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**Family Members Affected by a Close Relative's Addiction: the Stress-Strain-Coping-Support Model**

**Jim Orford, Alex Copello, Richard Velleman and Lorna Templeton**

**ABSTRACT**

This chapter outlines the stress-strain-coping-support (SSCS) model which underpins the whole programme of work described in this supplement. The need for such a model is explained: previous models of substance misuse and the family have attributed dysfunction or deficiency to families or family members. In contrast, the SSCS model assumes that having a close relative with a substance misuse problem constitutes a form of stressful life circumstances, often long-standing, which puts affected family members at risk of experiencing strain in the form of physical and/or psychological ill-health. Coping and social support are the two other central building blocks of the model. Affected family members are viewed as ordinary people faced with the task of coping with such stressful life circumstances. It is an assumption of the model that, difficult though the coping task is, family members need not be powerless in maintaining their own health and helping their relatives. Good quality social support, in the form of emotional support, good information, and material help, is an invaluable resource for affected family members, supporting their coping efforts and contributing positively to their health. The 5-Step Method, to be described later in the supplement, is based on the SSCS model. It can be seen as a way of increasing the positive social support available from professional sources.

## **The need for an unambiguously non-pathological model**

One of the reasons why affected family members (AFMs) have been so neglected in health and social care policy and provision (see Velleman, 2010, this volume) has been the absence of a sound model of addiction problems and the family. It is for that reason that in our programme of research and action we have placed great emphasis on the model which underpins our work. That model we refer to as the stress-strain-coping-support model (the SSCS model – see Figure 1). Stress-coping models have been popular in health psychology and related disciplines for some time (Lazarus and Folkman, 1984). They conceive of certain sets of conditions that people face in their everyday lives as constituting seriously stressful circumstances or conditions of adversity which are often long-standing. Those conditions embrace war or chronic unemployment but they also include chronic personal illness or living with a close relative with such illness. Different people may respond to stressful conditions in different ways, and some of those ways may be more effective than others and better for their health. The mechanical analogy of stress and strain is thought to be useful: if stress is not satisfactorily coped with then strain is likely to be evident in the form of some departure from a state of health and well-being.

A central idea is that people facing such conditions have the capacity to ‘cope’ with them much as one would attempt to cope with any difficult and complex ‘task’ in life. That incorporates the idea of being active in the face of adversity, of effective problem solving, of being an agent in one’s own destiny, of *not* being powerless. In one form or another the stress-coping model has been applied to a very wide range of conditions and circumstances, including coping with cancer and caring for a close

relative with dementia (Orford, 1987; Zeidner and Endler, 1996). We believe such a model is one that is potentially empowering for AFMs.

Figure 1 about here

It might be thought that such a conceptually straightforward model would be obvious and without rival contenders. But in fact the modern history of professional thinking about AFMs has been dominated by models which, in contrast to stress-coping models such as SSCS, view family members in a more or less pathological light (Orford, Natera, Copello, Atkinson et al, 2005; Kokin and Walker, 1989). The evidence for that statement is most clearly seen in professional and populist writings about wives of men with drinking problems, who were seen as psychopathological themselves, or more recently as ‘codependent’ (Hurcom, 2000; and see Beattie, 1987, for an example). Parents of young adults with drug problems were viewed as having been abusive to their children or as otherwise inadequate in their parenting. Husbands of women with drinking problems, when they had been noticed at all, were described in very unsympathetic terms, being stereotyped as men who left their wives at the earliest opportunity. Other family members concerned about their relatives’ drinking or drug taking, such as sisters and brothers, grandparents, aunts and uncles and cousins, had received no attention (but see now Barnard, 2007). That negative view of family members is subtle and pervasive and by no means limited to the most obviously dated and extreme statements of some authors writing about ‘wives of alcoholics’ half a century ago. AFMs have too often been typecast in negative roles. The SSCS model views AFMs as ordinary people struggling to cope with stressful circumstances which are not of their own making. The weight of all that

unsympathetic past theorising about AFMs forms the background against which the model was developed.

