

**EXPLORING THE HELP-SEEKING EXPERIENCES OF
FAMILY MEMBERS AFFECTED BY SOMEONE ELSE'S
DRUG AND/OR ALCOHOL USE.**

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ABSTRACT

Background & Aims: The impact of an individual's drug or alcohol use on their family members has been widely acknowledged and policy and clinical practice guidelines advise that drug and alcohol services offer family members practical and therapeutic support. However, research in this area is limited with a focus on the experiences of children affected by parental drug and alcohol use or how family members can help improve outcomes for their relatives in treatment for drug and alcohol use. Little is known about the experiences of affected adult family members in receipt of support services for themselves. The current research aimed to explore the impact that having a relative who uses drugs and/or alcohol had on family members' lives as well as affected family members' experiences of seeking help for themselves. **Method:** Semi structured interviews were carried out with eleven adults affected by a family member's drug and/or alcohol use and receiving support from a family, partners and friends service in London. Interviews were transcribed verbatim and analysed using thematic analysis (TA), informed by Braun and Clarke's (2006) six-phase model of TA and underpinned by a critical realist epistemology. **Results:** The analysis produced five main themes across the data. Each indicated important factors in the journey of having a relative who uses drugs or alcohol. The themes were: 'family members' distress'; 'ruptures in relationships'; 'responsibility'; 'routes to receiving help' and 'relieving the pressure' **Conclusion:** The results of the analysis highlight the multi-faceted impact of drug and alcohol use on affected family members' lives as well as the ways that services could help to facilitate help seeking. Findings support previous literature surrounding affected family members and drug and alcohol use and offer new insights into family members' motivations for seeking help, as well as why many family members become isolated. The findings highlight the need for ongoing research in this area. Implications for future research, policy and clinical practice are discussed.

List of Abbreviations

FPF	Family, Partners and Friends
SSCS model	Stress-Strain-Coping-Support model
IAPT	Improving Access to Psychological Therapies
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
UK	United Kingdom

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CHAPTER ONE: INTRODUCTION

Numerous theories and studies have indicated that an individual's drug or alcohol use has a negative impact on their family and the systems around them (Orford, Velleman, Copello, Templeton & Ibanga, 2010). Although literature exploring these negative impacts is steadily growing, more is known about the impact of parental substance use on children than there is about the impact of drug and alcohol use on adult family members (Copello, Velleman & Templeton, 2005) and little is known about the help-seeking experiences of affected family members. This research set out to explore the effects of adults' drinking and drug use on their adult family members and the help seeking experiences of those affected family members.

1.1. Overview of the Chapter

In this chapter I will outline definitions of drug and alcohol use. I will go on to set the context by describing prevalence rates and relevant statistics with regards to those who use drugs and alcohol and those who are affected. This will be followed by a critical review of relevant theory, research and policy. I will conclude the chapter with a rationale for the current study, the research aims and questions.

1.2. Drug & Alcohol use in the UK

1.2.1. Language

I have opted to write in the first person, in keeping with the aim for reflexivity in qualitative research (Webb, 1992). Inverted commas have been used to denote words that have multiple interpretations or are contested.

1.2.2. Terminology

A variety of terms are used to describe 'problematic' drug and alcohol use. Examples include; addiction, drug and alcohol dependency and substance use/misuse/abuse. Drug and alcohol dependence has been defined by the Department of Health (DOH) as; characterised by cravings, inability to control

substance taking behaviour, tolerance, withdrawals and persistent substance use despite harmful consequences (DOH, 2012). Addiction has been defined as 'not having control over doing, taking or using something to the point where it could be harmful to you' (NHS.uk, 2015).

The terms 'addiction' 'misuse' 'abuse' and 'dependency' are viewed by many as having moral, value laden connotations and implications about social unacceptability (Ghodse, 2005). Furthermore, there is ambiguity in the literature about what is meant by these terms, sometimes it denotes frequency and quantity of use, sometimes it denotes nature of use (i.e. illegal drug). In an effort to avoid conceptual ambiguity and value judgements, I have opted to use the terms: 'drug or alcohol use' or 'drinking' throughout this thesis. In the literature review, it will be noted whether research is about alcohol or drugs and the type of drug, where the information is available.

1.3. Prevalence of Drug & Alcohol Use in the UK

'Problematic' drug and alcohol use is deemed to be an individual and public health issue in the UK and worldwide (HM Government, 2010; World Health Organisation, 2007; 2016), associated with health, economic and social harm; such as poverty, family breakdown and crime. In 2015-16, an estimated 2.7 million adults (aged 16-59) in England and Wales had taken an illicit drug in the last year and 11.4 million adults (aged 16-59) had taken an illicit drug in their lifetime (Home Office Statistics, 2016). The prevalence of illicit drug use in England and Wales has been measured by the Crime Survey for England and Wales (Home office Statistics, 2016). It is an annual household survey of a nationally representative sample of adults (aged 16-59). In 2015-16 the most commonly used drug in England and Wales was cannabis with around 2.1 million adults reporting to have used it in the last year (Home Office Statistics, 2016). After cannabis, the second most commonly used drug in the last year was reported to be cocaine powder with around 725,000 adults having used it. Ecstasy was reported to have been used by 492,000 adults in the last year. A low number of adults reported to have used new psychoactive substances, also

known as 'legal highs' in the last year. Fewer than 1 in 100 adults which equates to 244,000 adults. The drugs that were reported to be the least commonly used were opiates (0.1%), crack cocaine (0.1%) and methamphetamines (0.0%). These figures only highlight how many people report to have used specific drugs in a one year period rather than how often they were used in that year or whether the use was deemed to be problematic. Given that these figures are based on a self-report measure, it is worth considering whether they reflect the social acceptability of reporting cannabis use and the under reporting of other drugs such as crack cocaine and opiate use due to lower social acceptability (Home office Statistics, 2016). Furthermore, 'problematic' opiate and crack cocaine use can lead to people being marginalised and becoming homeless or institutionalised (United Nations Office on Drugs and Crime, 2017). Therefore, people who use these drugs may not be captured in surveys sent out to 'typical' households.

Data from a self-report survey shows that in 2014, 12.5 million adults over the age of 16 in Britain reported to have consumed more alcohol than the weekly low risk threshold and 2.5 million reported to have consumed more than the government's recommended weekly limit of alcohol in a single day (Health & Social Care Information Centre, 2016). In 2014-15, increased frequency of alcohol consumption was associated with increased levels of drug use in the last year among adults aged 16- 59 (Health & Social Care Information Centre, 2016).

All drug treatment services in England routinely collect data about the number of people receiving drug and alcohol treatment which is recorded by the to the National Drug Treatment Monitoring System (NTDMS). These statistics highlight the high prevalence of polydrug use amongst individuals in treatment, which is when people use more than one drug sequentially or concurrently to enhance the psychoactive effect. In 2015-16, 288,843 individuals were in contact with drug and alcohol services (Public Health England, 2016). The largest proportion of adults in treatment (52%) were in treatment for opiate use. Forty one percent of individuals were using both opiates and crack cocaine. Fifty percent (144,908) of adults in treatment presented with alcohol problems, making up the second largest group in treatment. Of those, 85,035 were treated for drinking alone and

59,873 were treated for alcohol use alongside other substances (Public Health England, 2016).

1.4. International Prevalence of Drug & Alcohol Use

The World Health Organisation (WHO) statistics show that alcohol is consumed worldwide, though the rates of consumption and level of health impact vary between countries. In general, more alcohol is consumed in countries which have the greatest economic wealth (WHO, 2014). Recorded data on annual alcohol sales show that compared to the rest of the world, during the year 2013, the UK had relatively high rates of alcohol consumption per person along with countries such as Australia, Belgium and Spain (OECD Health statistics, 2015). The highest rates of alcohol consumption in the year 2013 were recorded in Estonia, Austria, Lithuania and the Czech Republic. The lowest rates of alcohol consumption were recorded in India, Turkey, Israel and Indonesia where alcohol consumption is restricted among some populations due to religious and cultural traditions (OECD Health statistics, 2015).

Globally, an estimated 255 million adults aged 15-64 used an illicit drug at least once in the year 2015 (United Nations Office on Drugs and Crime, 2017). This equates to about 5 per cent of the world population. Of those, 29.5 million were considered to exhibit problem drug use (regular use, drug use 'disorder' or 'dependence'). Cannabis was the most used drug worldwide based on a self-report questionnaire, followed by amphetamines, 'misuse' of pharmaceutical opioids, ecstasy, opiates (heroin and opium) and then cocaine. Opioids including heroin were associated with the most negative health impact and globally, on average, more people received treatment for cannabis and opioid use than other drugs (United Nations Office on Drugs and Crime, 2017). Of note, what constitutes treatment for cannabis use varies from a one-off online contact or brief intervention in an outpatient clinic to more comprehensive treatment of cannabis and co-occurring health problems treated in in-patient or outpatient settings. Variation in the drugs people commonly receive treatment for were reported across continents. In 2015, most people were in treatment for opioids in

South-West and Central Asia and Eastern and South-Eastern Europe. There were high numbers of people in treatment for Cannabis and Cocaine use in Latin America and the Caribbean. The majority of people receiving treatment for drug use in Africa was for cannabis use (United Nations Office on Drugs and Crime, 2017). The above data represents the best data available from member states submitted to the United Nations through an annual report questionnaire. However, there are variations in the methodology used and quality of data available from different countries.

It is reasonable to infer from the statistics outlined above that for each individual who uses drugs and alcohol there are likely to be large numbers of family members and other significant people in their lives. Nonetheless, drug and alcohol theories and interventions continue to focus on the individual using drugs or alcohol despite the significant impact of an individual's drug or alcohol use on the people close to them (Copello & Orford, 2002; Copello & Walsh, 2016).

1.5. 'Affected Others'

1.5.1. Prevalence

The adults affected by somebody else's drug or alcohol use are an underacknowledged group (UK Drug Policy Commission, 2009). Therefore, the number of adults in the UK affected by somebody else's drug use is unknown and it has been argued that this is due to the individualistic nature of drug treatment services and the associated lack of routine data collection about family members (Copello, Templeton & Powell, 2010). However, in 2008 the UK Drug Policy Commission (UKDPC) developed a model to estimate that at the very least nearly 1.5 million adults were significantly affected by a relative's drug use based on adults living with a person who is 'dependent' on an illicit drug (opiates, crack cocaine, cocaine powder and cannabis) and who were not themselves, using illicit drugs (UKDPC, 2009; Copello, Templeton, & Powell, 2009, 2010). The authors acknowledge that this is likely to be an underestimate as it does not capture adults who are not living with their family member but who are nevertheless concerned and affected by their drug use nor the impact of lower levels of drug use on affected others. These estimates did not include the effects

of alcohol. However, it can be assumed that the estimates of people affected by alcohol use is significantly higher given that alcohol use is more prevalent than drug use in the UK (UKDPC, 2009).

1.5.2. Societal Costs

The cost of harm that families affected by relatives' opiate or crack cocaine use experience in the form of financial and health care costs has been estimated at about £1.8 billion per year in the UK (Copello et al., 2009; UKDPC, 2009).

Moreover, the support that they provide would cost the NHS or local authorities about £750 million if it were not provided by family members. These estimates were produced with limited information sources on which to base them on so are intended to be conservative estimates. In the absence of any robust UK evidence, the £1.8 billion per year figure was produced by applying data from the United States to the UK to examine average annual financial costs per family member and average excess annual healthcare costs per family member. These figures were then applied to the number of family members estimated to be affected; costs were only attributed to partners and parents as they were estimated to provide most of the care. Family members provided health and social care resource savings through providing support such as accommodation and detoxification at home. Financial costs incurred by family members included day to day financial support, money given to relatives to help them obtain drugs, crime on family members (e.g. theft to fund drug use), loss of employment opportunities and affected family members' own health care costs due to the stressors associated with drug use within the family. Research in the United States has found that the physical and psychological impact that an individual's drug or alcohol use had on family members was associated with an increase in family members' use of health care services (Lennox, Scott-Lennox & Holder, 1992; Ray, Mertens & Wiesner, 2007).

