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Family Emotional Support and Outcomes for People with Opioid Use Disorder: A Systematic Review

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ABSTRACT

Millions of people worldwide live with opioid use disorder (OUD). Family members of people living with OUD may decide to provide or deny emotional support, and these choices have important implications for the well-being of individuals with OUD. This study investigated the impact of family emotional support, or lack thereof, on people' s ability to reduce their drug use and pursue sobriety. This study uses systematic review, a method that allows for the systematic collection of articles about a particular topic, even when they have diverse disciplinary backgrounds and methodologies. Eighteen studies about the impact of emotional support from family members on drug use reduction were identified from MEDLINE and Sociology Abstracts primarily, as well as Directory of Open Access Journals, ProQuest Social Sciences, and Toxicology Abstracts. These articles were then synthesized into four outcome categories: treatment adherence and retention, sobriety and abstinence, treatment seeking, and recovery. Across the studies, family emotional support was generally beneficial for reducing drug use, although people living with OUD sometimes grappled with complex feelings of guilt or pressure in their supportive interactions with family members. Strengths, limitations, and future directions for studies about family emotional support in the context of OUD are discussed.

Keywords: Emotional Support, Family Communication, Opioid Use Disorder, Sobriety, Systematic Review.

INTRODUCTION

Opioid use disorder (OUD) and its personal and relational outcomes have become increasingly dire in the United States and around the world. This condition affects over 16 million people worldwide, and opioid overdoses occur at a higher rate than any other type of drug overdose (Dydyk et al., 2022; Ritchie & Roser, 2022). OUD can be very taxing on the personal relationships of people living with this disease. Drug use can prompt a host of relational issues, and even well-meaning family members can sometimes fail to provide adequate support to loved ones with OUD (Fals-Stewart, n.d.). For example, family members may be accepting and supportive to the extent that they become permissive of drug use. At the other extreme, they might stigmatize their loved one due to lack of knowledge or misconceptions about OUD, leaving them without a support system (Crowley & Miller, 2020; Zhou et al., 2017b). Navigating family issues related to OUD may be particularly difficult when the person living with the disorder is an adult, as their family does not have the same power over or responsibilities to that individual as they would to a child. When the person with OUD is a minor, family members can use their legal authority to intervene in drug use. When the person with OUD is an adult, however, family members must rely more heavily on interpersonal processes such as support provision and conflict management to influence outcomes for a person with OUD. Because of the chronic, relapsing nature of OUD, people must incorporate emotional support into their toolkit for helping adult family members with OUD.

Emotional support is verbal or nonverbal behavior that attempts to make someone feel better when they are perceived as being upset or in need (MacGeorge, Feng, & Burleson, 2011). Quality emotional support validates the

recipient's emotions and helps facilitate coping (MacGeorge et al., 2011). Received emotional support is support that individuals actually report getting from family members, whereas perceived emotional support is an individual's assessment of the support their network could provide if they needed it (Cohen, 2004). There is some evidence that perceived support is more beneficial than received support, as hypothetical support may be less threatening to one's autonomy or competence (Cohen, 2004). Especially for stigmatized conditions such as OUD, perceived support could help reduce this threat to autonomy and support the self-esteem of people living with this condition. Although receiving support can be more complicated, received emotional support is also overwhelmingly positive for people's well-being (MacGeorge et al., 2011). Emotionally supportive exchanges are particularly important in health contexts, and they can foster disease management and self-care while reducing disease-related distress (MacGeorge et al., 2011). The role of emotional support in the context of a chronic, stigmatized illness is generally positive, albeit complicated.

The goal of this systematic review is to examine how received and perceived emotional support from family members can promote or inhibit the sobriety of adults with OUD, their treatment seeking and adherence, and the recovery process overall. This systematic review has two specific aims: (a) to clarify how support can best function for people living with OUD and (b) to elaborate how this knowledge can empower family members to support their loved ones through this illness. As such, this review provides a comprehensive understanding of the tensions of family support for people living with OUD and begins the work of clarifying them. Clarifying lingering questions about family support in the context of OUD provides a basis for future researchers to conduct more detailed study of particular supportive interactions. The sections that follow are used to expand upon the intersection between support, stigma, and OUD and explain the systematic review search strategy and inclusion criteria. A summary of findings and contributions to the literature, as well as strengths, limitations, and future directions, follow.

INTEGRATING OUD, STIGMA, AND SUPPORT

The stigmatized nature of OUD can make getting support particularly challenging. Misinformation and suspicion about people living with OUD abound, and many people associate OUD with low morality. This stigma can make it even more difficult for people living with OUD to get support, thus making emotional support a highly contentious topic in this literature. This section outlines the intersections between stigma and support that make OUD particularly difficult in relationships.

Stigma in the OUD Context

OUD is a highly stigmatized condition. A stigma is a mark of disgrace or social disapproval associated with a certain quality or circumstance, such as living with OUD (Smith, 2007). People living with OUD face stigma, discrimination, and negative stereotypes in the media, from healthcare professionals, and even from their own loved ones (Kresovich, 2023; Skaggs, Bell, Scutchfield, & Robinson, 2023). People who experience stigma often internalize it, and this internalization can be a significant barrier to care and support (Cheetham, Picco, Barnett, Lubman, & Nielsen, 2022). Fear of being stigmatized often keeps people from participating in lifesaving harm reduction measures such as carrying naloxone or participating in syringe exchanges (Cheetham et al., 2022). Internalized stigma can also harm long-term recovery efforts, particularly if people's guilt or shame about OUD fosters a sense of being irredeemable or unable to change (Snoek, McGeer, Brandenburg, & Kennett, 2021). Stigma is a major barrier to accessing lifesaving care for people living with OUD.

