the family itself are rigid to maintain the family secret of substance abuse. Healthy boundaries are important in the normal development of a family and children.

FAMILY IMPACT

Genetic and environmental factors contribute to the development of SUDs. Given that the family in which one is raised influences both of these, it is important to explore the impact of SUDs on the family. Studies looking at the relative weight of these influences show that both add contribution and impact (Haber et al., 2010). The impact will vary depending on the role and gender that the individual with the SUD has in the family. For example, if an adolescent child is identified as having a SUD, this will affect the family differently than if a parent has an SUD. The attitudes and beliefs that family members have about SUDs are also of importance as these will influence the individuals as they try to get sober and will influence the efficacy of treatment interventions. For example, if a parent sees a SUD as a moral failing and thinks his or her adolescent child should just use "will power" to quit, this will be important to know if the treating therapist is working from a disease model of addiction. Education with the family about SUDs, their development, progression, and treatment will be needed. When family members have appropriate education and treatment

for themselves they can play a significant role in the abusers' recognition of the problem and acceptance of treatment. The evidence-based family treatment Community Reinforcement And Family Training (CRAFT) has demonstrated its effectiveness in increasing the rate at which abusers enter treatment (Roozen, de Waart, & van der Kroft, 2010).

When one person in a family begins to change his or her behavior, the change will affect the entire family system. It is helpful to think of the family system as a mobile: when one part in a hanging mobile moves, this affects all parts of the mobile but in different ways, and each part adjusts to maintain a balance in the system. One consequence of this accommodation can be that various family members may inadvertently sabotage treatment with their own behaviors as they respond to the change in the individual using substances. For example, if an adult son tries to get sober and his retired father feels as if he has lost his “drinking buddy,” he might express to his son that he can have “just a couple beers at the game.” This will put pressure on the son to continue his use so as not to disappoint his father. These behaviors can be seen as an attempt to maintain the comfortable equilibrium of the system because as one person changes it upsets the equilibrium of the whole family system including extended family relationships. Family therapy can be a useful intervention where the therapist can assist and support the son in setting limits with the father saying he does not want to drink at all and suggesting alternative non-drinking-related activities. Individual therapy can be used with the son to affirm his decision to remain sober and reinforce the importance of his establishing his own identity as a nondrinking person.

We know that individuals who grow up in a family where there is an SUD are at significantly higher risk to develop SUDs due to genetic and environmental factors (Hawkins, Catalano, & Miller, 1992). It is essential to assess for active substance abuse in the immediate and extended family. Knowing that an individual with an SUD grew up in a family with an SUD has significant implications in treatment. Active substance abuse in the family of a client who is trying to get clean will also put that client at risk for relapse.

Developmental Stages of the Family

Understanding the family's specific developmental stage can help with assessing the interventional needs of a family. Carter and McGoldrick (1989) identify eight stages of the family life cycle and corresponding developmental tasks. SUDs can disrupt these developmental tasks depending on who has the SUD and at what developmental stage the family is in when the SUD develops. Table 1 is an adaptation of Carter and McGoldrick's family life cycle stages as applied to families with SUDs. When families do not move through the life cycle and get stuck, individual members can exhibit clinical symptoms. It should be noted that blended families with stepparents and stepchildren have their own developmental needs that are impaired by SUDs as well, but those are not detailed in this table.

Impact of Parental Substance Abuse on Children

Clinicians have speculated that what are called “attachment disorders” may occur at elevated rates among children affected by alcohol, in part due to abuse and neglect (when these have happened), and in part because of alcohol-related deficits in cognitive and social-emotional functioning that lead to less resilience (Coles et al., 1997). Studies indicate that between one third and two thirds of child maltreatment cases involve some degree of substance use (U.S. Department of Health and Human Services [USDHHS], 1996). The negative consequences of having one or both parents with a SUD ranges from covert damage that is mild and may play out when a child or adolescent is having difficulty establishing trusting relationships with people, to being overly emotionally responsible in relationships and taking on adult roles much younger than developmentally appropriate. An even more severe impact can

begin in utero with maternal substance abuse that causes damage to the growing fetus resulting in birth defects, fetal alcohol syndrome, and/or fetal alcohol effects. These difficulties may cause disabilities that require early intervention and often ongoing and social and mental health services. Social workers can help by encouraging their clients who abuse substances to use precautions to prevent pregnancy and providing education about the risks of maternal drug use on the developing fetus. If a social worker is working with a pregnant client with an SUD, referral to a Perinatal Addiction Clinic and/or high-risk pregnancy OB/GYN clinic is indicated.