The limitations of translating research evidence from the United States to the UK context to provide estimates were made explicit in Copello and colleagues' (2009) report. Namely that health care systems in the United States and UK are financed differently and there are differences in demographic patterns within the healthcare systems with regards to ethnicity and deprivation. Nonetheless, these

figures provide a starting point for understanding the cost of harm to families within the UK and highlight the enormity of the impact drug and alcohol use can have on affected others as well as the economic value of the support they provide.

1.6. Policy

Historically UK policy has focused individualistically on intrapsychic effects and solutions to drug and alcohol problems. Any brief mention of families pertained to the ways that families were part of the problem rather than the solution or any reference to their own wellbeing (Velleman, 2010). There has been a recent shift in acknowledgement of families within national and local drug and alcohol policy including the drug strategy, alcohol strategy and the recovery agenda (HM Government, 2012; HM Government, 2010; UKDPC, 2008). It is promising that the national drug strategy makes some reference to the need to consider "...the provision of support services for families and carers in their own right" (HM Government, 2010; p21). However, there is more of a focus in policy on how families can be utilised as a vehicle for enhancing the entry, retention and outcomes of people using drugs and alcohol in treatment as opposed to the needs and experiences of affected others in their own right (Copello & Templeton, 2012). This could potentially hide the individual needs of the people within the support network of people who use drugs or alcohol. Similarly to what has been noted in literature regarding carers of people with mental health problems (Oyebode, 2003), concerned and affected others are likely to be in a better position to support the person using drugs or alcohol if their own wellbeing is also considered.

There is also a policy focus on children affected by parental substance 'misuse' with a discourse of dysfunctional or vulnerable, 'at risk' families (HM Government, 2015). For example, the national drug strategy sets out aims to provide treatment for children whose parental substance use may be putting them at risk, providing parenting support alongside parents' drug treatment and generally protecting children from harm where there is parental drug use (HM Government, 2010).

The national alcohol strategy includes a similar narrative around protecting children from 'troubled families' (HM Government, 2012) There is no doubt that these are important measures to take. However, Velleman (2010) argues that to focus solely on children neglects the needs of other family members who are affected and misses an opportunity to support other adult affected family members which in turn is likely to contribute to the wellbeing of children.

Treatment for heroin and crack cocaine use has been a political priority due to the harms associated with their use. The 'Harm reduction' discourse within government policy (HM Government, 2010) focuses on drug-related harms to individuals and society. Strategies to reduce harm include substitute prescribing, and needle exchanges, preventing drug related deaths and the spread of blood borne viruses. Currently, 'harm reduction' is approached at an individualistic level. Arguably, supporting family members would also reduce harms from the impact of an individual's drinking and drug use on their family member's health and psychological wellbeing. Improved relationships with family members, friends and partners is acknowledged as one indicator of recovery (HM Government, 2010). More research into the ways that family members are affected by their relatives' drinking and drug use will aid understanding of how relationships can be improved.

More financial investment has gone toward the treatment of drug problems than alcohol problems despite use of alcohol being associated with similar harms to individuals and families, such as crime and poverty (HM Government, 2010). Unlike drugs, alcohol is part of cultural and family life in the UK. Pubs, bars and clubs are revenue generators for the economy and alcohol production, retail and hospitality industries employ large numbers of people. Simultaneously, harmful use of alcohol contributes to crime and antisocial behaviour and preventable illness, costing the NHS an estimated £3.5 billion a year (Public Health England, 2014). Recent concerns about rates of people attending Accident and Emergency departments with alcohol related ill-health is drawing attention to the need for increased government funding for alcohol treatment services (Currie, Davies, Blunt, Ariti & Bardsley, 2015).

The National Treatment Agency (2008) and The National Institute for Health and Care Excellence (NICE, 2011; 2007) guidelines have acknowledged the need to support adult family members and significant others in their own right. However, the translation of these guidelines in practice is variable across England and Scotland (Copello & Templeton, 2012). The NICE guidelines (2011; 2007), recommend drug and alcohol treatment services offer family members a carer's assessment, guided self-help, information and advice but there is a lack of consistent practice based evidence for what works. Family interventions are not implemented in routine practice (Fals-Stewart & Birchler, 2001; Williams, 2004). Furthermore, research has found that relationships between services, policy makers and carers of people with drug and alcohol problems in Scotland is poor (Orr, Barbour & Elliott, 2014). Interviews and focus group data revealed a dominant narrative among service providers and policy makers of carers being part of the problem. In this study carers were defined as someone over the age of 18 who self identifies as being responsible for the care of someone who uses drugs and/or the children of the individual who uses drugs. Narratives were filled with constructions of carers as unable to provide reliable and consistent support for their relative who was using drugs due to their own issues such as fractured relationships, poverty and unemployment. Subsequently carers felt misunderstood and unconvinced that services wanted to engage with them. This created barriers to family involvement with drug services and led to poor communication between adult drug services and carers.

A thematic analysis of interviews with commissioners in the UK about implementing policy guidance to engage and support adult family members affected by somebody else's drug or alcohol use (Copello & Templeton, 2012), identified four main themes. Firstly, commissioners did not feel that they had a good understanding of the prevalence rates of affected family members to guide service provision. Secondly, affected family members rarely initiate help from professionals; possibly due to stigma, shame and not identifying as a 'carer'. The third theme was that commissioners were unsure what support to offer. Lastly, commissioners felt there were no clear referral pathways for families. Most services were undergoing a process of retendering and recommissioning which

for some was perceived as a threat to family provision and to some an opportunity to put more in place for families. These findings raise questions about what would help significant others to access support and what that support should look like.

In summary, the needs of the large number of family members affected by a relative's drinking or drug use has been acknowledged. As such, policy and guidelines encourage service providers to support affected others. I will now provide a review of the relevant literature that has been published in this area.

1.7. Literature Review

1.7.1. Literature Search Strategy

I searched the following databases for literature concerning people affected by somebody else's drug and/or alcohol use: PsycINFO, PsycARTICLES and CINAHL Plus. The search was filtered by the year of publication (1980 to March 2017) to reflect the time frame that research into the experiences of family members affected by relatives' drug and alcohol use began to emerge. The search yielded 3,477 results. After duplicate articles and articles not relevant to the topic of the current research were discarded there were 79 articles left which were reviewed. I also searched Google Scholar and grey literature for articles relevant to themes mentioned in the core articles. Due to the paucity of UK based studies in this area, the search was not restricted to studies carried out in the UK but was limited to work written in the English language. Search terms used included variants of the word 'family' combined with a variant of 'drug' or 'alcohol misuse' and 'help-seeking' (see appendix A for a full list of search terms).

1.7.2. Structure of the Literature Review

In this literature review I will evaluate literature pertaining to the experiences of adults affected by family members' drug and/or alcohol use and their experience of help-seeking. I will begin by outlining the historical context of research and theory surrounding drugs, alcohol and families, contrasting this with more recent views and developments in the field. I will then review evidence for the various

ways that family members are affected, the interventions available to them and discuss relevant help-seeking theories and research.

1.8. Historical Research into Families Affected by Drugs and Alcohol

1.8.1. Pathology Models

Historically, family members have been viewed negatively within the dominant discourse of the literature (Orford et al., 2005). Within pathology models, families are viewed as the cause of drug and alcohol problems whereby pathology within the family environment serves to develop and maintain the problem. Factors such as genetic risk, family structure and parent-child relationships have all been described as contributors to the development and maintenance of drug and alcohol problems (Bierut, et al., 1998; Selnow, 1987). Many studies which support genetic risk factors for drug and alcohol use in families downplay environmental factors (Guze, Cloninger, Martin & Clayton, 1986; Pickens et al., 1991). For example, Bierut and colleagues (1998) conclude from their research that alcohol, marijuana and cocaine 'dependence' are 'transmitted' within families. Conclusions of genetic causality were drawn from correlations which showed that siblings of people with 'alcohol and substance dependence' had an increased risk of developing 'alcohol and substance dependence' compared to siblings of people in a control group. Although they considered and clarified in their analysis that the results were not confounded by family members supplying drugs to their siblings, this is a narrow lens on the many potential social and environmental influences on drug and alcohol use within families such as shared stressors, availability of drugs within their shared environment and the influence of peers.

1.8.2. Co-dependency

One branch of this pathology model is the co-dependency movement which has been influential and began in the 1940s-1960s with research into what the researchers term 'wives of alcoholics'. The co-dependency construct describes partners (particularly wives) of people with drug and alcohol problems as having their own 'psychopathology' which explains their attraction to and desire to satisfy their own needs through living with someone with a drug or alcohol problem (e.g. Rothberg, 1986; Schutt, 1985). Partners have been described as obsessed or pre-

occupied with their relationship with the other person and as 'addicted' to the person needing them (Heineman, 1987).

The co-dependency construct has been critiqued for having sexist assumptions, stereotypical biases and for victim blaming (Decker, Redhourse, Green & Starrett, 1983). It is argued to be a disease model applied to interpersonal relationships which can be internalised as an identity and character flaw and have a negative impact on wellbeing (Anderson, 1994).

Orford and colleagues, argue that "although some of these 'pathology' notions are now of historical interest, the underlying idea that family members contribute to the problem has not gone away" (2005; p6). In contrast, Copello and colleagues strongly advocate for non-pathologising models of the family and interventions designed to support family members with the effect that their relatives drug and alcohol use has on them rather than to treat family members' own 'pathology' (Copello, Templeton, Orford, & Velleman, 2010a). This will be discussed in more detail later in the chapter.

1.9. Family Systems Theory

Family systems theory (Freeman, 1993) suggests that family members are an interconnected group such that anything happening to one member has an effect on other family members. 'Problematic' drug and alcohol use in the family affects family functioning which in turn affects the person who is drinking or using drugs (Liepman, Silvia, & Nirenberg, 1989). A family systems technique for assessing family interactions called family behaviour loop mapping (Rotunda, Scherer, & Imm, 1995) posits that drug and alcohol use can serve a function within the family as a solution to other family problems when the family are unable to cope effectively with a crisis. Additionally, the ways that families respond to their relative's drinking and drug use can inadvertently maintain the problem (e.g. by 'enabling' them to continue their use of alcohol or drugs while meaning to be supportive).

This allows families to see how they function during periods of drug and alcohol use and abstinence which could enable them to engage in patterns of behaviour that support abstinence. However, this model assumes that there are correct and incorrect ways to respond to a relative's drinking or drug use. It emphasises the whole family system rather than the impact of drug and alcohol use on individual family member.

1.10. Impact of Drug Use on Adult Family Members

There is growing evidence for the negative impact of an individual's drug and alcohol use on their relatives in the UK, predominantly carried out by a small team of researchers (Copello & Walsh, 2016; Orford et al., 2005; Velleman, et al., 1993) and in other countries (Arcidiacono, et al., 2010; Berends, Ferris, & Laslett, 2012 & 2014; Csiernik, 2002; Dussailant & Fernandez 2015; Husaarts, Roozen, Meyers, van de Wetering, & McCrady, 2012; Selbekk & Sagvaag, 2016). The stresses experienced by families from the effect of drug or alcohol use has been found to be similar across cultures (Arcidiacono, Velleman, Procentese, Albanesi & Sommantico, 2009; Orford et al., 2005; Velleman & Templeton, 2003).

Some contrasts between cultures have been observed. For example, white English family members in the south west of England emphasised concern about the impact of their relative's drug or alcohol use on the affected family member's individual autonomy owing to a more individualistic culture. Conversely, the more collectivist close knit family and community networks provided the potential for social support within the Pakistani-Kashmiri community in the West Midlands but at the same time a dominant feature was the threat of greater exposure and dishonour. In Mexico, family members living in poverty were particularly concerned about the threat to family financial security due to drinking and drug use (Orford et al., 2001; Orford et al., 2010). These studies referred to illicit drugs and alcohol and did not specify the types of drugs that were being used. The impact on family members may vary by type of drug or drugs being used by their relatives. There was no mention in these studies about whether the affected family members were

asked if they drink or use drugs. This information would help to assess whether family members' experiences may be influenced by their own drinking or drug use.

