Abstract

Objective: This study was conducted to compare the environment of families with and without substance-dependent members to investigate the functioning of families with substance-dependent members and also provide them with appropriate treatment strategies. **Method:** A causative-comparative method followed by an ex post facto design was used in this study. A sample consisting of 50 persons suffering from substance dependence disorder referring to outpatient treatment centers, located in west and east of Tehran, constituted the participants of the study. Another 50-person group not suffering from the disorder participated in this study as the former group's counterpart, as well. The participants answered the questions of environment of family scale (EFS) (Moos & Moos, 1986). **Results:** The results showed that there was a significant difference between two groups in dimensions of cohesion, conflict, achievement orientation, intellectual-cultural orientation, religious orientation, organization, and control whereas there was no significant difference between the two groups in dimensions of expressiveness, independency, and recreational orientation. **Conclusion:** The study recommends the authorities to opt for the application of efficient interventionist treatment strategies appropriate to the characteristics of families with drug-dependent member.

Keywords: Family Environment, Substance-Dependent, Interventionist Strategies

On the Comparison of Family Environment Profiles between Substance-Dependent and Normal Groups towards Providing Family-Based Interventions

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Introduction

Family plays a major role in initiation, continuation and establishment of pathological symptoms such as drug dependence (Janke & Hagedron, 2006; Kaffman & yoshioka, 2005; Soyes, Tatrai, Broekaert & Bracke, 2004). When a family member demonstrates a pathological symptom, it would be the central core for the function of family system around which interactional patterns of family are organized (Szapocznic, Hervis & Schowartz, 2003). Structurally, drug abuse by a family member can act as a factor for keeping the family system and develop a balance in it; therefore, substance dependence continues. Living in a family suffering drug abuse and substance dependence produces significant stress and family tries to use any means to resist against it. Sometimes this means an extensive change inside the family system, family interactions and growing direction of children. Family interaction, in systemic point of view, works in a way that it always changes to keep "stability". From this perspective, drug abuse by a family member is a behavior developed for taking stability and balance in family function. Family reaction to drug abuse is just for the purpose of such a balance to keep living. Drug or alcohol abuse could significantly challenge family potential for regulating the emotional and behavioral function of family. Family as a unit eventually would take its balance, but it could emerge as a defective one (Ghafari, 2009).

Drug dependent persons compared to their normal counterparts, more probably belong to families with defective traits and unhealthy structures. Studies have shown that substance abuse by parents (Caviello, Alterman, Cacciola Rutherford & Zanis, 2004; Vungkhanching, Sher, Jachson & Parra, 2004) could cause behavioral problems and substance abuse among children by more or less lack of involvement in children affairs (Sim, Wong, 2008), weak quality of relationship between children and parents, lack of specified and clear regulations, lack of coordination between parents in the enforcement of rules and insufficient stewardship of parents over children' activities (Horigian et al, 2005). Repetti, Taylor & Seeman, (2002) believe that an unstable family environment plays a major role in growing problems in relation to alcohol and substance abuse among adolescents. Also unstable family environment leads to stress among children which, in turn, has a direct relation with substance abuse (Haffman & Serbone, 2002). Family solidarity is also related to substance abuse among parents and children. When children do not have an intimate and close relation with their parents, they are more likely to involve themselves in substance abuse (Haffman & Serbone, 2002). Severe conflict is the prominent feature of turbulent families (Dakof, Tejeda & Liddel). There is a lack of control and weak stewardship of parents over behaviors and activities of children in the families with members suffering substance abuse (Ledoux, Miller, Choquet & Plant, 2002). Studies have shown there is a negative relation between substance abuse and criminal

behaviors which is followed by a lack of reading and cultural activities among family members. Weak family communication and family conflicts are among prominent factors effective in increasing the risk of substance abuse (Guo, Hill, Hawkins, Catalano & Abbot, 2002).