As previously mentioned, all primates learn how to regulate their affect from their primary attachment figures through the attachment system and modeling. Parents who have substance use problems will likely have their own affect dysregulation that may have preceded or resulted from their substance use. Consequently, development of healthy affect regulation will be difficult for children and adolescents to achieve. This can result in children and adolescents having an increased risk for internalizing problems such as depression, anxiety, substance abuse, and so on or externalizing problems such as opposition, conduct problems (stealing, lying, and truancy), anger outbursts, aggressivity, impulsivity, and again substance abuse. Children may present to a social worker in direct practice at community mental health center or a school setting. Social workers can assist these clients by looking for signs and symptoms of parental substance use while observing the child's behavior in social settings and in play behavior. Social workers should look for how the child's presenting symptoms serve a function in the family system to maintain homeostasis. Providing family therapy, parent training and education, play therapy, social skills training, and coping skills training either in individual or group therapy in an outpatient, school or in-home therapy setting are ways that social workers can be helpful. Sometimes a referral to Child Protective Services will be indicated.

Parental Substance Abuse and Child Abuse and Neglect

A parent with a SUD is 3 times more likely to physically or sexually abuse their child. The sequalae of this is that these children are more than 50% more likely to be arrested as juveniles, and 40% more likely to commit a violent crime (USDHHS, 1996). Children who have experienced abuse are more likely to have the externalizing disorders such as anger, aggression, conduct, and behavioral problems whereas children who experience neglect are more likely to have internalizing disorders (depression, anxiety, social withdrawal, poor peer relations). Incest has a very high association with parental substance abuse as do all types of sexual abuse. About two thirds of incest perpetrators report using alcohol directly before the offending incident (USDHHS, 1996).

Although active substance abuse can impair attachment and healthy modeling for affect regulation, sometimes the consequences of severe and ongoing substance abuse on the part of a parent can result in parent and child separation. This separation could be because of parental incarceration, long-term treatment or an intervention on the part of child protective services that removes the child from an unsafe or high-risk home environment and places him or her in an out-of-home placement such as foster care, relative placement, or a group or residential home. In extreme cases, the separation may be due to the substance-related death of the parent from overdose, motor vehicle accident, or medical complications due to substance abuse. The significant increase in out-of-home child placements in the 1980s and 1990s closely paralleled the pandemic drug addiction in the United States during those decades (Jaudes & Edwo, 1997). Any long-term separation will have a negative impact on the child's ability to attach, regulate affect, and can lead to a trauma response of numbing or hyperarousal (inability to discriminate and respond appropriately to stimulus). These impairments in the psychological emergency response system are directly related to, and substantially increase, subsequent traumatic victimization. Maltreated children of parents

with a SUD are more likely to have poorer physical, intellectual, social, and emotional outcomes and are at greater risk of developing substance abuse problems themselves (USDHHS, 2003).

Social workers can help by using trauma-informed, attachment-informed, and systems-based approaches to direct practice in individual therapy and family therapy with special attention to multigenerational trauma and substance abuse. The role of the social worker may include providing in-home therapy supporting parents in being more effective with parental supervision, providing structure, and facilitating healthy caring communication. Social workers may serve on multidisciplinary teams to advocate for a child who is adjudicated, abused, and/or neglected. In addition, social workers may provide expert testimony in courts and participate in permanency planning for children in out-of-home placements. Lastly, social workers play an essential role in specialized courts (family courts, mental health courts, adult drug courts, and juvenile drug courts), providing a unique person in environment and multisystems lens to helping children and families. Specialized drug courts have been shown to produce favorable outcomes for the whole family (Burns, Pullman, Weathers, Wirschem, & Murphy, 2012).

Parental Substance Abuse and Child Social and Emotional Functioning

Many children living in a home where there is an addiction develop into “parentified children.” This occurs when the caretaker is unable to meet the developmental needs of the child, and the child begins to parent themselves and perhaps younger siblings earlier than developmentally appropriate. In a phenomenon called “reversal of dependence needs” the child actually begins to parent the parent.

Case Example

> Ashley was a 15-year-old female who was referred to treatment by her school counselor for self-injury. She is a classic “hero” child who has excellent grades and is well liked by her peers. Her parents separated when she was age 5, and she lived with her biological mother until she was 12. Her father obtained full custody of her after being contacted by the domestic violence shelter where she was living with her mother and younger brother. They had moved to the shelter after a domestic violence incident involving her mother's boyfriend. Her biological mother was alcohol dependent; she had difficulty keeping a job and moved frequently. In fifth grade, Ashley changed schools 7 times in a single academic year. Her mother worked as a waitress and a bartender and would often go out drinking after her evening shifts. Ashley then became the caregiver to her younger brother. From age 9 she remembers her mother coming home, being intoxicated sometimes in a black-out, and Ashley helping her into bed. She remembers caring for her mother at night, cleaning up her vomit, wiping her face, and tending to her younger brother in the mornings by getting his breakfast and helping him get ready for school. She stated to her therapist that she remembers thinking, “If only I take really good care of her, maybe she'll be able to take care of me someday.”