Drug and alcohol use has been found to have a multi-faceted impact on people who use drugs and alcohol and the systems around them (Copello et al., 2005), affecting areas such as physical and psychological wellbeing, social life, employment, relationships and finances. Research as early as the 1980s found an individual's drinking to impact the emotional wellbeing of significant others. For example, Jung (1986) gave questionnaires to college students about a 'problem drinker' they were affected by. The majority of affected others in the study reported that they drank alcohol themselves, but on the whole, reported to have drunk less frequently and less on each occasion (lower quantity) than their significant other who they viewed subjectively as a problem drinker.

Severity of the impact of an individual's alcohol use on family members has been found to be significantly associated with them living together (Berends, Ferris, & Laslett, 2012). This study highlights the negative impact of alcohol use on family members across a large geographical spread of participants in the general population in Australia. Through telephone surveys, 415 respondents who responded yes to having a family member who was a 'fairly heavy drinker' or 'drinks a lot sometimes' were asked closed ended questions about whether and how often they had been negatively impacted in a certain way in the last 12 months. The description of the methodology does not mention asking participants about their own drinking. Therefore, the participants own drinking has not been ruled out as a confounding variable impacting the severity of their negative experience. These findings are relatively comparable to the UK as rates of drinking in Australia have been found to be similar to drinking rates in the UK (OECD Health statistics, 2015).

In the UK family members have reported to have had arguments over money or to be disadvantaged by financially helping their relative who uses drugs, for example providing accommodation, assisting with childcare (Copello, Templeton, & Powell, 2010) or assisting when a relative loses their job (Burton-Phillips,

2007). Results from a study carried out in Germany suggests that treating alcohol use with detoxification reduces family financial burden and improves quality of life (Salize, Jacke, Kief, Franz, & Mann, 2013). Financial burden and quality of life were only measured one year after detoxification, so the results do not indicate whether improvements were sustained.

Research has found that supporting family members can have a positive effect on their psychological wellbeing (e.g. Miller, Meyers & Tonigan, 1999; Roozen, de Waart, & van der Kroft, 2010) and in turn enhance the wellbeing of their relative who uses drugs or alcohol. Consistent with the systemic notion of circularity (Guttman, 1991), the wellbeing of people who drink or use drug is likely to further enhance their family members' wellbeing.

1.10.1. Stress-Strain-Coping-Support Model

The Stress-strain-coping-support (SSCS) model was developed in the UK by Orford, Copello and colleagues (Orford, Templeton, Velleman & Copello, 2005; Orford, Copello, Velleman & Templeton, 2010) as an alternative to pathology models and systemic models which the researchers argued are both blaming of affected family members, centring on dysfunction within the relationship. In contrast the SSCS model aims to be a non-blaming approach to understanding the needs of affected family members and social networks, in their own right. The premise of the model is that family members are understood to be ordinary people affected by the stress of their relative's drinking or drug use. The family members engage in a number of behaviours in response, which are described by the model as 'methods of coping.' Three methods of coping are described: 'putting up' (e.g. accommodating or tolerating drug or alcohol use), 'withdrawing' (e.g. distancing oneself, distraction, focussing on one's own needs) and 'standing up' (e.g. efforts to control their relative's drinking or drug use, no longer tolerating it). Family members often experience dilemmas about how to cope often oscillating between engaging with their relative's drug use problems or leaving them to their own devices (Velleman et al., 1993). The way in which family members cope with the situation impacts on the level of physical and psychological strain experienced by the family. It follows that improving family

members' ability to cope through providing knowledge and developing and enhancing social and professional support is imperative for reducing affected family members' stress and strain. Good quality social support has been found to act as a buffer against ill health (Cohen & Wills, 1985). The 5-step intervention, discussed later in this chapter, was born out of the SSCS model as a way to address affected family members' individual needs.

The SSCS model has been tested using standardised measures (Orford et al., 2005) and recently received support from a study conducted in Greece which reported that families respond to their relatives' drinking or drug use in ways consistent with the SSCS model (Fotopoulou & Parkes, 2017).

1.10.2. Health Impact

Family members of individuals who use drugs and alcohol have been found to have a heightened risk of physical and psychological health problems (Benishek, Kirby & Dugosh, 2011; Orford, 1990; Orford et al., 2010; Ray et al., 2007; Roberts & Brent, 1982; Wiseman, 1991). Adult family members living with a relative who is drinking or using drugs repeatedly obtain high mean scores on the Symptom Rating Test (SRT): a standard measure of general ill-health (Orford, Velleman & Copello, 2005).

It has been argued that the significant global impact of drug and alcohol use on affected family members' ill health has been neglected by research and policy (Orford, Velleman, Natera, Templeton & Copello, 2013). Quantitative and qualitative cross cultural data collected from the UK, USA, Mexico and Australia, has revealed that affected family members commonly referred to health complaints such as poor eating and sleeping, an increase in their own substance use such as tobacco smoking and use of prescribed medication and physical health symptoms (e.g. headaches, hypertension, asthma, palpitations and back pain) (Orford et al., 2013).

Similar findings were found by a large quantitative study carried out in the USA (Ray, Mertens & Weisner, 2009). Using a regression analysis to compare 25,464 family members of people diagnosed with 'alcohol or drug dependency' to matched

controls whose relative had been diagnosed with asthma or diabetes, family members affected by a relative's drug or alcohol use were more likely to be diagnosed with 'trauma', 'depression' or 'substance dependency' and had higher healthcare costs than family members of people with diabetes or asthma over a three-year period. Although causation cannot be inferred from the results, the fact that family members of people diagnosed with 'drug or alcohol dependency' were consistently more likely to be diagnosed with 'depression', 'trauma' and 'substance dependency' suggests there may be unique stressors associated with having a family member with a drug or alcohol problem. Alternatively, the findings could reflect that affected family members of people who use drugs or alcohol are more likely to receive these diagnoses because they are in contact with mental health and drug services when accompanying their relative or they are more likely to seek help for their mental health than family members of people with physical health conditions.

1.10.3. Family Relationships

Research has found that an individual's drug use can cause huge strain on relationships within the family and lead to a distortion of roles within the family dynamic (Barnard, 2006). For example, the findings from a large telephone survey carried out in Australia revealed that being emotionally hurt and having serious arguments were commonly reported by family members of people who use alcohol in the general population (Berends, Ferris & Laslett, 2014). A study utilising the same data found that those who described themselves as taking on a caring role due to their family member's drinking reported a lower quality of life than those who did not (Jiang, Callinan, Laslett & Room, 2015).

Barnard (2005) carried out qualitative research in Scotland into the effects of drug use on family life from the perspective of parents and siblings. The index family members were aged 16-26 and had long standing issues with drug use (heroin or polydrug). Most participants were recruited through a local drug service. Some participants were recruited through a family support group. Semi-structured interviews were carried out with 24 index family members their 20 younger siblings and 20 parents (majority mothers). Common themes were that families initially

attempted to contain and manage the drug use, whilst maintaining a 'normal' family life, the negative impacts of the drug use created strain in the form of arguments, drugs being the centre of attention, theft, violence, stress and anxiety. Eventually families excluded the person with the drug problem. Furthermore, role differences between parents and siblings mediated the impact that the drug use had. Parents generally felt responsible for the family including their adult son or daughter using drugs. Whereas the sibling role did not carry the same level of responsibility. However, in a family where parents' attention is diverted to the sibling who uses drugs, brothers and sisters mourned the loss of a supportive, positive, protective relationship they would expect in a 'normal' sibling relationship. However, what was shared between parents and siblings was stress and worry about the wellbeing of their family member who was using drugs. This research highlights the importance of considering the nature of relationships and role expectations when doing research into drugs and alcohol and the family.

Some research has found that an individual's heavy drinking does not have a negative impact on their partner's quality of life (Orford & Dalton, 2005; Livingston, 2009). This could be due to methodological differences such as the use of self-report questionnaires and surveys that measure drinking consumption but do not capture pattern or context of drinking. The 'problematic' nature of the drinking may be more important than the quantity of consumption or there may be potential benefits of the alcohol's effect (e.g. inducing positive moods and sociability).

1.10.4. Social Networks Beyond the Family

It is worth considering that wider social networks, outside of the family, can be affected by somebody's drug or alcohol use and in turn impact upon the individual using alcohol or drugs. Room and colleagues (2010) for example, highlight the harms to an individual's social environment as a result of drinking. It is possible for a neighbour, a colleague or a friend to deem themselves adversely affected by the drinking or drug use of somebody else. However, less is known about this.

Qualitative research in the UK has found that affected family members often have social networks beyond their family who could be a source of support but often

were deemed by family members as being unsupportive due to factors such as being critical and demonstrating a lack of understanding (Orford et al., 2010). Many expressed finding it more helpful to speak to people who have been through a similar experience and are therefore deemed as more likely to understand.

1.11. Family Oriented Interventions

I have thus far outlined evidence for the impact of drug and alcohol use on family members. However, despite the overwhelming evidence, support available for family members is sporadic and ill defined (Orford et al., 2013). Qualitative interviews with commissioners and service providers in England and Scotland revealed that there was significant variation in service provision for families and carers across services. Provision varied from carers involvement with needs assessments, service review and monitoring to support groups for family and carers and there was little emphasis on training a workforce to deliver evidence based interventions to adult family members (Copello & Templeton, 2012).

Velleman and Templeton (2002) posit that the majority of interventions that have been designed with affected family members in mind do not focus on those family members' own needs but rather the outcomes for the person using drugs or alcohol. The interventions that are available in the UK fall into two broad categories. There are those that support the family in their own right, such as the 5-step method and mutual aid groups like Al-anon (Fromme, 1990; Orford et al., 2013). Then there are interventions that are delivered through the family's involvement in the treatment of the person using drugs or alcohol (e.g. social behaviour and network therapy and family therapy) (Copello et al., 2009; Copello, Templeton & Velleman, 2006).

I will outline below the two approaches developed by Copello and colleagues (Copello et al., 2002; 2010) to address affected family members' needs and behavioural couples therapy (Fals-Stewart, Birchler & O'farrell, 1996) which are all supported by NICE guidelines (2008; 2011).

1.11.1 The 5–Step Method

Based on the stress-strain-coping-support model aforementioned, the 5-step method aims to systematically provide support to affected family members in their own right (Copello, Orford, Velleman, Templeton & Krishnan, 2000; Copello, et al., 2010a; Orford et al., 2013). The method utilises family members' coping resources and can be delivered over a series of sessions or in a single session with the aid of self-help material. The five steps are as follows; listening to the family members' experiences to identify stresses, providing targeted information: reducing stress arising from lack of knowledge, exploring coping responses, identifying and enhancing social support and discussing any additional needs. Evaluation of the 5-step method has shown a reduction in affected family members' strain (physical and psychological distress) and improved coping behaviours (Copello et al., 2009; Copello, Templeton, Orford & Velleman, 2010b) and improvements were sustained at twelve month follow up (Velleman et al., 2011). The 5-step method has been proven to be adaptable and flexible to delivery by various health care professionals in a variety of settings including primary care and specialist drug and alcohol services, producing positive outcomes (Templeton, 2009; Templeton, Zohhadi & Velleman, 2007). Among primary care health professionals delivering the intervention an improvement was found in attitudes held and motivations to support relatives of people using drugs and alcohol (Copello, Templeton, Krishnan, Orford & Velleman, 2000).

Copello and Walsh (2016) highlight that affected family members are a highly prevalent group who will come into contact with various services to address the stress associated with a relatives' drug and alcohol use such as primary care or mental health services. In these settings family members needs may not be immediately apparent unless staff are adequately trained to identify and address them. As such, developing family focussed interventions in drug and alcohol services is not sufficient to meet their needs. Psychologists are well placed to train staff and continue research into ways to reduce the harms of drug and alcohol use on affected family members that stems wider than specialist drug and alcohol services. One attempt to make the 5-step method more widely available to people who may not necessarily come to the attention of services was the

development of a web based version (Ibanga, 2010) which was found to have equally positive outcomes.

