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**ADDICTION IN THE FAMILY IS A MAJOR BUT NEGLECTED  
CONTRIBUTOR TO THE GLOBAL BURDEN OF ADULT ILL-HEALTH**

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## **HIGHLIGHTS OF THE PAPER**

- Globally 100 million adults are likely to be affected by their relatives' addiction problems
- Affected family members experience multiple stresses, coping dilemmas, and lack of information and support
- They are at heightened risk for ill-health and the results are very costly personally and for public services
- The stress-strain-coping-support model offers a non-pathological way of understanding their circumstances
- A flexible and adaptable five-step procedure for responding to affected family members is described

## **Addiction in the family is a major but neglected contributor to the global burden of adult ill-health**

### **ABSTRACT**

This paper offers a conceptual overview of a neglected field. Evidence is presented to suggest that, globally, addiction is sufficiently stressful to cause pain and suffering to a large but uncounted number of adult affected family members (AFMs). A non-pathological stress-strain-coping-support model of the experience of AFMs is presented. The model is based on research in a number of countries and sociocultural groups and aims to be sensitive to the circumstances of AFMs in low and middle income countries and in minority ethnic and indigenous groups as well to those of majorities in richer countries. It highlights the social and economic stressors of many kinds which AFMs face, their lack of information and social support, dilemmas about how to cope, and resulting high risk for ill-health. A start has been made at calculating the size of the problem and associated public sector costs. Attention is drawn to the relative lack of forms of help designed for AFMs in their own right. A form of help aiming to fill that gap is briefly described. The family effects of addiction on the well-being and health of children is an equally, if not more important topic, but one which is outside the scope of the present paper.

## INTRODUCTION

In her influential book, *Women and Human Development*, the philosopher Martha Nussbaum (2000) developed her theory of human capabilities, referring throughout the book to two Indian women. Their husbands' excessive engagement in forms of consumption which have addiction potential is mentioned in both cases: 'Vasanti's husband was a gambler and an alcoholic. He used the household money to get drunk... Eventually, as her husband became physically abusive, she could live with him no longer and returned to her own family'... 'Jayamma's husband usually used up all his income (not large in any case) on tobacco, drink, and meals out for himself, leaving it to Jayamma not only to do all the housework after her backbreaking day, but also to provide the core financial support for children and house' (pp.16, 21). It will be the argument of this paper that there has been neglect of a massive source of adult ill-health, constituting a major factor undermining the capabilities of individuals throughout the world, and with enormous implications for public sector costs and countries' development. We refer, not to addiction *per se*, but to the impact of addiction (defined socially and broadly to include dependence/pathological use or misuse/problem use of sufficient severity to cause significant difficulties for both the using relative and family members; including non-substance addictions such as gambling) on the lives of wives, mothers, husbands, fathers, children and other close family members of those who themselves are experiencing alcohol, drug or some other form of addiction.

The present paper provides a conceptual overview (Grant and Booth, 2009) of a field that remains under-researched. It uses, as a framework, a model designed specifically to describe and explain the experience of AFMs, and rests heavily on the findings of

one programme of research carried out in Mexico and England and with indigenous family members in Australia (Orford et al., 2005a) and in Italy (Velleman et al., 2008). It is not a systematic review of the literature, which is in any case very small, although other research is cited where relevant. We believe this field would benefit from a clear conceptualisation of the kind we offer here in order to guide research in different countries.

Throughout this paper use is made of the expression ‘family members affected by addiction’ or ‘affected family members’ or AFMs. Particularly in mind are partners or parents who live under the same roof with relatives with addiction problems. Also included are family members with other relationships to their relatives (e.g. siblings, grandparents, aunts and uncles), family members not living under the same roof but who are closely affected, other extended family members who have obligations to their relatives, as well as close friends and associates whose involvement is sufficiently close that they are ‘like family’. A very important group of AFMs, referred to in places in the paper but who are not the focus of it, are children of parents with addictions. There are whole literatures devoted specifically to the offspring of parents with addiction problems (Velleman and Templeton, 2007; Arria et al., 2012) and it is not possible to do justice to their experiences in this paper.