Table 1 about here

Table 1 summarises the main ways in which a stress coping model takes a fundamentally different stance compared to models which clearly point to whole family or family member pathology, dysfunction or deficiency or those that take an ambiguous or unclear stand on this issue (such as family systems models which in some forms see substance misuse as a symptom of family dysfunction and in other forms are less clear about this). Perhaps the clearest point of divergence of the two types of model is the way they view a family member's actions, such as guarding the relative's finances or otherwise treating the relative in a way that implies that the latter is less than fully responsible. The SSCS model is clear that such actions are best interpreted as reactions of involved and caring family members who have good and powerful reasons for acting in those ways given their circumstances; whereas a model which inclines towards interpreting such actions in terms of pathology or deficiency is likely to treat such actions as personal or family failings.

### **The SSCS model in more detail**

#### *Stress and strain*

The first assumption behind the stress-coping viewpoint on addiction problems in the family is that when one person has a serious drinking or drug (or indeed gambling)

problem, this can be **highly stressful** for anyone who is a close family member (the ‘family member’) as well as for the person whose drinking or drug taking constitutes a problem (the ‘relative’). This is because serious drinking or drug problems are, by their very nature, associated with a number of characteristics which are damaging to intimate relationships and can be extremely unpleasant to live with (Adams, 2008; and see Orford et al, 2010, this volume). Such problems frequently continue unabated, often intensifying, over a period of years and are appropriately construed as long-standing stressful conditions for family members.

It is worth pausing at this point to consider for a moment the nature of addiction or dependence and why it should have such an impact on a person’s family. Addiction is viewed here as an appetite for a substance (or an activity such as gambling) that has become excessive (Orford, 2001). A strong attachment has been formed to the substance or activity so that the person’s resources – in the form of attention, time, money, etc – are diverted away from his or her primary life commitments such as family, work or education. The object of the person’s addiction competes for his or her commitment, and the ability to play a normal, full part in family and other domains is compromised. This diversion of commitment, as a result of excessive attachment to the object of addiction, is stressful for other members of the person’s primary groups or networks. In different ways they are let down by the person who is failing to play his or her full part or to fulfil obligations. It poses a threat to the happiness, productivity and even the very existence of the group. It creates tensions and conflict and poses dilemmas for group members about how to cope with the person’s behaviour and its effects on the group. It may be thought of as a major threat to the group’s resources.

The group which is most affected by a person's excessive attachment is the family. The SSCS model is first and foremost a model of family health and it is affected *family* members with whom this journal supplement is principally concerned. However, the model is applicable also to members of the extended family and to members of other affected groups and networks of which the dependent or addicted person is a part; for example, a work group, a community group, a friendship or leisure group. They are all groups of people who are, to one degree or another, secondarily affected. It is for this reason that we and other writers and researchers into this area sometimes use the term 'concerned and affected others' – capturing the concern that people close to the person misusing alcohol or drugs feel, the fact that they *are* so affected, and the fact that it is not *only* family members who can be both concerned and affected.

The second of the four main components of the SSCS model is the **strain** experienced by family members as a direct consequence of the stressful set of circumstances associated with a close relative's addiction problem. By 'strain' we mean the effects on a family member's health. The model takes a clear position here about cause and effect. Whatever a family member's health may have been prior to or in the absence of the development of the relative's addiction, the latter is generally sufficiently stressful that it is bound to put a family member's health at risk. Disturbances of behaviour and apparent changes in personality or extreme distress, on the part of a close relative, are known to be amongst the most disturbing aspects of chronic mental and physical illnesses and disabilities for family members (Orford, 1987). They are amongst the experiences that family members find it most difficult to deal with,

which are most likely to undermine their feelings of self-confidence, and which put family members' own health at risk. Since such changes and disturbances are prominent components of the stress experienced by family members of relatives with drinking or drug problems (see Orford et al, 2010, this volume), it is safe to conclude that the latter experiences are likely to be amongst the most threatening and difficult to handle of all chronic family stressors. It is not surprising, therefore, to find that research from a number of countries has indicated that AFMs have an increased rate of physical, mental and general ill-health (Orford, 1990; Wiseman, 1991; Ray et al, 2007; Orford et al, 2010, this volume).