1.11.2. Social and Behavioural Network Therapy

In contrast with the 5-step method, Social Behavioural Network Therapy (SBNT) aims to involve family members and social networks (including friends and colleagues) in interventions for service users to boost positive support for behaviour change (Copello et al., 2009). It is a psychosocial intervention developed in the UK and tested as part of the UK Alcohol Treatment Trial (UKATT). SBNT was found to be cost effective, reduced alcohol use and improved mental health.

1.11.3. Couples Therapy

Behavioural Couples Therapy (BCT), supported by NICE guidelines (2007;2011) is a structured behavioural approach aimed at both improving communication skills and behavioural interactions in the relationship between the person using drugs or alcohol and their partner and promoting abstinence. Efficacy studies have indicated that BCT leads to reduced drinking and improved relationships (Fals-Stewart, et al., 1996).

1.11.4. Non-therapeutic Support: Self-help Groups and Mutual Aid

There are carers support groups all over the UK, usually delivered by charities or drug and alcohol services. They provide emotional support and information to people who identify as carers of someone who uses drugs or alcohol. Carers who attended a carers support group in the West Midlands reported to benefit from emotional support and learning from others (George et al., 2009). Another avenue of support available are mutual aid groups which generally bring people together to address a shared problem, in the form of peer-led support groups and those based on 12-step fellowships (e.g. Al-non, Nar-anon and Families Anonymous). The limited research into these types of groups is reflective of the anonymous nature of them. However, evaluations that do exist have shown anger, 'depression', family conflict and relationship satisfaction improved for wives who attend al-anon. A reduction was found among people attending al-anon in attempting to control their relative's behaviour (Humphreys, 2003;

Miller, et al., 1999). Al-anon newcomers who were surveyed stated their reasons for attendance were motivated by factors such as the philosophy of al-anon, it's spirituality, anonymity and group dynamics (Timko et al., 2013; Young & Timko, 2015).

1.12. Help-Seeking

The topic of help seeking is worthy of attention because in order to ensure interventions are useful and effective they need to be accessible to prospective service users. Information about the help-seeking behaviour of adults affected by somebody else's drinking or drug use is sparse. One way help-seeking has been defined is as "the intentional action to solve a problem that challenges personal abilities" (Cornally & McCarthy, 2011; p286). This theory posits that help-seeking follows a process of defining a problem, deciding to seek help and actively seeking help. There are many psychological factors such as trust, control, fear, stigma and self-esteem which influence help-seeking behaviour. Social factors have also been found to influence help-seeking (George & Tucker, 1996).

An important factor to consider when researching into help-seeking is an individual's relationship to help (Reder & Fredman, 1996). That is their attitudes, narratives and beliefs about help influenced by societal context and relationships with previous helpers which is likely to influence help seeking behaviour.

Stigma, shame and embarrassment have been noted by previous researchers as potential barriers for relatives of people who use drugs and alcohol seeking help (Ahmedani et al., 2013; Copello, et al., 2005). This is similar to the trends in people who use drugs and alcohol not seeking help (Cellucci, Krogh & Vik, 2006; Cunningham et al., 1993). These factors need to be considered in help-seeking research.

The results of a quantitative study found that psychological distress, family and social problems undermine motivation to enter treatment following referral among people with drug problems (Hser, Maglione, Polinsky & Anglin, 1998). Similar

factors may influence the help-seeking behaviour among the family of people who use drugs and alcohol. However, it has been argued that conclusions drawn from research on help-seeking among referred populations, limits our understanding of the experiences of those who do not engage with services (Broadhurst, 2003), as people may also seek non-professional sources of help in the form of religion, family, and community support.

My literature search revealed there to be a small number of studies that touch on the topic of help-seeking with regards to adults affected by somebody else's drinking or drug use. Most attempt to profile or quantify people who seek help. For example, an Australian study sought to uncover the prevalence and profile of people who call the police or seek health care for the effect of others' drinking (Mugavin, Livingston & Laslett, 2014). They found differences in the profile of people who call the police and people who use health care services. Being older and more educated decreased the likelihood of calling the police because of the drinking of others. Living in regional or remote locations increased the likelihood of contacting health care services. Of note, this study included both people who were affected by the drinking of people they knew and strangers.

A quantitative study in the Midlands UK, surveyed people in contact with an Improving Access to Psychological Therapies (IAPT) service and found that 22 out of 100 people accessing one IAPT service had a relative who was using drugs or alcohol that concerns them and nearly half felt that it contributed to their presenting problems (Newton, Shepherd, Orford & Copello, 2016). The research is limited in that it is a small-scale study and under-reporting cannot be ruled out due to the use of self-report measures. However, the authors conclude that if this result was replicated across IAPT services, then it would be safe to say a significant number of people seeking help from IAPT services are concerned about a relative who uses drugs or alcohol. This suggests that people may seek support from non-drug and alcohol related services for the psychological effects of somebody else's drinking or drug use but may not mention this if not routinely asked. Contrary to what the researchers predicted, most of the affected family members were siblings or parents who were not living with the person using drugs or alcohol. This

highlights that close proximity does not necessarily increase the likelihood of being affected.

Through qualitative research on family dynamics in Scotland (Barnard 2005; 2006) a theme was noted that most parents would seek help from their GP for advice about their adult son's and daughter's drug use but that shame would usually prevent parents generally seeking outside help. Most parents would attempt to resolve the problem within the family because their focus was on the drug use rather than their own needs. Similarly, in a quantitative study in the UK it was found by Howell and Orford (2006) that the majority of people concerned about their partner's drinking problem sought help for their partner alone. Those who sought help for themselves were more likely to do so when there had been domestic violence.

A quantitative study carried out in Brazil highlighted the importance of services considering the difficulties that families face when trying to access help (Sakiyama, Padin, Canfield, Laranjeira & Mitsuhiro, 2015). Through surveying five hundred family members attending mutual self-help groups, they identified that after discovering their relative's drinking or drug (cannabis and cocaine) problem there was an average 2.6 years delay in seeking help by 58 per cent of the sample. Help was sought for the range of problems associated with having a relative who uses drugs or alcohol. Family members sought help from doctors, psychologists, therapists, support groups for themselves and support groups for the individual who uses drugs or alcohol. The main reason for the delay in seeking help was that families downplayed the problem and felt that they could cope with the situation themselves. Participants also reported uncertainty about where to find help. The researchers concluded that services should consider that family members have difficulty establishing when drinking and drug use becomes problematic and that shame may drive family members to want to deal with the problem alone.

A quantitative American study about the variables that predict help-seeking among caregivers of women using inpatient and outpatient substance misuse services found that among eighty-two caregivers, almost half reported that they were

unlikely to seek help. Results of a multiple regression showed that predictors of seeking help were providing assistance with daily living and worry (Brown, Biegel & Tracy, 2011). Of note, this research investigated the experiences of caregivers of women with either substance use problems or co-occurring substance use problems and a mental health diagnosis. Participants interviewed were caregivers nominated by the women in treatment so do not capture the experiences of other people who were not nominated and may be affected.

Qualitative focus groups and interviews were conducted in 2007-2008 with carers, service providers and policy makers in North-East Scotland (Orr, Barbour & Elliott, 2013). The research explored carers involvement with services. They found service providers had limited contact with carers and aspired to involve them more. Carers were sceptical that services wanted to involve them to support their loved one or to help them in their own right. They expected drug services to involve them when their relative went into treatment and were surprised when this did not happen or happened in a limited way. The term 'carer' was contested. These beliefs about services are likely to discourage help-seeking. Dislike of the term 'carer' among some affected family members suggests the need to make sure service promotion material does not inadvertently alienate people with the terminology.

1.12.1. Summary

It is clear from the review that has been presented that there are many ways an individual's drug or alcohol use impacts on the lives of those around them.

Mothers and female partners represent most of the participants in the majority of these studies which may be reflective of the types of family members most likely to take part in research.

There have been mixed findings regarding whether close proximity to the person using drugs or alcohol appears to increase the severity of the impact on family members. This may reflect differences in clinical and non-clinical samples.

Perhaps family members who seek help are less likely to live with their relative who is drinking or using drugs. The similarities and differences that were found across countries and cultures suggests that the stress response is universal and

similar issues are faced by affected family members in different locations. However, there are differences in the emphasis of certain stressors in different cultures due to the socio-political context. This highlights the need for research to be carried out in different towns and cities within the UK as well as other countries so as to consider potential contextual differences.

The areas outlined in this review are unlikely to represent an exhaustive list of the ways a person can be affected by their family member's drinking or drug use. Instead it reflects factors that are measurable through recorded data and that people are aware of or more likely to report. This excludes potential harms of drug or alcohol use that affected family members do not attribute to the drug or alcohol use or are less likely to report, potentially due to embarrassment, or significance of the impact to their lives.

Few studies state whether the affected family members in their sample use alcohol or drugs themselves. This information would help the reader to consider research findings within the context of how the negative impacts reported by affected family members may be complicated by their own drinking or drug use. Many studies outlined in this literature review refer to drug use or drug and alcohol use in general rather than specific drugs. It is worth considering that the impact of specific types of drugs, alcohol and poly drug use may affect family members differently due to factors such as legality and cultural acceptability, financial implications, associated with alcohol and particular drugs and the impact of psychoactive effects of specific drugs (e.g. acting as a stimulant or depressant) on behaviour.

The SSCS model provides a framework to understand the interaction between the stresses and strains associated with a relative's drinking or drug use and a guide for how to intervene. An advantage of the structured nature of the model means that it is non-complex and does not require extensive training (Copello, 2010). The researchers acknowledge that the model is not reductionist and that there is often overlap between the methods of coping they outline. However, as with any structured model there is a danger of it being used in a rigid and unhelpful way that does not account for unique or unexpected stresses, ways of coping or sources of support for family members.

Help-seeking research has found that many affected family members are likely to seek help for their relative using drugs or alcohol rather than for themselves and want to be involved in their loved one's care. There is a discourse of families dealing with the problem alone possibly due to stigma and shame. Variables that influence family members seeking help for themselves appear to be their own mental health issues and experience of alcohol related domestic violence. Research related to help-seeking has been mostly quantitative and profiling. Motivation to seek help has been explored quantitatively but did not explore in detail the nature of worries that encouraged help-seeking. There is scope to explore help seeking experiences in more detail.

1.13. Rationale for The Current Study & Relevance to Clinical Psychology

The impact of drinking and drug use on families has been well documented. Estimates suggest that the numbers of people affected is vast. The severity and cost of harm to family members and society have been established and national policy and NICE guidelines have acknowledged the need for services to support this understated group.

Psychosocial and self-help interventions which address family members' needs have been developed and proved feasible and effective. However, further research is needed to help bridge the gap between policy, guidelines and practice because there is inconsistency and variation in how policy is implemented in practice across the UK.

Little is currently known about help-seeking behaviours and habits among adults who are affected by somebody else's drug or alcohol use. The little research that there is, is mainly quantitative and does not explore in detail the factors influencing help-seeking behaviours and experiences of help-seeking for affected others. Understanding more about the experience of help-seeking for those who have successfully accessed family support services may give clues about how

services can facilitate more people to access and benefit from the support which is available.

To my knowledge most of the research in the UK into the effects of drug and alcohol use on family members has been carried out outside of London (e.g. Scotland, West Midlands and South West of England). Therefore, there is a need to conduct similar research in London to explore potential contextual differences in the findings.

Clinical psychologists have a role in delivering psychosocial interventions within drug and alcohol treatment services as well as training and consulting with staff. It is important that staff assess and support wellbeing within the systems around people who use drugs and alcohol in order to improve outcomes for everyone within the network. Currently, there is considerable variation in how much and in what way families, friends and partners of people who use drugs and alcohol are engaged and supported by drug treatment services, carers services and other healthcare services.

I hope that the results of this study will help to inform service planning and policy around how to design services with a better understanding of the types of issues affected others seek help for, how they like to receive help and how affected others can be facilitated to receive the help available. It is hoped that this study will help to bridge the gap between policy and practice by highlighting potential facilitators and barriers to help-seeking that can be addressed.

1.13.1. Aims

In this study, I aim to explore the effects of an individual's drinking and/or drug use on adult family members' and help-seeking experiences among affected family members attending a third sector service for family, partners and friends. I will explore the impact drinking or drug use has had on their lives, motivations, barriers and facilitators to seeking help and the experience of the help which was received.

