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Elizabeth A. Slowinski  
The Role of the Rural Family in  
Opiate Addiction

### **ABSTRACT**

Both popular media and academics have noted that rural communities are beset with an opiate epidemic. However, research related to opiate abuse tends to focus on those living in urban settings. The present study compared the responses of urban and rural clinicians who work with opiate/opioid-dependent clients, as it was hypothesized that addiction is uniquely influenced by population density. Specifically, this research focused on the role an opiate-dependent client's family plays in their opiate use and whether this role differs based on location. Bowen's Family Systems Theory was used to frame the study, as it was hypothesized that family norms were influenced by location. This research found differences in the role of rural families when compared to urban families. Implications for rural practitioners who treat opiate/opioid dependent clients are discussed.

# **THE ROLE OF THE RURAL FAMILY IN OPIATE ADDICTION**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2015

## **ACKNOWLEDGEMENTS**

You know who you are.

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## CHAPTER I

### Introduction

The increase in opiate/opioid-related deaths is a growing topic of interest and concern to mental health clinicians and researchers alike (Cicero, Ellis, Surratt, & Kurtz, 2014; Sigmon, 2014). Some communities have deemed the increase in opiate/opioid abuse to be an epidemic (Centers for Disease Control and Prevention, 2015), yet few answers have surfaced to as to how to help stem the problem. This current study is concerned with how opiate/opioid dependence is treated in rural communities, as extant research in this area tends to focus on urban communities (Dew, Elifson, & Dozier, 2007). Specifically, this study examines how addiction and the family system interface, and whether this dynamic should be taken into consideration when coordinating rural care for adults struggling with opiate dependence. The decision to focus on the role of family was influenced by Murray Bowen's Family Systems Theory (1976), which suggests that differentiating the self from the family is challenging, and perhaps even more challenging within certain types of families. As research has shown that addiction is more of a family affair in rural communities than in urban settings (Draus & Carlson, 2006), it might be important to consider the unique role of the family in this population.

In this study, *addiction* will refer solely to the use of opiates and opioids. The term opiate typically refers to drugs derived from opium, while the term opioid typically refers to synthetic opiates (Torrens, Fonseca, Galindo, & Farre, 2015). In this study, the terms opiate and opioid will be used interchangeably.



Opiate dependence is on the rise in rural communities (Cicero et al., 2014) and, despite the trend of opiate abuse and associated deaths in these small communities, there is little research on the mechanisms that influence this problem. Given this, investigating the unique situation of the rural opiate abuser seems a worthy endeavor, as investigating these needs might allow for rural treatment providers to consider adapting current treatment models. The aim of this research is to better understand those struggling with opiate dependence in rural communities. Ideally, this research will contribute to ideas for the design and implementation of future treatment models tailored to this population.

Considered by many to be the pioneer of family systems theory and family therapy, Murray Bowen treated patients with a variety of mental health issues, and believed that understanding the interplay of family members was crucial to understanding a patient's mental health. He believed this so strongly that he sometimes hospitalized whole families when attempting to pinpoint the root of a client's schizophrenia (Papero, 1990). Therefore, to truly understand and best support a person struggling with substance abuse, considering the role of the family seems necessary (Stanton & Shadish, 1997). This may be particularly relevant for those living in low-density/rural areas, where a client's family is more likely to occupy a greater portion of their social network (Beggs, Haines, & Hurlbert, 1996). Bowen's addiction work focused on alcoholism, although the treatment of substance abuse tends to overlap independently of the substance being abused (Stanton & Shadish, 1997). Therefore, Bowen's theories, as they apply to alcoholism, are applicable to opiate abuse and dependence.

Bowen's Family Systems Theory posits that differentiating one's family from oneself can be challenging, if not impossible. That is, a person's notion of self is borne of interactions with family, and these interactions have a lasting effect (Bowen, 1976). Furthermore, one's role in a

family is often replicated outside of the home and in interactions with others. For example, according to Bowen, a child who is the peacekeeper between frequently quarrelling parents might find later themselves placating coworkers in adulthood. Or, a family member who takes the brunt of a family's disdain may grow up to cultivate emotionally abusive relationships with partners later in life. Bowen (1974) also put forth the idea that the health of a family system is reflected in the individual. For example, a person from a family marked by love, warmth, and support (markers that refer to a healthy family) is more likely to be emotionally secure and develop sustainable relationships. To contrast this, a person from a family marked by anger, shame, fear, coldness, and ridicule (markers that refer to a dysfunctional family) is more likely to be emotionally insecure and have unhealthy relationships, perhaps even develop an addiction. In short, Bowen's Family Systems Theory is concerned with how the family system affects a person on multiple social levels.

Bowen's concept of differentiation is based on the idea that a person is an integral aspect of a family unit, a group of people whose actions affect each other. *Differentiation* is a term Bowen used to describe to what degree a person is able to function independently of their family, both intellectually and emotionally. He suggested that a high level of differentiation is imperative to healthy functioning in adulthood. Furthermore, according to Bowen, one's degree of differentiation is a direct indicator of how healthy his or her family system is and, by extension, how high functioning an individual is in a variety of life domains. A highly differentiated family is more likely to produce members who are confident in themselves and have healthy coping techniques when confronted with stressors. A person with high differentiation, or someone with a high degree of independence from his or her family, exists in what Bowen refers to as an *intellectual state*, and this is Bowen's idea of a healthy person. This is an individual who is able

to entertain objective stances and therefore is less affected by the actions or feelings of the family.

Conversely, a family with low differentiation is more likely to produce members who struggle to process complex emotions and perhaps more likely to use substances as a coping mechanism (Prest & Protinsky, 1993). According to Bowen, a person with low differentiation is a person mired in the emotional state, as opposed to the intellectual state. For a lowly differentiated person, feelings are processed almost entirely via the subjective lens, meaning their actions are dictated by how to best accommodate others, or with the mindset of avoiding confrontation (Bowen, 1978). This is a highly reactive individual.

Differentiation is a useful concept to frame a study of the role of family and addiction, as it can shed light on the nuance of an individual's struggle. Ideally, understanding a person's level of differentiation will help explain how they view and interact with the world. This seems especially pertinent when the ability to physically differentiate may be limited due to the actual landscape of the community. A limited ability to interact with others outside the family may increase the chances that behavioral and emotional norms will be based primarily on family culture. In thinking about treatment, mental health providers may benefit from having this type of insight regarding a client's lifestyle and influences.