Some studies have shown the effects of family components on the initiation and continuation of substance abuse. The results of Heidarinia & Charkhian's (2007) studies showed the state of parent-sibling relation in all dimensions is better in normal families than families with dependent adolescents. No meaningful difference was reported in relations between parents and children in normal families. However, among substance dependent adolescents, the state of the adolescents' relation with their mother was better than their father which suggests a coalition between mother and adolescent against his/her father to keep going substance abuse. Bijttebier, Goethals & Ansoms (2006) investigated the relation between parents' alcohol abuse, familial environment and children' adjustment. The results showed that alcohol abuse of parents was associated with low integrity and weak organization in family and low self-confidence among children. Stewart & Brown (1993), in a longitudinal study, worked on the relation between consequences of substance abuse and family function after treatment of substance abuse and the results showed that treated persons compared to the adolescents who relapsed into substance abuse had experienced better family relations and lower conflicts. Findings hold the gradual adjustment in relations among families which their adolescents were treated. Mousvi (2003) carried out a study with the aim of specifying function of family system with addicted adolescents. For this purpose, the total of 60 people was selected for both normal and addicted groups alongside their families (father, mother and children) in this investigation. The results showed that the presence of father in families with addicted adolescent is physically and emotionally inconspicuous, discipline is unsuitable, and control is unfavorable. Unity in these families is weak and parental conflicts and parent-child conflicts are meaningfully greater compared to those in the control group.

Staying in a maladjusted family environment during childhood period may negatively affect the risk of substance abuse in adolescence and adulthood. Skeer, McCornick, Normal, Buka & Gilman (2009) in a longitudinal study investigated the relationship of family conflicts and environmental stresses in childhood period with substance abuse disorder in adolescence and its presence in adulthood. The results showed that there is a significant relationship between family conflict and risk of substance abuse in adolescence. External social support cannot neutralize the strong negative effects of family conflict on substance abuse in adolescence. Taffa & Baiocco (2009) investigated the role of family system in predicting addictive behavioral patterns. The results showed that the features of family system are predictors of addictive behavior so that the families with low integrity and

weak adjustment and low capacity for changing the power structure with defective roles and maladjusted relations had more addictive behaviors. Luk, Farhat, Jannotti, & Simons-Morton (2010) investigated the state of the relations between parents and children according to substance abuse. The results showed that the state of the relations of the parents with their sons is a supporting factor for the initiation of substance abuse; however, there were no significant relationship in this regard about daughters. Costantini, wermuth, Sorenson & Lyons (1992) investigated the status of family function in relation to treatment advancement in substance abuse. The results showed that family function, especially family integration predicts disorder originated from substance abuse problems, family or psychological factors. This study confirms the importance of family factors in treatment of substance dependence.

Given the preceding discussion, reviewing the structure and social environment of families with drug dependent children is a requirement for developing preventive strategies and treatment interventions with a focus on family. Therefore, the aim of this study is to compare the environmental profile of families with drug dependent children and normal families in order to suggest treatment interventions according to the conditions of these families by investigating family grounds for suffering drug dependence disorders. For this purpose, the present study tried to answer this question: "is there a significant difference between environment of families with drug dependent children and environment of normal families?"

Method

The method of study was causative-comparative. The subjects of the study included families settled in west and east part of Tehran city with drug dependent children who had referred to outpatient treatment centers. For the purpose of sampling, first the governmental treatment centers dependent on health organization in the west and east part of the city were identified and some of these centers were randomly chosen. Referring to these centers and presenting the university application for cooperation, we just received 4 positive answers among the chosen centers. Each of these centers served from 150 to 200 patients per month. With the cooperation of authorities from these centers, the patients' files were delivered to one of the researchers for initial investigation. After the investigation of the files, 70 patients were randomly chosen as the individuals qualified for the entrance into the study. Entrance criteria included: to be male, to have at least diploma level of education, to have normal economic and social status, to be between 20 to 30 years old, to be single, and to live with family. After a brief interview, the aim of this study was explained to the participants and they were assured that their private information would be kept confidential and their agreement to stay in the study was officially confirmed. Since the control group (70 people) was

homogenous with experimental group in terms of gender, age, social-economic status, marital status and living with parents; they were chosen among the friends of this group and their conditions were nearly similar to the experimental group and questionnaires were delivered to them by the participants of the first group and were collected after one week. Some of the collected questionnaires from the experimental group were put out of the study, since they were defective and, at the end, 50 questionnaires were accepted. From 70 questionnaires delivered by the control group, 58 of them were accepted, but 8 of them were excluded for keeping the balance between two groups.

Instrument

1. Questionnaire of demographic data: this questionnaire has been developed to complete the information by the researcher. It includes initial information about samples' traits, such as age, education, marital status, social-economic status, occupation, history of addiction, age at the outset of substance abuse, history of addiction in the family and close relatives.

