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Investigating the Effect of Family Counseling on the Acceptance and Support of Patients under Methadone Maintenance Treatment

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Abstract

Background: Family plays a crucial role in improvement and treatment continuation of individuals under methadone treatment. Understanding, supporting, and accepting the patient by the family and friends are factors influencing the treatment and rehabilitation process.

Objectives: The aim of this study was to determine the effect of family counseling on acceptance and support rates of patients under MMT.

Methods: In this quasi-experimental study, 50 patients (25 in the intervention group and 25 in the control group) under methadone treatment, in addiction treatment centers, in Kermanshah were selected through cluster sampling and randomly divided into 2 intervention and control groups. Data collection from the patients in both groups was conducted before and 4 weeks after last session intervention using family support and acceptance questionnaires. Intervention for patients' family members (2 primary members for each patient) was held as a group-counseling meeting using Michael Free's methodology. Patients in the intervention and control group received only the usual care of the center. Data were entered into SPSS software (version 18) and analyzed using appropriate statistical tests.

Results: The family social support rate for the patients before and 4 weeks after counseling in the control group changed from 165.14 $\pm$ 23.91 to 152.36 $\pm$ 17.66, indicating no significant difference. Additionally, this rate increased in the intervention group from 156.16 $\pm$ 22.88 to 167.6 $\pm$ 20.41, showing a significant difference. The rate of family acceptance of patients before and 4 weeks after counseling in the control group changed from 26.86 $\pm$ 4.94 to 26.30 $\pm$ 4.48, showing no significant difference. Furthermore, this rate in the intervention group increased from 26.93 $\pm$ 6.38 to 31.76 $\pm$ 3.72, indicating a significant difference.

Conclusions: The results of the study showed that family counseling could increase the support rate for drug addicts and their acceptance by the family.

Keywords: Addiction, Family, Social Acceptance, Social Support

1. Background

Family is a system in which people are chainlike interconnected, and their behaviors completely affect each other (1). Addicted individuals are also one component of this system, and to treat this component or change their behavior, we must change the behaviors and other components with respect to them (2). During the addiction process, addicts lose their family confidence and support deliberately or unintentionally and are rejected by the family. Studies show that addicts benefitting from family support during treatment enjoyed a more successful treatment than those deprived from this support (3). Addicts always face physical and psychological stress factors since the time of drug rehabilitation. They are at war and escape with themselves owing to the need to be accepted by the family (4), since they know that by reusing drugs, they will lose their new confidence and will be rejected by the family. In this respect, if the sense of being accepted by the family is not created in the addict, he/she will turn to their addicted friends and reengage in the drug use cycle (3). If the family has a stable structure with positive and reasonable attitudes and constructive interactions, the family atmosphere can have a positive impact on the patient. Oth-

erwise, the family atmosphere is by itself a factor in driving the patient to use drugs (5, 6). Considering the family's role in the lives of individuals as well as the Middle Eastern cultural community, particularly in Iran, family support can be considered a useful source of social support for drug users (5). Results of studies about qualitative investigation of the concept of drug relapse by presenting a model in this concern demonstrated that family played a crucial role in the treatment and rehabilitation of patients. It was stated in this research that family support and induction of family acceptance could be a powerful factor in increasing the patients' motivation to continue their treatment and stay away from drugs (3, 5). Therefore, therapists and health employees should use effective measures to improve the community culture and their knowledge about the drugs and treatment, thereby improving their attitudes, and particularly the patients' families. Thus, the patients do not lose the support of important and influential persons in their lives during the rehabilitation process (5, 7). One of the most important interventions for drug abuse disorder is the cognitive-behavioral approach (8). Cognitive-behavioral therapy is created using different models and approaches. An approach that can be group-based and well-coordinated with cognitive therapies and counseling is cognitive counseling using Michael Free's approach. This approach includes group-based steps consisting of cognitive counseling (9). The main purpose of this approach is to help group members identify and experience their feelings, as well as to change their mental beliefs and help the individual to substitute for the right behaviors in lieu of past misconduct through free discussion of suppressed feelings and active participation in predetermined programs (10). According to the results of the conducted studies and various texts, cognitive-behavioral counseling, as one of the effective methods that can lead to increase the feeling of support and acceptance in the patient, is a psychological approach for changing the unreasonable beliefs of individuals and their families' concerning drugs.