1.13.2. Decision to Research the Effects of Both Drugs and Alcohol

I acknowledge that in the UK, there are disparate legal, social and moral implications associated with illicit drug use and alcohol use. I had considered researching the effects of a specific type of drug or alcohol alone on family members. However, given that this is exploratory research into affected family members' own needs and experiences rather than the needs of the individuals drinking or taking drugs, it felt at odds with the research aims and presumptive to categorise people based on the drug their family member was using (assuming this was even known). Furthermore, given the scant research on the topic of help-seeking, this study will begin to explore whether it would benefit our understanding for future research to refine the nature of the substance use family members are affected by.

1.13.3. Research Questions

- What is the impact of somebody else's drug and/or alcohol use on affected family members' lives?
- What have been affected family members' experiences of seeking help for themselves? (motivations, challenges and facilitators)
- What were the helpful and unhelpful aspects of help received?

CHAPTER TWO: METHODOLOGY

2.1. Chapter Overview

I will begin this chapter with an outline of my epistemological position in relation to how I approached the research and reflections on my position as a researcher within the context of the study. This will be followed by an outline of the research design, procedure, participant demographics and ethical considerations. I will conclude the chapter with a rationale for the method of analysis employed for this study.

2.2. Epistemology

Epistemology is a branch of philosophy which refers to how knowledge is acquired (Willig, 2001). Epistemology is related to ontology (the nature of reality and existence). The epistemological position a researcher takes impacts their choice of method for collecting and analysing data as the choice of research method reflects certain claims and assumptions about how knowledge is acquired.

2.2.1. Epistemological Position

The design and analysis of the current research was approached from a critical realist position: retaining an ontological realism but accepting epistemological relativism. A critical realist view is that there are multiple interpretations of reality because reality cannot be accessed independent of our thinking (Harper, 2012). Thus, I take the stance that there is an ontological reality to drug and alcohol use and its impact on an individual's family. However, the nature of the impact of an individual's drug or alcohol use upon another person and the way that its impact is constructed will be influenced by factors such as an individual's beliefs, meaning making systems, experiences, language and societal discourses. Conceptualisation of needs and experiences as an 'affected other' and decisions around seeking help will be grounded within a cultural and societal context (Hammersley, 1992).

2.3. Reflexivity

The critical realist position rejects the positivist notion that researchers are outside observers of objective truth and assumes that research is a social process influenced by the beliefs and values of the researcher. Therefore, reflexivity is important in qualitative research because it enables the researcher to acknowledge and consider their position within the research process (Willig, 2013).

My interest in this topic of research stems from my clinical and research work experience in substance misuse services in London, prior to commencing clinical psychology training. I became aware that interventions tend to be individualistic, yet service users would often talk about their significant others. Additionally, doing research at a carers' charity exposed me to the multi-layered impact of an individual's physical and mental health difficulties on the people close to them. I learnt about the support that they had found invaluable such as respite, advice, counselling and meeting others in a similar situation. However, the numbers of people engaged with the charity who were affected by someone else's drug or alcohol use was scarce which made me wonder about their experiences of seeking help. I was aware that my previous research with carers might make me more likely to hold presumptions about the needs and experiences of the participants in the current study. Thus, I was mindful about remaining curious and open to unexpected responses during interviews.

I shared my interest in the study as outlined above with participants and offered to answer any further questions they had about me or the study prior to interviews. This was done in an effort to create transparency and minimise a potential power imbalance, so that participants would be more open and comfortable. None of the participants took up the offer to ask further questions, which implies that perhaps my position as a researcher and/or trainee clinical psychologist influenced how comfortable participants felt to ask questions despite my efforts to minimise the inherent power imbalance.

I hoped that my non-affiliation with the service I recruited participants from would make it easier for participants to be honest when asked questions about

challenges to seeking help or the unhelpful aspects of help they had received. However, during prior experience of conducting a service evaluation into the reasons why people drop out of an alcohol relapse prevention group, I noticed people were reluctant to make negative comments about the group. This led me to wonder if my position as a trainee clinical psychologist, working within a profession which helps people and is biased towards help seeking being a good thing might make participants more inclined to highlight positive more than negative experiences of help they had received. In an attempt to minimise this, I prefaced these questions with an acknowledgement that seeking help is not always a positive experience.

2.4. Design

2.4.1. Qualitative Research

A qualitative research design was deemed most fitting with the current research aims and epistemological position. Qualitative methods of data collection and analysis aid the in-depth exploration of under researched topic areas (Ritchie, Lewis, Nicholls & Ormston, 2013). It was felt qualitative research would situate people within their context to understand the motivations for help seeking and what underpins decisions and behaviours.

The quality of the research will be evaluated in the discussion chapter using Yardley's (2008) evaluation criteria.

2.4.2. Rationale for Methodological Approach

The use of focus groups was considered but was not utilized within this study because there was a danger of participants being influenced by other people's opinions especially as many of them knew each other from the groups they attended. Instead data was collected via semi structured interviews. It seemed appropriate to conduct semi-structured interviews as they provide an in depth first-hand account of participants' help-seeking experiences to date. It allows the researcher to prompt and probe in order to gather data relevant to the research question. I devised the interview schedule informed by the existing literature (see appendix B).

2.4.3. Recruitment Site

In an effort to explore a variety of experiences, I had planned to collect data from two different London based third sector organisations. Both offer support to family, partners and friends affected by someone else's drug or alcohol use. However, one of the services required my research proposal to be reviewed by their in-house ethical approval procedure before I could collect data there. This was a lengthier process than anticipated and by the time ethical approval was granted, pragmatically there was not enough time to collect and analysis more data. Therefore, all of the data was collected from one service.

Participants were recruited from a family, partners and friends service in North London. It is a free and confidential third sector organisation for adults whose lives are affected by someone else's drug or alcohol use. The service is attached to an alcohol treatment service and provides; information and advice about 'addiction' and treatment, individual support and counselling, support groups, couple and family meetings, workshops and liaison with drug and alcohol agencies. Support can be offered over the phone or in person. To be eligible for the service, family, partners or friends must be over the age of 18, and either the family member, partner or friend or the person using drugs or alcohol must reside in the catchment area. They aim to support the wellbeing of family, partners and friends in their own right as well as where appropriate help them to support the person using drugs or alcohol in their recovery. The service works closely with a peer led project that runs groups and organises social activities at the third sector site. I visited this service as a researcher and had never worked at the service.

2.5. Procedure

The facilitator of a peer led group at the family, partners and friends service contacted potential participants on my behalf and sent them a research flyer (see appendix C). With permission from service users, the facilitator gave me the contact details of those who expressed an interest in taking part. I phoned each potential participant to give them more details about the study and arrange a date and time to conduct an interview. Fifteen potential participants were phoned, four

interviews were unable to be arranged due to work commitments and holidays. I emailed all but one participant an information sheet and consent form to read before we met (see appendix D). One participant did not have an email address so was given time to read the information sheet on the day of the interview.

Interviews took place during August and September 2016. The interviews were carried out in a private room at the family, partners and friends service. Before each interview, I checked that participants had read and understood the information sheet before asking them to sign a consent form. The interviews lasted between 40 and 70 minutes and were audio-recorded. At the end of each interview participants were debriefed by asking them how they were feeling and how they found the interview. They were each given a sheet with a list of support services they could contact should they feel distressed following the interview (see appendix E). This included emotional support services and organisations which provide drug and alcohol information, support and advice. Interviews were anonymously transcribed verbatim by me, the researcher (see appendix F for transcription convention used).

The FPF service have requested a copy of the research findings. I also informed participants that the results would be made available to them. Therefore, a summary of the main themes developed will be produced and disseminated to the service and the participants.

2.5.1. Participant Inclusion and Exclusion Criteria

To be eligible to take part in the study, participants were required to be adults (over the age of eighteen) who self-identify as affected by another adult's drug or alcohol use; regardless of whether the individual using drugs or alcohol was receiving professional support or not. Potential participants were receiving some form of help for the impact of somebody else's drug or alcohol use on themselves. Adults unable to understand verbal explanations and written information in English without assistance were excluded from the study. This is because translated data can lose its meaning and impact on the quality of the themes generated. It was also decided to exclude anyone who self-disclosed that they were experiencing problematic drug or alcohol use themselves. This is

because it would be difficult to separate their own experiences of drug or alcohol use from the impact of someone else's drug or alcohol use.

The research was open to participants who self-identify as an 'affected other' regardless of their relationship to the person using drugs or alcohol. Friends and non-married partners were invited to take part. This is due to the gap in research into systems beyond the immediate family and the acknowledgement that various people within a drug or alcohol user's system may be affected by their substance use. However, the final sample is made up solely of immediate family members (parents, children and spouses) and this is reflective of the people who were using the family, partners and friends service at the time.

2.5.2. Participants

A purposive sample of eleven participants were recruited. Eight female and three male participants were interviewed. The table below summarises the demographics of the participant sample.

Table 1. Participant Demographics

Participant* (Gender)	Age	Ethnicity	Support being received by family member	Affected by	Age	Substance used	Support being received by person using drugs/alcohol
Charlotte (F)	59	White British	FPF support group, one-one & workshops	Son	30	Alcohol	12 step fellowship
Tariq (M)	62	Pakistani British	FPF one-one & workshops	Son	21	Alcohol, Hallucinogens & Cannabis	Supported living
Margaret (F)	67	White Irish	FPF support group & workshops	Daughter	32	Primarily Alcohol & occasional Cannabis	Residential rehabilitation
Florence (F)	47	White British	FPF one to one, peer led group & workshops	Daughter	29	Alcohol & Cocaine	Not receiving support
Emily (F)	68	White British	FPF one to one & peer led group	Husband	71	Alcohol (in the past)	12 Step Fellowship

Lance (M)	55	White mixed decent	FPF peer led group	Wife	55	Alcohol	Community detox
Cory (M)	36	White British	FPF one- one	Mother Father (deceased)	58 60	Mother using Alcohol (& heroin in the past) Father was using Alcohol, Cocaine, Heroin & Cannabis	Not receiving support
Louise (F)	55	White British	FPF one to one & workshops	Husband	55	Alcohol	Not receiving support
Jackie (F)	57	White Irish	FPF support group Used to attend peer led group	Son	33	Alcohol & Drugs	Community detox

Finia (F)	59	White British	FPF peer led group, workshops (carers group & one to one- elsewhere)	Son	19	Alcohol, Cocaine & Cannabis	Counselling
Martina (F)	67	White Irish	FPF peer led group & one to one & workshops	Husband, Son & Son's wife	62 36 42	Husband using Alcohol Son & his Wife using Alcohol, Heroin & Cocaine	Husband receiving unknown support Son & wife not receiving support

**Participants' names have been changed to preserve anonymity*

2.6. Ethical Considerations

2.6.1. Ethical Approval

Prior to commencing with data collection, the study received favourable ethical approval from the school of psychology at the University of East London (see appendix G). This was required by the family, partners and friends service before data collection began.

2.6.2. Informed Consent

All potential participants received an information sheet outlining information required to make an informed decision to consent to taking part in the study (see appendix D). The information sheet and consent form were read, clarified and signed by participants prior to commencement of interviews. Participants were given the opportunity to ask questions before signing consent and participants were reminded before the interview that they were free to withdraw at any time, to take breaks or reschedule.

2.6.3. Confidentiality

Prior to commencing the interviews, participants were informed that any identifying information about them would be stored confidentially and that interviews would be transcribed and analysed anonymously. They were informed that confidentiality would only need to be broken in the event that the researcher was concerned about the participant's safety or the safety of someone else. It was not necessary to break confidentiality during this research.

To keep participant information confidential, demographic details were recorded by hand before the interview recordings began and were linked to the interviews, transcripts and consent forms with a number code. Interviews were recorded onto a password protected dictaphone. As soon as possible, they were transferred onto a password protected computer file and deleted from the dictaphone. Consent forms and demographic information were stored separately. Interview transcripts were stored on a password protected computer file. In transcripts and

the thesis write up, names and any other identifying features have been changed or omitted in order to preserve participant anonymity. In the write up of the analysis, the content of individual interviews has been kept confidential and only themes and anonymous quotes have been used.