2. Family environment questionnaire: this questionnaire was developed by Moos & Moos (1986) with the aim of identifying family environment and consisted of 90 questions and 10 subcategories which assess the features of social environment of different families in three dimensions. The dimension of relation (integrity, expression and conflict), integrity that is the degree of commitment, help and support which family members regard among each other; expression that is the degree in which family members are encouraged to be honest and directly express themselves. Conflict means the degree of frankness in expressing anger, aggression and conflict which exist among family members. Individual growth dimension is subcategory of independence, progress orientation, thinking and cultural orientation, recreational activities and moral-religious emphasis. Independence is an area in which family members can express their audacity, self-capability and power of decision making. Progress orientation: it is an area in which activities such as school assignments or job-related areas are followed competitively. Thinking and cultural orientation is the degree of interest in which family members follow political, social, thinking and cultural activities. Recreational orientation includes: the degree of contribution to social and recreational activities. Moral-religious orientation includes the degree of emphasis over moral and religious values. The dimension of family survival is a subcategory of organization and control. Organization includes the degree of importance which is emphasized over transparent and structural organizing in planning activities and responsibilities in the family. Control is an area in which rules and regulations in relation to performing any activity for the persistence of family life are applied. Among different versions of this questionnaire, the original version which assesses the individual's

understanding of nuclear family environment was employed for the purpose of this study. The items of this questionnaire had two choices, i.e. true or false answers. This self-reporting questionnaire is used for individuals aged older than 11 years. Reliability of this test for the whole scale has been reported from 0.61 to 0.78 with the data gathered from 1500 families from all over the US. Test-retest reliability in a 2-month interval has been reported 0.68 to 0.86 and in a 12-month interval and it has been reported 0.52 to 0.89. Correlation of this test with the scale of "positive relations of family" in different research samplings has been calculated 0.81 to 0.86 (Lidel & Row, 1996). The reliability of this questionnaire in the present study by Cronbach's Alpha was reported as 0.72.

Results

Table 1: Descriptive statistics of familial environment components according to groups

Components	*Group*	*N*	*Mean*	*SD*
Integrity	Drug dependent	50	5.06	1.60
	Normal	50	6.09	1.50
Expression	Drug dependent	50	4.60	1.20
	Normal	50	5.10	1.50
Conflict	Drug dependent	50	4.20	1.60
	Normal	50	2.40	1.70
independence	Drug dependent	50	4.90	1.60
	Norma	50	5.20	1.10
Progress orientation	Drug dependent	50	4.90	1.60
	Normal	50	6.40	1.70
Logical-cultural orientation	Drug dependent	50	3.10	1.70
	Normal	50	4.80	1.80
Recreational orientation	Drug dependent	50	3.50	1.40
	Normal	50	4.60	2.00
Religious orientation	Drug dependent	50	5.20	1.20
	Normal	50	5.70	2.10
Organizing	Drug dependent	50	4.70	1.80
	Normal	50	6.30	2.30
Control	Drug dependent	50	3.40	1.50
	Normal	50	4.30	1.60

Age average and standard deviation (SD) of drug dependent group and normal group were respectively as follows: 26.5 (2.40) year; 25.20 (2.80) year. About, % 90 of the participants in drug dependent group and %52 of participants in normal group held diploma degrees and under diploma education, %10 of dependent group and %24 of normal group had degrees higher than diploma and only %24 of normal group had a bachelor's degree. In addition, %38 of drug dependent group and %70 of normal group had a

job while %62 of drug dependent group and %30 of normal were unemployed.

Descriptive statistics of family environment components have been shown in the table1 for each group.

Multivariate analysis of variance should be used to investigate the groups' differences in the above-mentioned components. One of the assumptions of this analysis is the equality of error variances. The result of Leven's test represents the satisfaction of this assumption for all the components as shown in the table 2.

Table 2: Results of Leven's test for investigating of equality of error variances

Components	***Df***	***F***	***Sig.***
Integrity	98	0.01	0.89
Expression	98	1.15	0.28
Conflict	98	0.001	0.92
Independence	98	3.10	0.051
Progress orientation	98	0.64	0.42
Logical-cultural orientation	98	0.18	0.67
Recreational orientation	98	3.08	0.051
Religious orientation	98	3.29	0.051
Organization	98	2.61	0.10
Control	98	0.06	0.79

Due to the satisfaction of the assumption for all components, MANOVA test was carried out and the results showed difference on linear combine of components in two groups (Eta squared=0.40, P<0.001, F=5.90, Wilks' Lambda=0.59). Univariate analysis of variance was performed to explore the differences in patterns as follows.