2. Objectives

In this study, we intend to investigate the effect of this intervention on the support and acceptance of family members of drug addicts through cognitive counseling, while raising the knowledge and understanding of the family concerning the phenomenon of drug addiction and its treatment and rehabilitation process.

3. Methods

The present research is a single-blind experimental intervention (randomized clinical trial) of pre-test and post-test type with a control group. Data collection was carried out by the researchers before and after counseling in 2 groups. The research population in this study included all patients using drugs under methadone treatment in private and public clinics of Kermanshah who were selected by cluster sampling and divided according to coin throwing into 2 groups of intervention and control.

For this study, 50 patients under methadone treatment were conveniently selected and randomly divided into intervention and control groups. In the intervention group, in addition to the usual intervention of the clinics, 2 primary family members (father, mother, spouse, brother, or children) were selected with their own willingness and participated in-group cognitive counseling sessions following Michael's free method (9, 11), and in the control group only usual clinical interventions were performed. Family group counseling was offered in 6 weekly sessions for approximately 70 - 90 minutes per session for groups of 15 - 17 people (in this study, the family members of the intervention group were divided into 3 groups of 16, 17 and 17 peoples).

Entry criteria for this study: the patient underwent treatment with methadone for at least 1 month or more (stabilization phase), family members of these patients who were not drug users and who lived with the patient, the addict's age was between 18 - 65 years old, family members had the willingness and ability to attend counseling sessions, at least 1 and at most 2 members per family attend counseling sessions, the patient and the candidate family members were not previously included in a similar program, the patient and the candidates family members did not have mental retardation, physical impairments such as deafness and blindness, and finally, the patient and the candidates family members had the ability to read and write.

Exclusion criteria from the study: if each member of the family of patients who participated in counseling sessions had more than 2 absence times, he/she would be excluded from the study. In addition, if a patient sought withdrawal from the therapeutic program during the counseling phase and 4 weeks afterward for any reason, including relapsing of drug use, the related samples would be excluded from the study.

Prior to the intervention, a colleague of the researcher distributed the tools, and the patients under treatment completed both the Crowne and Marlowe social desirability scale and the social support tool for chronic patients-family scale. Subsequently, interventions were made in

groups regarding drug abuse, addict support and acceptance, as well as family needs for each of the intervention group. Unfortunately, 15 people left the study (3 members of the 1st group in the 3rd session, 2 members of the 2nd group in the 4th week, 5 members of the 3rd group in the 2nd week, and 5 members of the 3rd group in the 4th week). Four weeks after the last counseling session, the questionnaires were redistributed by a colleague of the researcher and completed by the patients of the intervention and control groups.

To study the coherence of the 2 groups, Chi-square and Fisher tests were used for qualitative variables. In addition, independent t-test was used to compare the coherence of the 2 groups in the quantitative variable. This study was approved by the ethics committee of Kermanshah University of Medical Sciences (KUMS.REC.1395.85) and registered in IRCT (IRCT2016022926844N1) (Table 1).