2.6.4. Potential Distress

All efforts were made to ensure the interviews felt like a safe and comfortable space to talk. However, I was aware that the topic under investigation was potentially distressing for participants. As such, participants were offered a break, the opportunity to re-schedule or withdraw from the interview. None of the participants took this offer up.

2.7. Data Analysis

2.7.1. Thematic Analysis

Data was analysed using thematic analysis (Braun & Clarke 2006). Thematic analysis has been described as ‘a search for themes that emerge as being important to the description of the phenomenon’ (Fereday & Muir-Cochrane, 2006; 82). Thematic analysis involves systematically finding common threads or patterns in the data and grouping them together into categories of meaning. These categories are then clustered into higher order themes (Willig, 2013). Therefore, identifying communalities in the way a topic is talked about that is relevant to answering the research questions.

Previously, thematic analysis has been viewed as a tool which forms the basis for many qualitative methods of analysis (Ryan & Bernard, 2000). However, thematic analysis has recently been acknowledged as a valuable method of analysis in its own right (Braun & Clarke, 2014). Thematic analysis benefits from being a flexible method because it does not commit the researcher to a particular epistemological or theoretical position. The way that the researcher codes and analyses the data is guided by their epistemological position and research questions. The researcher can analyse explicitly stated patterns of meaning or

latent patterns of meaning within the data. For the purposes of this thesis, thematic analysis enables the identification, analysis and reporting of patterns of meaning that emerged from semi-structured interviews with regards to the impact of drug and alcohol use on family members and the motivations, facilitators and barriers to seeking help. As this area is under-researched, an exploratory inductive approach was taken. This means that themes were generated from the data (bottom- up) rather than coding the data based on existing theory (top-down).

2.7.2. Consideration of Other Qualitative Analytic Methods

When choosing an appropriate method to analyse my research data, I considered the methods of analyses outlined below.

Interpretive phenomenological analysis (IPA) was considered (Smith & Osborn, 2003). There are similarities between IPA and thematic analysis, both aim to identify and analyse patterns of meaning across the data set. IPA focuses on exploring in-depth subjective experiences of people experiencing the same phenomenon and the meanings that people attach to them rather than describing objective events. This fits with my epistemological position. However, IPA is theoretically underpinned by phenomenology, geared towards a small sample size (typically three to six participants for a student project) and reasonably homogeneous groups (Smith, Flowers & Larkin, 2009). Thematic analysis was deemed more fitting with my research because the participant sample varied in gender, age and their relationship to person drinking and/or taking drugs and are therefore not homogenous.

Grounded theory was developed by sociologists in the 1960s (Glasser & Strauss, 1967) but is growing in popularity in psychology. It is a method of systematically generating a theory grounded within the data collected (Charmaz & Bryant, 2011). Therefore, an inductive approach is taken to data analysis. Data collection and analysis occur simultaneously in a process which aims to construct a theory rather than use existing theories to describe the data (Strauss & Corbin, 1990). There have been some disagreements about how inductive grounded theory is.

Grounded theory has been criticised for having positivist assumptions about induction which are that data can be analysed objectively free from the influence of researcher's pre-conceptions (Willig, 2013). A social constructionist view of grounded theory (Charmz, 2006) acknowledges the active role of the researcher in the research process. A critical-realist epistemological position can be applied to grounded theory as long as the researcher's assumptions are made explicit (Oliver, 2011).

Discourse analysis involves the study of language within text (Willig, 2013). The two main discourse analysis approaches are discursive psychology and Foucauldian discourse analysis. Closely tied with social constructionist epistemology and relativist ontological perspective, it is assumed that an individual's experience and knowledge is constructed through social interaction and language (Burr, 2003). Thus, language does not simply reflect reality, instead our understanding of reality is constructed through language. Discursive psychology is interested in how people use language within social interactions to achieve certain objectives (Gee, 2014). Foucauldian discourse analysis pays particular attention to power and how it operates and is maintained through language (Willig, 2013). A discursive psychology approach would have been an appropriate method to use had my research aims and questions inquired about how family members construct their experiences of having a relative who uses drugs and alcohol and their experience of help-seeking.

As the help-seeking experiences of family members affected by a relative's drinking or drug use is a relatively under-researched topic, thematic analysis was chosen as the preferred method as it offers the flexibility for themes to develop from the data unbound by a particular theoretical framework. This allows for unanticipated findings to emerge.

2.7.3. Thematic Analysis Six Phase Approach

The analysis process was guided by the six-phase approach to thematic analysis (Braun & Clarke, 2006). During phase one, I familiarised myself with the data. During phase two I generated initial codes. Phase three involved a search for

themes. In phase four potential themes were reviewed. Phase five involved defining and naming themes. Lastly phase six was producing a report of the analysis.

Phase one: Familiarisation with the Data

My familiarisation with the data began with transcribing the interviews. Words were transcribed verbatim using a simple transcription approach (Banister et al., 2011) which retained the semantic meaning but did not record non-verbal utterances. Braun and Clarke (2006) state that this level of transcription detail is adequate for a thematic analysis. I read each transcript at least twice to immerse myself in the data noting initial thoughts and observations before beginning to generate codes.

Phase two: Generating Initial Codes

I began the process of generating codes by scouring the transcripts for data which referred to the ways in which people were affected by their family member's drug or alcohol use and their help-seeking experiences. I identified both semantic and conceptual codes (appendix H). The codes I noted in the margins reflected information explicitly flagged up by participants as important, phrases and concepts that were repeated several times in the transcript and data that related to relevant theory. I adopted an inductive approach to the coding process, deriving codes from the data rather than looking for pre-conceived concepts. Although the analysis was data driven, I acknowledge that the process was inevitably influenced by my research questions, knowledge and beliefs as the researcher.

Phase three: Searching for Themes

All the initial codes across the 11 transcripts and related interview extracts were recorded in a table (see appendices I & J). I selected the codes that appeared to represent repeated patterns across the whole data set. With the aid of sticky notes, I arranged these into meaningful categories on a piece of paper depicting codes that seemed to share a unifying feature. These categories were labelled to describe the way that they were connected and this formed the initial themes.

Phase four: Reviewing Themes

The process of reviewing themes was two-fold. Firstly, it involved rereading all the interview extracts related to my initial codes to ensure that they accurately characterised the themes. Through this process some extracts were re-coded and some discarded. Secondly, a thematic map (appendix K) aided me in refining my themes by looking at how themes were connected and comparing the themes to each other and assessing whether they were distinct from each other and told a coherent story about my data in relation to the research question.

Phase five: Defining and naming Themes

I further refined and defined my themes through devising two additional thematic maps (see appendices L and M). This process produced overarching themes and sub-themes. I gave each theme a definition and name.

Phase six: Producing the Report

A report was produced, describing the meaning of each theme and sub-theme identified, illustrated by relevant data extracts. The report is outlined in the next chapter.

CHAPTER THREE: RESULTS

3.1. Chapter Overview

In this chapter I will present the overarching themes derived from the thematic analysis and their component sub themes (Table 2). Each theme will be illustrated and discussed and raw data extracts will be presented as evidence to support each theme.

Table 2. Themes and Sub-themes

Main Themes	Sub-themes
1. Family members' distress	Psychological distress Impact on daily life Out of my control
2. Ruptures in relationships	Isolation Relationships have changed
3. Responsibility	Guilt and blame Duty to protect
4. Routes to receiving help	
5. Relieving the pressure	

3.2. Themes

Five overarching themes were identified in the analysis, with seven sub-themes. Excerpts are provided to illustrate each theme with participants' pseudonyms and location in the transcript. The family member affected by someone else's drinking or drug use will be referred to as 'family members' and the person they are affected by will be referred to as 'relatives'. Dotted lines inside brackets (...) indicates where words have been omitted. My words as the interviewer are represented in italics. Square brackets [text] are used to denote personally identifiable information and where words have been added to provide context. I will elaborate on each of the themes below.

3.3. Family Members' Distress

The first theme reflects that the language used by family members to describe their relatives' drinking and drug use and the behaviours that accompanied it suggested it was experienced as wearing and all-consuming, resulting in disruption to daily functioning and emotional distress.

3.3.1. Psychological distress

This sub-theme relays how family members described a myriad of emotions that come with adjusting to their relative's' drinking and drug use. Participants described sadness, anger, trauma, loss, fear, stress, worry about the future and worry about their loved one's safety.

In the extract below, I was struck by Louise's use of the word 'trauma' to describe how she felt. It signified the magnitude of the situation which is not always recognised by other people in her life:

(...) um cos I cannot be asked to talk such trivial shit when I've got this trauma inside. (Louise: 131-132).

Many participants described worries. Some participants worried about what their relative's future would be like if they did not stop drinking or taking drugs.

Whereas others were pre-occupied with worry about their loved one's safety:

Yeah, it's the you know, when he's out late I won't sleep because I'm waiting for the door to go to know that he's back and he's safe and things like that. (Charlotte: 26-27).

It was evident that the emotions experienced by family members altered their behaviour. For example, Charlotte explains above how she is kept awake due to worry. Below, Florence describes how "depression" gets in the way of her plans:

(...) and it's also impacted on me because the depression sometimes I don't want to get up. Sometimes I can't do my practical things because of how it makes me feel. (Florence: 91-92).

The above accounts focus on the consequence of emotions for affected family members. Other people gave an insight into how they felt about events that had occurred:

No, it's when like you know she went into detox we had six months where she was completely sober and when she started drinking again in June, I got extremely angry. I mean really, really, angry. (Lance: 429-431).

Lance highlighted a common experience among participants of having hope that their relative had turned a new leaf after receiving treatment, only for their sobriety to be short lived. The anger implies that Lance had more optimistic expectations for his wife's detoxification treatment.

Florence described how her daughter's drinking and drug use was affecting her:

It causes a lot of anxiety, worrying, stress, especially emotionally. It has a big effect. (Florence: 4).

Florence and Lance's accounts above really emphasise the intensity of emotions they experienced, as Florence experienced "a lot" of "anxiety" and Lance was "really" angry. This echoes the "trauma" inside described earlier by Louise.

3.3.2. Impact on daily life

This sub-theme pertains to the way family members described their relative's drinking or drug use as disruptive to daily activity, such as work, finances, shopping and home life and that supporting their relative sometimes interrupted other commitments and involved making changes to their routine.

Several family members described how their daily life was also impacted by their various attempts to contain the situation:

Interviewer: You said when you were living with her you didn't see friends. Why was that?

Because I was worried that if I left her she would turn to drink or drugs. (Florence: 93-95).

It was really funny. There was one day... so I was watching her 24/7. There was one day I had to go to a meeting in [city name] in December so I had to get someone to mind, to kind of house watch whatever you call it, mind Judith. (Margaret: 243-245).

The examples of close surveillance illustrated above, highlight how desperately family members wanted to prevent their loved ones from drinking and using drugs. These efforts to control the situation seemed to put restrictions on family member's lives and rarely achieved the desired result.

Another method of trying to contain the situation was by attempting to remove the relative's means of obtaining alcohol or drugs:

And if I had a drink I was the one hiding the wine bottle in the cupboard [laugh] which is crazy, I'm not the alcoholic and I got to hide the drink. (Emily: 122-123).

A prominent feature of family members' accounts was the financial troubles that they experienced, either by their spouse losing their job, financially contributing to their loved one's food or accommodation because they had spent their own money on drugs or alcohol or they were not working. Sometimes, family members provided financial assistance that went towards their relative's drug or alcohol use:

Interviewer: And you mentioned that he would steal things and take money and things to get drugs. Was there ever a time when you helped him financially?

Yes. Yeah I've done that. Get drawn into it. but if I don't he will say "I'm going to start shaking and my legs will hurt and I'm going to be in so much pain and all I need is £10" and I can still do that today. I can still get drawn into it unless I've like prepped myself. Whereas sometimes when I can hear him on the phone, I think, what does he want? If I can prep myself, I'll be ok I can say no but other times I can't so I have to be conscious of that when I speak to him as well. (Jackie: 142-149).