To our knowledge there are no sources that would enable us to estimate the numbers of AFMs other than by simply applying a multiplier to the estimated prevalence of addiction problems. If it is assumed, cautiously, that on average one adult is adversely affected by each case of addiction, then the number of AFMs worldwide, based on WHO (2006; 2011) figures, may well be in the region of 100 million. Although

reports by WHO, UN and EU sometimes recognise the harm caused to AFMs, they are unable to calculate the magnitude of that harm (Velleman, 2010). AFMs remain largely unknown and uncounted and they mostly suffer in silence. This is not a group of people who themselves suffer from a single diagnosable illness – although they are at heightened risk for a wide variety of stress-related conditions (Ray et al., 2009) – or who constitute an obvious threat to public health or order. Nor do they generally wield collective power for social change (although there have been exceptions e.g. Marshall and Marshall, 1990; Brent, 2009; Wright, 2009).

AFMs appear in large numbers amongst the users of services, or participants in research, dedicated to mental ill-health and domestic violence, however. A notable illustration is research carried out by Brown and colleagues on stressful life circumstances, in which relatives' excessive drinking has regularly appeared as an example of the kinds of stress involving 'humiliation' and 'entrapment' that puts women at risk of depression (Brown & Moran, 1997). It is noticeable, however, that the mental health literature rarely highlights the circumstances faced by family members living with serious drug or alcohol problems as deserving of special attention or comment. The area that we are principally interested in – the experiences of AFMs and the contribution that makes to ill-health globally – and that of domestic violence, overlap substantially (Lipsey et al., 1997; Chermack et al., 2008). They are not identical however: serious addictions nearly always give rise to family conflict but are not always associated with domestic violence; the latter is very often associated with excessive alcohol, cocaine or other substance use but very often exists in its absence. In many parts of the world the combination of patriarchal gender relations, domestic violence and heavy alcohol or drug use is a frequent one which affects

women's capabilities and health, and that combination also exists for some women in all countries (Yang, 1997; Saggars and Gray, 1998; Nussbaum, 2000; Bourgois et al., 2004). Even in those conditions, however, it is probably unhelpful to ignore the substance misuse component or to consider it as purely secondary to patriarchy and violence. To ignore the way in which the addictive use of a substance is itself disempowering for wives, mothers and other AFMs, both female and male, is to be neglectful of what is often one of the most important factors constraining people's lives.

Nor is it simply neglect that has been suffered by affected family members (AFMs) at the hands of theorists and service providers. When they have been identified they have typically been referred to in pejorative ways. The sub-group that has probably received the most attention – wives and partners of men with drinking problems – was for many years described in frankly psychopathological terms, as possessing various character defects, showing complementary 'fit' with a dysfunctional husband, having a stake in his continued deviance, and undermining any attempt he might make at recovery (e.g. Whalen, 1953). Continuous with that tradition has been the more recent concept of codependency which, despite its critics (e.g. Krestan & Becko, 1991) and the absence of other than anecdotal evidence for psychopathology and codependency theories (Orford, et al., 2005a), remains a leading perspective in many parts of the world. As we shall see later, women and other family members affected by addiction are usually in circumstances that make them particularly vulnerable to attack. The derogatory and unsympathetic way in which theory and practice has often



dealt with them therefore serves to compound those circumstances (Jackson, 1954; Kokin & Walker, 1989).

Other affected adult family members have fared no better. Parents of young adults with drug problems have generally been viewed as inadequate in their parenting. Reviews on the subject typically take the form of a catalogue of failures and dysfunctions on the part of mothers and fathers which, it is assumed, have contributed to a young person's drug misuse (e.g. Clark et al., 1998), although more sympathetic attention is starting to be given to parents in their role as grandparents caring for the young children of their drug misusing offspring (e.g. Barnard, 2007). Husbands of women with drinking problems, when they have been noticed at all, have generally been described in very unsympathetic terms, often being stereotyped as men who show little interest in their wives' problems and who leave at the earliest opportunity. Other family members concerned about their relatives' drug taking or drinking, such as siblings, aunts and uncles and cousins, or in-laws, have received scarcely any attention (Orford et al, 2005a).