*Codependence* is a term commonly used in addictions literature to refer to the unhealthy dependence one individual has on another (Gibson & Donigian, 1993). While not a Bowenian term, it is an important concept related to family systems theory, as codependence, like low differentiation, stems from dysfunctional families (Gibson & Donigian, 1993). Historically, this term has been associated primarily with alcoholism, usually when referring to a spouse of an alcoholic (Prest & Protinsky, 1993). As with Bowen Family Systems Theory, this is because

alcoholism was more commonly discussed at the time this literature was being produced. However, as with differentiation, it is logical that codependence as it pertains to alcoholism overlaps with issues related to other substances, including opiates. Codependence is typically used to describe the individual who is in the caretaking role, not necessarily to the family unit as a whole. However, in the Bowenian realm, this role could easily be described as a person who lacks differentiation. For the purposes of this study, the concept of codependence is useful when thinking about the many roles of family in substance abuse. Simply put, the addicted individual is not the only person of interest in a family unit; those who support or take care of them are also persons of import, as their actions are reflected in the behavior of the person seeking help. For example, a client's denial of their addiction may be related to a partner's minimization of the addictive behavior. By no means is this study suggesting that the entirety of a family unit should be in treatment; rather, the historical and current role of a client's family should be considered when attempting treatment. Ideally, key family members will be involved in treatment planning but at the very least the interplay should be explored when formulating a treatment plan.

*Triangulation* is the action of involving a third party in a dyadic situation. A common metaphor for this is the stability of a two-legged stool in comparison to a three-legged stool. When a dyad is feeling unstable or wobbly, the action of involving a third entity is an attempt to reduce the anxiety between or borne-of the dyadic interaction, just as the third leg of a stool would stabilize the structure (Bowen, 1978). It is important to note that triangulation is traditionally not seen as solely maladaptive, nor is it specific to low differentiation families. For example, new parents involving a grandparent in the care of an infant might be an example of healthy triangulation. However, for the purposes of this inquiry, triangulation will be construed as an unhealthy coping mechanism.

While this term has traditionally been applied to how a person triangulates, this study will focus on triangulation as a metaphor. That is, how a substance might be triangulated into a family or a partnership in order to relieve anxiety or tension (Prest & Protinsky, 1993).

In sum, using Bowen Family Systems Theory may help formulate thinking about addiction in families and may provide useful insight into the role of the rural family in opiate abuse. With this in mind, one point of investigation is whether rural families generally have lower differentiation than urban families. This study attempts to answer the following question: *Is the role that family plays in addiction different among those living in a rural setting than those living in an urban setting?* The aim of this study is to identify key differences in family mechanisms between rural and urban opiate dependence. Implications will focus on treatment recommendations.

## **CHAPTER II**

### **Literature Review**

The importance of the role of family while working with rural opiate addiction is an ill-addressed concept. While extant research varies in population and study type, there is little literature addressing the challenges specific to rural substance dependence itself. Therefore, the scope of this literature review includes research that focuses on rural substance abuse, as well as work that highlights the changing landscape of addiction more generally. Four specific themes will be presented: new trends in addiction, accessibility to opiates and treatment resources, the unique social structure of rural communities, and drawing comparisons between protective factors against substance use in urban communities with risk factors for substance abuse in rural ones.

#### **New Trends in Addiction**

As opioid-related death is on the rise in rural communities, the idea that opioid abuse is becoming a rural problem is starting to gain momentum (Paulozzi & Yongli, 2008). While opiate dependence once was common among the young, urban set, the modern-day opiate abuser is most likely older and living in a non-urban setting (Cicero et al., 2014). Indeed, the face of heroin dependence has changed drastically over the past 50 years (Cicero et al., 2014), perhaps explaining the lack of literature on the impact of opiate abuse on rural residents. This may also explain why current treatment models appear ineffective in abating opiate abuse as a rural epidemic (Centers for Disease Control and Prevention, 2015). The interaction of social and

environmental factors has been found to impact risk factors related to addiction (Cicero, Surratt, Inciardi, & Munoz, 2007). Therefore, it makes sense that opioid addiction and abuse varies based on location (Anderson & Henry, 1994; Dew et al., 2007; Keyes, Cerdá, Brady, Havens, & Galea, 2014). Research has shown that small communities outside of urban centers have higher rates of opioid prescription abuse than in more densely populated regions (Cicero et al., 2007), which may indicate the increased availability of opiates in rural areas and a lack of local resources geared towards the modern substance-dependent person (Blanco et al., 2007).

### **Accessibility**

An important theme in the literature is the limited availability of resources available to handle the onslaught of need caused by the growing trend in rural opioid abuse. Due to the increasing accessibility and exponential use of drugs in rural communities, rural locales could be justifiably deemed a risk factor for addiction (Dew et al., 2007; Havens, Young, & Havens, 2011). Interestingly, as rural communities are ill-equipped to support the growing community of opiate dependent residents, this deficiency may be born of denial and the related lack of funding (Blanco et al., 2007; Cicero et al., 2014; Havens et al., 2007; Sigmon, 2014). In fact, Schoeneberger and colleagues (2006) reported that the effects of a rural locale on addiction have been largely overlooked due to a longstanding belief that dependence is an urban disorder, and further noted that the documented increase in substance abuse in rural communities, coupled with this ignorance, may have resulted in poorly prepared communities. However, even if a rural community does have treatment programs or clinics, those in need may not be able to access it (Sigmon, 2014). The reason for this is that medication-assisted treatment, such as with Methadone or Suboxone, which are commonly used to treat opiate dependence, typically

requires either frequent, in-person visits to the clinic where medicines are dispensed, or visits from a clinician with special certifications to administer such treatment.

Depending on where a client is in their treatment (i.e., withdrawing, introduction, or maintenance), the required appointments may be multiple times a week (Dunlop et al., 2003). It is important to remember that rural communities are not outfitted with the same level of public transportation found in urban centers (Blanco et al., 2007). Similarly, *community* is a loose term; it may refer to a neighborhood, a few square miles, or an entire county. Therefore, it might not be unusual for a client to live an hour or more away from the nearest treatment facility. Clearly, these timelines and expectations require a great deal more coordination and access to resources in a rural community than they do in an urban one (Sigmon, 2014). Given that accessibility to treatment is a necessary consideration when attempting to combat rural addiction (Jackson & Shannon, 2012), it is important for clinicians to confront the reality of modern addiction and the communities that it affects.

### **Rural Family Structure**

The rural family is one of the aspects of pastoral life that has long been touted as a protective factor against substance abuse and dependence (Dew et al., 2007). However, as new knowledge related to the epistemology of addiction in rural communities is created, a number of rural factors thought to be protective for many people are now considered to be risk factors associated with addiction (Dew et al., 2007).