The data collection tools consisted of 3 sections: 1- individual profile form, including the age of the patients and their family member(s), their gender, educational level, employment status, income level etc., 2- social support tool for chronic diseases - family scale: this questionnaire measures family social protection in 4 domains; emotional domain (18 questions, minimum 18, and maximum 72 points), information domain (10 questions, minimum 10, and maximum 40 points), protection domain (6 questions, minimum 6, and maximum 24 points), and instrumental domain (6 questions, minimum 6 and, maximum 24 points). In total, this tool had 79 questions, a minimum of 79 points, and a maximum of 316. If the tool scores are between 79 and 138, then the social support level in this community is considered weak. If the scores of the questionnaire range from 138 to 197, then the social support is estimated at a moderate level. Furthermore, scores more than 197 indicate a very good social support. The social support questionnaire for chronic diseases had excellent internal consistency with a Cronbach's alpha coefficient of 0.97. In the emotional domain with 18 questions, the Cronbach's alpha coefficient was 95%. The support domain had 6 questions and a Cronbach's alpha coefficient of 0.74; the instrumental support domain had 6 questions with a Cronbach's alpha coefficient of 0.85, and the information support domain with 10 questions had a Cronbach's alpha coefficient of 0.87 (12). 3- Crowne and Marlowe's social desirability scale: this scale had 33 questions that were answered by right or wrong. It aimed to measure social acceptance in individuals. On this scale, individuals scored between 0 and 8 points were those whose responses did not seek social acceptance and were likely to be rejected. Individuals scored between 9 and 19 points had social acceptance on average, and their behavior was consistent with social rules and norms. Individuals whose scores ranged from 20 to 33 points had their true behavior greatly consistent with social rules and norms. Validity and reliability of this tool were investigated by Samari and Lali Phaz (2005) (13). Its validity coefficient was more than 80% by the rerunning method. From the validity point of view, this test also showed high correlation with other psychological tools designed to measure social acceptance (14).

4. Results

In the present study, 50 people (25 in the control group and 25 in the intervention group) were studied. The mean age of the individuals in the control group was 39.32 ± 9.49 and in the intervention group was 38.36 ± 12.83. Among the total research units, 60% had a diploma and lower education level, and 40% had a university education. A total of 76% of the individuals were male, and 24% were female. In total, 84% who were married and 16% who were single. In terms of employment status, 88% were employed and 12% were unemployed. Additionally, Table 2 shows demographic characteristics of the intervention group's family members participated in consoling session.

The research samples were homogenous in the 2 groups of intervention and control in terms of age, education level, gender, marital status, and employment status (P value > 0.05) (Table 3).

The results of the paired t-test showed that the mean scores of family social support before and after the intervention were significantly different in the intervention group ($P < 0.05$), however, the mean scores of family social support before and after the intervention were not significantly different in the control group ($P > 0.05$). Furthermore, the results of the paired t-test showed that the mean scores of the studied individuals in the social acceptance in the intervention group before and after the intervention were significantly different ($P < 0.05$), however, the mean scores of social acceptance before and after the intervention in the control group were not significantly different ($P > 0.05$) (Tables 4 and 5).

5. Discussion

The results of this study showed that family counseling significantly increased the mean of the individuals' support scores ($P < 0.001$). This finding is consistent with the results of some previous studies, including Manchurry et al. (2013) who showed that having high social support played a great role in confronting and better adaptability of addicts' families with stressors and providing their social and mental health (4), and the study by Jalali et al. (2015) who indicated that family and interaction, family

Table 1. Topics and Techniques Used in Counseling Sessions Based on Michael Free's Model

Sessions	Subject	Activities
First session	Members' familiarity with each other and forming group correlation	Familiarity among group members
		Familiarity with drug abuse process and its rehabilitation
		Explaining the status and needs of drug users under treatment
		Expressing the views of group members and guiding the group toward the recognition of emotions
Second session	Views and attitudes toward drug abuse and drug user	Encouraging members to discuss their views on drug use
		Expression of emotions, familiarity with their own thoughts and negative thoughts and how they are formed
		Homework: Writing 10 of the worst events of their own life and that of their family in interaction with and facing drug addict
Third session	Views and attitudes toward drug abuse and drug user	Continuing the topics of the 2nd session
		Reviewing members' homework, reviewing each event and members' discussion about it
		Using purposed questions to determine the results and effects of views and attitudes to events
		Homework: Record the expectations of family members from a drug addict and express their feelings about the expectations of drug addict of them as family members.
Fourth session	Acceptance and support of patients and their impact on the rehabilitation process	Reviewing the homework of the previous week and expressing the views of members
		Discussing the feeling of being accepted and the need of patients under treatment for it
		Discussing family support and its role in patients' rehabilitation
		Expressing the members' views and opinions
		Homework: Record methods to support a drug addict and how to inspire the sense of being accepted by them
Fifth session	Acceptance and support of patients and their impact on the rehabilitation process	Reviewing the homework of the previous week and expressing the views of members
		Expressing the members' views and opinions about each other's homework
		Discussing the family role and the continuity of drug abuse or drug reuse
		Talking about the role of the family in helping patients to cope with temptation
		Explaining the treatment process and relapse in rehabilitation and drug addiction
		Expressing the members' views and opinions
		Homework: Record relapse cases and suspected behaviors of drug addiction recurrence and the interventions done by the family.
Sixth session	Conclusion	Discussing the homework of the previous week
		The views of group members
		Expressing their own views and feelings about relapse
		Answering questions
		Answering the concerns and views of the group members.

