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HEALTHY FAMILY BOUNDARIES TRAINING PACKAGE FOR LIVING WITH A LOVED ONE WITH SUBSTANCE USE DISORDER IN THE TÜRKİYE CONTEXT

SUPPORTING FAMILIES OF PERSONS TRYING TO GET RID OF DRUG ADDICTION

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Healthy Family Boundaries Training Package for Living with a Loved One with Substance Use Disorder in the Türkiye Context

Substance Use Disorder (SUD) in a household is exactly where "boundaries" stop being a nice idea and become a **non-negotiable requirement** for safety, sustainability, and a realistic path to treatment. When a family doesn't set boundaries "with good intentions," three predictable things usually happen: (i) the family buffers the consequences of use, (ii) the family burns out and conflict becomes chronic, and (iii) treatment motivation weakens. This package was built to break that cycle: it provides family members with boundary language that is both compassionate and firm; an age-adapted approach (adolescent vs. adult); what to do in a crisis; evidence-based practical tools; and accessible support channels in Türkiye. The fact that **ALO 191** operates 24/7 and can guide ambivalent individuals toward treatment using **Motivational Interviewing** is a major advantage families in Türkiye can use directly as a "first contact" point.

The backbone of this material is the family-adapted, practical application of four evidence-based approaches: (1) family-based therapies (especially for adolescents), (2) Cognitive Behavioral Therapy (CBT) and relapse-prevention skills, (3) Motivational Interviewing (MI) communication style, (4) boundaries/hierarchy in family systems (especially the logic of structural family therapy). Comprehensive guidelines exist showing that family involvement can improve treatment entry, retention, and outcomes; however, they also clearly emphasize that in situations like violence/abuse risk or withdrawal, joint sessions may not be appropriate.

This package includes four formats: (i) a short training brochure (about 1–2 pages), (ii) a longer guide (about 10–15 pages in "dense summary" form), (iii) a 5-slide presentation outline, (iv) practice appendices: case examples, exercises, role-play scenarios, communication sentence templates, crisis steps + a table of contact numbers, and a Mermaid flowchart. The content is suitable for print and digital distribution (short, modular, copy-ready templates).

Evidence-based framework and the Türkiye context

Boundary work in families is often confused with "making rules." A rule tries to control the other person (often producing bargaining and threats). A boundary answers: **"What will I do / not do?"**—and its implementation is under your control. Family systems approaches describe how boundaries between subsystems (parent–child, etc.) regulate communication and behavior, and how in addiction these boundaries often blur (e.g., the parent role shifts to the child). That's why boundary work is fundamentally about **rebuilding the family order**.

Motivational Interviewing (MI) was developed to work with ambivalence (very common in addiction). It is empathy-based and aims to "evoke intrinsic motivation rather than crush with authority." One of MI's core messages is: motivation is not a fixed personality trait; it's a dynamic process shaped by relational interactions. Empathy and collaboration are more functional than power and authority. In Türkiye, ALO 191 stating that it supports people who are

ambivalent about quitting substances via motivational interviewing makes it practically meaningful for families to learn and use a similar communication style at home.

On the CBT side, there's a strong body of findings: meta-analyses report that in adults with alcohol or substance use disorders, CBT can provide small-to-moderate benefits in controlled studies; effects may be more noticeable in early follow-up; and CBT is not always superior to other specific effective methods (meaning it isn't the single "one true" approach). For families, this translates into a simple takeaway: stop hunting for a "magic sentence" at home—consistently practice the skills that work (trigger analysis, coping, problem-solving, relapse planning).

In family therapy / couples therapy, two distinctions matter. For adolescents, family-based approaches (MDFT, BSFT, FFT, MST, etc.) can reduce substance use and co-occurring problems and may be advantageous in keeping difficult adolescents and families engaged in treatment. For adults, meta-analyses and clinical studies on behavioral couples therapy suggest it can outperform individual approaches in some cases on both substance outcomes and relationship adjustment.

This material draws a hard safety line: if there is violence in the intimate relationship, joint couple/family sessions are generally not recommended; safety planning comes first. Guidelines also emphasize that in situations with abuse risk, vulnerable individuals such as children/older adults should not be included in family sessions. In Türkiye, the existence of channels such as 112, ALO 183, KADES, the Gelincik Line, and the legal framework of Law No. 6284 makes it easier for families to know where to go during a crisis.