The research of Keyes and colleagues (2014) concluded that rural residents reported being closer to their communities more than urban dwellers did, either by social or familial ties. This research indicates that rural communities have residents who are highly invested in each other, and, therefore, to the community. Traditionally, a close-knit community has been seen as a



protective factor, breeding an air of security (Keyes et al., 2014). This idea has been based on the idea that the rural community promotes positive social influences, essentially buffering a person from substance abuse (Marsiglia et al., 2002). This feeling of safety, in many ways, is supported by the fact that rural personal networks are frequently based on kinship instead of friendship (Beggs et al., 1996).

Historically, researchers have believed that the more engaged and emotionally attuned a family is, the less likely it is for a person in that family to look to substances (Dew et al., 2007; Draus & Carlson, 2013; Keyes et al., 2014). This sentiment appears to be mirrored in the societal idealization of rural life, as the rural community has traditionally been seen as an extension of the nuclear family. As there are higher rural birth rates per capita, and thus larger kinship networks, there is some logic to this sentiment (Glasgow, 1988). In essence, the rural community has been portrayed as a safe place, partially due to the idea that neighbors are well acquainted with each other (Draus & Carlson, 2013).

Despite the positive associations made with rural living, these same factors lend some insight in to how the familial network in rural communities may spread addiction. If familial networks abuse substances, then such behavior may be deemed socially acceptable, thereby normalizing it (Draus & Carlson, 2013). This seems worthy of thought when considering both the practical and theoretical means by which to combat rural drug use (Dew et al., 2007). A close network may allow for substance abuse to occur via authorized prescriptions as family and friends are likely to be more amenable to sharing than non-kinship networks. Therefore, it follows that the strong social ties of a rural population permit a faster spread of substances than what typically occurs in urban areas, where family ties tend to be more diffuse or less likely to exist (Keyes et al., 2014). If rural communities are a constellation of familial networks, then

understanding this unique social structure is imperative when considering what treatment options will be most effective, simply using models based on the urban construct will not yield the best results (Draus & Carlson, 2006; Keyes et al., 2014).

### **Protective Factors or Risk Factors?**

Interestingly, research regarding urban substance abuse is rife with references to the importance of engaged parenting, and an actively involved extended family (Marsiglia et al., 2002), suggesting that the more involved a family is, the less likely family members are to abuse substances. Similarly, in an urban setting the strength of an individual's ties with their community is seen as an indicator of developmental health (Anderson, Sabatelli, & Kosutic, 2007). This indicates that close social ties in an urban community are not seen as a risk factor for substance abuse. Moreover, research suggests that urban residents are less likely to be involved in their communities, and this lack of connection is associated with poor health (Beaudoin, Wendel, & Drake, 2014). Again, this seems the complete opposite of what is purported to encourage rural substance use. However, it is important to note that urban social networks are more likely to be based on friendship rather than family (Beggs, et al., 1996).

In sum, there is evidence that opiate abuse is increasing at an alarming rate in rural communities, in part due to the unique role of the family in rural communities that has largely been overlooked by researchers to date. The increased presence of opiates, coupled with kinship networks, supports the idea that rural families may be a primary means for circulating drugs and normalizing abuse. Sadly, these communities are not equipped with the resources to handle the influx of need; and, unfortunately, current treatment offerings appear to be ill suited to the needs of rural opiate dependents. This is evidenced by the fact that rural opiate abuse is trending upwards and suggests that current programs lack efficacy. The discussed literature indicates that

this may be related to a lack of resources, and that programs currently may not be suited to evolving rural opiate abuse. In addition to a dearth of services, notable factors that may contribute to this risk include concerns around stigma and confidentiality in intimate communities (Havens et al., 2011; Sigmon, 2014). As noted previously, literature specific to opiate abuse in rural areas is sparse. This may be because the majority of the studies focus on urban communities with larger populations; or, perhaps, it is due to denial about the changing rural landscape and profile of substance abusers. Many opioid abuse studies minimize the role of location, which is worrisome and underscores the traditional urban-centric theories and viewpoints. This collection of literature outlined some of the differences between urban and rural addiction, and particularly the role of the family. Given these insights, and with the noted accessibility issues in mind, the need for further research into opiate abuse in rural areas appears merited.

## **CHAPTER III**

### **Methodology**

In an attempt to ascertain whether there are trends unique to rural families with opiate/opioid-dependent members, this study used a quantitative and inferential research model. The specific goal of this research was to measure whether the role of family is a significant factor in rural opiate dependence. This research focused on the question of how the role of family is different in rural and in urban populations in the treatment of opiate/opioid dependence.

#### **Research Design**

The current study uses Quantitative Methods. Data for the study was confidentially collected using a cross-sectional, nonrandomized, convenience sample. The current study was designed with the intention of exploring urban and rural clinicians' impressions of family functioning among their opiate/opioid-abusing clients; it is hoped this will, in turn, help social workers better understand and work with rural populations of opiate abusers. In an effort to reach a large and diverse participant pool and to maximize the effort for sample, the researcher used a self-administered online survey instrument.

#### **Sample**

The sample participants were 18 years or older, residing in the United States, working as a healthcare professional (e.g., clinical social worker, mental health counselor, nurse), and actively working with an opiate/opioid-dependent population. In order to elicit an appropriate sampling frame, clinician referrals were requested in both rural and urban communities across

the country. Inclusion criteria was defined as individuals who agreed to fill out the survey, and who were either themselves an active, licensed practitioner or who were under the direct supervision of a licensed practitioner.

**Sampling Techniques.** Nonprobability convenience sampling and snowball sampling were used to recruit participants. Data was collected via Survey Monkey, an online survey tool, from January 27, 2015 through April 6, 2015. Following approval from the Human Subjects Review Committee (HSRC) at Smith College School for Social Work (Appendix A), contact with different agencies that may have communication with the target population was established. Emails were sent out to Baystate Franklin Medical Center, Service Net, Clinical & Support Options and The Brien Center, all located in the western part of Massachusetts (Appendix B). These letters described the study and the selection criteria for participants. The researcher had an existing connection with Baystate Franklin Medical Center, having previously worked there.

Additionally, a message was posted on Facebook (Appendix C) asking the Facebook community if they, or anyone they knew, was a clinician working with an opiate/opioid-dependent clientele, and if so asking them to consider participating in the study. The message on Facebook was posted through the researcher's personal page and to an informal page associated with the Smith College MSW program. Both posts included the option for others to share the researcher's post so as to reach a larger audience.