challenges, and family structure were the main layers effective in the relapse process (6, 15). In explaining these results, it can be mentioned that the cold emotional atmosphere exacerbates indifference among the members of the addicted family, the use of drugs and even failure in drug rehabilitation. The lack of collaboration, cooperation, unity, and intimate relationships in the family results in deprivations, which makes family members ready for drug abuse. Therefore, it can be stated that family plays a major role in the tendency of its members to abuse drugs. On the other hand, lack of family support, changes in the emotional bond, and attachment to the family play a significant role in drug abuse. It seems that lack of family essence causes individual's insecurity, and insecure individuals use drugs as a self-medication mechanism to suppress negative emotions and injurious events (16, 17). Furthermore, receiving family support resources such as family cohesion, communication of parents with children, sense of happiness, positive excitement, interest, relaxation, internal control, and compensatory factors against risk can increase flexibility in individuals, reduce the risk of drug use, and increase the success rate of rehabilitation. It seems that if the family has the necessary efficiency as well as emotionally supports its members, they act based on family values that are often opposed to drug use, and therefore, choose friends who are less likely to divert, and do not tend to use drugs. Therefore, an efficient family can act as a protective agent to compensate for risk factors (peers, colleagues and unhealthy social tissues) (6, 18). In addition, families with a more supportive atmosphere tend to have more willingness to talk, leading to the mutual understanding of its members, and this increases development of various psychological aspects and maintains the mental health of individuals.

However, these findings are not consistent with those of the study by Olin et al. (2014) who showed that family

Table 2. Descriptive Information of Intervention Group's Family Members

Variable	Intervention Family Members[a]
Gender	
Male	7 (20)
Female	28 (80)
Marital Status	
Married	24 (68.6)
Single	11 (31.4)
Graduate Level	
Under Diploma and Diploma	19 (54.3)
College	14 (45.7)
Job State	
Employed	17 (48.6)
House wife	18 (51.4)
Age group, y	
< 35	18 (51.4)
35 - 55	16 (45.7)
> 55	1 (2.9)
Relative Statue	
Parents	8 (22.9)
Spouse	12 (34.3)
Children	9 (25.7)
Sister	4 (11.4)
Brother	2 (5.7)

[a] Values are expressed as No. (%).

Table 3. Descriptive Information of Consistency of the Two Groups[a]

Group Variable	Intervention	Control	Chi Square
Gender			1.754
Male	21 (84)	17 (68)	
Female	4 (16)	8 (32)	
Marital Status			2.381
Married	23 (92)	19 (76)	
Single	2 (8)	6 (24)	
Graduate Level			1.333
Under Diploma and Diploma	17 (68)	13 (52)	
College	8 (32)	12 (48)	
Job State			3.030
Employed	24 (96)	20 (80)	
Unemployed	1 (4)	5 (20)	
Age			-0.301[b]; 0.765
Intervention	38.36 ± 12.83		
Control	39.32 ± 9.45		

[a] Values are expressed as No. (%) or mean ± SD.
[b] Independent t-test.

support, especially if it is extreme, can cause fragility and reduce the members' flexibility facing obstacles and problems (19). The findings are also inconsistent with those of the study by McCollum et al. (2014), who showed that people who were always supported by the family members had inefficient conflict resolution strategies and solutions to problems (20), as well as the study by Bertrand et al. (2013), who believed that family support for addicted people could lead to individual's coquetry and lack of effort to obtain a job and, as a result, unemployment and more free time, and this led them to drug reuse (21). Generally speaking, these studies more emphasize the extreme support provided by the family to people with drug abuse, while the focus of our study is on the positive aspects of social, informational, and instrumental support.