Confidentiality and mandatory reporting has two parts. First, personal health data is considered "sensitive" and is subject to stricter rules for protection and processing. Second, in the Turkish Penal Code there are provisions about failing to report an ongoing crime or one whose consequences could still be limited; there is also a specific article imposing a reporting obligation on health professionals who detect signs of a crime during duty. This package is not legal advice—but it clearly states that in topics like child safety, severe violence threats, sexual abuse, and life-threatening emergencies, professional/institutional help should not be delayed.

Training brochure

Title: Healthy Family Boundaries While Living With a Loved One With Substance Use Disorder
Target audience: Parents, spouse/partner, children (adolescent/adult), extended family members
Purpose: Increase safety, stop the "enabling" cycle, clarify the path to treatment, reduce family burnout.

What is a boundary, and why is it essential?

A boundary is not about "changing them," but about clarifying **your own behavior and the rules of your home**. Addiction disrupts roles and boundaries in the family: a child can become parentified, a spouse can slide into police/rescuer roles, extended family can pressure "just manage it." If that disruption continues, the family system stops functioning; conflict grows and the person with addiction can continue without facing real consequences.

The one-minute reality: what you can and cannot do

You cannot control the person's use on your own. But you can control: money flow in the home, in-home safety, protection of children, whether there is use in the home, who stays/doesn't stay at home, the tone and frequency of communication, and which institution you will call in a crisis. That difference is the core of boundary work.

The line between "support" and "enabling"

Support: Make treatment access easier (book appointments, go together), talk when sober/clear-minded, acknowledge recovery behaviors, ensure the family member gets their own support.
Enabling: Lying/covering up, paying off debts, constantly giving money, normalizing violence, leaving children in risky conditions, stating a boundary but not enforcing it. Even if done with good intentions, this can serve continued use (family behaviors feeding the problem).

Quick steps for setting boundaries

1. **Write your red lines:** No violence. No use in the home. No interaction with children while intoxicated/under the influence. No stealing money/items from the home.
2. **Clarify the consequence:** "What will I do if it happens?" (call 112, leave the home, ask them to leave, change locks, move the child to a safe place, etc.).
3. **Say it in one sentence:** Long explanations = room for bargaining.
4. **Enforce:** If the first violation becomes an "exception," the boundary is over.
5. **Review:** If it doesn't work, make it more realistic—but it doesn't have to be "looser."

Adolescent or adult?

For adolescents, monitoring/supervision, school routine, and family structure are more central; family-based approaches have evidence of effectiveness. For adults, spouse/partner boundaries (home, money, child safety) and motivation for treatment access come to the front; there is evidence for couple-based approaches.

Short crisis card

- **Immediate danger / loss of consciousness / violence / suicide threat: 112** (free; all emergency lines are consolidated under 112).
- **Substance counseling and treatment referral: 191** (24/7; free from landlines; can coordinate with 112 when needed; uses motivational interviewing).
- **Support and appointment guidance for relatives: 115** (nationwide counseling; psychologists; referrals).
- **Violence/abuse risk: ALO 183 (24/7) + KADES + Gelincik Line 444 43 06**.

Extended guide

The goal of healthy boundaries

The aim is not “to manage the person with addiction,” but to restore the family’s safety and functioning. As family functioning improves, the probability of moving toward treatment can increase; however, every intervention—including family therapy—has safety and suitability conditions (violence, abuse, withdrawal, etc.).

Core concepts

- **SUD can be chronic and relapse-prone.** Relapse is not “inevitable,” but it is common; the family plan must include in advance: “What will we do if relapse happens?”
- **The whole family system is affected.** Addiction can disrupt boundaries and roles; parent–child boundaries can blur and the power balance can shift. Structural family therapy offers a framework for clarifying these boundaries.
- **Co-occurring risks matter.** If there is violence, child neglect/abuse, severe withdrawal periods, or acute crises, “safety first” overrides; joint family sessions may not be appropriate.