### **Researcher Biases**

Prior to addressing the data collection methods it is important to discuss personal biases. The researcher has a large, rural family rife with substance dependence. This author is aware of this bias, and has depended on the thesis advisor to help hold her accountable and to think critically throughout the research process.

## **Data Collection Methods**

**Informed Consent Procedures.** Before participants began the questionnaire, they were provided with an informed consent letter (Appendix D). This letter explained the purpose of the current study, eligibility criteria, a description of the study procedures, any potential risks or discomforts, an explanation of benefits of the current study, confidentiality, payments, the right to refuse or withdraw from the study, and the right to ask questions. Participants were then able to electronically indicate whether or not they consented to participate in the study. They were asked to select either “I agree to participate” or “I do not agree to participate.” If participants did not agree, they were directed to a web page thanking them for their participation and encouraging them to directly contact the researcher should they have any questions. For those who agreed to participate in the study, when they hit the “next” button they were directed to the demographic data questions.

Participants were advised that they were taking the survey anonymously. Due to the anonymous nature of the study, there was no reasonable, foreseeable or expected risk to participants. The fact that some minor emotional distress related to thinking about clients, their families, or substance dependence might occur for clinicians who find this anxiety-producing was disclosed in the informed consent. Participants were informed that their decision to participate in the study was voluntary and that a refusal to take the survey would not affect their relationship with the researcher or Smith College. The informed consent stated that a decision to refuse would not result in any loss of benefits (including access to services) to which they were otherwise entitled. Participants were also notified that they did not have to answer any single question and could withdraw completely before completing the survey. Furthermore, it was noted that all data related to the survey was password-protected and not linked to an email

address or other personal identifiers, that there was no way to identify individuals who completed all or any part of the survey. Lastly, participants were advised that they could ask questions during or after the research, and were provided with contact information for both the researcher and the institution.

**Demographic Data.** The demographic questions were used with the hope of gathering specific information on participants, such as: zip code, age, sex, and race. (To see a full copy of the survey used for this study, see Appendix E.)

**Quantitative Data.** The purpose of this research study was to investigate how population density affects the role of family in opioid dependence. Urban and rural locations were derived from participant-provided zip codes, which were matched to categories within U.S. Census Bureau definitions. These include Urbanized areas (UAs) with 50,000 or more people; Urban Clusters (UCs) of at least 2,500 and less than 50,000 people; and “Rural,” which encompasses all population, housing, and territory not included within an urban area (U.S. Census Bureau, 2015). It is important to note that this study focused specifically on the differences between urbanized areas and rural areas, urban clusters were not taken into consideration.

After demographic data were collected, the participants were asked 10 questions about the role of the family among their opiate/opioid-dependent clients. All questions had the same four answer choices: “Rarely,” “Sometimes,” “Often,” and “I do not know.”

The following is an example of questions used: When working with your clients with an identified opioid/opiate dependence: How frequently is there another member of a client’s immediate family struggling with a current opiate/opioid dependence? How frequently is there another member of a client’s immediate family in recovery from opiate/opioid dependence? When thinking about your client’s access to opiate/opioids: How frequently do clients have a

legal opiate/opioid prescription? How frequently is there a member of the client's household with a legal opiate/opioid prescription? (See Appendix E for the full survey.)

### **Data Analysis**

Descriptive statistics were used to measure the sample in terms of geographic location, age, sex, and race. A Spearman's rank correlation coefficient (Spearman's rho) was used to measure the relationship between having a family member with legal access to opiates and abuse by others in the family, as well as the relationship between having a family member in recovery and abuse by others in the family. Fisher's Exact tests were used to compare the responses of rural and urban clinicians on the relationship between family and the addiction of their clients.



## CHAPTER IV

### Findings

#### Descriptive Statistics

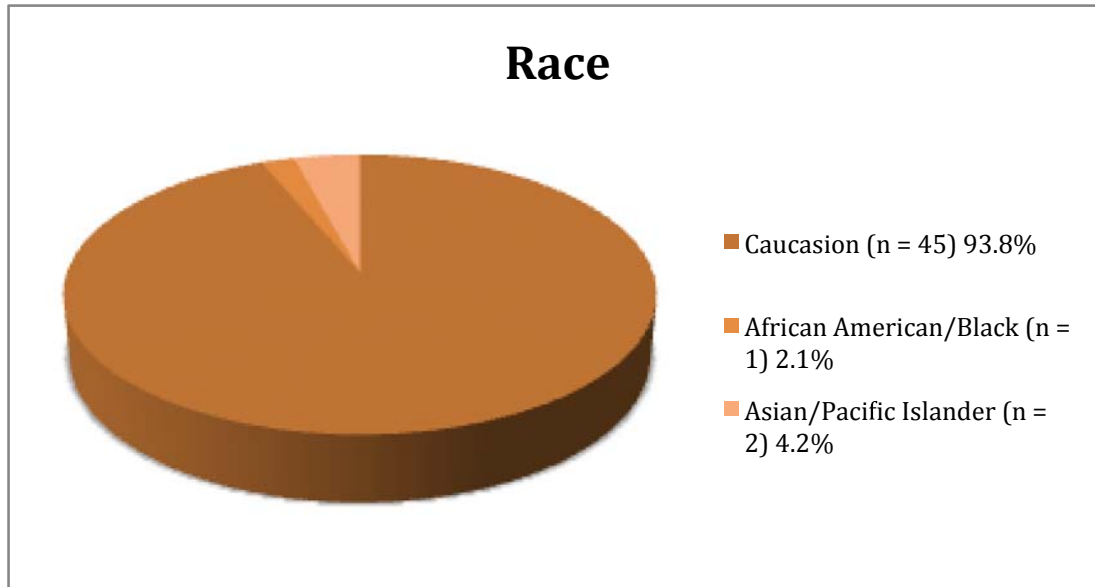
Of the 48 participants who completed the survey, approximately 40 percent ( $n = 20$ , 41.6%) indicated that they worked in an urban community. They were predominantly female ( $n = 34$ , 70.8%) and White ( $n = 45$ , 93.8%), although the age of the respondents varied widely, with a mean age of 44 ( $SD = 14$ ). See Table 1 and Figure 1 for demographics.