The results of our study showed that family counseling significantly improved the acceptance of patients under methadone treatment referring to the rehabilitation centers in Kermanshah ($P < 0.001$). These findings are consistent with the results of some previous studies, including the study by Weinbrecht et al. (2016), who indicated that family-centered interventions and counseling increased their acceptance of the client having a problem and, consequently, reduce the symptoms of the diseases (22). The findings are also consistent with the result of the study by Lee et al. (2015), who showed that promoting acceptance for alcohol addicts improved them and reduced the relapse among them (23). In explaining these findings, it can be mentioned that in today's world, family is usually considered as a trust institution and safe haven, and the majority of people do not have the family environment only to escape the pressure of life, however, they consider it an environment in which individuals receive acceptance and support by others. Every human being needs essential social acceptance from family, friends, school, and society, since social acceptance makes individuals resistant to physical and emotional problems and offers them confidence to face life problems. The main dimensions of social acceptance are: attachment and interest in others; commitment to family, work and friends; continuous engagement and participation in life, work and family activities; and belief in the values and ethics of a group or community. The weakness of each of these 4 dimensions in individuals can lead to deviant behaviors and drug abuse in them. Overall, in explaining the effect of family counseling on

Table 4. Mean Score of Social Support and Social Acceptance of Control and Experiment Groups Before and After the Family Counseling

Variables	Family Counseling	Group	Mean ± SD	Independent T test	P Value	Observed Power
Emotional Domain	Before	Exp.	43.08 ± 14.53	0.87	0.388	0.896
		Con.	39.64 ± 13.27			
	After	Exp.	50.76 ± 11.46	3.64	0.001	
		Con.	38.76 ± 11.86			
Information Domain	Before	Exp.	20.00 ± 6.05	-0.27	0.788	0.956
		Con.	20.52 ± 7.16			
	After	Exp.	24.28 ± 5.47	2.25	0.029	
		Con.	20.40 ± 6.67			
Protection Domain	Before	Exp.	12.36 ± 3.65	-0.21	0.837	0.728
		Con.	12.6 ± 4.51			
	After	Exp.	14.24 ± 3.19	1.12	0.27	
		Con.	13.4 ± 1.98			
Instrument Domain	Before	Exp.	12.56 ± 3.89	-0.68	0.499	0.873
		Con.	13.36 ± 4.36			
	After	Exp.	16.72 ± 2.99	4.93	0.001	
		Con.	12.48 ± 3.09			
Family Social Support	Before	Exp.	156.16 ± 22.83	-1.34	0.183	0.76
		Con.	165.04 ± 23.91			
	After	Exp.	167.6 ± 20.41	2.32	0.024	
		Con.	162.36 ± 17.64			
Social Acceptance	Before	Exp.	26.93 ± 6.38	-1.48	0.145	0.84
		Con.	26.86 ± 4.94			
	After	Exp.	31.76 ± 3.72	2.58	0.012	
		Con.	26.30 ± 4.48			

the support and acceptance of patients under methadone treatment, it can be mentioned that family is a small element of society and is the root of all future events, which is both foreseeable and controllable (23). The diagnosis of all families of addicted individuals is an incentive to address this problem within the family and solve it without any reference to others. In most cases, the shame of having a drug-addicted member creates an incentive to keep this problem in the family. The focus of the family is on the addicted person and on the problem caused by drug abuse for other family members.

This finding is also inconsistent with the study by Kaminer (2013) and the study by Matejevic et al. (2014), who indicated that family-based interventions had no effect on family acceptance (7, 24); however, this inconsistency can be expected, since the sample group of these studies was teenagers having a history of committing crimes and high-risk behaviors.

One of the limitations of the research was the long time necessity for the tools and tests used in this study, causing the subjects to be tired, where the researcher's colleague made the situation more responsive by providing full explanations to the participants and receiving them. Another research limitation was the difficulty of finding methadone-treated patients who were voluntary to participate in the study, which was thankfully greatly overcome by the psychologists' good collaboration in addiction treatment centers. Furthermore, another limitation of the study was the problems of patients' family members who all initially showed willingness to participate in the study, however, they left the study at the beginning of the study, and mostly for various reasons by justifying that 1 member of the family is in the study. Fortunately, 2 family members were considered at 1st for each patient. Thus, for each patient in the intervention group, a family member was finally present in the study until the end.