Stigma is also damaging to the interpersonal relationships of people living with OUD, particularly support seeking. People living with OUD often keep their condition a secret and choose not to reach out when they need help (Schuler & Seney, 2024). Often, they might desire to reach out to their loved ones for help but feel too ashamed to do so, perhaps struggling to accept others' support. This shame and stigma can result in poor coping (Schuler & Seney, 2024). Misconceptions and myths about OUD are also quite common, including the belief that people living with OUD lack willpower or morality (Chen, 2017). Highly stigmatizing language about people who use opioids is an issue in healthcare and interpersonal contexts. Labels such as "junkie" or "clean versus dirty" reinforce the negative stereotype that opioid use is an immoral choice (National Institute on Drug Abuse, 2021). Thus, people who choose to reach out for help or support may be met with rejection by people who do not understand their condition and—knowingly or unknowingly—reinforce stigma. OUD is not only a devastating and deadly illness, but it also has unfortunately dire social consequences.

Support in the OUD Context

Receiving emotional support is generally beneficial, but it is not uncommon for someone living with OUD to suffer from a lack of support, also known as a support gap. Support gaps are discrepancies between desired and received support (Crowley & High, 2020). Although this discrepancy can go in either direction, people are more likely to experience a deficit of emotional support, given its numerous benefits for well-being (Crowley & High, 2020). Some research has examined potential support providers' reasons for not providing support to a loved one. Potential support providers of cancer patients noted that they sometimes chose not to provide emotional support because they felt that the person did not deserve support (Ray, Manusov, & McLaren, 2019). Many cancers are decidedly less stigmatized and misunderstood than OUD, so the feeling that someone is an undeserving support recipient may be far greater in this context. Additionally, OUD is a chronic, relapsing disease which many people mistakenly believe to be the result of low willpower. People may come to believe that a loved one's relapse is a sign that their support was ineffective, thus making them less willing to provide support in the future (Johnson, 2024). Potential support providers may be unwilling to emotionally support someone living with OUD, thus resulting in challenges with emotional support.

Communication is incredibly consequential in the context of OUD. Emotional support, although it is generally beneficial, can be complicated, and these complications become even more severe when someone is living with a stigmatized disorder such as OUD. At the same time, people living with OUD and their loved ones must navigate these types of interactions every day, and their consequences can be dire. Resolving these tensions is crucial to the study of communication because, at present, researchers lack a clear framework for understanding mixed findings about support in the context of OUD. Thus, it becomes important to identify and synthesize otherwise-disparate research about this topic. The following section outlines systematic review as a method for accomplishing these goals.

METHODOLOGY

Systematic review involves gathering published research on a specific topic using specific inclusion criteria (Khan, Kunz, Kleijnen, & Antes, 2003). This method allows for review of research about the same topic when there is variation in conceptual and methodological choices. In the case of this paper, family emotional support was defined broadly. Some studies gave participants the freedom to define "family" and "emotional support." All studies included in this review are about close, often related loved ones providing support that attempts to comfort and uplift individuals living with OUD, but the measures vary. The papers included in this review are both qualitative and quantitative, thus, this method ensures that large-scale survey studies and small-sample interview studies can be in conversation with each other. Systematic review allows for review of a breadth of related studies that might not otherwise have been considered as a group.

Systematic review involves an iterative process of identifying literature on the same topic (Khan et al., 2003). Initially, specific search terms are used to identify all of the studies on a topic. Then titles and abstracts are then examined to exclude off-topic papers that were returned by the initial search. At this point, it is also appropriate to create additional search terms from topics that appear frequently in titles and abstracts. Once papers that are irrelevant to the topic are excluded, additional inclusion and exclusion criteria are created. These criteria may include considerations like age of the sample (i.e., studies of children vs adults), specific measures, year the paper was published, and more. Inclusion and exclusion criteria aid the authors in selecting only the most relevant papers, to ensure that the most comprehensive and conceptually-related literature is used (Pati & Lorusso, 2018). Once inclusion and exclusion are complete, the remaining papers are used in the systematic review.

The Current Study

In this paper, the library database of a large public university in the Northeast was used to search for relevant literature. This database is comprised of relevant subject-specific databases in psychological, relationship, and health literature. The vast majority of articles reviewed in this study came from MEDLINE and Sociology Abstracts (many articles were housed on both), followed by Directory of Open Access Journals (DOAJ), ProQuest Social Sciences, and Toxicology Abstracts. Only articles from the last ten years (2012-2022) were included, because the climate surrounding OUD has changed and accelerated so much in the recent past, and it is important to synthesize articles that reflect the current challenges presented by opioids. The literature search occurred in fall of 2022. Various search terms were identified to capture the multitude of ways in which researchers examine emotional support, OUD, and family relationships.

Search terms for emotional support from family were social support, family, and family support. Emotional support returned no additional studies when used as a search term. Given the focus on OUD, the search terms

opioid use disorder, opioid dependence, and drug use were also used. The term "drug use" was used because some studies examined multiple substance use disorders; these studies are only reviewed here if they specifically reported results about OUD. To capture the myriad drug use outcomes that individuals might experience, the search terms treatment adherence, sobriety, abstinence, recovery, and opioid use reduction were also used. In selecting these search terms, the goal was to include any outcome that was common in the overall literature, which was achieved by inspecting the titles and abstracts of studies that were returned by initial searches. The use of these search terms resulted in 238 articles published between 2012 and 2022.