#### A STRESS-COPING MODEL OF ADDICTION AND THE FAMILY

The model developed in the course of our programme of research, the stress-strain-coping-support (SSCS) model, is depicted in summary form in Figure 1. Unlike other models in the addiction field its focus is deliberately on the experiences of, and outcomes for AFMs. It is in the tradition of stress-coping models, popular in health psychology and related disciplines (e.g. Lazarus & Folkman, 1984). It treats the affected family member as an ordinary person exposed to a set of seriously stressful

circumstances or conditions of adversity. Analogous conditions include a relative's illness or disability, chronic family unemployment or poverty, and exposure to catastrophic events and their aftermath such as flood, famine or earthquake. In contrast to a number of earlier models of addiction and the family, the SSCS model is designed to be non-pathological in its assumptions about AFMs and their thoughts, emotions and actions in relation to their addicted relatives. In particular the model avoids any suggestion that blame for the development or maintenance of the relative's addiction problem can be attributed to family members' actions: family members are often only too ready to blame themselves, and the experts' theories have too often explicitly or implicitly reinforced self-blame.

Figure 1 about here

It is important to point out that although our focus is on the effects of addiction on family members, and not on addiction *per se*, we do not wish to advocate on behalf of affected family members at the expense of further stigmatising substance users. In general we think of AFMs as disempowered through close contact with their relatives, who are themselves disempowered through their addiction (Levy, 2006) and their circumstances – often ones of poverty and social exclusion (e.g. Seddon, 2006).

#### THE EXPERIENCE OF BEING AN AFFECTED FAMILY MEMBER

In this section we illustrate the model just described by drawing on the findings of research carried out with AFMs, including our own programme of research,

particularly the three-country study of AFMs in Mexico, England and Australia (Orford et al., 2005a). Five sub-sections cover the five main building blocks of the model: stress, coping, information and understanding, support, and symptoms of strain.

A sixth sub-section describes a small number of new studies attempting to estimate the size of the problem and the costs associated with harms to AFMs.

*Stress on family members: uncertainty, threat and loss*

There are many overlapping facets to the stress experienced by AFMs. Psychometric analysis provides some evidence for a two-factor structure (Orford et al., 2005b). Worry is the defining feature of the first factor. Worry for the relative is often at the forefront; including worry about the relative's physical and mental health, self-care, educational, work or other performance, finances, the company the relative is keeping, and his/her future. But it usually also includes concern about the functioning of the whole family, the maintenance of good quality relationships both within the family and with others and concern about the ability of the family to function well now and in the future for the sake of all its members. The greatest weight of worry is often about possible effects on children: concern at the possibility of violence or neglect, more general worry about interference with good upbringing of the children, or concern that children might repeat the relative's behaviour.

The second very broad facet is more actively disruptive in nature. It always involves a decline in the quality of family relationships. At the very least good communication is

diminished and behaviour expected of a partner, now-adult child, parent or other family member is to some degree neglected. Usually there is some element of open conflict and very often, but by no means always, there is aggressiveness and physical violence:

The Padre [who had recommended acceptance of drinking] can't know how we think. ... He can't know how campesinos like us live. He can't know how a woman suffers when her husband drinks too much and hits her and yells at her. The issue for us when we criticise rum is exploitation and injustice toward women. Everyone knows women and children who suffer from hunger, lack of clothing, or medicine because their husbands or fathers drink too much and don't handle their money right ... (an indigenous Mexican wife, Eber, 1995, p.227).