Table 5. Mean score of Social Support and Social Acceptance of Control and Experiment Groups Before and After the Family Counseling

Variables	Group	Family Counseling	Mean ± SD	Paired T Test	P Value
Emotional Domain	Exp.	Before	43.08 ± 14.53	-4.90	0.001
		After	50.76 ± 11.46		
	Con	Before	39.64 ± 13.27	1.41	0.171
		After	38.76 ± 11.86		
Information Domain	Exp.	Before	20.00 ± 6.05	-5.45	0.001
		After	24.28 ± 5.47		
	Con	Before	20.52 ± 7.16	0.24	0.812
		After	20.4 ± 6.67		
Protection Domain	Exp.	Before	12.36 ± 3.65	-3.00	0.006
		After	14.24 ± 3.19		
	Con	Before	12.6 ± 4.51	-0.99	0.322
		After	13.4 ± 1.98		
Instrument Domain	Exp.	Before	12.56 ± 3.89	-7.97	0.001
		After	16.72 ± 2.99		
	Con	Before	13.36 ± 4.36	1.61	0.120
		After	12.48 ± 3.09		
Family Social Support	Exp.	Before	156.16 ± 22.83	-4.08	0.001
		After	167.6 ± 20.41		
	Con	Before	165.04 ± 23.91	1.94	0.064
		After	162.36 ± 17.64		
Social Acceptance	Exp.	Before	26.93 ± 6.38	-5.55	0.001
		After	31.76 ± 3.72		
	Con	Before	26.86 ± 4.94	0.07	0.944
		After	26.30 ± 4.48		

5.1. Conclusions

In summary, it can be stated that family counseling is an appropriate intervention for patients under methadone treatment. In fact, family counseling can reduce the tension between members and cause unconditional acceptance of the addict, increasing support, and acceptance. Overall, family counseling can be effective and useful in reducing the challenges associated with drug abuse for the family's emotional, social, and educational balance. In this regard, it is suggested that therapists take the necessary care in using this approach in order to be able to take valuable steps to increase social and family support and promote acceptance.

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Authors' Contribution: The authors alone are responsible for the content and writing of the paper.