The above extract captures Jackie's struggle to resist succumbing to the pressure to give her son money. It is easier to say "no" to him when she pre-empts his request for money and can mentally prepare herself to refuse his request. Implicit in her account is that at other times, she gets "drawn in" to giving him money because she does not want him to suffer.

Emily described how her husband's behaviour impacted on her daily life after they had children:

(...) as he progressed more into alcohol so he started to lose jobs and make very unwise decisions financial and business decisions that were very unwise and I was incredibly upset and stressed by all of that. (Emily: 6-8).

The above extract highlights that relatives' drug and alcohol use can generate stress within the family due to worries about financial insecurity.

Participants mentioned how their work life was affected by their relatives drinking or drug use:

I had to get up at certain times and get him out of bed instead of having the smooth period of getting ready for work and getting to work and by the time I get into work I'm not necessarily in a relaxed frame of mind. (Tariq:107-109).

Common language used by family members to describe their experiences signified that it felt as though their relative's drug or alcohol use had consumed their entire life. This suggests that the effects were multifaceted and profound. Participants described their experiences in the following ways:

Interviewer: So, [it's affected you in] lots of different ways
Every conceivable way really [starts crying]. (Louise: 18-19).

(...) I had no knowledge at all about drugs or anything so I didn't really know um yeah it just sort of takes over your whole life and everything. (Jackie: 385-387).

Yeah and so yeah it turned my life upside down. (Margaret: 42).

3.3.3. Out of my control

This sub-theme reflects how each participant wanted their relative to stop drinking or taking drugs. A number of participants described repeated cycles of their relative attempting to stop or stating they were going to stop. However, this resulted in broken promises and let downs which appeared to render family members feeling powerless to change the situation. This was accompanied with uncertainty and dilemmas about how to respond and how to help their relative. They described seeking reassurance and advice about what to do.

Family members described endless patterns of lies and broken promises which is likely to become wearisome over time:

Well I think because time has proved so often that people say they're going to stop indulging in which ever habit it is and they can't and they don't and they make promises and they don't keep them and it's just experience. (Emily: 642-644).

Charlotte explicitly talked about this experience being draining:

And so you're being lied to constantly. [*Yeah*]. So, then you question everything and it's very draining. Very draining. (Charlotte: 10-12).

Broken promises often led family members to lose hope. Furthermore, accounts of previous failed attempts to control the situation were associated with a sense of powerlessness:

I locked the door at five to eleven because he was going out for more drink and he was about to jump out the window. So I knew there was no point hiding it. He knew how much drink there was in the house. (Louise: 208-211).

Obviously the choices she's making is having a big effect on her not only mentally but physically, her health is going downhill and I get really frustrated that as a mum I can't do anything about it I think that's the biggest thing that I have no control. (Florence: 30-33).

The above extracts illustrate that relative's decisions were out of family members' control. Family members were left with many uncertainties about how to respond and behave. Torn between conflicting emotions; their sense of responsibility and obligation and a desire to prevent repeated patterns of unwelcome drink and drug related behaviour by their relative, as illustrated below:

It used to make me angry but it was like I was torn emotionally like I was angry because she had spent her money on drink and drugs and that I had to give it to her but then if I didn't give it I felt torn like how can I leave her with no food? (Florence: 144-146).

You know like for simple things like for example I wasn't letting him into the house when he was drunk and he'd be drunk in the evenings so that he'd be spending the night out. Which obviously means that he's in danger. Being young being out and about at night. So part of me felt that my boundary that I set on him was very, very important because if I didn't set that everything just falls apart but equally I felt that if I'm putting him outside, I'm putting him into even more danger. (Tariq: 496-498).

Florence describes being powerless to stop her daughter spending all her own money as well as powerless to resist giving her money due to the anticipated consequence being that her daughter would not be able to eat. Tariq's attempts to control the situation by setting boundaries equally led him to feel the situation was out of his control because he did not know if his son was safe or not.

With all the uncertainty, participants commonly referred to whether they were doing the 'right' or 'wrong' thing, actively seeking advice about what they should be doing and learning over time either through experience or through receiving help about what the 'right' things to do were:

Um so it was like living on a helter-skelter or a merry-go-round where you never knew whether it was going to be up or down and I now know that I did all the wrong things you know to try and counteract it but I didn't know that at the time. (Emily: 32-34).

Interviewer: And what did the leaflet... can you remember roughly what was in it? What appealed to you?

It was more that...it said it was for friends and family and I just felt at that time that I needed to be able to...that I wasn't sure that I was doing the right things. And I wanted someone to say to me "erm yes what you're doing is right or no you shouldn't be doing that" (Charlotte: 145-150).

There was an implicit assumption that there was a right and wrong way to deal with a loved one's drinking or drug use and that 'experts' could or should be able to tell them what to do. Most of the participants' motivation for getting help was centred around getting advice about the 'right' and 'wrong' things to do.

3.4. Ruptures in Relationships

This theme refers to feelings of isolation, the tension which occurred in the relationships between family members and their relatives in the form of arguments, mistrust, lies, actual and potential loss due to separation, moving out or death. Relationships with other members of the family and wider networks were also hampered by their relative's drinking and drug use.

3.4.1. Isolation

This sub-theme pertains to family members not wanting to burden friends. Feeling alone and unsupported to deal with the problem and therefore the importance of sharing experiences with people who could relate because they were in a similar position. This made people feel less alone.

The experience of being affected by a relative who uses drugs or alcohol was described as a lonely one:

Friends will be there to listen to you for a week. For two weeks but eventually they don't wanna know. I don't blame them I'd be the same. How much longer could you sit there listening to somebody's woes and all that. You know and it's not their job to do that. They've got no obligation to do that. Then kind of after a while you end up feeling like you're on your own so it was quite useful to come here and offload as it were. (Tariq: 511-515).

I've been in groups before and if certain people get friendly you think 'oh' you feel a little bit pushed out. You don't wanna... you don't wanna feel like that when you're in those circumstances of having a drug or alcohol person near you, because you're already isolated. (Jackie: 365-368).

Many family members reported not wanting to burden their friends with what they were going through:

[Tariq was talking about the effects of his son, Ali's drug and alcohol use]. I don't have family as such apart from the two boys and Nash [Ali's brother] didn't particularly want to talk about it and I could quite understand that so I was relying on those few friends that I had and those friends that are at that level that you can discuss things with them, you don't want to be burdening them that much. (Tariq: 608-611).

I talk to my close friend but I think they just feel there's nothing they can really do for me so I try not to burden people with it. I try to talk to like I see my therapist so I try to talk to them. (Florence: 115-117).

(...) but one way or another, however you handle it. However good your friends are. However strong they are cos how can they cope with listening to all this shit all the time. (Louise: 54-56).

There was a common narrative in the three extracts above about friendships needing to be a certain quality of friendship before friends could even tolerate hearing about their problems in the first place and even then, family members did not feel friends could cope with it. This is potentially due to a belief that friends could not relate because they did not know what it was like to be affected by a relative's drinking or drug use.

Conversely, the existence of a shared experience with other people seemed to serve two functions in family members' lives. For some, it made advice more credible. But for others it counteracted feeling alone:

Yeah I have another friend who actually had an alcoholic partner for years and years and years so she actually knew what it was like so I talked to her (Margaret: 399-401).

Yeah getting advice and other people in the same position so you knew you weren't alone and yeah it was really helpful. (Cory: 337-338).

3.4.2. Relationships have changed

This sub-theme reflects breakdown in relationships between family members and their relatives. Relatives were described as behaving in ways that were out of character or unwelcomed such as constantly letting their family member down,

lying and stealing, arguments and being aggressive. Relationships with wider networks have changed because affected family members were less interested in other people's lives (e.g. colleagues, friends) and less in the mood to socialise.

Emily and Charlotte's accounts above alluded to family members' distress in relation to the belief that they were being repeatedly lied to by their relative's. Participants also talked about how lies had led to mistrust within relationships:

(...) so he...basically I would go to work and he abused that trust by bringing alcohol back. (Tariq: 20-21).

Another problem in our relationship and I know it occurs in others is the total lack of trust that you develop in your partner or family member or friend and that's why you're living on a knife edge all the time because even when they've stopped you don't trust them not to pick up [alcohol] again. (Emily: 631-634).

I got the sense that mistrust in relationships was highly disappointing to participants. Repeated cycles of disappointment described by some family members implied that their relative was letting them down:

We got him in [detox service] and he done the detox and he was doing well and then he came back and he was then meant to go to abstaining one but he couldn't keep to it. He never keeps to it. I mean I've had him... sometimes I don't even know he's had a drink before he comes home from work. (Martina: 309-313).

Another example of changes in relationships was when people had experienced loss or fear of loss:

(...) it's because the alcoholism has lost me my partner... It's lost me the man I love and the man I lived with and the man I would have nice banal enjoyments with. (Louise: 137-140).

Well the loss in the sense that you have a child. A period down the line, it's no longer that child. It's another child. It's almost like a monster. So it's like you've lost that child you feel that and you've lost that family life. (Tariq: 433-435).

She put herself into a lot of bad situations where she has been hurt. She's been she's been attacked and I always worry that the worst is going to happen. (Florence: 8-9).

Relationships can be hindered by anger and arguments between family members and their relatives. Finia described actively taking steps to avoid conflict with her son:

Errm. Like sometimes he didn't want me in his bedroom. That's when I know somethings in there, shouldn't be in there (...) if I'm upset I can't just shout at him because he won't hear that. It would go straight through or he'll get angry and it won't get us anywhere. I have to errm suss things out in my mind, how to talk to him. When to talk to him. It may not be for a week that I can say what I wanna say because I know it's not the right time. (Finia: 96-101).

Below are extracts from accounts about how relationships with wider networks such as friends and colleagues have been affected:

(...) and the other way it's affected friendships is um it's um a lot of the time you're not in the mood to socialise so you see people less often. (Louise: 33-35).

Relationships as well because sometimes if I'm really low I can't be myself so it's hard to mix with people. (Florence: 173-174).

This, considered alongside the narrative about not wanting to burden friends and feeling alone with the problem, it is not surprising that socialising takes a back seat.

3.5. Responsibility

Common themes in the family members' narratives centred around responsibility both in terms of feeling to blame for their relative's drinking or drug use and a responsibility to get their relative help to stop drinking or taking drugs. Family members sense of responsibility often drove them to actively seek help for their relative, through health and social care services whilst neglecting their own wellbeing in the process.

3.5.1. Guilt and blame

This sub-theme encompasses family members' descriptions of having a part to play in their relatives' drinking or drug use, either through doing something to cause it or not picking up on the problem soon enough and preventing it.

Family members described feeling responsible for their relatives' drinking and drug use:

(...) I kind of felt very guilty cos I felt somewhere or another I must be to blame. You know when your daughter doesn't turn out as you'd hoped but she's in serious trouble, you kind of just think oh god it must have been my fault somewhere along the line and especially as she was very angry as well with both her dad and me. (Margaret: 36-40).

Yeah. I feel it reflects on me.

Interviewer: What does? The fact that he's using drugs?

Yeah. Something must have happened to him that makes him want to do that and you know, just the effect on well yeah something must have happened to him. I'm his mother. (Jackie: 107-110).

The other emotion is you know guilt. You feel guilty as a parent, you think you have failed your child. You know is there something you could have done differently? (Tariq: 345-347).

Interestingly, only participants who were parents talked about feeling that they were to blame. This is potentially because of a perception they were unable to fulfil societal role expectations that parents protect their children from harm such as drinking or taking drugs.

Several family members appeared to go through a process of resolving this guilt which is related to the final theme in this chapter 'relieving the pressure':

Well it's a release of tension and emotion but also quite an education and a support. You feel like... you're not... the feeling of failure goes away to a certain extent and of guilt and all that. So you learn to cope with that. Then of course once you've got rid of those negative feelings then you're in a better position to help the user, the person you're caring for because you don't have that holding you back as it were. (Tariq: 666-670).

3.5.2. Duty to protect

This sub-theme pertains to family members seeking help for their relative in line with their sense of duty to protect their relative from the harms of drinking and drug use. If an individual believes that they are to blame for something, they are likely to feel it is their responsibility to rectify it.