AFMs often talk of their feelings of loss of the good quality relationships they once had with their now-addicted children, partners, parents or siblings, along with altered feelings towards the substance misusing relatives. Such feelings usually contain negative elements such as feelings of hurt, bitterness, being let down, anger or hatred, but in total are almost invariably highly ambivalent, containing positive references to good qualities the relative showed in the past, or which are on display when substances are not being used, or positive hopes for the future (Velleman et al., 1993):

In the evenings, I used to imagine I would kill him, or whatever bad I could do to him. Then, at 2.00 a.m. I would ask God to get him home. Then if God did,

I was ready to kill him again (wife of a man with an alcohol problem in Finland, Wiseman, 1991, p.166).

The majority of AFMs who have taken part in research are women, particularly but not only partners and mothers. Male AFMs have appeared in research in the largest numbers as fathers (although brothers have appeared, as have sisters, and occasionally other male AFMs such as uncles and male cousins, as have aunts and female cousins – see Barnard, 2007). If it is appropriate, as we believe, to think of AFMs as being disempowered as a result of living with their relatives' addiction, then women AFMs, particularly partners of men with a traditional gender-role orientation, might be said to be doubly disempowered. How, then, should we think of male AFMs? The conclusion we draw from interviews with men who are partners of women with alcohol or drug problems is that they have very similar experiences to women who are partners of men with such problems. Other studies have drawn the same conclusions although numbers are small and there are undoubtedly sampling issues (Estes & Baker, 1982; Philpott & Christie, 2008).

### *Ways family members cope*

Central to the distinctive approach offered by the SSCS model is the way in which family members' actions in the face of addiction are construed. The SSCS model recognises three broad ways of coping: putting up, withdrawing, and standing up (see Figure 1). Nearly all accounts of what AFMs do include examples of the ways in which they appear *to put up with* their relatives' problematic consumption. This is a large category of coping actions, including acceptance of things as they are, self-

sacrifices made by restricting oneself or putting oneself out in some way to accommodate the relative's substance use, uncritical support for the relative's behaviour, or simply inaction and resignation. This large category has sometimes been termed 'tolerant-inaction' (Orford et al., 2001), sometimes 'inactive resignation' (Ahuja et al., 2003) or 'resigning and maintaining façade' (Holmila, 1997). But this apparent 'putting up with' a relative's substance misuse, although it may be more common in cultures where a higher value is placed upon hierarchy or 'power distance' (Smith et al., 2006), or where family structures are more traditional, is found to be common in all cultures, including in the USA (Wiseman, 1991) and amongst white English AFMs (Orford et al., 2005a).

Viewed from the perspective of the SSCS model, the ubiquity of such ways of acting is an indication of the very difficult and fraught *coping dilemmas* which otherwise ordinary family members find themselves caught up in, placed as they are in circumstances which provoke a complex set of strong feelings towards the relative and the relative's excessive behaviour, and which involve a complex set of obligations towards the relative and other family members. When AFMs are interviewed about this in any depth, they are able to explain the many sources of constraint affecting their decisions. Some of the constraints are material, others to do with the need to maintain stability for children and oneself, and others to do with the AFM's own reduced self-confidence or health. Other constraints are related to coercion by the relative, and often they derive from the AFM's own feelings of care, concern and obligation towards the relative. As a South Korean wife of a problem drinking husband said, 'I try very hard to take care of my husband's health. Every day

I make a special diet and traditional remedies for him. I do not wish to be left a widow and my children fatherless' (Yang, 1997, p.162).

