



## Alcohol and families

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## Introduction

The impact of alcohol problems in the family has been a sub-topic for as long as there has been a field of alcohol studies. But it has always remained on the periphery of the field, never offering models of understanding or ways of intervening which have become routine parts of service provision. Up to the 1980s there had been sporadic work in a number of other countries including the USA (e.g. Jackson, 1954; Ablon, 1979), Finland (Holmila, 1988), Serbia (Gacic et al, 1980), Russia (Sysenko, 1982), Australia (Kamien, 1995), and Mexico (Figueroa-Rosales, 1971). The UK contributed at least its fair share, with notable research groups for example in Dumfries, London and Newcastle. The Dumfries group explored relationships between men with drinking problems and their wives using the technique of interpersonal perception which was popular at the time (e.g. Drewery and Rae, 1969). The London group explored the way wives coped with their husbands' excessive drinking in the context of the treatment versus advice trial (Orford et al, 1975, 1976). The Newcastle group developed the first UK-grown method, termed 'co-operative counselling', for responding directly to the needs of family members affected by and concerned about the problem drinking of a relative (Yates, 1988).

## Existing research

But that work remained highly specialised and none of it became mainstream. In our view this is partly attributable to the lack of a model of problem drinking and family functioning which was widely acceptable and would sit happily within developing public services. The latter increasingly recognised the large scale of the problem, the fact that alcohol problems presented themselves in a wide variety of settings, especially primary care, and was increasingly oriented towards evidence-based, cost-effective, user-acceptable services. Two specialist models have been promoted but neither fits the bill, particularly in the UK context. One, the codependency model (e.g. Cutland, 1998), is somewhat prescriptive, is not in line with ways of understanding the experiences of family members facing other kinds of difficulty or disorder amongst relatives (e.g. mental illness, dementia, domestic violence), and is often unacceptable to service providers. For example, it tends to assume that family members have become 'part of the problem' and are themselves now suffering from a condition - codependency. The other, the family systems model (e.g. Steinglass, 1982; Vetere, 1998), never achieved anything other than very marginal status in the treatment of drinking problems, probably because it required highly specialist training, very intensive supervision, and a degree of engagement on the part of several members of the same family which is often difficult to achieve when there is an active drinking problem in the family.

The absence of a widely acceptable model is only half of the problem. The lack of service commitment to families is the other. Primary health care professionals are not confident in recognising or dealing with alcohol problem-related family problems, and the specialist alcohol services, whilst they may pay lip service to the importance of family aspects, generally devote very little of their resources to them (Howells, 1996; Velleman and Orford, 1999; Copello et al, 2000a).

The last decade of the 20th century saw welcome indications that the situation is changing. A number of new family treatment approaches have been developed, particularly in the USA, Australia and the UK.

Signs that the topic was maturing and moving towards the mainstream in the USA were the publication of O'Farrell's (1993a) edited book, *Treating Alcohol Problems: Marital and Family Interventions*, and the dedication of the 1998 ICTAB (International Conference on the Treatment of Addictive Behaviors) conference to the subject of Addictive Behaviors and the Family. Family treatment approaches from the USA which have been evaluated include: unilateral family therapy (Thomas and Ager, 1993), behavioural marital therapy (O'Farrell, 1993b; Noel and McCrady, 1993), community reinforcement-type family treatment (Meyers et al, 1996; Miller et al, 1999), and network therapy (Galanter, 1993, 1999). What all these approaches have in common is a theoretical stance which is broadly social-behavioural, and between them approaches to treatment which allow for a variety of combinations of family members (a single affected family member, couples, larger networks). Evaluation studies have focused on two related sets of outcomes 1) better coping and improved health for family members, and 2) increased rate of treatment engagement and reduced drinking for problem drinking relatives. In Australia an approach known as the 'pressures to change' method for family members has been developed and evaluated, in which the emphasis is on helping family members find ways to encourage their problem drinking relatives to change (Barber and Crisp, 1995). Other very relevant work is that of Moos and his colleagues who have studied the effects of treatment for alcohol problems (not itself family oriented) on family members (Moos et al, 1990).