Table 1  
*Descriptive Characteristics of Sample*  
( $N = 48$ )

<b>Age</b>	<b><i>n</i></b>	<b>%</b>
18-34 years old	17	35.4
35-54 years old	15	31.3
55-74 years old	16	33.3
Total	48	100
<b>Zip code</b>	<b><i>n</i></b>	<b>%</b>
Urban	20	41.6
Rural	28	58.4
Total	48	100.0
<b>Gender Identity</b>	<b><i>n</i></b>	<b>%</b>
Female	34	70.8
Male	12	25
Other/Prefer Not to Answer	2	4.2
Total	48	100.0

\*None of the participants chose the “Female to Male Transgender,” “Male to Female Transgender,” or “Unsure” options.

**Figure 1. Racial and Ethnic Characteristics of Sample (N = 48)**



*\*None of the participants chose the “Native American/American Indian,” “Hispanic/Latino” or “Other” options.*

**Clients coping with dependence.** There were four questions under the heading: “When working with your adult clients with an identified opioid/opiate dependence.” The clinicians were asked about how often their opioid/opiate dependent clients had another member of a client’s immediate family struggling with current opiate/opioid dependence.

Table 2  
*How Frequently Is There Another Member of a Client’s Immediate Family Struggling With a Current Opiate/Opioid Dependence? (N = 48)*

	<i>n</i>	%
Rarely	8	16.7
Sometimes	25	52.1
Often	10	20.8
I do not know	2	4.2
Missing	3	6.3
Total	48	100

As seen in Table 2, more than 70% of the sample reported clients with family members with opiate/opioid dependence at least “sometimes” or “often.”

Similarly, nearly 70% responded “sometimes” or “often” when asked how frequently a member of their client’s immediate family is in recovery from opiate or opioid dependence (see Table 3), suggesting that opiate dependence may run in families.

Table 3  
*How Frequently Is There Another Member of a Client’s Immediate Family in Recovery From Opiate/Opioid Dependence? (N = 48)*

	<i>n</i>	%
Rarely	8	16.7
Sometimes	32	66.7
Often	1	2.1
I do not know	4	8.3
Missing	3	6.3
Total	48	100.0

Among clinicians there were few extremes regarding family members facilitating initial opiate abuse. Once again, as shown in Table 4, the category “sometimes” garnered the majority of answers with more than 43% of the total responses.

Table 4  
*How Frequently Is a Client’s Initial Opiate Abuse Experience Facilitated by a Family Member? (N = 48)*

	<i>n</i>	%
Rarely	11	22.9
Sometimes	21	43.8
Often	6	12.5
I do not know	6	12.5
Missing	4	8.3
Total	48	100.0

Similarly, fewer clinicians reported that families abuse opiates together. As seen in Table 5, fewer than 15% reported this to be the case “often”.

Table 5  
*In Families With Opiate/Opioid-Dependent Members,  
 How Frequently Do Family Members Abuse  
 Opiate/Opioids Together? (N = 48)*

	<i>n</i>	%
Rarely	12	25.0
Sometimes	21	43.8
Often	7	14.6
I do not know	5	10.4
Missing	3	6.3
Total	48	100.0

**A client’s access to opiates.** Under the heading: “When thinking about your adult clients’ access to opiate/opioids,” there were six questions ranging from initial facilitation to treatment.

The results from the first question are shown in Table 6, below. It is interesting that a client’s access to legal prescriptions generated little consensus among the clinicians, with three categories amassing percentages with a 3% difference. Also of note is that only one respondent marked “I do not know,” which may indicate that care providers generally have some insight as to what kind of access a client has to legal opioids.

Table 6  
*How Frequently Do Clients Have a Legal  
 Opiate/Opioid Prescription? (N = 48)*

	<i>n</i>	%
Rarely	15	31.3
Sometimes	16	33.3
Often	13	27.1
I do not know	1	2.1
Missing	3	6.3
Total	48	100.0

Clinicians were further divided regarding client’s being prescribed legal opioids. Table 7 shows that there was only a one-person difference between the “rarely” and “often” categories. As these two answers are the most polarized, it seems important to note the lack of consensus.

Table 7  
*How Frequently Is There a Member of the Client's Household With a Legal Opiate/Opioid Prescription?*  
*(N = 48)*

	<i>n</i>	<i>%</i>
Rarely	8	16.7
Sometimes	22	45.8
Often	9	18.8
I do not know	5	10.4
Missing	4	8.3
Total	48	100.0

Interestingly, the majority of clinicians acknowledged that legal opiates probably have some presence in their clients' homes. The combined responses "sometimes" and "often" totaled 66.9% of the responses, suggesting that it is likely that legal prescriptions are abused in homes with opioid-dependent members. However the "rarely" category accumulated 12.5% of the responses, perhaps suggesting some resistance to this notion and also perhaps speaking to a general lack of consensus (see Table 8).

Table 8  
*How Frequently Are Legal Opiate/Opioid Prescriptions Abused in Client's Household?*  
*(N = 48)*

	<i>n</i>	<i>%</i>
Rarely	6	12.5
Sometimes	19	39.6
Often	13	27.1
I do not know	6	12.5
Missing	4	8.3
Total	48	100.0

As seen in Table 9, below, clinicians overwhelmingly indicated "rarely" to the question about whether families are involved in treatment planning, with 47.9% providing this answer.

Table 9  
*How Frequently Are Family Members Involved in Treatment Planning for Opiate/Opioid-Dependent Clients (N = 48)*

	<i>n</i>	%
Rarely	23	47.9
Sometimes	13	27.1
Often	6	12.5
I do not know	1	2.1
Missing	5	10.4
Total	48	100.0

In questioning clinicians about whether they think that family members are detrimental to treatment planning, only 8.3% of respondents responded “often” (see Table 10). At first glance, these numbers seem to suggest that a client’s family is a positive element in treatment, as “rarely” and “sometimes” amassed 27.1% and 41.7% of the responses, respectively.

Table 10  
*How Frequently Do You Believe That Family Members Are a Detriment to the Treatment Planning Process of Your Opiate/Opioid-Dependent Clients? (N = 48)*

	<i>n</i>	%
Rarely	13	27.1
Sometimes	20	41.7
Often	4	8.3
I do not know	4	8.3
Missing	7	14.6
Total	48	100.0

The final questions of the survey queried clinicians about their impressions of family participation in treatment planning. Clinicians had some positive impressions of a family’s role in treatment planning, as the category “rarely” was second only to “sometimes” (see Table 11). This sentiment appears to be replicated in their impression of their client’s beliefs about this topic as well.

Again, as shown in Table 11, the majority of responses fell within the “sometimes” category, with 54.2% providing this response. These answers, coupled with the answers of the previous question, may suggest the families are generally seen as positive elements in treatment planning.