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References

1. Manubay JM, Muchow C, Sullivan MA. Prescription drug abuse: epidemiology, regulatory issues, chronic pain management

with narcotic analgesics. *Prim Care*. 2011;**38**(1):71–90. vi. doi: 10.1016/j.pop.2010.11.006. [PubMed: 21356422].
2. Seyedfatemi N, Peyrovi H, Jalali A. Relapse experience in Iranian opiate users: a qualitative study. *Int J Community Based Nurs Midwifery*. 2014;**2**(2):85–93. [PubMed: 25349849].
3. Jalali A, Seyedfatemi N, Peyrovi H. Relapse model among iranian drug users: A qualitative study. *Int J Community Based Nurs Midwifery*. 2015;**3**(1):2–11. [PubMed: 25553329].
4. Mancheri H, Heidari M, Ghodusi Borujeni M. Correlation of Psychosocial problems with perception of social support families with addicted member admitted. *Iran J Psychiatr Nurs*. 2013;**1**(3).
5. Peyrovi H, Seyedfatemi N, Jalali A. The Role of Family Atmosphere in the Relapse Behavior of Iranian Opiate Users: a Qualitative Study. *J Caring Sci*. 2015;**4**(3):189–96. doi: 10.15171/jcs.2015.019. [PubMed: 26464835].
6. Turner RA, Irwin Jr CE, Millstein SG. Family structure, family processes, and experimenting with substances during adolescence. *Risks Problem Behav Adolescence*. 2014;**1**(11):229–47.
7. Matejevic M, Jovanovic D, Lazarevic V. Functionality of Family Relationships and Parenting Style in Families of Adolescents with Substance Abuse Problems. *Proc Soc Behav Sci*. 2014;**128**:281–7. doi: 10.1016/j.sbspro.2014.03.157.
8. McKay JR. Lessons learned from psychotherapy research. *Alcohol Clin Exp Res*. 2007;**31**(10 Suppl):48s–54s. doi: 10.1111/j.1530-0277.2007.00493.x. [PubMed: 17880346].
9. Free ML. *Cognitive therapy in groups: Guidelines and resources for practice*. John Wiley Sons; 2007.
10. McHugh RK, Hearon BA, Otto MW. Cognitive behavioral therapy for substance use disorders. *Psychiatr Clin North Am*. 2010;**33**(3):511–25. doi: 10.1016/j.psc.2010.04.012. [PubMed: 20599130].
11. Free ML. *CBT and christianity: Strategies and resources for reconciling faith in therapy*. John Wiley Sons; 2015.
12. Khodapanahi MK, Asghari A, Sedghpoor BS, Katebaii J. Preparing and investigating the reliability and validation of the family social support questionnaire (FSSQ). *J Fam Res*. 2009;**5**(4):423–39.
13. Samari AA, Lalifaz A. The Study of reciprocal relationships of personality characteristics and job stress in work area. *Q J Fund Ment Health*. 2005;**22**(6):19–28.
14. Rajabi Gilan N, Ghasemi SR, Reshadat S, Zangeneh A, Saeidi S. Health-related quality of life of women in marginal areas of Kermanshah and some related factors. *J Kermanshah Univ Med Sci*. 2015;**18**(12):547–56.
15. Jalali A, Dehkordi H, Mahvar T, Moradi M, Dinmohammadi M. Psychological needs of men under methadone maintenance treatment: A mixed method study. *Heroin Addict Relat Clin Problems*. 2015;**17**(1):23–31.
16. Bazrafshan M, Jahangir F, Shokrpour N. What Protects Adolescents from Suicidal Attempt: A Qualitative Study. *Shiraz E Med J*. 2017;**18**(9).
17. Tsai HF, Cheng SH, Yeh TL, Shih CC, Chen KC, Yang YC, et al. The risk factors of Internet addiction–a survey of university freshmen. *Psychiatry Res*. 2009;**167**(3):294–9. doi: 10.1016/j.psychres.2008.01.015. [PubMed: 19395052].
18. Rafi Bazrafshan M, Sharif F, Molazem Z, Mani A. The effect of paternal addiction on adolescent suicide attempts: a qualitative study. *Int J High Risk Behav Addict*. 2016;**5**(3). e22588. doi: 10.5812/ijhrba.22588. [PubMed: 27818961].
19. Olin SS, Williams N, Pollock M, Armusewicz K, Kutash K, Glisson C, et al. Quality indicators for family support services and their relationship to organizational social context. *Adm Policy Ment Health*. 2014;**41**(1):43–54. doi: 10.1007/s10488-013-0499-z. [PubMed: 23709286].
20. McCollum EE, Trepper TS. *Family solutions for substance abuse: Clinical and counseling approaches*. Routledge; 2014.
21. Bertrand K, Richer I, Brunelle N, Beaudoin I, Lemieux A, Menard JM. Substance abuse treatment for adolescents: how are family factors related to substance use change? *J Psychoactive Drugs*. 2013;**45**(1):28–38. doi: 10.1080/02791072.2013.763560. [PubMed: 23662329].
22. Weinbrecht A, Rieckmann N, Renneberg B. Acceptance and efficacy of interventions for family caregivers of elderly persons with a mental disorder: a meta-analysis. *Int Psychogeriatr*. 2016;**28**(10):1615–29. doi: 10.1017/S1041610216000806. [PubMed: 27268305].
23. Lee EB, An W, Levin ME, Twohig MP. An initial meta-analysis of Acceptance and Commitment Therapy for treating substance use disorders. *Drug Alcohol Depend*. 2015;**155**:1–7. doi: 10.1016/j.drugalcdep.2015.08.004. [PubMed: 26298552].
24. Kaminer Y. *Adolescent substance abuse: A comprehensive guide to theory and practice*. Springer Science Business Media; 2013.