Boundary strategies by family member

Parents

The most common trap for parents is unlimited resource-giving and “zeroing out consequences” out of fear (“what if my child dies?”). Short term, it reduces crisis; long term, addiction expands into more space. This matches the idea that family behaviors can inadvertently support the problem.

For an adolescent, parental boundaries should be more “structural”: home rules, supervision, school routine, risky peer environment, digital monitoring (within legal limits), a shared treatment plan. There is international evidence and practice packages supporting the effectiveness of family-based approaches in adolescent substance use.

For an adult child, parental boundaries operate more through “home and resources”: conditions for staying at home, no money, no use in the home, protecting children/other siblings. The critical principle: the boundary must be realistic enough to enforce; “threatening and not doing it” kills the boundary.

Mini-case (parent–adult child):
A 29-year-old son frequently asks for money, saying “I’m looking for a job,” then disappears. The mother gives money “at least he can eat.” Then gold goes missing from the home. The mother swings between extremes: “What if something terrible happens if I don’t give money?” Here, the target is not only “stop giving money,” but also “structure safety”: secure valuables; no cash; plan with 191/115 for referral; no staying at home if there is use; family unity (if mother and father speak differently, the boundary gets breached).

Spouse/partner

In spouse/partner relationships, boundaries serve two main aims: (1) eliminate violence/abuse risk, (2) break the "police–suspect" cycle. Joint therapy is generally not recommended if there is violence; safety planning comes first.

If there is no violence and both are willing, meta-analyses suggest couple-based approaches can benefit substance outcomes and relationship adjustment in some couples.

Mini-case (partner–alcohol/substance):
The partner uses every night saying "just this week I'm stressed." The spouse stays silent to avoid conflict; it builds up and then explodes. The addicted partner says "you're overreacting."
This loop is cut with MI language: clear boundary + choice instead of blame. "I won't argue in the same room while there is use. We'll talk when you're sober. There is no use in this home. If you plan a treatment consult, I'll be with you."

Children

For children (non-adolescents), the core need is "safety + clarity + hearing that it isn't their responsibility." You don't need to overload them with details, but the frame matters: "There is an illness in the home; adults are getting help; it's not your fault." Parentification (the child taking the parent role) is described as a boundary violation and is a target to correct.

For adolescents, there are two major risks: (1) taking over the "addicted role" in the family (modeling, access), (2) drifting into risky peer groups to escape home chaos. UNODC-based adolescent family work emphasizes the central role of family management, monitoring, and warmth among risk/protective factors.

Mini-case (adolescent):
A 16-year-old has school absenteeism and comes home late at night. Parents split: one says "don't pressure," the other forcibly takes the phone. The adolescent avoids home more.
Target: parental alliance + a clear monitoring plan + school cooperation + treatment referral.
Referencing that ALO 191 provides age-adapted counseling and guidance on school/social routine gives the family a concrete "first step" and legitimizes actions like contacting school counseling.

Extended family

In Türkiye, extended family often has two common effects: (1) support (childcare, practical help, economic buffer), (2) stigma/shame pressure ("what will people say," "just manage it"). The core strategy: if you take help from extended family, structure it so it **doesn't breach boundaries**.
Example: childcare can help; "paying off debts and lying" breaks the boundary. One goal of family counseling is to identify and change family behaviors that unintentionally support the problem.

Setting and maintaining boundaries: evidence-based practices

MI-consistent boundary talk

MI's core is "empathy + collaboration + autonomy": the person has to choose change; you influence not through pressure but through structure and options. This doesn't soften the boundary—it clarifies it: "This is my boundary; here are your options; here's the support I can offer."

CBT logic: mapping "trigger–response"

CBT makes context visible: what triggers use, how the family responds, what that response relieves short term (e.g., avoiding a fight), and what it amplifies long term (continued use). CBT's evidence base in addictions is linked especially to relapse prevention and coping skills.

Family therapy lens: correcting roles

Structural family work aims to re-clarify parent–child boundaries, strengthen the parental alliance, and stop child parentification. When addiction disrupts family hierarchy, this becomes a practical compass.

Practical exercises

These are not "therapy sessions." They're home-practice skills. If there is violence/abuse risk, do exercises only safely and ideally with a professional.