A contrast that is often drawn is between ways of putting up with a relative's addictive behaviour and ways family members find for *withdrawing and gaining independence*. A number of authors have described the struggle which AFMs undergo in achieving such independence. For example Asher (1992), on the basis of her study of US wives of men with drinking problems, wrote of their struggle to refocus attention on their own rights, obligations and needs, and to take what was happening less personally (what she called 'depersonalising'). In the three-country study we identified the following elements to 'gaining independence': not worrying, doing what the family member wants to do, getting involved in other activities, escaping or getting away, sorting oneself out, and getting a new and better life for oneself and other members of the family (Orford et al., 2005a, Chapter 6). Much of the literature which pin-points AFMs' achievement of autonomy in the face of relatives' addiction comes from the USA and other high income countries such as Canada (Wiseman 1991; Banister & Peavy, 1994) and the UK (Velleman et al., 1993), and it might be predicted that this theme would be less prominent in countries and areas with poorer material resources and/or in cultures where a higher value is placed upon collectivism (sometimes referred to as 'embeddedness': Smith et al., 2006). However, independent coping by AFMs has also been identified as a way of coping in relatively poor indigenous communities in Mexico and Australia. For example, in one such community in Hidalgo state, Mexico, whilst it was recognised that opportunities for personal development were limited, nevertheless mention was made of various activities, such as studying, playing basketball, weaving and sewing, working in the

fields, religious involvement, visiting relatives in other communities, or going out to chat with friends and neighbours, which provided women with distraction and satisfaction (Tiburcio Sainz, 2009, p.140).

The foregoing suggests a one-dimensional view of AFMs' coping which contrasts 'putting up with it' versus 'withdrawing and gaining independence'. Although that contrast identifies one of the most important forms of struggle for AFMs, it fails in our view to acknowledge the constraints that women and other AFMs are living under in most parts of the world and the many other forms of action which AFMs find in the face of their disempowerment. Others have recognised the more complex, multidimensional nature of AFM coping and the many active solutions which AFMs find to their dilemmas (Dorn et al., 1987; Holmila, 1997; Yang, 1997). We have termed this broad array of actions 'engaged coping' or *standing up to* the drinking or drug taking. At least three separate facets can be distinguished. One group (emotional and controlling), about which few AFMs have much positive to say in the light of their own experience, consists of getting aggressive or otherwise emotional with their relatives or interfering in their relatives' drinking or drug taking in an effort to control it. A second sub-group (protecting self, family and home) embraces those ways of coping which have the 'harm minimisation' aim of protecting the family member, the home, and particularly children, from the harmful effects of the problem, rather than the aim of controlling the excessive drinking or drug use itself. The third group (assertive and supportive) covers ways of asserting the AFM's own understanding of the seriousness of the problem, what is acceptable and unacceptable behaviour, and supporting the relative in efforts to control use of drink or drugs and/or to seek treatment.



### *Information and understanding*

Closely related to ways of coping, but conceptually distinct, is the understanding an AFM has of what is taking place, her or his stance towards it, and the sense that is made of it. Part of gaining better understanding is receiving good, accurate information. Sometimes this is of a purely factual kind; for example, the names of types of illicit drug, the means of their administration and some of their effects, or information about the strength of different alcoholic beverages. In our experience AFMs also often find it useful to discuss the nature of addiction or dependence and the difficulties their relatives have in overcoming it. In a study of AFMs receiving an intervention in primary care (Orford et al, 2007), we also heard of many examples of what we termed 'seeing the links' i.e. AFMs spoke of gaining understanding about their relatives' drinking or drug taking, and a realisation of the links between the drinking or drug problem and their own physical and mental health. An example was a wife who had undergone a number of medical tests but had come to the realisation that her pain and depression were probably linked to her husband's excessive drinking. At a deeper level is what Asher (1992), in her study referred to as the problem of 'definitional ambivalence' for wives of 'alcoholics', which focused on the struggle for understanding, meaning and the image of husband and self. The key questions AFMs asked were: 'Am I an OK person? Wife? Mother? What's wrong with me? Why is he treating me like this? Why is my life like this? What can I do? What do I want? What have I become? and What is to become of me?' (p.11).

### *Social support for family members*

In view of the established importance of social support generally for good health, and particularly as a buffer in the face of stressful circumstances (Cohen & Wills, 1985), AFMs might be thought of as a group in particular need of good social support. Yet the evidence is that social support for AFMs is highly problematic. Wiseman (1991) described social support for wives as 'fragile' and our group has found there to be a number of barriers that stand in the way of AFMs receiving the support they find most helpful. Family members themselves often express reluctance to talk about the problem to others, believing that problems should be dealt with in the family, that a good parent or a good wife should be able to cope, that knowledge of the problem might bring shame or dishonour, that the addicted relative would react badly if others knew, or simply that other people are too busy with their own affairs or would be unable to help.