### *Coping*

A central assumption of the SSCS model is that family members are faced with the substantial and difficult life task of how to understand what is going wrong in the family and what to do about it. It involves mental struggle and many uncertainties, in particular the central dilemma of **how to respond** to the relative whose drinking or drug taking behaviour is a problem. The ways of understanding reached by the family member at a particular point in time, and her (or his) actions, are what are referred to collectively as 'coping' – responding, reacting or managing are synonyms. This is the third main component in the model. The expression 'coping' is certainly not limited to well thought out and articulated strategies. It includes ways of understanding or responding that the family member believes to be ineffective as well as those judged to be effective. Family members may find some ways of responding to be more productive than others in buffering the effects of stress and hence preventing or reducing the strain they themselves or other members of the family – children for

example – experience. Furthermore, family members may find some ways of managing the problem to be relatively effective and others relatively counter-productive in having a desired effect upon the relative’s substance use. Their particular circumstances and the resources available to them affect how family members can cope; but a basic assumption of the SCSS model is that AFMs are not totally powerless and *can* both improve their own health and have an impact on their relatives’ substance use. That is an important assumption and one which distinguishes the model from others. This key theme of coping is elaborated in Orford et al (2010, this volume).

### *Support*

The model is completed with the addition of the fourth element – **social support**. For a good many years research has been showing that the availability to people of good quality social support is an important determinant of health (e.g. Cohen and Wills, 1985). For AFMs good social support is seen as an important resource for coping. The two components – coping and social support – are therefore closely interconnected. Two additional points should be made about social support and how it is viewed in the model. The first is that good social support cannot simply be equated with the number of people who exist in a family member’s close social network. It is the *quality* of social support that is thought to be important; and in the context of an addiction problem in the family it is specifically a question of how well the support that a family member receives from others assists the family member in coping adequately with the problem. We see in Orford et al (2010, this volume) that there exist many barriers in the way of AFMs receiving good quality support,

disagreements amongst people about how to handle the problem being just one of them. The other general point to make is that social support is defined in the model in an inclusive way which embraces support that may come from a number of different directions, both informal and formal, and is not confined to support from the closest members of the social network. It includes social support of a variety of different kinds, including emotional, informational and material support (Wills, 1985). Orford et al (2010, this volume) provides illustrations.

### **The model as a backdrop to later papers in the supplement**

Social support is a vital element in the SSCS model. In fact as a resource for coping for AFMs it could be seen as one of the central themes of this whole supplement. The 5-Step Method, introduced in Section III, is our way of attempting to improve the quality of professional social support upon which AFMs can draw. The SSCS model as a whole provides a constant backdrop to the contents of the rest of this supplement. We shall often be reminded in the following chapters that having a serious substance misuse problem in the family is potentially disempowering and demoralising for family members. What they are facing is akin to a disaster or other set of circumstances that threatens to test or erode family resources. It can be highly stressful and family members need reassurance that it is not of their making. That way of looking at substance misuse and the family challenges many of the assumptions that have been made in the past about this subject. We believe that such a model is essential if the neglect of affected family members is to be reversed. The programme of work described in the remainder of this supplement cannot be understood without fully grasping the model which underpins it.