Exercise: Boundary vs. rule (10 minutes)
Write three sentences:

- "What I want them to do" (rule tendency)
- "What I will do" (boundary)
- "What consequence I will apply if it's violated"
  Goal: stop chasing what you can't control; structure what you can.

Exercise: Trigger chain (CBT style, 15 minutes)
Pick the last crisis and write: Event → Thought → Emotion → Behavior → Short-term result → Long-term result. Then answer: "Next time, what is my alternative behavior?"

Exercise: 'One voice' family protocol (20 minutes)
Parents/partners align on three topics: (1) use in the home, (2) money/debt, (3) violence/threat. Put it in writing. Then reduce the message for extended family to one sentence. This stabilizes boundaries and power in the system.

Exercise: Two-chair conversation (MI practice, 10 minutes)
One chair speaks as "the part that wants to change," the other as "the part that wants to keep using." The family member only reflects: "Part of you wants to quit because…, part of you struggles because…" MI's approach to ambivalence relies on this kind of reflective communication.

Common mistakes and better alternatives

- **Mistake:** “This is the last time I’m giving money” (repeated)
  Need underneath: guilt, fear
  Better: cut money + make treatment access easier
  Sentence: “I can’t give money; we can call 191 together.”
- **Mistake:** long lecturing during crisis
  Need underneath: urge to control
  Better: safety during crisis, talk later
  Sentence: “I won’t talk now; safety matters.”
- **Mistake:** normalize violence as “substance effect”
  Need underneath: preserving the relationship
  Better: zero tolerance for violence + support channels
  Sentence: “If there’s violence: 112/183.”
- **Mistake:** letting the adolescent fully free or fully controlling
  Need underneath: panic
  Better: structured monitoring + warm relationship
  Sentence: “Rules are clear; I’m open to talking.”
- **Mistake:** telling extended family every detail
  Need underneath: searching for support
  Better: minimum information + clear request
  Sentence: “We’re not sharing details; what we need is…”

Safety note on crisis and withdrawal

Some crises are not the kind you “manage at home.” Examples: severe intoxication/poisoning, loss of consciousness, slowed breathing, seizure, severe agitation/psychosis, serious suicidal intent, violence threat—these require emergency services. 112 is free and consolidates emergency lines; ALO 191 also states it can direct to 112 in emergencies and coordinate.

Alcohol withdrawal can be life-threatening in severe cases and can require medical treatment; international sources emphasize medication treatment (e.g., benzodiazepines) as first-line in withdrawal management. Trying to “quit on your own at home” can be risky; when in doubt, urgent medical assessment is necessary.

Tools and appendices

Role-play scenarios

Role-play A: Parent–adolescent
Story: 16-year-old comes home late on weekdays; suspected substance smell. Father yells; mother says “be quiet.”
Goal: (1) parents speak with one voice, (2) clear boundary + monitoring plan, (3) treatment referral.

Roles: mother, father, adolescent, (optional) school counselor/psychological counselor.
Bad version: yelling, threats, forcibly taking the phone, “you’ll embarrass us.”
Good version: “talk when sober” + “no use in the home” + “tomorrow we call 191 / book with 115” + “plan with school.” Use the fact that 191 offers age-adapted counseling and school/social routine guidance to give a concrete first step.

Role-play B: Spouse/partner–adult with addiction
Story: Partner asks for money on payday; last month debts were paid off; it repeats.
Goal: money boundary + treatment option + no escalation.
Roles: spouse/partner, the person with addiction, (optional) supportive friend.
Good version: “No money” (firm) + “I’ll plan treatment with you” (support) + “I won’t talk while there’s use” (timing). Note: couple-based approaches may help some couples, but joint sessions are not appropriate if there is violence.

Role-play C: Extended family–nuclear family
Story: Grandparent/aunt says “poor kid, give money, just manage it.”
Goal: privacy + prevent extended family from undermining boundaries.
Roles: parent(s), extended family member, (optional) mediator elder.
Good version: minimum info + clear ask: “We’re not sharing details. We’re not giving money. If you want to help, do it like this…” Remind that health data is sensitive and unnecessary spread can harm.