Because addiction evokes strong feelings in others, and because how to respond is problematic and debatable, others who might support an AFM in her coping efforts or in her way of understanding what is going on, are often perceived as unsupportive, critical or even overtly hostile to the AFM's position. Some AFMs are criticised by others for being too tough, others for not being firm enough. AFMs often feel that the attitude of others is, as one English female partner of a male drug user expressed it, 'put up or shut up or kick him out' (Orford et al., 2005a, p.157). Mexican mothers were sometimes reluctant to be open to their husbands about their children's alcohol or drug problems for fear of their husbands' violent response. The sensitivity of parents to other people's comments about their children's drug problems was recognised by Dorn et al. (1997). One parent, for example, said, 'It hurts me so much

when people assume that by rejecting what your son's doing, you're rejecting him. Because that isn't so' (p.38). The criticism and lack of support from family and neighbours experienced by South Korean wives was described by Yang (1997). One wife, for example, said, 'When I asked for help from my neighbours, they said, "How can a man survive without a drink in our society? You should change your attitude towards your husband's drinking". After this incident I never asked for help again' (p.160). There were many examples in our data of AFMs feeling pressure from others to put up with their relatives' addiction problems. Some had been directly criticised for trying to get a new and better life for themselves by moving away or taking up studying. AFMs had been described by others as 'hard', 'cold', 'cruel', or 'getting too big for yourself'. Some anticipated rebuke if they responded to relatives in ways that broke with traditional family responsibilities, including specific role responsibilities, for example as a wife, or which ran contrary to general cultural norms for sharing and hospitality. That theme was present in all groups but particularly in some, including the indigenous Australian sample (Orford et al., 2005a).

Professional support for AFMs appears to be as problematic as is informal support. In countries with less well developed professional services AFMs were sometimes critical of the unsympathetic and even brutal treatment their relatives received from the police or in institutions. But even in countries with comparatively well developed services, professionals are often perceived by AFMs as lacking in knowledge, awareness or even sympathetic understanding. If their relatives are receiving help from specialist agencies, AFMs often feel deprived of information, in part because professional models of treatment largely exclude them and prevent imparting information to them because of rigid and unimaginative rules of client confidentiality.

Religious institutions are available almost everywhere as potential sources of support. Religion is sometimes portrayed by AFMs as generally supportive (as, for example, in a church group praying together and providing mutual emotional support) and sometimes as an institution offering specific coping tactics giving AFMs hope (for example, witnessing the taking of a non-drinking oath, often perceived as helpful by Mexican wives). At other times religion and its ministers are seen as encouraging sacrifice and endurance in the face of hardship, supporting putting up with addiction and discouraging independence (Orford et al., 2005a).

### *Family strain*

It is a central argument of this paper that adult AFMs constitute a group, probably of colossal size globally, which is at high risk of ill-health. Our data are full of references by AFMs to feelings of anxiety, depression, despair and fear, besides feelings directed at their relatives (e.g. anger and resentment) or directed at themselves (e.g. guilt, loss of self-confidence). Family members very frequently referred to their general poor health, to disturbances of sleeping and eating, an increase or instability in their own use of substances including tobacco smoking and use of prescribed medication, as well as to symptoms of physical illness (e.g. anaemia, headaches, back pain, hypertension, asthma, palpitations, migraines, diarrhoea). Much the same has been reported from countries as varied as Finland, the USA, former Czechoslovakia and South Korea (Student & Matova, 1969; Wiseman, 1991; Yang, 1997).