Table 3: Univariate analysis results for representing the differences patterns

Components	**Mean square**	**F**	**Sig.**
Integrity	90.20	26.40	0.0005
Expression	6.20	3.20	0.07
Conflict	86.40	29.40	0.0005
Independence	2.50	1.20	0.27
Progress orientation	50.40	17.80	0.001
Logical-cultural orientation	72.20	23.18	0.0005
Recreational orientation	27.12	8.40	0.001
Religious orientation	7.20	2.30	0.34
Organization	68.80	15.70	0.005
Control	22.23	7.40	0.001

As it is shown in the above table, there is a significant difference between the groups in terms of integrity, conflict, progress orientation, logical-cultural orientation, recreational orientation, organization and control. Given the

descriptive statistics, it can be claimed that only drug dependent group received higher scores in one component, namely conflict. In other components, the normal group received higher scores.

Discussion and Conclusion

The aim of this research was to compare the profile of the family environment with drug dependent members and that of families without drug dependent members in order to provide useful family-based interventions. Findings showed that weak solidarity and integrity are the features of the families with substance dependent members. These results are in line with the findings of Stewart and Brown (1993), Skier et al (2009), Taffa and Biko (2009) and Mousavi (2003). Integrity or somehow the amount of commitment, support, help, feeling of dependency, and spirit of cooperation are weak in families with drug dependent members. Weak integration causes maladjustment between family members and makes them not support each other in critical situation and in the face of problems. The results showed a high conflict in families with drug dependent members. The existence of chaos in families, especially disagreement between parents can be a risk factor for growing substance abuse among children. In families with drug dependent children, individual growth and progress of members are not encouraged. Logical discussions and cultural activities in the environment of such families have no priority. The faith and religious tendencies in such families are weak. Family organization in families with drug dependent members is unstructured and unorganized. It means that the family in following its activity and responsibility has no clear and structured organization. This might make the members feel ambiguous in their roles and responsibilities. Lack of an appropriate organization in the family increases the possibility of substance abuse by one of the family members. The degree of control in families with drug dependent members is also less than that in normal families. Control refers to the determination of regulations and the quality of performing activities among the family members and members are required to follow these regulations and action model. The families with insufficient control and with parents who are not able to enforce any control over the members are more likely to suffer chaos.

Findings showed that there was no significant difference in other dimensions of familial environment such as expression, independence and recreational orientation from the common model of society. In other words, these dimensions in the Iranian culture are more uniformed. Since there is deterrence in clear and straight expression of feelings, recreational activities are not much among priorities of family and independence of members from the original family is not normally encouraged by the society. As a result, there was no significant difference in this area. The profile of familial environment among families with drug dependent members was featured with

a weak integrity; high conflict; lack of encouragement to progress and lack of logical, cultural, and sport orientation; lack of organization; and insufficient control. Given the results of this research, two strategies as preventive and treatment interventions were presented. A) Preventive intervention: based on the findings of the present study, familial environment and its components among families with drug dependent members are defective and dysfunctional. In addition, since today emphasis on risk has been shifted to emphasis on protective factors, it is possible to enforce protective factors by providing training provisions especially for the families. Protective factors against tendencies to substance abuse can be listed as: Parental skills' training and appropriate monitoring over behaviors and actions of children, appropriate management of responsibilities among the children according to their age, enforcement of familial regulations within providing training and effective communication, training conflict and problem solving skills, and the encouragement of families to plan for healthy recreations. B) Treatment interventions: given the role of family in initiation, preservation and continuation of symptomatic diseases such as substance abuse, family-based treatment models towards the treatment of addicts have been developed and expanded in the past three decades. The effect of different treatment models has also been tested. Among these models, the effect of some family therapies on the improvement of familial environment and substance abuse has been confirmed (Ashley, 2005; Waldron & Turner, 2008). Among these models, Brief Strategic Family Therapy (Szapocznik et al, 2003), multidimensional Family Therapy (Liddel, 2003), Functional Family Therapy and multi-systemic Family Therapy (Henggeler & Schaeffer, 2010) can be named.