Table 11  
*How Frequently Do Clients Report That Family Members Are a Detriment to Their Treatment Planning Process for Opiate/Opioid Dependence? (N = 48)*

	<i>n</i>	%
Rarely	11	22.9
Sometimes	26	54.2
Often	2	4.2
I do not know	3	6.3
Missing	6	12.5
Total	48	100.0

## Analysis

**Family use of legal prescriptions.** A Spearman’s rank correlation coefficient (Spearman’s rho) was used to determine whether there was a relationship between having a family member with a legal prescription, and opiate abuse by another family member. The hypothesis was that, regardless of where one is from, if there is one member of a family struggling with dependence, it is likely that there is another member of the family with an active prescription. The results indicate that this hypothesis was supported (see Table 12).

Table 12  
*Family Use of Prescriptions*

HH prescription	legal	Correlation	1.000	.655***
		Coefficient		
		Sig. (2-tailed)		.000
		N	39	34
HH prescription abuse	legal	Correlation	.655**	1.000
		Coefficient		
		Sig. (2-tailed)	.000	
		N	34	38

\*\* Correlation is significant at the 0.001 level (2-tailed).

A Spearman's rho was also used to determine whether there is a relationship between having a family member in recovery from opiate dependence, and abuse by another family member. The hypothesis was that families with members in recovery are more likely to have members who are also struggling with current opiate dependence. Indeed, the results support this hypothesis, and with a high degree of statistical significance.

Table 13  
*Family in Recovery*

Fam current dependence	with	Correlation	1.000	.699***
		Coefficient		
		Sig. (2-tailed)		.000
		N	43	41
Fam recovery	in	Correlation	.699**	1.000
		Coefficient		
		Sig. (2-tailed)	.000	
		N	41	41

\*\* Correlation is significant at the 0.001 level (2-tailed).

### Urban and Rural Differences

Using zip codes provided by the respondents and the U.S. Census Bureau definition of rural and urban (U.S. Census Bureau, 2015), a series of analyses were conducted to determine if there was a difference in the role of family in urban and rural opiate abuse and treatment.



The hypothesis was that rural families are more likely to be deemed a detriment to treatment. However, the analysis seems to indicate otherwise, as rural clinicians reported 76.9% of the total “rarely” responses and 60% of the total “sometimes” responses.

Table 14  
*Clinician Believes Family to be Detrimental to Treatment Planning*

	RURAL_URBAN		Total
Rarely	10 76.9%	3 23.1%	13 100.0%
Sometimes	12 60.0%	8 40.0%	20 100.0%
Often	2 50.0%	2 50.0%	4 100.0%
Total	24 64.9%	13 35.1%	37 100.0%

*\*Cell counts were not large enough to determine statistical significance using a Fisher's Exact test*

Although there were not enough respondents to determine the significance of the findings using Fisher's Exact tests in any of the analyses comparing urban to rural clinicians the numbers suggest some differences, beginning with rural families perceived to be less of a detriment to treatment than their urban counterparts (see Table 14).

In considering the role of family in initial abuse of opioids, the hypothesis was that first abuse is more likely to be facilitated by family in rural communities than in urban settings.

Table 15  
*Initial Use Facilitated by Family Member*

	RURAL_URBAN		Total
Rarely	6 54.5%	5 45.5%	11 100.0%
Sometimes	13 61.9%	8 38.1%	21 100.0%
Often	4 66.7%	2 33.3%	6 100.0%
Total	23 60.5%	15 39.5%	38 100.0%

*\*Cell counts were not large enough to determine statistical significance using a Fisher's Exact test*

As seen in Table 15, there was variance in clinician responses based on location. While there was only minor difference in the number of those who responded “rarely,” 61.9% of those who reported “sometimes” were rural clinicians, as were 66.7% of those who reported often. This may suggest that initial abuse is more likely to be facilitated within the rural family than in the urban.

Lastly, it was hypothesized that there is a greater likelihood of rural families abusing opiates together than in urban communities.

Table 16  
*Family Abuse of Opiates*

	RURAL_URBAN		Total
Rarely	8 66.7%	4 33.3%	12 100.0%
Sometimes	13 61.9%	8 38.1%	21 100.0%
Often	4 57.1%	3 42.9%	7 100.0%
Total	25 62.5%	15 37.5%	40 100.0%

*\*Cell counts were not large enough to determine statistical significance using a Fisher's Exact test*

As shown in Table 16, there was little difference in the answers regarding family opiate abuse. While both rural and urban clinicians preferred the answers “sometimes” and “rarely,” 66.7% of those who chose latter category were rural clinicians. Again, while the difference in response is minute, it does appear that rural clinicians are less inclined to report that families abuse opiates together. This difference may be illustrative of family opiate abuse being more of a reported trend in urban communities.

## **CHAPTER V**

### **Discussion**

The primary goal of this research was to determine the role of family in opiate addiction. Indeed, the findings of this study demonstrate that the family matters. This research is consistent with existing literature regarding the interplay of family and addiction (Draus & Carlson, 2006) and lends further insight via the perspective of the clinician. The second aim of this research was to determine whether there are differences in the roles of rural families compared to urban families. Specifically, this study investigated whether urban and rural families differ in how they facilitate the treatment and dependence of opiate addiction. While the findings were not statistically significant, the results suggested that there are some differences between the roles of rural and urban families among opiate dependent clients.

This study supports the hypothesis that a family's relationship with opiates is an important factor, both in understanding the origin of the addiction, and in continued dependence. Awareness of family culture is pertinent when attempting effective treatment, as findings from this study suggest that families can both provide the logistics of accessing opiates and a culture supportive of their use.

That almost half of the survey participants reported family members sometimes facilitate initial abuse is intriguing. If a family member indoctrinates a client into opiate dependence, then attempting treatment may be akin to combating family culture. Drawing upon Bowen Family Systems Theory, it is important to remember that an individual is a reflection of their family's

health, and a client's struggle with opiates may be a window into their family life. Results regarding initial abuse reflect this concept, and might suggest that it is important to be mindful that opiate use may be an aspect of the family ethos. If attempting treatment is tantamount to combating the values of a client's family and friends, this is likely a far more daunting task than simply treating the person and assuming their dependence is born of their singular experiences. Not only are the practical aspects of treatment, such as how to prevent access to opiates, complicated, but also the treatment of physical dependence may be worsened if the client emotionally relates opiate use to their family.