In our own clinical studies we have consistently found AFMs obtaining high mean scores on a standard measure of general ill-health, and significant correlations between poorer health and the degree of impact they report their relatives' substance problems having on their lives and that of their families (Orford et al., 2005b). Two studies have recently appeared which aimed to estimate the health effects of being an AFM based on general population samples, one in Australia (Laslett et al., 2010), the other in New Zealand (Caswell et al., 2011). Both asked about the existence of people in their lives whom they considered to be 'a fairly heavy drinker or someone who drinks a lot'. In the Australian study additional questions were asked about whether identified heavy drinkers had affected respondents in some way in the previous 12 months, which drinkers had affected them most, and whether they had been affected 'a lot' or 'a little'. Both studies used the European Quality of Life-5 Dimensions (EQ5-D) to measure health, which was found to be significantly poorer amongst those who identified a heavy drinker, particularly when the latter lived with the respondent at least half the time (Caswell et al., 2011) and amongst those who identified heavy drinkers who had affected them, especially when they said they had been affected a lot (Laslett et al., 2010).

*Estimating the financial costs associated with the effects of addiction on family members*

It is evident that AFMs bear personal and household or family-wide 'costs', often substantial, of living with addiction. Some of those costs would otherwise be borne by governments. Estimating the size of these costs in monetary terms is beset with conceptual and methodological problems (Navarro et al., 2011). A report for the UK

Drugs Policy Commission has attempted to cost the harm to AFMs associated with relatives' illicit drug use (Copello et al., 2009a, 2010a). A number of economic costs were considered: financial support to the relative from family resources; money innocently or unwillingly given to relatives which helps them obtain drugs; theft of money or property; lost opportunity for employment for AFMs; costs of AFMs' ill-health.

The total estimated annual cost per AFM (2008 prices) was approximately £13,500 (approx. US\$25,000), of which £4,000 (\$7,500) were resource savings to the National Health Service (NHS) or local government social care. Multiplied by the estimated number of adult AFMs, the total for the UK as a whole was calculated as approximately £2.5bn (\$4.8bn) of which £750m (\$1,400m) were NHS and local authority resource savings. The authors of the report acknowledge the difficulties in arriving at such estimates; in particular they were not able to include the 'unhappiness' caused to a partner, child, parent or other AFM. Arguably it is the way addiction in the family disempowers AFMs by constraining their capabilities which constitutes the most significant burden of addiction on families and one which a narrow economic analysis is in danger of ignoring. However, this work does represent a first step in estimating in financial terms what is undoubtedly an enormous and generally overlooked cost of addiction.

Weisner et al (2010) compared the healthcare costs of several thousand spouses and children of patients receiving treatment for an alcohol or other drug problem with a matched control group, using data from a private health plan in the USA. The former were found to have significantly higher average monthly healthcare costs (\$91 versus

\$62), with evidence of significantly higher prevalence of medical conditions such as congestive heart failure, ischemic heart disease, diabetes, asthma, lower back pain, injuries, poisoning and hepatitis C, with much higher odds of having any psychiatric diagnosis, especially depression. Both groups were followed for five years: family members' average healthcare costs reduced to control group levels in years when relatives had been abstinent, but remained high on average when relatives were non-abstinent. Another study of over 25,000 AFMs in the USA found that they contributed to significantly higher total health care costs over a two-year period compared to family members of people with diabetes or asthma (Ray et al., 2009).

Laslett et al. (2010) used the EQ-5D results from the Australian national Alcohol's Harm To Others survey to estimate the intangible costs to AFMs of having a heavy drinker in their lives who was affecting them. By comparing the mean scores with those of respondents who were not negatively affected by a heavy drinker, and by using a generally accepted figure of AU\$50,000 for the value of a quality adjusted life year (QALY), they estimated the cost per person to be \$700 if affected 'a little' and \$3800 if affected 'a lot'. Multiplied up, these figures produced Australian population estimates of the intangible costs of \$1.9bn and \$4.5bn respectively.