In reversal of dependence needs, the parent's needs are placed before the child's. This sets the child up for a potential lifetime of inability to set healthy boundaries in relationships and make the important triad connections between thoughts, feelings, and behaviors. It creates a lack of self-awareness and sometimes an over awareness of others' needs. In the literature one can find these difficulties well-documented under children of alcoholics and adult children of alcoholics research (Berkowitz & Perkins, 1988; Cork, 1969; Hecht, 1973; Morehouse & Richards, 1982; Stroufe, Egeland, Carlson, & Collins, 2005; Tarter, 2002; Zucker, Donovan, Masten, Mattson, & Moss, 2009).

Communication is a significant social skill for interpersonal effectiveness. Parents with a SUD may have difficulty with assertiveness and direct communication. Many subjects are covertly “off-limits” to discuss. Children in these families also often witness the convergence of poor communication and affect dysregulation with their caregivers that frequently results in domestic violence. Although these difficulties may not be overtly diagnosable with a physical or psychological disorder, the patterns have significant developmental, social, and interpersonal consequences. Common emotions these children experience are anxiety, fear, depression guilt, shame, loneliness, confusion, and anger. They may believe that they caused their parent's SUD, or perhaps they are expected to keep the drug use a secret from others in the family or in the community. Perhaps they recognize their parent is mood altered or in withdrawal but are told that, “Your dad is just sick; he needs his medicine.” A parent's moodiness, forgetfulness, and preoccupation can create a chaotic and unstructured, unpredictable environment that leaves the child guessing and asking the questions, “What is going to happen next?” and “What is normal?” Children may present in community mental health settings with a variety of presentations. In terms of diagnosable mental and emotional disorders, children affected by parental substance abuse are virtually at higher risk for nearly every childhood disorder in the *Diagnostic Statistical Manual of Mental Disorders* (*DSM-IV-TR*; American Psychiatric Association, 2000). Of most significant correlation are the following: eating disorders, behavior disorders, anxiety disorders, depression, post-traumatic stress disorder, and SUDs. Social workers can help by evaluating the function of the presenting symptoms through a family systems perspective. Social workers can help children and families have more direct and honest, yet developmentally appropriate communications; and helping youth to deal with covert and overt emotions that are related to their parent's substance use. Social workers can achieve this through the provision of play therapy, individual therapy, family therapy, and group therapy in a variety inpatient, outpatient, in-home, and community based settings.

Parental Substance Abuse and Educational Functioning

Educational problems are also characteristic of some children affected by parental substance use. Problems with unexcused absences in childhood can turn into more serious truancy problems in adolescence and culminate in school dropout. In early childhood, parents read less and provide less learning-based stimulation to their infants and toddlers. In school-age years, parents are less available to provide assistance with homework, monitor school performance, and track assignments. These children may have difficulty with attention and concentration due to increased anxiety levels related to a chaotic home environment. Unstructured bedtimes and mealtimes as well as witnessing domestic violence and safety issues all contribute to an increase in learning problems and behavioral problems for these children at school. It is difficult for children to focus on higher order thinking and learning when basic survival needs are not met. Similar to the home environment, communication between substance abusing parents and teachers and the larger school system is poor. Many parents struggling with an SUD had difficulty with the school system in their own school-age years and avoid interacting with it due to their own anxiety or shame.

The role of the social worker may include providing school-based supportive services to the youth as well as connecting clients with afterschool care, tutoring services, or mentoring agencies such as Big Brothers Big Sisters. In-home and outpatient family therapy and education, supporting parents in being more effective with parental supervision and discipline, providing structure, rewards, and consequences for school attendance and performance and supporting parents in communicating with the school systems can help as well. Social workers can also help by participating in Individualized Education Plan (IEP) meetings, making school referrals for special education, and requesting psychoeducational and neuropsychological testing. Referral to a child and adolescent psychiatrist for a

medication evaluation may also be helpful as well as assisting teachers with behavioral interventions in the classroom.