The study also showed that clinicians believe that the families of their clients tend to abuse opiates together. Although this may seem counterintuitive to many, and contradicts the work of researchers who have found family to be a protective factor against substance abuse (Marsiglia et al., 2002), these findings reinforce the work of previous researchers who have found that family can be instrumental to developing an addiction (Dew et al., 2007). From this, it is clear that, when assessing a client with an opiate dependence, use among other family members should be explored. If a clinician is only treating the person struggling with dependence and not paying heed to the larger cultural conditions (i.e., the family), then it seems possible that a client's chances for relapse would be increased if there is access and abuse in the home.

This study also found that there seems to be a difference between the role of rural and urban families in opiate addiction, as there was marked dissimilarity in the themes reported by rural and urban clients. Although not statistically significant, trends in the data reveal that clinicians in rural communities were more likely than urban clinicians to report that their clients' family members facilitated initial opiate abuse, were more likely to have family members with

opiate prescriptions, and more likely to have family members in recovery from opiate dependence. These findings support the research of others who found that understanding the unique aspects of the rural social structure is imperative to understanding rural addiction (Draus & Carlson, 2006; Keyes et al., 2014). These researchers found that rural communities are often comprised of groupings of extended families, and have suggested that emphasis should be placed on understanding a rural client's family.

While this study did not explicitly investigate familial structures in rural communities, the findings seem to support the importance of understanding the role of the family in a small community. Results suggested that family is a factor in both addiction and treatment. Although urban clinicians also noted that the role of family is a factor, it was to a lesser extent than rural clinicians. Perhaps the most salient example of this is that clinicians reported rural families are both likely to be involved in treatment and that their clients seem to find this helpful. This contradicted my hypothesis, as I believed that rural families would be seen as a detriment to treatment both by the clients and the clinicians. Initially, I believed this contradiction to have been born of my own personal bias. While this may be true, I think this assumption was also related to the idea that those who use illicit substances might be hesitant to engage in situations that highlight the socially taboo nature of their lifestyle. Ostensibly, I am suggesting that treatment planning and opiate dependence counseling could be viewed as tantamount to leveling judgment on the opiate dependent lifestyle. Further assuming, that any family members who agree to be involved in a client's treatment, do so with reservation, resulting in them acting as an obstacle to care. An alternative explanation is that clinicians hold fast to the idea that involving family is always beneficial, and despite possible evidence to the contrary, they have difficulty reporting them as a hindrance.

## **Limitations**

One of the limitations of this study was the small, homogenous sample. The subjects in this study were overwhelmingly female, White, and living in the Northeast. Future research might attempt a similar study on a larger scale, perhaps broadening the geographical region, so as to make the data more generalizable. Similarly, garnering insight from a more diverse ethnic and gender pool may also help in expanding the generalizability of data.

Another limitation of this study is that information was gathered from clinicians and not active opiate abusers. Ideally, those who are struggling with opioid dependence would take a similar survey themselves. Doing so would eliminate clinician bias, as clients will certainly have more insight into their family dynamics than a third party.

## **Research Implications**

The role of family in opiate abuse appears to merit further study. Even with the small number of participants in this study, distinct differences seemed to surface. As the trend in rural opiate abuse shows no evidence of abating, this type of inquiry may be invaluable for those designing programming and treatment.

This study has illustrated the means by which opiates can be disseminated in rural communities, via the family. Remembering that the literature shows that a rural community is often comprised of smaller, extended family systems, this technique of dissemination may reflect a social problem that is far-reaching in rural communities. However, as this study has not investigated the relationship between population density and the point at which the family influence starts to wane, future research could focus on this. Ideally, this type of inquiry would establish if there is a population density point at which a client's friends replace the family as the

significant risk factor in developing an addiction. This line of research could be helpful in further teasing apart social influences, which might inform clinical work. A good example of this would be determining the population density at which family therapy is a necessary staple in comprehensive opiate dependence treatment.

Another research implication highlighted by this study is that urban and rural clients appear to be influenced differently by their families. As noted in the literature review, urban families are seen as a protective factor against substance dependence, while rural families are quickly being seen as a risk factor. Attempting to further specify the factors that facilitate as much could prove to be an interesting research topic, as it may help in determining if there are ways that clinicians or communities could mitigate the risk. In theory, the varied influence may be the result of the differences in how social and family structures may vary based on location. While meriting more research, these differences should be taken into consideration, as this type of insight may illuminate the social aspects of these communities that should be targeted when attempting to thwart opioid addiction.

### **Clinical Implications**

The most important implication of this research is reinforcement of the idea that clinicians need to understand their clients' relationships with their families, especially when working with rural populations. With this in mind, it appears that Bowen Family Systems Theory may be useful in conceptualizing the means by which to best support those struggling with opiate dependence. At the very least, the Bowenian concepts regarding a person's role in their family, and general interaction with family members, should be considered when thinking about how to combat rural access and dependency. For example, determining whether an individual's opiate use is born of an unhealthy family system, one that is highly enmeshed and has triangulated an



opiate, resulting in rampant family substance dependence can shed some light as to how emotionally ingrained the addiction is. Simply put, effective opiate dependence treatment requires some insight as to the emotional aspects of the addiction, and this theory could be instrumental in as much.

In an enmeshed family, substance abuse can easily spread within the family, as the family is highly engaged and entrenched in their own personal, family culture. This is of course reminiscent of the work of Anderson and Henry (1994) and their ideas about the bonded family. The authors defined a “bonded family” as a combination of three factors: emotional attunement between family members, the ability to act as an integrated family unit, and the manner and degree to which the unit interacts with outsiders. Their research found that families who are highly bonded tend to be too heavily involved in each other’s lives, such as a parent’s involvement in the life of the child.

The fact that clinicians answered “I do not know” to questions with some frequency may be indicative of some oversight, or at the very least an underestimation, of the importance of a client’s family. Those working with opiate/opioid dependent population might want to consider how tight knit or expansive a client’s family may be in smaller communities. This assertion is based on a pivotal difference between urban and rural communities, that being the intensity of social personal networks. This is particularly notable in the context of prevention and treatment, as it speaks to how the rural scope may need to include community implementation. Clinicians who work with a rural clientele may have to consider how to support a client who is entrenched in a social scene comprised of family, and who may be amenable to opiate use.

Thinking about the implications of this research, treating a person without some insight as to where they live, and their social and familial climate, may result in less effective treatment.

For example, the fact that a client may be living with someone who has legal or illegal access to opiates may merit addressing when drafting a treatment or discharge plan. Similarly, it might be important to have knowledge of the community or family member that may have facilitated initial abuse, and whether or not the client is still immersed in that group. While treatment should be focused on the individual, this research seems to speak to the dire importance of understanding the broader client – their family. In general, it speaks to how necessary it is to learn a great deal about a client’s history and family, both current and remote.