From these 238 studies, titles and abstracts were examined to exclude irrelevant articles, such as articles that were about social networks, and studies that did not have outcomes about opioids or opioid use disorder. Importantly, studies were not excluded based on participants' current or past treatment experiences. OUD is a chronic condition that has some of the highest relapse rates of any substance use disorder. As many as 91% of people in recovery from opioid use will experience relapse at some point (American Addiction Centers, 2024). Thus, many people might experience cycles of active addiction, early recovery, and long-term recovery. To capture the full range of experiences had by people living with OUD, no study was excluded due to its sample's prior recovery status.

After excluding the studies based on the above criteria, there were 107 remaining studies. To be included in the final review, studies had to (a) report results about adults' perceived or received emotional support from family members, (b) include results about behaviors that are intended to reduce drug use, and (c) be a quantitative or qualitative empirical study (i.e. not a review paper). No study was excluded based on their definition of family emotional support. Some authors extensively described who might be considered a family member, while others were more open and let the participants define family for themselves. This process resulted in 18 total studies included in this systematic review. Details of the literature search are available in **Figure 1**.

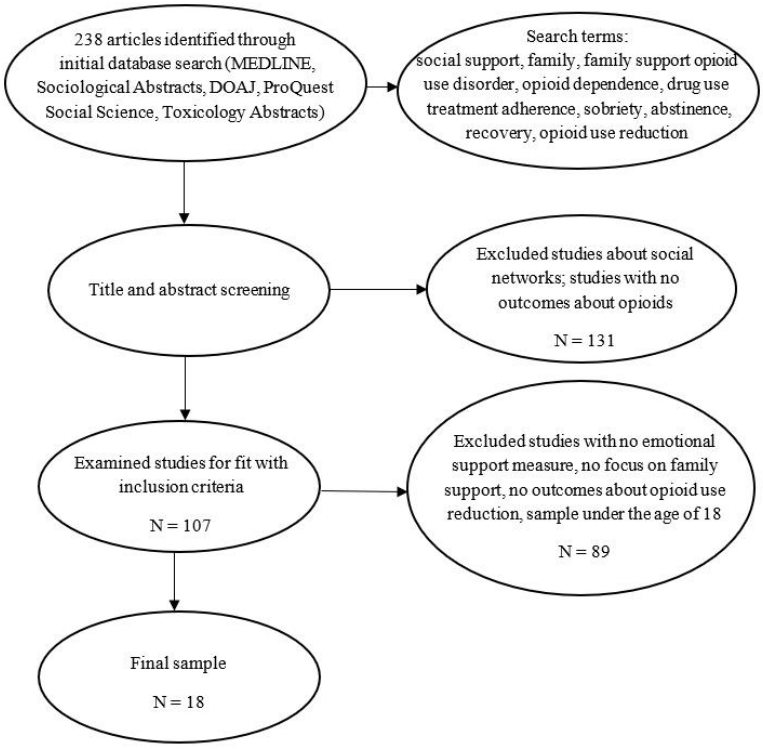

Figure 1. The PRISMA Diagram

Data Preparation

The studies included in this review were coded by the opioid use reduction behavior that was used as the primary outcome variable in the study. The outcome themes were allowed to emerge naturally from the sample of articles, rather than being pre-set. Studies were coded by the author, and codes were assigned by reading the paper to identify the primary outcome variable measured in the study. No study was associated with more than one category. The process of coding the studies may have been subject to the author's personal biases in identifying the main outcome variables. An effort was made to be as objective as possible by allowing the

categories to emerge from the sample of studies, rather than creating categories a priori and attempting to fit the studies into them.

Seven articles fell into the sobriety and abstinence category, which examined the role of family emotional support in maintaining abstinence and preventing relapse. These studies emphasize that emotional support from family in sobriety can be complicated and is not always positive for people living with OUD. Six articles covered the role of family support in treatment adherence and remaining involved in one's treatment process. Studies about treatment adherence and retention generally find that social support is a protective factor for remaining in treatment, whereas lacking social support increases risk of dropping out. Two studies included in this review were about the role of family support in treatment seeking, either for the first time or after a relapse. They emphasize that the line between family emotional support and family pressure can be blurry when an individual is considering treatment for OUD. Three articles were about recovery, which was informed by participants' experiences in recovery and may include treatment seeking and adherence, maintaining sobriety, and healing family relationships. Studies about recovery highlight the importance of family emotional support as people make choices that will best help them recover from OUD. These four categories helped examine and synthesize the major themes of research on family emotional support in OUD. **Table 1** provides a summary of article information.

Table 1. Study Characteristics

Study	Sample	Country	Study Design	Findings	Outcome
Aghakhani et al., 2017	16 men on MMT	Iran	Qualitative interview analysis	Poor family support is extremely detrimental to well-being.	Recovery
Akdağ et al., 2018	145 males receiving outpatient OUD treatment	Turkey	Cross-sectional survey	Emotional support is beneficial for treatment adherence.	Treatment adherence
Amini-Rarani et al., 2020	155 men receiving treatment	Iran	Qualitative interview analysis	Family is a major motivator in seeking treatment.	Treatment seeking
Bleasdale et al., 2022	31 women in opioid intervention court	USA	Qualitative interview analysis	Family emotional support enhances treatment adherence.	Treatment adherence
Brown et al., 2022	44 patients with HIV receiving OUD treatment; 30 family members of patients	Vietnam	Qualitative interview analysis	"Being there" is a type of family support.	Treatment adherence
Cavaiola et al., 2015	151 people in a methadone treatment program	USA	Cross-sectional survey	Perceived emotional support predicts HQoL.	Sobriety/ abstinence
Cleveland et al., 2020	47 women who relapsed or overdosed non-fatally during maternal period; 27 family members of women fatally overdosed during maternal period	USA	Mixed methods study including focus groups and interviews	Support deficits make relapse more common.	Sobriety/ abstinence
Cooper et al., 2018	108 pharmaceutical-opioid dependent people in treatment	USA	Prospective cohort study using phone interviews	Unsanctioned opioid use is associated with lower support.	Sobriety/ abstinence
Crowley & Miller, 2020	41 opioid dependent individuals	USA	Qualitative interview analysis	Family impedes recovery by implicitly approving of drug use.	Recovery
Goldberg et al., 2019	15 women in drug treatment court	USA	Qualitative secondary analysis of intervention data	Family provision of emotional support hinges on sobriety.	Sobriety/ abstinence
Hiller et al., 2013	47 female sex workers who inject drugs	Mexico	Qualitative interview analysis	Support sometimes elicits mixed results, including encouraging drug use.	Recovery