Ten communication sentence templates

1. “I care about you; and there is no substance use in this home. If you use, you can’t stay here.”
2. “You’re under the influence right now; I won’t argue. We’ll talk when you’re sober.”
3. “I can’t give money. If you want, we can call 191 together and talk about treatment options.”
4. “Treatment is your decision; I can support appointments and transportation.”
5. “If there’s yelling/threats around the children, I will call 112.”
6. “I’m not doing a ‘who’s right’ debate today. Only this is clear: no violence, no threats.”
7. “To trust you, I have to ensure safety first. That’s not punishment; it’s protection.”
8. “I won’t hide this. For my own health, I will get support (115 / counseling).”
9. “If relapse happens, I’m not calling you ‘finished’; but our plan activates: no use at home, treatment consult.”
10. “We’re not sharing details with extended family. If help is needed, practical support looks like: childcare / going with us to appointments.”

Crisis steps and contact numbers table

Crisis type	Quick assessment	First step	Contact / application	Note
Loss of consciousness, slowed breathing, seizure, suspected severe poisoning	Life-threatening	Stop the discussion, establish safety	112 (free; all emergency lines consolidated)	ALO 191 can direct to 112 and coordinate
Violence, serious threats, in-home safety risk	Safety-first	Move to a safe room, remove children	112 + ALO 183 + KADES + 444 43 06	If violence exists, joint couple/family sessions usually not recommended
Suicide threat / self-harm risk	High urgency	Don't leave alone; remove dangerous objects	112	In crisis, don't "explain logic"—get emergency help
Treatment refusal + family burnout	Moderate urgency	One-sentence boundary + option	191 (24/7) + 115 (support for relatives)	191 uses motivational interviewing
Adolescent use suspicion + school/home routine breakdown	Moderate–high	Parent alliance + monitoring plan	191 (age-adapted counseling)	Family-based approaches can help
Alcohol withdrawal signs (severe tremor, hallucinations, seizure, etc.)	Medical risk	Medical evaluation; no bargaining	112 / Emergency	Withdrawal may require medical treatment

Support resources list

National/local official lines and services

- **191 Substance Counseling and Support Line:** 24/7; free from landlines; counseling, referral, motivational interviewing; emergency direction/coordination with 112.

- **YEDAM 115:** Nationwide counseling for people with addiction and their relatives; psychologists; referral and face-to-face planning when needed.
- **ALO 183 (Ministry of Family and Social Services):** 24/7 guidance/counseling; key channel for violence response and social support applications.
- **112 Emergency Call Center:** Free from mobile/landlines; emergency lines consolidated in one number.
- **KADES (mobile app):** Aims to enable one-tap access to emergency call services in urgent situations.

Access to treatment centers (AMATEM/ÇEMATEM and others)

- Hospital-based AMATEMs are described as offering multidisciplinary services such as outpatient/inpatient care, psychosocial support, and family counseling.
- ÇEMATEMs focus on detox–treatment–rehabilitation for children/adolescents and include family counseling/family work.
- The ALO 191 site publishes province-based "Treatment Centers" lists; you can use these to reach inpatient/outpatient units in your province.

Mutual support groups

These groups are not a substitute for treatment, but can be complementary—especially for reducing family burnout and breaking loneliness (many guidelines list mutual-help groups as a support element).

- Alcoholics Anonymous Türkiye
- Narcotics Anonymous Türkiye (online/in-person meetings)
- Al-Anon Türkiye (for relatives/family)
- Nar-Anon Türkiye (for relatives/family)

Ethical and safety warnings

This package is educational; it does not replace medical/psychiatric diagnosis or treatment, or legal advice. In violence/abuse, serious threats, loss of consciousness, severe poisoning, or suicide risk, do not attempt "family-only solutions"—call emergency help.

Personal health data is sensitive; even within the family, unnecessary disclosure can create stigma and loss of trust. There are official statements noting that health data is a special category of personal data.

The Turkish Penal Code contains provisions on failing to report an ongoing/preventable crime and reporting obligations for health professionals who encounter signs of a crime during duty. The practical implication for families: trying to "hide" child safety issues or severe violence inside the family carries serious risk; applications to appropriate authorities should not be delayed.