### **Development in the UK of a stress-strain-coping-support model and family interventions**

The UK has been a leading player in these recent developments, in particular through the work of individuals and groups associated with the Alcohol, Drugs and the Family Special Interest Group, which brought together people from a number of centres over a period of several years from the mid 1980s onwards. In recent years this has centred on a collaborative research programme between the Universities of Birmingham and Bath and associated mental health NHS Trusts. This British work complements work in the USA and elsewhere but has taken a distinctive form. Unlike work elsewhere it has explored in detail, using both qualitative and quantitative research methods, the experiences of family members. The model adopted conceives of an alcohol problem in the family as creating chronic stress for family members, putting the latter at risk of signs of strain, and giving them the task of finding ways of coping with that stress, and of seeking support both professional and informal in meeting that task. Hence the focus of the work has been upon 1) the stresses experienced by family members (e.g. Orford et al, 1998a), 2) the family members' health (e.g. Orford et al, 1998a), 3) the ways in which family members cope (Orford et al, 1975, 1992, 1998b), and 4) the kinds of support that family members either receive or do not receive (e.g. Orford et al, 1998c). The same work has been carried out amongst Sikh families in England (Ahuja et al, 2001), in families living in Mexico City, and in Aboriginal families living in remote Australia. Much of the experience described by English families when there is a drinking problem seems to be universal (Orford et al, 1999, 2001). Conceiving of the experience of family members according to a stress model appears to have been productive in helping understand the family experience. Many family members in these circumstances can be characterised as experiencing chronic high stress, low control and low support, exactly the conditions that would be expected to be associated with poor immune functioning and a high risk of physical and mental ill-health. How to cope in these circumstances creates difficult dilemmas for family members who often find themselves coping in ways (e.g. tolerant-accepting, tolerant-sacrificing, and/or highly engaged in trying to

control a relative's drinking behaviour) which may do nothing to moderate the effects of stress upon family members' own health and may sometimes meet with negative reactions from problem drinking relatives (Krishnan et al, 2001).

The stress-strain-coping-support model has been helpful in looking at change and in developing professional forms of intervention. Three PhD theses (two in the UK, the third in Australia) have shown that family members' ways of coping can change very quickly (towards less tolerance and engagement) and that reported psychological health can improve very quickly, once family members are able to talk to an informed person about their experiences and options (Howells, 1996; Fairburn, 2001; Copello, 2002). One of those theses has demonstrated that such changes can occur even when relatives' substance misuse remains unchanged (Copello, 2002).

Two separate but complementary forms of family-based intervention, with origins in the stress-coping-support work, have been developed in the UK. The first has been designed for family members (wives, husbands, parents, etc) who are concerned about and affected by the excessive drinking (and/or other drug use) of a relative (i.e. 'concerned and affected others' or CAOs). The approach is being tested out in a series of studies in primary care, although the approach would be perfectly suitable for use with family members in more specialist settings. The method, in the form of a 5-step intervention delivered by GPs, health visitors or practice nurses, has been successfully tested in a case series (Copello et al, 2000a, b), and is now the subject of a RCT, also in primary care, comparing the 5-step intervention with the provision of a self-help manual which covers the same content.

The second intervention which has been developed as part of this UK line of family research is Social Behaviour and Network Therapy (SBNT), which is one of the two forms of intervention being compared in the UK Alcohol Treatment Trial (UKATT). Unlike the primary care intervention for family members, SBNT starts with the person with a drinking problem but proceeds by identifying supportive family members and friends and engaging them in the treatment process whenever and as much as is possible (UKATT Research Group, 2001; Copello et al, 2002).

The general approach to families and alcohol problems offered by the stress-strain-coping-support model and the interventions derived from it, being developed in a programme of research in the UK, may offer a way of understanding families and responding to their needs and engaging them in treatment which could be widely disseminated in practice around the country (and perhaps beyond). If results of present trials are promising, much would remain to be done; for example testing these interventions in new settings, combining the two approaches (one that starts with a CAO, the other with the person with a drinking problem) into a single form of flexible treatment that fully involves family members, and integrating these treatments with other treatments for alcohol problems that are more individually based.

## Recommendations for future research

1. Research on how to influence the policy of service providing agencies, both at primary and secondary level, to include a more contextual and family-focused approach.
2. The development and evaluation of family-focused interventions that reach family members at an earlier stage in the development of alcohol problems.
3. Further research on the relationship between alcohol misuse and family functioning: for example clarifying the impact on family functioning of different patterns of heavy alcohol consumption.
4. More research on alcohol-related family and domestic violence. Such research should link the two, hitherto largely separate, research areas of alcohol-related problems and domestic violence. It should include social policy research.
5. More research on ethnic and cultural variations in the relationship between excessive alcohol use and the family.
6. Research that starts to make a link between existing work on alcohol, drugs and the family, with its background in the clinical area, and work on community influence, area regeneration and development, and community psychology generally.

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