Study	Sample	Country	Study Design	Findings	Outcome
Lin et al., 2013	368 IV heroin users on MMT	Taiwan	Over-time analysis of MMT retention	People who receive more support have lower MMT dropout rates	Treatment adherence
Liu et al., 2018	427 people who use heroin	China	Analysis of heroin users' outcomes and comparison with meth users	Perceived family support is non-significant for people who use heroin.	Sobriety/ abstinence
Makarenko et al., 2017	855 opioid dependent people who inject drugs	Ukraine	Analysis of a sub-sample of a nationwide survey	Family support increases willingness to pay for continued opioid agonist treatment.	Treatment seeking
Shourie & Singh, 2018	200 opioid dependent men (100 abstinent, 100 relapsed)	India	Comparison of abstinent and relapsed samples	Family support is non-significant.	Sobriety/ abstinence
Tomori et al., 2014	43 males who inject drugs and recently left compulsory treatment	Vietnam	Qualitative analysis of interviews	Family expects participants to be able to adhere to advice about their substance use.	Sobriety/ abstinence
Zhou et al., 2017a	1,212 people receiving MMT	China	Prospective survey	People with less perceived support have worse treatment retention.	Treatment adherence
Zhou et al., 2017b	1,212 people receiving MMT	China	Cross-sectional survey	Higher perceived and received support are associated with higher HQoL.	Treatment adherence

Note. HQoL = health-related quality of life; MMT = methadone maintenance therapy; maternal period = during pregnancy and year following birth; meth, or methamphetamine, is not an opioid; Zhou et al., 2017a and 2017b use the same sample and different outcome measures.

FINDINGS AND ANALYSIS

Of the 18 studies included in this paper, 8 used qualitative methods, 9 used quantitative methods, and 1 used mixed methods (i.e., both quantitative and qualitative data). All of the qualitative studies used interview data. Of the quantitative studies, one was a natural experiment between a sample of individuals who had experienced relapse and individuals who had remained abstinent. A majority of the studies reviewed in this paper were conducted in the United States, but other countries were also represented: 3 studies were conducted in China, 2 two studies each were conducted in Vietnam and Iran; and one study each was conducted in Turkey, Mexico, Taiwan, Ukraine, and India. The sample sizes ranged from 15 to 1,212. As described previously, the articles included in this study were categorized based on four themes—treatment adherence and retention, sobriety and abstinence, seeking and entering treatment, and recovery. Findings for each theme are outlined in the following paragraphs. Key findings for each theme can be found in **Table 2**.

Treatment Adherence and Retention

Studies about treatment adherence and retention included findings about both perceived and received emotional support. Both support types were broadly beneficial, but received emotional support is not without some relational difficulties. Participants expressed the importance of "being there" through the recovery process, but also sometimes struggled with their family relationships, perhaps as a result of misconceptions and stigma about OUD. This section outlines the benefits—and difficulties—of perceived and received emotional support in treatment adherence and retention.

Perceived Emotional Support

Perceived emotional support from family is generally effective at helping individuals adhere to treatment procedures. Perceived family support is associated with greater treatment adherence in three studies, including two longitudinal studies that emphasize the importance of perceived emotional support over time (Akdağ et al.,

2018; Lin et al., 2013; Zhou, Li, Wei, Li, & Zhuang, 2017a). Zhou et al. (2017a) find that participants who report less perceived support also have a lower likelihood of retention in methadone maintenance therapy (MMT). Inversely, Lin et al. (2013) find that individuals with higher perceived family support had a lower rate of MMT dropout. It is important to note that retention rates in MMT are not particularly high overall. More than 40% of Zhou et al.'s (2017a) participants had terminated treatment by the time of the authors' followup, while Lin et al. (2013) found that approximately 60% and 68% of participants had terminated treatment by the 12 and 18 month followups, respectively. The authors of both papers assert that these dropout rates are in line with other research. In such a precarious and challenging situation, individuals need all of the supports they can get, including perceived family support. These studies provide evidence for the effectiveness of emotional support from family, even when it is not actually enacted.

Received Emotional Support

Simultaneously examining perceived and received support provides additional insight into the impact of emotional support. Perceived and received social support are positively correlated, and both types of support are associated with higher health-related quality of life (HQoL), which is a factor in treatment adherence (Zhou et al., 2017b). Although perceived and received support are both generally beneficial for participants in this study, Zhou et al. (2017b) also emphasize the challenges of family emotional support. Specifically, around 30% of the sample reported a poor family relationship. The authors speculate that this high proportion of strained relationships could be caused by stigma or family misunderstanding of OUD and its treatment options (Zhou et al. 2017b). Thus, this study provides evidence of the benefits of perceived and received support, as well as some of the difficulties of navigating relationships when living with OUD. Although good family support is beneficial for well-being and treatment adherence, family relationships are often strained when an individual is living with OUD.