Many of the successful treatment programs follow a structural-strategic tradition. Common ground of the acquired approaches is a vigilant action strategy which focuses on the problem. Strategic family therapy originated from a structural-strategic approach (Kaffman & Poushio, 2005). The advantage of this method has been proved in many of the studies carried out in the field of substance abuse, modifications in defective interactional models, and the function and familial environment of families with drug dependent children (Robbins et al, 2011, Chofier, 2008; Feaster, Robines, Henderson & Horigian, 2010; Santisteban et al, 2003; Zapostic & Williams, 2000, Robines e al, 2009). It is suggested that experts and therapists in the field of addiction use family-based interventions for modifying the defective familial interactional model and developing a stable treatment. The limitation of majority of the studies in the field of human sciences, as well as this study is the way the participants respond to the questionnaires and the judgment over the exactness of the responses. It means that it is not clear if they are right or wrong. Of course, in this study, all efforts were taken into account to get the original edition of the questionnaire and to reduce the errors and

ambiguities of questions as much as possible by back-translation and corrections.

Given the role of familial components in initiation and continuation of substance abuse, the therapists are recommended not only to consider medical and biological treatments in their treatment interventions, but also to focus on family-based interventions as a part of their treatment system. The authorities in the field of addiction are suggested to develop psychological and educational programs with an emphasis on supporting factors at the level of family via social approaches.

Reference

Ashley, A. (2005). Effective family-based interventions for adolescents with substance use problems: A systematic review. *Research on Social Work Practice, 15(2),* 67-83.

Bijttebier, P., Goethahals, E., & Ansoms, S. (2006). Parental Prinking as a risk factor for children`s maladjustment: The mediating role of family environment. *Psychology of Addictive Behaviors, 20(2),* 126-130.

Caviello, D. M., Alterman, A. I., Cacciola, J. S., Rutherford, M. J., & Zanis. (2004).the role of family history in addiction severity and treatment response. *Journal of Abuse Treatment, 26,* 1-11.

Costantini, M. F., Wermuth, L., Sorenson, J., & Lyons, J. (1992). Family functioning as a predictor of progress in substance abuse treatment. *Journal of substance abuse treatment, 9(4),* 331-335.

Dakof, G.A., Tejeda, M., & Liddel, H. A. (2001). Predictors of engagement in adolescent drug abuse treatment. *American Academy of Child & Adolescent Psychiatry, 40(3),* 274-281.

Feaster, D. J., Robbins, M., Henderson, C., & Horigian, V. (2010). Equivalence of family functioning and externalizing behaviors in adolescent substance abuser of different race/ethnicity. *Journal of substance abuse treatment, 1,* 113-124.

Ghafari, F. (2009). *The effect of Bowen's systemic family treatment approach on differentiation and function of the family members with addicted members*. Unpublished MA Thesis, University of Social Welfare and Rehabilitation.

Guo, J., Hill, K., Hawkins, D., Catalano, R., & Abbot, R. (2002). A developmental analysis of socio-demographic family, and peer effect on adolescent illicit drug initiation. *American Academy of Child & Adolescent Psychiatry, 41(7),* 838-845.

Haffmann, J. P., & Cerbone, F. G. (2002). Parental substance use disorder and the risk of adolescent drug abuse: An event history analysis. *Drug and Alcohol Dependence, 66(3),* 255-64.

Heidarnia, A. & Charkhian, A. (2007). On the comparison of the quality of child-parent relations between the adolescents suffering addiction and normal adolescents, *Journal of social welfare, 16 (25),* 39-57.

Henggeler, S. W, & Schaeffer, C. M. (2010). Treating serious emotional and behavioural problems using multisystemic therapy. *Australian & New Zealand Journal of Family therapy, 31(2),* 149-164.

Horigian,V. E; Suares-Morales,L; Robbins, M. S; Zarate, M; Mayorga, C. M; Mitrani, V.B, Zapocznik, J. (2005). *Brief strategic family therapy for adolescents with behavior problems*. In J. L. Lebow (Eds.), Handbook of clinical family therapy (73-101). Hoboken, New Jersey: Jon Willy & Sons.

Junke, G.A., & Hagedorn, W.B. (2006). *Counseling addicted families: an integrated assessment and treatment model.* Routledge: Taylor & Francis group.

Kaufman, E & Yoshioka, M. (2005). *Substance abuse treatment and family therapy: A treatment improvement protocol (TIP 39).* Rockvill, MD20857.

Ledoux, S., Miller, P; Choquet, M., Plant, M. (2002). Family structure, parent-child relationships, and alcohol and other drug use among teenagers in France and United Kingdom, *Alcohol Alcohol.37 (1),* 52-60.