## THE NEED FOR HELP FOR AFFECTED FAMILY MEMBERS IN THEIR OWN RIGHT

In the context of health care in some richer countries, psychosocial interventions have been developed with AFMs in mind. From our perspective, however, they mostly

suffer from one or more of a number of limitations. For a start the majority lack a clear focus on AFMs. They can roughly be divided into three categories, although the boundaries between the categories are fuzzy: 1) those in which AFMs join their relatives in the latter's treatment (behavioural marital therapy [O'Farrell et al., 1992], family therapy [Stanton et al., 1982] and social behaviour and network therapy [Copello et al., 2009b] are examples); 2) those that work with AFMs with the aim of encouraging their relatives to engage in treatment (e.g. community reinforcement and family training [Meyers et al., 1999], pressures to change [Barber & Crisp, 1995] and a relational intervention sequence for engagement [Garrett et al., 1999]; and 3) those which respond to the needs of AFMs in their own right. There have been very few which fall in the last of those categories. Few studies have assessed outcomes pertaining directly to family member health or ways of coping, or to the quality of family relationships. The main focus has been on outcomes for the substance using relatives, with AFMs given the adjunctive role of helping to engage their relatives in treatment and/or to support them in their treatment. Amongst interventions which do focus on AFMs in their own right are a number designed specifically for parents of drug using adolescents (McGillicuddy et al., 2001; Toumbourou et al., 2001), group therapy or mutual help groups for AFMs (including groups such as Al-Anon, Families Anonymous and GamAnon), our own 5-Step Method, briefly described below (Copello et al., 2000; the Alcohol, Drugs and the Family Research Group, 2010), and a small number of other interventions which have been reported which focus on counselling or providing coping skills training for AFMs (Halford et al., 2001; Howells & Orford, 2005; Rychtarik & McGillicuddy, 2006). The greatest limitation of most of these interventions lies in their specialist nature. They have nearly all been carried out in a small number of research centres in richer countries and the providers



of these interventions have nearly always been specialists in the treatment of addiction problems. Since the very large majority of the tens of millions of AFMs worldwide have no access to specialist services, these interventions are unlikely to be helpful in dealing with the practicalities of delivering help to AFMs on a larger scale and in a variety of socio-cultural settings.

For the aforementioned reasons the intervention arm of our own programme of research has focused on the development and testing of a 5-Step Method which is based on the model described earlier, and is designed specifically to meet the needs of AFMs. It aims to be sufficiently flexible to be delivered in a variety of different formats (including group, self-help handbook and web-based [Copello et al., 2009c; Templeton, 2009; Ibanga, 2010]), and by a variety of frontline/primary care personnel. Those who deliver the intervention need not be specialists in addiction or mental health but they do require a brief period of induction/training (6 to 12 hours ideally). It also aims to be relevant to AFMs facing addiction, whatever its nature and level of complexity (problems of addiction to one type of substance or activity often co-occur with other addictions and are often combined with other psychological problems and with social and economic difficulties [Baker & Velleman, 2007; Singer, 2008]). The method has been used with promising results in a variety of countries and sociocultural groups, as follows: in primary care and specialist treatment settings in three regions in Italy (Velleman et al., 2008); amongst majority White and minority Muslim AFMs in England (Copello et al., 2009c; Orford et al., 2010a); in workplace and community settings in Mexico, both in the capital city and in a rural indigenous community (Natera et al., 2010); and as a basis for work with AFMs in Australian Aboriginal communities (Orford et al, 2005a). The principal outcomes assessed are

AFM ways of coping and symptoms of physical and psychological ill-health (Orford et al, 2005b; 2010b). The results of these intervention studies are summarised elsewhere (Copello et al, 2010b). It is unlikely that one type of intervention alone will go far in addressing the needs of AFMs in a variety of countries. Ideally it should be part of broader programmes of community and national development which address the social causes of addiction problems and the concurrent difficulties in the social contexts in which they occur. But we believe a flexible intervention like this, focused specifically on the needs of AFMs, should be part of a campaign to reverse the state of neglect surrounding the family impacts of addiction and the burden which that places on the health and well-being of wives, mothers, children and other affected female and male family members around the world.

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**Figure 1: The Stress-Strain-Coping-Support Model**