Two qualitative interview studies provide additional nuance to quantitative findings about family emotional support. One woman involved in a drug court program emphasized that family emotional support enhanced her treatment adherence by supporting her autonomy as she works to better her life (Bleasdale et al., 2022). She also states that her mother is her best friend and is very supportive of her efforts to be "clean" (Bleasdale et al., 2022). Several other women in this study emphasized that instrumental support, such as money, housing, or rides, was more important to their treatment journey, but this woman felt that her mother's emotional support truly helped her keep going. Another study included both people receiving treatment for OUD and their family members (Brown et al., 2022). Participants in this study felt that their families were a major motivator in treatment, such as one participant, who emphasized that he was in treatment because he did not want to see his son grow up without a paternal figure. In this way, it is simply his son's presence that motivates him to adhere to his treatment. The family members involved in this study also echo the importance of "being there," with one mother mentioning the importance of being a confidante for her daughter's struggles during treatment. Qualitative interview studies further emphasize the importance of supportive family relationships in promoting treatment adherence.

The articles reviewed in this section provide convincing evidence for the importance of family emotional support in people's treatment adherence. Specifically, family support aids in adherence while a lack of family support is detrimental to it. Individuals' appreciation of their family's support is evident in the interview studies, especially in the finding that simply being there is a form of emotional support. Unfortunately, even with all of the benefits of family emotional support, it is relatively common for people living with OUD to have strained family relationships. In as difficult a process as OUD treatment, family emotional support is an important factor impacting treatment adherence.

Sobriety and Abstinence

The findings for the impact of emotional support from family on sobriety are mixed. One study compared perceived support between two groups, one which had experienced relapse and one which had maintained their sobriety (Shourie & Singh, 2018). Overall, perceived social support was significantly higher for individuals who had remained sober. Family support specifically, however, was not significantly different between the two groups, thus suggesting that it has little impact on maintaining sobriety. In another study of people who use heroin, perceived family support had no impact on individuals' abstinence intentions (Liu, Wang, Chui, & Cao, 2018). The authors emphasized their surprise at this finding and speculate that people's families are potentially ambivalent toward their loved ones' heroin use, which might make their support seem trivial to people who are considering abstaining from opioids. In contrast, in one study on perceived social support, family members were perceived as the most frequent social support providers (Cavaiola, Fulmer, & Stout, 2015). In this study, perceived emotional support from family significantly predicted HQoL, a well-known factor in abstinence, as well as predicting abstinence itself (Cavaiola et al. 2015). Another study finds that receiving less emotional support from family members is associated with unsanctioned opioid use (Cooper, Campbell, Larance, Murnion, & Nielsen, 2018). Taken together, these studies show that more research on the complexities of family support in sobriety is needed.

Three qualitative interview studies offer insight into the nuances of personal experiences with receiving family support for sobriety. A woman participating in a drug court program discussed that her mother's emotional supportiveness hinged on her sobriety (Goldberg, Chin, Alio, Williams, & Morse, 2019). Her mother never supported her when she was using drugs, she says, but supports her now that she's "clean" (Goldberg et al., 2019). She goes on to emphasize how good it feels to receive that support. On the other hand, women participating in Cleveland, McGlothen - Bell, and Recto's (2020) study discuss the difficulties of support deficits. Lack of emotional support contributed to relapse and even overdose for some of the individuals in this study. This sentiment is echoed by a participant in another study, who stated that his family members are disappointed that he has not taken their advice and remained sober, and thus are beginning to limit their relationship with him (Tomori et al., 2014). OUD is a chronic, relapsing condition which makes it nearly impossible to stop using drugs without treatment and support. If family members are not aware of the severity of the condition, their advice might be a sort of misguided attempt at support. Importantly, Tomori et al. (2014) point out that families do tend to provide support and care for loved ones who relapse, even when their relationship is strained. These interview studies unpack some of the tensions that come with supporting a loved one through sobriety and the possibility of relapse.

The associations between family emotional support and sobriety are complex. In some studies, family support is not significantly impactful, whereas in others, it promotes sustained sobriety. The qualitative interview studies in this section emphasize that family support in sobriety is often associated with relational strain. While family support in sobriety is generally positive or neutral, there are relational difficulties associated with it, especially when the risk of overdose is high.

Seeking and Entering Treatment

People often seek treatment for OUD under challenging circumstances, such as participants in Makarenko et al. (2017). The Ukranian government committed to supporting opioid agonist treatment (OAT) for 21,000 people who inject drugs (PWID) living in Ukraine. When the funding plan fell through, the government had to go back on their commitment, leaving them able to support only one-third of the original number of patients. Thus, the authors of this paper sampled 855 PWID who had various levels of experience with OAT and assessed them on various factors, including willingness to seek OAT even if it meant they would have to pay for it. Among people who had previously been involved in OAT, family support was positively associated with willingness to pay (Makarenko et al., 2017). Family support was not significant for those who were currently using or had never used OAT. Although the authors do not discuss this finding extensively, it is possible that people who had prior success using OAT saw their family members' satisfaction with their outcomes and therefore would participate in it again if necessary. The family members of people who were currently using or had never used OAT might not have had such strong feelings about their loved ones' choices. Even when such challenging choices must be made, family support is not an insignificant factor in them.

Another study exemplifies the tension between support and pressure. One participant cited his wife's encouragement in making the decision to enter treatment, stating that she asked him to "come down to earth for another while" and spend some time considering treatment as an option (Amini-Rarani, Khedmati Morasae, Pashaei, & Moeeni, 2020, p. 4). This participant goes on to state that entering treatment was a great decision and one for which he gives his wife credit. On the other hand, pressure and even threats sometimes motivate a participant to seek treatment, including one whose wife threatened to divorce him if he did not enter treatment. Although both of these are examples of entering treatment due to family influence, the well-being outcomes cannot be overlooked. Prior sections of this review have established the importance of good quality, supportive relationships in continuing sobriety. Thus, although pressure and threats may work in the short term, people seeking treatment may lack long-term support and fulfilling relationships.