The Impact of Substance Abuse on Parents of Adult Children

As children transition into adulthood they are still strongly affected by their parents as their parents are by them. One of the factors that can perpetuate SUDs is the enabling that family members frequently engage in. Enabling is a form of accommodation that protects the individual with the SUD from fully experiencing the consequences of his or her substance use. An example of enabling is when the parents of a 25-year-old man repeatedly bail him out of jail and pay for lawyer and court fees generated as a result of drug-related arrests. The parents are attempting to help their son and maintain homeostasis in the system by preventing him from going to jail, however the secondary effect is that the son experiences no consequence to his use. As a result, his SUD is more likely to continue. Parents and grandparents do not always agree on how to “help” an adult child with an SUD. Social workers can encourage parents of adult children to seek their own help in Al-Anon and Nar-Anon. These are 12-Step programs for family members that will help them disengage with love, so that they stop enabling and begin to care for themselves. Often parents blame themselves for their children's substance use and feel responsible for fixing the problem. In Al-Anon and Nar-Anon they receive support from other family members and learn they did not cause the SUD, nor can they control it or cure it.

How Social Workers in Nonaddiction Settings Can Help

It is beyond the scope of this article to present in detail how to assess for an SUD, and social workers inexperienced in this area should refer patients to those who specialize in the treatment of SUDs. However with the prevalence of SUDs in the general population being at least 10%, and higher for those presenting with mental health problems, social workers in all settings will find themselves working with individuals with SUDs. All clients, and especially those with known or suspected SUDs, should be reassured of confidentiality. Due to the shame and stigma associated with having an SUD, this is of utmost importance to obtain accurate information. Clients should be asked if they believe they have an SUD and can be informed of how the social worker typically helps those with SUDs. Social workers need to educate themselves about the clinical and community resources in their area available for the treatment of SUD and refer to these resources when indicated. This includes outpatient substance abuse programs, methadone clinics, intensive outpatient programs, detoxification, and residential settings as well as self-help meetings.

Most social workers are mandated reporters so this can present an ethical issue for those who work with individuals with SUDs, especially those with dependent children. Many patients know this and may withhold information about their substance use out of fear of being reported to Child Protective Services. Mandated reporters should disclose this role to their clients and be specific about what circumstances require reporting, while also emphasizing they will do everything they can to assist clients in obtaining the help they need. Being honest in this way helps establish rapport. Social workers should be aware of their own biases, if any, regarding substance abuse. Only if clients feel a positive therapeutic rapport and trust the social worker will they disclose substance use.

SUDs affect families and children in every area of their development. Social workers have opportunities to intervene and change the trajectory of these potential problems at many junctions. When assessing any client is it essential to inquire about substance use history in the family, in the individual, and current use. There is a way to do this that is sensitive and does not put the person on the defensive. Motivational interviewing strategies can be employed to build rapport, increase motivation for change, and decrease resistance (Miller

& Rollnick, 2002; W. R. Miller & Rose, 2010). In addition a variety of objective measures can be presented as part of your normal evaluation (Michigan Alcohol Screening Test [MAST; Selzer, 1971], Drug Abuse Screening Test [DAST; Skinner, 1982], and Substance Abuse Subtle Screening Inventory for Adolescents [SASSI-A2; Miller, 1999]). Assessment not only of the individual in front of you but of their family members as well such as parents, siblings, and extended family members may be needed. One way to approach this is with a genogram (McGoldrick & Gerson, 1985). Genograms can reveal SUD patterns in a visual way and help to obtain family details of substance use without directly asking about the problem thereby decreasing defensiveness.

Once a substance use problem has been identified, educating the client about what it means to have a SUD, the treatments available, and the stages of recovery can be useful. Clients can be encouraged to share the impact of the substance use on themselves and on their family system. Encouraging clients to share their feelings related to their experiences in the family is important as it helps them to break the silence so often associated with living with an SUD, and it can also increase their awareness about cognitive and behavioral patterns that contribute to the SUD. If through the assessment it becomes clear that your client or someone in the family would benefit from treatment specifically for his or her SUD, facilitating a formal evaluation or referral to treatment will be helpful. An undetected SUD can cause treatment of any type of problem to be ineffective.

Following are some specific steps that social workers can take to be helpful when a SUD is suspected or identified:

1. Routinely assess for SUD problem and refer the individual to a specialty clinic for further assessment or treatment when indicated.
2. If problem is identified, educate about SUD, treatment, recovery, and relapse.
    a. Assess for past/present SUD in family or origin
3. Explore impact of SUD on client and the family.
    a. Explore feelings
    b. Explore impact on children and extended family
4. Know the structure of the family that the individual you are working with comes from (i.e., blended family, single-parent family).
5. Know the developmental stage of the family that the individual you are working with comes from (family with teenagers, aging family).
6. Provide treatment referrals for family, members (children, spouses, adult parents) where appropriate.
    a. Family therapy, couples therapy
    b. Play therapy, social skills training
    c. Parent training
    d. Psychiatric services
7. Coordinate with school systems to help clients access school-based services, after-school care, and tutoring. Help parents with advocating in the school system for their children if psychoeducational/neuropsychological testing is needed or the development of an Individualized Education Plan.