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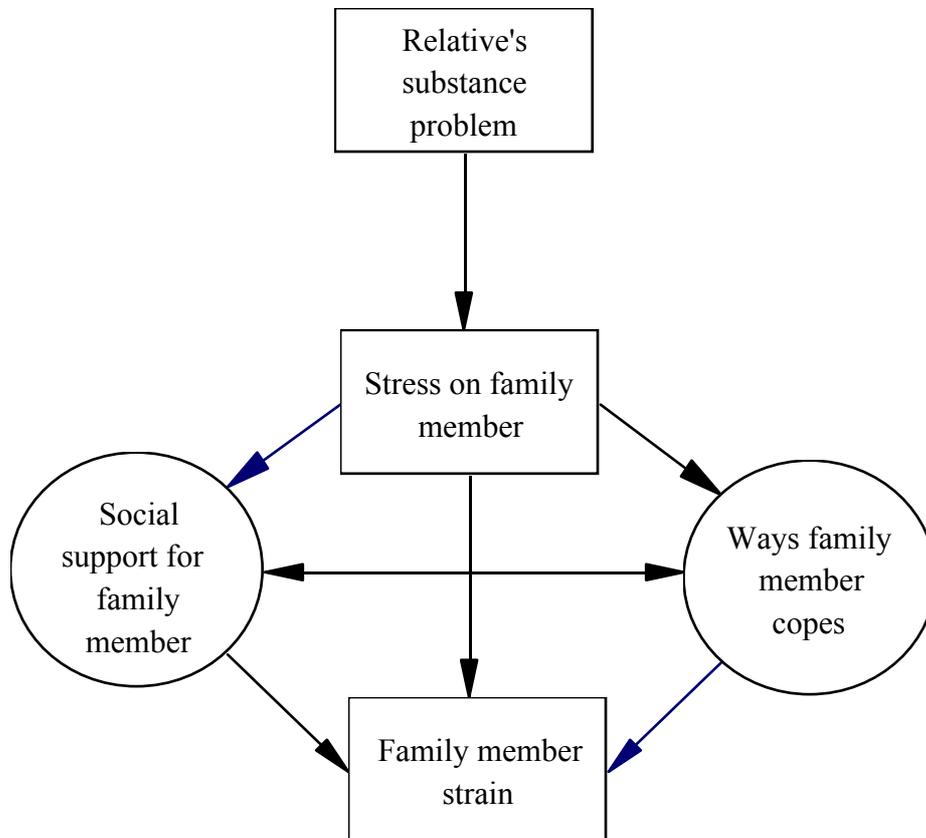
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**Table 1: Main ways in which the SSCS model differs from models of family pathology (AFM: Affected family member)**

	<b>Non-pathological models such as SSCS</b>	<b>Pathology, dysfunction or deficiency models</b>
The AFM experience is similar to...	Other, often chronic, sets of stressful circumstances or disasters such as chronic family illness, unemployment, flood or famine	Other forms of difficulty which are often construed in terms of family pathology, such as anorexia
AFMs are assumed to be...	A cross section of the general population	A group selected in terms of dysfunction or deficiency
Are AFMs' actions construed as deficient or maladaptive?	No. They are viewed as understandable given the particular events and circumstances to which AFMs are exposed	Yes, sometimes
Are factors to do with the family member, her/his relationship with the substance misusing relative, and/or whole family factors seen as causes of the substance misuse?	Not emphasised. Causes are seen as multiple, including the exposure of the substance misusing relative to opportunities for alcohol/drug consumption	Yes, often seen as amongst the most important causes
Key concepts	Stress, strain, coping, support	Deficiency concepts such codependency, family enmeshment, enabling
AFMs have the power to...	Act to maintain own health and to assist the substance misusing relative	Help themselves but are powerless to help the substance misusing relative
AFMS need...	Good quality social support to help them cope	Individual or family therapy

**Figure 1: The stress-strain-coping-support (SSCS) model**



**Relative's substance problem**

- I. Stress on family member**
  - A. Ways family member copes**
  - B. Family member strain**
  - C. Social support for family member**