These studies both provide evidence that family relationships are a factor in entering treatment, although these relationships are not always supportive. While a person may be motivated to enter treatment by the risk of losing their family relationships, this lack of supportiveness is likely detrimental to the long-term quality of the relationship as well as the individual's sense of autonomy. On the other hand, when people do have support from their family members, they are able to make difficult decisions such as paying for their own OAT. Although entering treatment is one step in recovery, it is important that it occurs on people's own terms and without damaging their emotional and relational well-being.

Recovery

Hiller, Syvertsen, Lozada, and Ojeda (2013) interviewed Mexican women who do sex work and identified three types of support they receive from their family members: positive, negative, and problematic. Positive emotional support includes the supportiveness the women felt when family members visited them during residential treatment. These visits were especially impactful when the women felt guilty about their past behavior,

including Diana, whose family told her they did not hold a grudge even though she had stolen from them in the past (Hiller et al., 2013). Negative emotional support was a more complicated experience for women involved in this study. Family members sometimes held women back from reaching their goal, often by encouraging drug use or using drugs themselves. Some participants mentioned that family members even perceived using drugs together as a form of emotional support. Similarly, problematic support occurred when women felt guilty about receiving positive emotional support, even to the extent of isolating themselves to prevent "self-humiliation" (Hiller et al., 2013). Navigating family relationships in recovery from OUD is often challenging, even when family members are involved and well-meaning.

Participants in other studies echo the challenges of accepting support when it is offered, as well as lacking support when it is needed. One participant in Crowley and Miller (2020) discusssed the inter-generational cycle of drug use, stating that her father is not very supportive of her recovery attempts and even ignores her continued drug use. On the other hand, another participant in this study says that her mom is the most supportive person in her life and encourages her that one day she will overcome her condition. Family members also express emotional support by "being there" and going to recovery meetings with their loved one. In another study, Iranian men living with OUD discuss how truly devastating it can be to lose family support (Aghakhani, Lopez, & Cleary, 2017). One participant stated that his family blamed him for his struggle with OUD, causing him to lose self-confidence and fail to move forward in his recovery. Another participant emphasized that he desperately wanted family support, but that "everybody prefers our death and believes that any kindness for us is wasting time and money" (Aghakhani et al., 2017, p. 695). Participants also mention that they did not understand the severity of their decision to begin using opioids and wished they had someone to guide them away from that choice. These studies demonstrate the range of support outcomes in recovery, from feeling that a family member is a best friend and a staunch supporter, to having such little support that one cannot even successfully complete their recovery.

Although the studies included in this section understand recovery in a more general sense, they add nuance and depth to understanding the role of family emotional support in recovery. Aghakhani et al. (2017) demonstrate just how devastating it can be to lose family support, while Crowley and Miller (2020) and Hiller et al. (2013) emphasize the difficulties of receiving emotional support that may be well-intended but inappropriate. Although it is incredibly difficult when family has no experience with OUD, it can also be incredibly frustrating to have family members who encourage drug use or even use drugs themselves. People living with OUD must manage their loved ones' varying levels of understanding of and sympathy for their condition, which sometimes makes the recovery process even more difficult.

Table 2. Key Review Findings

	Key Findings
Treatment Adherence/Retention	Family emotional support is positive for treatment adherence and retention outcomes, and a lack of family support is negative for them. Even "being there" is a form of support.
Sobriety/Abstinence	Findings for family emotional support are mixed, and in some cases, its effect on sobriety and abstinence is non-significant. Family members sometimes withdraw support after after repeated attempts at sobriety or relapse.
Treatment Seeking	Family relationships are a predictor of seeking and entering treatment, but these relationships are not always supportive. Some participants report entering treatment out of a fear that they will otherwise lose their family relationships.
Recovery	Emotional support from family members might be well-intended, but that does not necessarily make it easy. Participants report sometimes carrying guilt about their behavior during active addiction. Being permissive of substance use is not supportive.

DISCUSSION

This systematic review examined how emotional support from family members impacts reductions in opioid use for people living with OUD. Eighteen studies were reviewed in this paper—6 that considered treatment adherence, 7 that considered sobriety/abstinence, 2 that considered treatment seeking, and 3 that considered recovery. Across these studies, emotional support from family was generally positive or neutral for these outcomes. It also enhanced other predictors of opioid use reduction behaviors, such as HQoL and intention to pursue abstinence. Individuals with OUD emphasized the importance of "being there" as an act of emotional support and often found support in family members attending meetings with them, visiting them in residential treatment

facilities, or holding them accountable.

Challenges in family emotional support were detrimental for both recovery goals and emotional well-being. Loss of a support system was an unfortunately common experience for people living with OUD. The articles cited various reasons that individuals with this condition may experience strained relationships, including stigmatization and marginalization, family frustration with their drug usage, and wrongs they committed against their family while in active addiction (Aghakhani et al., 2017; Hiller et al., 2013; Zhou et al., 2017b). Clearly, it is the case that some family members withhold emotional support because they believe someone with OUD to be an undeserving support recipient. This withholding of support can amplify the negative outcomes of OUD, especially when the family members who are often someone's closest and most reliable support system have abandoned them. Despite the relational challenges of family emotional support, some research indicated that families stood by their loved ones even when they felt frustrated with their drug use (Hiller et al., 2013; Tomori et al., 2014). This staunch support might be particularly impactful in the context of OUD, given the shame and stigma that many people living with this condition internalize. Providing emotional support, even in the form of "being there" through frustrations, was one of the most important things a family member could do for their loved one.