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## Appendix A: Human Subjects Review Committee Approval Letter



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**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

March 4, 2015

Elizabeth Slowinski

Dear Elizabeth,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Adam Brown, Research Advisor

## **Appendix B: Recruitment Email Script**

Hello!

Are you over 18? Are you a healthcare professional residing in the United States? Do you work with adult clients struggling with a current or remote history of opiate/opioid abuse? If so, you could help me with my Master's Thesis!

It is a brief 5-10 minute survey exploring the trends in families with opiate/opioid dependent members.

Please help me collect as many responses as possible by taking my survey and sending it to other adults working in your field: <https://www.surveymonkey.com/s/opioidfamily>

Thank you,  
Elizabeth Slowinski



## **Appendix C: Recruitment Posting on Facebook**

Hey... So you know how I am writing a thesis. No? Okay, well I am. It is the current bane of my existence.

Are you a licensed healthcare professional residing in the United States (or an intern being supervised by someone who is licensed)? Do you work with adult clients struggling with a current or remote history of opiate/opioid abuse? If so, you could help advance scientific research in your field by helping me with my Master's Thesis!

Please complete a brief, 5-10 minute, survey aimed at exploring trends among families with opiate/opioid dependent members. When you're done, please send the link to the survey to your colleagues working in the field:

<https://www.surveymonkey.com/s/opioidfamily>

Thank you,  
Elizabeth Slowinski

## Appendix D: Informed Consent Form

### Introduction

- You are being asked to be in a research study of trends in families with an opiate/opioid dependent family member.
- You were selected as a possible participant because you are a healthcare professional presently working with adults with a current or recent history of opiate/opioid dependence, are living in the United States, and are at least 18 years old.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

### Purpose of Study

- The purpose of the study is to identify trends in rural families with an opiate/opioid dependent family member(s).
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

### Description of the Study Procedures

- If you agree to be in this study, you will be asked to answer general questions about your clients and their families. The study is anonymous and will take you approximately five to ten minutes.

### Risks/Discomforts of Being in this Study

- There are no reasonable foreseeable or expected risks. Some minor emotional distress may occur if the thinking about your clients, their families or substance dependence is anxiety provoking.

### Benefits of Being in the Study

- If you would like a summary of the study results, you may sign up to receive as much by emailing this researcher at [eslowinski@smith.edu](mailto:eslowinski@smith.edu) with RESULTS as the subject line of the email.
- Understanding the unique trends of rural families may help social workers better support and design treatment plans for individuals coping with opiate dependence in low density populations. This insight may also speak to state and national policy changes social workers can advocate for.

### Confidentiality

- This study is anonymous. We will not be collecting or retaining any information about your identity.

### Payments/gift

- You will not receive any financial payment for your participation.

### Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely. If you choose to withdraw, only the responses that you entered will be collected for this study. To withdraw before you have completed the study you can just navigate away from the Survey Monkey site. Only the information you have provided up until that point will be retained. This study will only utilize fully completed surveys to allow for participants who decide to withdraw part way through to not have their responses included. Partially completed survey data will be kept on the password protected account of this researcher as an anonymous survey. Survey monkey does not link participants to any email addresses, accounts or other identifiers so there will be no way to identify individuals who completed all or any part of the survey.

### **Right to Ask Questions and Report Concerns**

• You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Elizabeth Slowinski at [eslowinski@smith.edu](mailto:eslowinski@smith.edu). If you would like a summary of the study results, you may sign up to receive as much by emailing this researcher at [eslowinski@smith.edu](mailto:eslowinski@smith.edu) with RESULTS as the subject line of the email. If you have any concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

### **\* Consent**

• **Selecting “I agree” below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. Please print a copy of this page for your records.**

I agree

I disagree

Appendix E: Online Survey Instrument

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**\* Are you 18 years of age or older?**

- Yes
- No

**\* Are you currently licensed to provide mental health/behavioral health services in your state? If not, are you currently supervised directly by someone who is licensed to provide mental health services in your state?**

- Yes
- No

**\* What is the ZIP code of where you work? (enter 5-digit ZIP code; for example, 00544 or 94305)**

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**How old are you?**

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65-74 years old
- 75 years or older

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**What is your gender identity?**

- Female
- Male
- Female to Male Transgender
- Male to Female Transgender
- Unsure
- Other (please specify)

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***What is your ethnicity origin (or Race)?***

- White
- Hispanic or Latino
- Black or African American
- Native American or American Indian
- Asian / Pacific Islander
- Other (please specify)

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When working with your adult clients with an identified opioid/opiate dependence:

***How frequently is there another member of a client's immediate family struggling with a current opiate/opioid dependence?***

- Rarely
- Sometimes
- Often
- I do not know

***How frequently is there another member of a client's immediate family in recovery from opiate/opioid dependence?***

- Rarely
- Sometimes
- Often
- I do not know

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***How frequently is a client's initial opiate abuse experience facilitated by a family member?***

- Rarely
- Sometimes
- Often
- I do not know

***In families with opiate/opioid dependent members, how frequently do family members abuse opiate/opioids together?***

- Rarely
- Sometimes
- Often
- I do not know

When thinking about your adult clients' access to opiate/opioids:

***How frequently do clients have a legal opiate/opioid prescription?***

- Rarely
- Sometimes
- Often
- I do not know

***How frequently is there a member of the client's household with a legal opiate/opioid prescription?***

- Rarely
- Sometimes
- Often
- I do not know

***How frequently are legal opiate/opioid prescriptions abused in the client's household?***

- Rarely
- Sometimes
- Often
- I do not know

***How frequently are family members involved in treatment planning for opiate/opioid dependent clients?***

- Rarely
- Sometimes
- Often
- I do not know

***How frequently do you believe that family members are a detriment to the treatment planning process of your opiate/opioid dependent clients?***

- Rarely
- Sometimes
- Often
- I do not know

***How frequently do clients report that family members are a detriment to their treatment planning process for opiate/opioid dependence?***

- Rarely
- Sometimes
- Often
- I do not know

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Thank you for taking the time to participate in my survey. If you would like a summary of the study results, you may sign up to receive as much by emailing this researcher at [eslowinski@smith.edu](mailto:eslowinski@smith.edu) with RESULTS as the subject line of the email. If you have any questions or concerns please do not hesitate to contact me at: [eslowinski@smith.edu](mailto:eslowinski@smith.edu). Have a great day!