Liddel, H. A. (2003). *Multidimensional Family Therapy for Adolescent Drug Abuse*: *Clinician's Manual,* MN: Hazelden Publishing Co.

Liddle, H & Rowe, C. L. (1996). *Family measures in drug abuse prevention research*. The National Institute on Drug Abuse (NIDA).

Lioyed, C. (1998). Risk factor for problem drug use: identifying vulnerable groups. *Drug: Education, Prevention and Policy, 5(3),* 217-232.

Luk, J. W., Farhat, T., Jannotti, R., & Simons-Morton, B. G. (2010). Parent-child communication and substance use among adolescent: Do father and mother communication play a different role for sons and daughters? *Addictive Behaviors, 35,* 426-431.

Moos, R. H., & Moos, B. S. (1986). *Family Environment Scale Manual*. 2nd Ed. Palo Alto.CA: Consulting Psychologists Press.

Mousavi, A. (2003). Quantitative/qualitative investigation of addicted youths' families. *Women studies, 1(3),* 60-88.

Repetti, R. L., Taylor, Sh. E., &Seaman. T. E. (2002). Risky families: family social environment and the mental and physical health of offspring. *Psychological Bulletin, 128(2),* 330-360.

Robbins, M. S., Szapocznik, J., Horigian. E., Feaster, D., Puccinilli, M., Jacobs, P., Burlew, K., Werstlien, R., Bachrach, K., & Brigham, G. (2009). Brief strategic family therapy for adolescent drug abuser: A multisite effectiveness study. *Contemporary Clinical Trials, 30,* 269-278.

Robbins, M., Feaster, D., Horigian, V., Puccinelli, M. J., Henderson, C., & Szapocznic, J. (2011). Therapist adherence in brief strategic family therapy for adolescent drug abusers. *Journal of Consulting & Clinical Psychology, 79(1),* 43-53.

Santisteban, D. A., Coatsworth, J. D., Prez-vidal, A., Kurtines, W. M., Schwartz, S. J., & Szapocznik, J. (2003). The efficacy of brief strategic family therapy in modifying adolescent behavior problem and substance use. *Journal of Psychology*, *17*, 121-133.

Schafer, G. (2008). Multiple family group therapy in a drug and alcohol rehabilitation Center: resident experiences. *Australian & New Zealand Journal of Family Therapy*, *29(2)*, 88-96.

Sim, T., & Wong, D. (2006). Working with Chinese families in adolescent drug treatment. *Journal of Social Work Practice*. *22(1)*, 103-118.

Skeer, M., McCornick, M., Normal, S. T., Buka, S. L., & Gilman, S. E. (2009). A Prospective study of familial conflict psychological stress and the development of substance use disorders in adolescence. *Drug and Alcohol Dependence*, *104(1-2)*, 65-72.

Soyes, V., Tatrai. H. Broekaert, E., & Bracke, R. (2004). The implementation of contextual therapy in the therapeutic community for substance abuser: a case study. *Journal of Family Therapy*, *26*, 286-305.

Stewart, M. A., & Brown, S. (1993). Family functioning following adolescent substance abuse treatment. *Journal of Substance Abuse, 5(4)*, 327-339.

Szapocznik, J., Hervis, O. E., & Schwartz, S. (2003). *Brief strategic family therapy for adolescent drug abuse* (NIH Publication No. 03-4751). NIDA Therapy Manuals for Drug Addiction. Rockville, MD: National Institute on Drug Abuse.

Szapocznik, J., & Williams, R. (2000). Brief strategic family therapy: Twenty- five years if interplay among theory, research and practice in adolescent behavior problem and drug abuse. Clinical *Child and Psychology Review*, *3(2)*, 117-134.

Tafa, M., & Baiocco, R. (2009). Addictive behavior and family functioning during adolescence. *The American Journal of family therapy, 37(5),* 388-398.

Vungkhanching, M., Sher, K. J., Jachson, K. M., & Parra, G. (2004). Relation of attachment style to family history of alcoholism and alcohol use disorders in early adulthood. *Drug and Dependence*, *75*, 47-53.

Waldron, H. B., & Turner, C. W. (2008). Evidence-based psychosocial treatment for adolescent substance abuse. *Journal of Clinical Child & Adolescent Psychology*, *37(1)*, 238-261.