The importance of family emotional support was not without caveats. Some studies in this review found non-significant results for emotional support. It is possible that instrumental support such as money, shelter, or other forms of practical assistance might have been a higher priority for people trying to make this major life change. Support gaps, if people living with OUD had them, might have taken the form of a deficiency in tangible support, and emotional support needs may only have become apparent once an individual achieved a sense of safety and security. Additionally, even well-meaning attempts at emotional support could be difficult and unpleasant. People may have felt guilty for their past behaviors during active addiction, or they might have had poor family relationships as a result of their condition (Hiller et al., 2013; Zhou et al., 2017b). Some family members were also overly permissive and did not hold their loved ones accountable, even when that is what they wanted (Crowley & Miller, 2020). The articles reviewed in this paper suggest that people living with OUD must simultaneously manage their condition and interpersonal tensions, which can place additional strain on people who are already in a marginalized position. Although family emotional support appeared generally positive, frustrations and misunderstandings were not uncommon.

Contribution to the Literature

This systematic review provides a conceptual framework for understanding and resolving some of the tensions of family emotional support in the context of OUD. Specifically, by reviewing literature across diverse samples, methodologies, and countries, this review clarifies some of the discrepant outcomes of family emotional support. This review makes particularly clear the importance of understanding the nature of OUD in order to give appropriate support. It also clarifies what qualifies as good support in the context of OUD and identifies common pitfalls across studies. This review provides a nuanced framework to help future researchers understand what effective family support looks like in the context of OUD.

Tensions in Supportive Interactions

One particularly important takeaway from the literature reviewed here is the importance of being steadfast in support of a loved one living with OUD, even when it is difficult. Given the chronic, relapsing nature of OUD, several studies included in this review report that support providers become frustrated with their loved ones over time (e.g., Aghakhani et al., 2017; Goldberg et al., 2016; Tomori et al., 2014). This frustration is often due to the sense that a person with OUD is not heeding their family members' advice to seek treatment and pursue sobriety. Some family members also retain hard feelings about the way their loved one behaved during active addiction. As a result, some frustrated family members might leave their loved one to cope with OUD on their own, mistakenly assuming that they will finally seek treatment so long as they hit rock bottom. Hitting rock bottom is understood as experiencing a painful, perhaps irreversible loss such as being cut off from family members, being arrested, or experiencing a serious health crisis due to drug use (Anderson, 2024). Although rock bottom can be the experience that finally motivates people to seek treatment for their substance use disorder, it is not universally effective, and it can have numerous, profoundly negative outcomes. Regardless, the articles reviewed here reflect common frustrations faced by people who might determine that the best course of action is to leave their loved one to manage their OUD alone.

Importantly, rock bottom is not a prerequisite nor a necessity for recovery, and efforts to change people's attitudes toward the necessity of hitting rock bottom persist (Becker, 2024). This review supports the idea that turning away from a loved one struggling with OUD is not a recovery-supportive behavior. Numerous participants across studies acknowledged that their struggle with addiction had, at times, made their relationships with family difficult. These participants almost universally expressed immense gratitude toward their family for standing by them, or intense pain at feeling as though they had lost their loved ones due to their struggles with addiction (e.g.,

Aghakhani et al., 2017; Bleasdale et al., 2022; Hiller et al., 2013; Tomori et al., 2014). Efforts to educate family members about OUD as a cyclical disease with high rates of relapse—rather than a moral failing—might promote more empathy and enhance family members' ability to manage their frustrations. Future research should explore the best ways to strengthen this strong supportive base, perhaps by helping family members manage the tension of being frustrated by their loved one's condition while still being available as a supportive resource. As such, this review emphasizes the importance of consistent, reliable support, even when tensions or negative emotions are high.

This review emphasizes striking a balance between being there for a loved one struggling with OUD and holding them accountable in recovery. Accountability can be interpersonally difficult for people in recovery and their loved ones. In particular, a person in recovery might feel that they will open themselves up to their family's judgment if they drop out of treatment or relapse (United Recovery Project, 2024). Holding a loved one accountable in a supportive, constructive manner can be a vulnerable interaction, and people may feel that it is easier to avoid this interaction altogether. Several studies included in this review, however, make it clear that permissive support is not supportive, and that accountability is appreciated (Cavaiola et al. 2015; Crowley & Miller, 2020; Hiller et al., 2013). In fact, lacking accountability often means lacking a true support system, which can be particularly isolating during the difficult recovery process. The genetic nature of substance use disorders made accountability even more difficult for some study participants, particularly ones whose family members also misused opioids (Hatoum et al., 2023). Naturally, these family relationships became challenging when one person was trying to recover while the other was actively using drugs (Golden Gate Recovery, n.d.). It is understandable that permissiveness might feel easier than holding loved ones accountable, but articles included in this review suggest that supportiveness includes having these difficult conversations.

Implications for Family Communication

This review offers a framework for understanding which behaviors are considered truly supportive to recovery efforts and which behaviors might be well-intentioned but ineffective. For example, families might be so supportive that they actually end up adopting a permissive attitude toward their loved one's drug use, even when that person has made it clear that they want to stop using drugs. On the other hand, families may feel that they must allow their loved one to reach some sort of "rock bottom" in which they have no support system, thus totally abandoning them during a very difficult time in their life. These tensions are represented by other research about relational tensions, also known as relational dialectics. One study about mental illness in families found that participants reported feelings of anger and frustration because they loved their mentally ill family member, but also felt that the mental illness held them back from getting close to them, and that trying to be closer to them might even further harm their relationship (Sporer & Toller, 2017). It is clear that families' ability to navigate these relational dialectics is both crucial for personal and relational well-being and also very difficult. This review, however, helps identify the range of supportive versus unsupportive behavior in the context of OUD. Future research should use the information included in this review to identify specific communication strategies for managing these challenging interactions.