8. Facilitate referrals to specialized courts is indicated: adult drug court, teen drug court, family court.
9. Educate clients with SUDs about pregnancy prevention and provide education about risks of drug exposure on fetus.
10. Inform about AA, NA for the patient with a SUD and Al-Anon, Nar-Anon, Alateen for family members. Provide location and times of meetings in their area.
11. If there are safety issues with regard to children or the elderly, Child Protective Services or Elder Protective Services referral may be needed.
12. Ask questions about if the current living situation is physically safe or if there have been past or present incidences of domestic violence.

SUMMARY

Individuals with SUDs cannot be understood and treated effectively without considering the impact on the whole family. Addictions researchers have confirmed the reciprocal relationship between the disease of addiction and the environment. All persons influence their social environment and in turn are influenced by it. The family system must be factored into the understanding of the disease development and maintenance as well as be included in the efforts necessary for successful ongoing treatment. The earlier we can intervene in the progression of an SUD, the better the outcomes for all family members. For further readings on this topic SAMHSA TIP #39 (Center for Substance Abuse Treatment, 2004) provides an overview of substance abuse treatment and how to incorporate the family, and TIP #24 (Center for Substance Abuse Treatment, 2004) is a guide to substance abuse services for primary care clinicians.

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TABLE 1

Impact of SUD on Family Life Cycle Stages

Stage	Developmental Tasks	Impact of SUD on Developmental Tasks	How Social Work Can Help
Married without children	Establish healthy marriage with boundary from family of origin.	Poor communication, impairment of emotional and physical intimacy, increased conflict.	SUD counseling, couples counseling, referral to AA/NA, Al-Anon, Nar-Anon.
Childbearing families	Create safe, loving home for infant and parents. Establish secure attachment with child.	Home not physically or emotionally safe due to impairment and labile mood. Insecure attachment with infants.	Assess safety for children and spouse, SUD counseling, couples counseling, referral to AA/NA, Al-Anon, Nar-Anon.
Families with preschool children	Adapt to needs of preschool children and promote their growth and development. Cope with energy depletion and lack of privacy.	Inconsistent parenting, possible abuse, neglect, Child Protective Services involvement, removal of children, marital conflict.	Assess safety for children and spouse. Provide parenting skills, SUD counseling, couples counseling, referral to AA/NA, Al-Anon, Nar-Anon.
Families with school-age children	Fitting into the community of school-age families. Encourage children's education.	Educational needs of children not met. Possible domestic violence, conflict at home.	Collateral contact with school, SUD counseling, couples counseling, referral to AA/NA, Al-Anon, Nar-Anon.
Families with teenagers	Balancing freedom with responsibility. Establish healthy peer relationships. Develop educational and career goals.	Teens may follow model of parent with SUD. Children have difficulty forming healthy peer relationships due to impaired early attachment. School/legal problems and family conflict. Anxiety, depression, or oppositional disorders.	Family therapy, Teen Drug Court, collateral contact with school, vocational training, referral to AA/NA, Al-Anon, Nar-Anon, Alateen.
Families launching young adults	Release young adults with appropriate assistance. Maintain supportive home base. Young adults develop careers.	Failure to launch due to adult children being unable to support themselves, relationship conflict.	Family therapy, vocational training for young adult, referral to AA/NA, Al-Anon, Nar-Anon.
Middle-age parents	Rebuild the marriage. Maintain ties with younger generations.	Marital conflict, adult children may disconnect from parents and not want them to be around their young children.	Couples counseling, connect with community activities, referral to AA/NA, Al-Anon, Nar-Anon.
Aging family members	Coping with bereavement and living alone. Closing the family home or adjusting to retirement.	Isolation, depression can lead to SUD or vice versa.	Individual therapy, collateral contact with adult children, help get elderly connected to senior community to reduce isolation.

Note. This table has been adapted from Carter and McGoldrick's (1989) model of the stages of the family life cycle. Modifications have been made to Column 2 to identify concepts relevant to the family with a SUD, and Columns 3 and 4 are contributions of the authors of this article.

SUD = substance use disorder; AA = Alcoholics Anonymous; NA = Narcotics Anonymous.