This systematic review examines the associations between received and perceived emotional support from family members and opioid use reduction. Four major themes were identified in the literature, and mixed findings were synthesized. Specifically, this review provides an overview of the tensions people experience as a result of family emotional support in the context of OUD, as well as providing suggestions for future research to further clarify these tensions. Across opioid use reduction outcomes, study participants generally express gratitude for family support and pain at having lost supportive family members. They also make it clear that support is not passive, but rather an active process of accountability. This review can serve as a basis for exploring what particular communication behaviors most effective during supportive interactions in the context of OUD.

CONCLUSION

Existing research about the role of family support in opioid use reduction offers valuable knowledge about the tensions that come with family relationships in this context. Gaps, weaknesses, and important future directions, however, are worthy of discussion. The scope of this review means that the role of culture in these studies was not considered. The studies included in this review also present some inevitable limitations, including self-selection issues. One particularly notable gap in existing literature is the absence of generalized well-being and quality of life outcome measures, which stands in opposition to the tenets of harm reduction. This section identifies some gaps and limitations in research about family emotional support in the context of OUD.

Strengths and Limitations

One of this review's strengths is that it represents studies from a variety of countries. There was not room in this paper, however, to examine the variation in attitudes toward OUD in various parts of the world. Culture plays an important role in stigma toward and perceptions of people living with OUD. For example, some research suggests that mental health issues are particularly strongly associated with shame in Asian cultures (Cigna Healthcare, 2020). In addition, a large-scale review of perceptions toward drug use in Central and Eastern Europe and Central Asia suggests that there is a significant "moral panic" surrounding drugs in these countries. Particularly, drug use in this part of the world is sometimes associated with foreign, Western behavior and is believed to stand in particular opposition to the religious and cultural values of local communities (Stuikyte, 2021). In the United States, the history of opioid use suggests that institutional discrimination toward people living with OUD is rooted in racist and classist ideologies, particularly discrimination against poor, immigrant communities struggling with addiction (Fine, Herzberg, & Wakeman, 2020). Although some stereotypes about people living with OUD—such as the idea that they are immoral—are pervasive globally, the particular social and political context of different countries impacts exactly how stigma is communicated and enacted. As such, this review passes over a particularly important element of the social context surrounding OUD.

As often occurs in participants living with a stigmatized condition, selection issues in individual studies pose a threat to the validity of this review. It is possible that individuals who choose to participate in studies about family emotional support might have very high or very low levels of it. Specifically, people who have felt that their family's support was absolutely integral to their recovery process might feel particularly enthusiastic about participating in a study about family emotional support. On the other hand, people whose families have cut off contact with them due to their addiction might also feel that family emotional support has had a particularly important role in their recovery—albeit for the worse—and feel compelled to participate in a study. For people with moderate levels of support, family emotional support might not be a topic they spend as much time thinking about. As such, the studies involved in this review may only represent the extremes of experiences with family emotional support.

One particularly notable gap in the literature is a focus on opioid use reduction or cessation, rather than generalized well-being outcomes. As mentioned throughout this paper, it is good practice to allow individuals with OUD to recover on their own terms and in their own time. This principle is one of the tenets of harm reduction (SAMHSA, 2022). This review has attempted to emphasize that the decision to reduce one's drug use is a personal one, not a moral one, and that the holistic well-being of people with OUD is paramount. In a review of the wider body of literature on family and OUD, however, most articles focus on some sort of opioid use reduction outcome. These outcomes tend to be more common in research than general health, well-being, or satisfaction outcomes. In order to acknowledge the importance of autonomy in making the very personal decision to reduce one's opioid use, future research should privilege individual well-being at the same level that it privileges reductions in opioid use. The personal and multifaceted nature of health decisions should not be disregarded in literature on OUD.

Directions for Future Research

The strengths and limitations of this review provide future directions for communication researchers. Specifically, balancing the tension between accountability and supportiveness might become easier if family members of people living with OUD had more guidance about the types of messages and behaviors that are perceived as supportive in this context. Communication researchers can use this review as a basis for future studies that examine skills for supportive interactions, which can in turn be used to provide communication skills training to families supporting a loved one with OUD.

This review has established that some people are well-meaning but misinformed about supporting loved ones with OUD. Communication researchers can further clarify this finding by studying specific messages and behaviors in supportive interactions. Holding a family member accountable in their recovery while remaining nonjudgmental requires skillful handling of both conflict management and supportive communication. This combination of support and accountability can be particularly difficult, perhaps taking the form of tough love. Future research can use this review as a starting point to examine exactly how "tough" these messages can become before they are perceived as judgmental and unsupportive. Many families might find it easier to avoid these difficult interactions altogether, which might result in unintentional isolation of their loved one. Communication researchers can explore various skills for overcoming communication anxieties in order to approach loves ones for difficult conversations. Studying strategies for successfully navigating difficult conversations is a potentially fruitful future path for communication researchers.

Research about best practices for these difficult conversations can also be used to provide communication skills training for family members supporting a loved one with OUD. Teaching skills such as approaching a loved one for a difficult conversation, deescalating interpersonal tension, or providing emotional validation without

being overly permissive could greatly improve family outcomes. Skills training would also allow researchers to have contact with and receive feedback from the people who are impacted by this research. This feedback could provide an opportunity to further clarify findings about supportive interactions for families supporting a loved one with OUD. Communication skills training is an important potential path for researchers hoping to improve the outcomes of people living with OUD and their families.

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