A number of participants took on the responsibility of seeking help for their relative, often not acknowledging their own needs in the process:

Yeah alcohol service yeah. But I found a lot of it was me making the calls. Me doing the running and it was like I became obsessed with it. It was terrible even though I had my own issues because I've got mental health issues it's like I wasn't bothered about them I was just so obsessed with trying to fix her. (Florence: 252-255).

Well I didn't [seek help for himself]. I contacted [FPF service] and I said "I need somebody to talk to my wife." (Lance: 268).

So I phoned these people up. I think it was [FPF service] or [residential rehab]. I was just off my mind, I says you've just gotta help him because I've took him to the hospital, they won't help and then he's in such a state and within 3 days we got him in [detox service]. (Martina: 307-310)

Despite it only being parents who explicitly stated a feeling of guilt. Both parents and spouses sought help for their loved one.

3.6. Routes to Receiving Help

This theme denotes that family members often sought advice from primary care services in the first instance. Structured peer support groups did not suit family members' needs. Many family members ended up receiving help from the FPF service either unintentionally or through enquiring about whether there was someone they could talk to. Therefore, family members wanted services to acknowledge affected family member's need and offer support early on.

A common avenue for support for family members was through primary care. Often to get help for their relative using drugs or alcohol but sometimes for their own mental health as well:

It was when I was seeing someone in IAPT and we were speaking about things and they recommended me to come here [FPF service]. So they referred me. (Florence: 195-196).

Florence reported that primary care psychology services (IAPT) assessed the circumstances around Florence accessing the service and were therefore able to recommend the FPF service.

Cory had received counselling as a child growing up with parental substance use and was used to talking about his feelings and found it helpful in the past. He recognised as an adult that he needed to speak to someone again:

Well you know, I went to the doctors to see if I could see a counsellor from the doctors kind of thing. (Cory: 249-250).

Experience of help sought through primary care varied. Some found the GP knowledgeable and helpful while others expected GPs to have more knowledge about local drug and alcohol support services:

Well I told my GP and she told me about the [name of a local drug service]. (Jackie: 167).

(...) In terms of otherwise getting support. It was a bit difficult but anyway going back to the GP. The GP we went to see and got different level of service depending on which GP we saw. Only after about 3 weeks or 4 weeks of him staying with me and having made several visits to the GP we saw the main GP who was the surgery holder or whatever the title is and she said "oh well we have a drug and alcohol service here". (Tariq: 47-51).

Interestingly, Tariq continued to make GP appointments after being dissatisfied with previous consultations. This, together with his previous mention of feelings of guilt and responsibility perhaps further highlights his unwavering determination to get help for his son.

Another common avenue of support that participants tried was attending 12 step fellowship family support groups. Although it did not suit most of the participants. Some reflected on it not being the 'right time' to attend:

Yeah I went to erm, yeah erm families anonymous I think. (Jackie: 271).

Oh I went to al-anon when he went to AA (...). (Martina: 262).

Yeah where with Al-anon it was just more about the problem where this [FPF service group] isn't like that. It's like you talk about the problem but then you talk about other things as well. (Florence: 326-327).

(...) but it [al-anon] was very ritualistic and not really very individual and there wasn't time for talking sort of outside of the group or if there was it would have taken up too much time. (Emily: 497-499).

Florence and Emily appreciated the informal, unstructured atmosphere at the FPF service peer led group compared to the more structured 12 steps approach which did not appeal to them.

A common sentiment expressed by participants was that they would have liked the FPF service to have picked them up sooner and this was made as suggestions for how the service could improve:

They could make sure that when the carers come in that they at least give them one interview to see if they want any help. Even if its ten minutes you know. That would be good because it's a shame to have such a brilliant service and then some people slipping through the net. (Tariq: 600-603).

I just said I needed someone to speak to. I said how can I get Lauren [wife] back involved with you and also what about me? And they said well you can see your own one to one person and they put me in contact with Mel [FPF service manager]. (Lance: 283-285).

The extract below illustrates Louise's response to a question about what she would have liked to be different in terms of the support she had received:

What could I have had... what do I say about it? I suppose more of it sooner really. So as soon as someone gets referred, as soon as someone's in the system. That... if only, then whoever is in there family get's offered (...) yeah like you know 'have you been a victim of a crime?' You can talk to who is it the police always offer you when you've been...I duno you've lost your keys or something? (Louise: 512-517).

Louise's use of humour perhaps illustrates her perception that family members' experiences are not taken seriously compared to victims of crime. She would have liked a faster route to the FPF service by being informed about the FPF service sooner by professionals involved in her husband's care at the time (e.g. the detox service or social worker).

3.7. Relieve the Pressure

The final theme reflects that in the context of broken relationships and isolation, participants valued having somebody to talk to. Family members described how helpful it was to offload and share their problem so that they were not left 'holding it all.' There is a relief of pressure in the context of the intense emotions that had built up. Many go through a process of learning to let go, either through receiving help or going through repeated cycles with their relatives. They pass responsibility back to their relative. Subsequently, they withdraw and re-engage with their own life.

A dominant narrative across individual accounts about what they liked about the support they received was that it is helpful to talk:

We could just get in there just to open up. Just get it off your chest.
(Martina: 405).

It was just like the one to one, talking to, you, you just trying to ... like explaining things and yeah it was real...really good actually. Yeah. (Cory: 232-233).

(...) and I had some private counselling which wasn't specifically around alcohol I suppose but it was just nice having somewhere to go and somebody to talk to. (Emily: 215-217).

It seemed as though talking to somebody else took the pressure off the family member holding guilt and responsibility and dealing with a difficult situation alone. It appears that the process of offloading and welcoming a space to talk about other topics besides drugs and alcohol enabled family members to pass responsibility over to their relative:

He goes to AA groups. He's trying to do it that way but I'm not sure if it's enough. I have to let him do it his way. Errm so I can maybe suggest things but that's about it. That's all I can do. (Charlotte: 234-236).

(...) Like trying not to look at it like it's my problem. [*I: Ok so like a bit of distance*]. Like letting her take responsibility instead of me try to do everything. (Florence: 344-346).

I'm not in the wrong. Nothing is to do with me. I don't make any of them drink or do drugs.

Interviewer: So, you've learnt that from the workshops?

Oh yeah. [*I: Yeah*]. definitely. I don't blame me anymore. (Martina: 448-449).

Many family members described having gone through a journey of learning to withdraw from trying to change their relative's behaviour and engaging with their own lives again:

I think since I've been coming to help I realise that I mustn't get sucked into it. I think you get sucked into it to a certain degree ermm but I've got to be able to stand away and look after myself and the rest of the family. I can't go down his path if that's what he's going to... if he's going to always be drinking I can't be part of that. (Charlotte: 412-416).

(...) so after that I said to her listen do you know what I'm actually not going to mind you because it's not working. It's just going to have to be you who stops drinking or who gets yourself to the next treatment day which is going to be after the new year. (Margaret: 252-255).

Yeah. She thinks I don't care about her and I'm not there for her but it's not the fact that I'm not there for her. It's I've tried for so long and really and truthfully there's no more I can do. I have to put myself first. (Florence: 338-340).

Letting go seemed to mark a significant learning curve for family members which was quite freeing. Family members had been "sucked into" (Charlotte: 412) repeatedly trying to help their relatives to no avail. Their efforts were futile and letting go was a resignation in some ways. The 'duty to protect' and 'relieving the pressure' themes appear to mark different stages in affected family members' journey where they eventually felt able to focus on themselves again and other people in their lives. However, some still talked about guilt and responsibility in the present tense which highlights that people were at different stages in the process.

CHAPTER FOUR: DISCUSSION

4.1. Chapter Overview

In this chapter I will present a summary and discussion of the results in relation to the research questions and relevant literature. Implications for clinical practice and future research will be highlighted. The chapter will conclude with a critical review of the strengths and limitations of the research as well as personal reflections.

4.2. Summary of the Findings

There were two aims of this research:

- 1) To explore the impact that having a relative who uses drugs/and or alcohol had on family members' lives.
- 2) To explore affected family members' experiences of seeking help, within a family, partners and friends service in London.

The results highlight that the impact on family members is multi-faceted and complex. Family members appear to go through different stages of a journey including; experiencing emotional distress and relationship breakdown, feeling alone, trying to control the situation, feeling powerless, out of control and uncertain, a duty to protect their loved one, relieving the pressure and learning to let go. These were not necessarily distinct stages as family members described any number of these occurring at the same time as well as going back and forth between them, but indicated that family members' beliefs, behaviours and emotions developed and changed over the course of being concerned about their relative's drinking or drug use.

The discussion chapter will be structured according to the research questions that were used to shape the study. Each question will be answered with relation to the five main themes that were developed during the analysis; 'family

members' distress,' ruptures in relationships,' responsibility,' routes to receiving help' and 'relieving the pressure.' I will refer back to the existing literature and relevant theories to make sense of the findings.

4.2.1. Question One: What is the impact of somebody else's drug and/or alcohol use on affected family members' lives?

To answer this question, I will refer to the themes 'family members' distress,' ruptures in relationships' and 'responsibility.'

With regards to the 'family members' distress' theme, findings were in line with existing evidence about the significant emotional impact of drug and alcohol use on family members (Copello et al., 2005; Jung, 1986; Ray et al., 2009) including worry about the wellbeing of their relative who uses drugs or alcohol (Barnard, 2005) and the strain that having a relative who uses drugs or alcohol causes (Orford et al., 2005; Orford et al., 2010). The participants in the current study used language which expressed the intensity of the emotions that they felt. They also emphasised that they felt that the impact of their relative's drinking or drug use was profound, affecting their entire lives. Barnard (2005) found that drugs became the centre of attention in family lives and this may also explain why many participants in the current study felt that it had consumed their whole life.

There was less emphasis by the participants in the current study on physical strain (ill-health) as a result of having a relative with a drug or alcohol problem. Although correlational studies have shown the impact of a relative's drinking or drug use is associated with an increased risk of physical health problems in family members (Lennox, Scott-Lennox & Holder, 1992; Ray, Mertens & Wiesner, 2007), family members may not attribute a deterioration in their health to the effects of having a relative who uses drugs or alcohol. Or it may not be something family members generally think of when asked directly how they have been affected.

The 'impact on daily life' sub-theme within the overarching theme of 'family distress' denotes disruptions to family members' daily activity due to efforts to contain their relative's behaviour. This includes impacts on work and finances.

In an effort to get their loved one to stop drinking or taking drugs, family members tried to contain the problem through methods such as close surveillance of their relative or attempting to remove their relative's means of obtaining alcohol or drugs. Family members' attempts to control the situation in this way were restrictive to their own lives and rarely achieved the desired result which was frustrating and resulted in feelings of powerlessness, uncertainty and isolation. The ways that family members responded to their relative's drinking and drug use would be categorised by Orford and colleagues' (2010) stress-strain-coping-support model as a 'standing up' method of coping (e.g. efforts to control their relative's drinking or drug use, no longer tolerating it). Within the model, the ways that family members cope is argued to impact on the level of physical and psychological strain. Indeed, the participants in the current study felt powerless to control the situation which certainly impacted psychological strain.

Family members' efforts to contain the situation themselves corresponds with existing studies like Barnard (2005) who found parents would not seek help because they thought they could maintain a 'normal' family life but this eventually led to relationship breakdowns and Sakiyama and colleagues (2015) who found family members delayed seeking help because they thought they could contain the problem. Sakiyama and colleagues (2015) concluded that family members may have difficulty establishing when drinking and drug use becomes problematic. Most of the family members in the current study talked about lies and broken promises and cycles of repeated let downs being an indicator that things were not changing. This was experienced as draining. Powerlessness ensued and brought with it dilemmas about how to respond, and about what the 'right' thing to do was. All of this was compounded by feeling overwhelmed with its disruptive impact and like the situation was 'out of their control'. Dilemmas about what to do is corroborated by existing literature (Orford et al., 2005: 2010).

In the current study, it was uncertainty about the 'right' thing to do that seemed to drive help-seeking in most cases.

All the family members in the current study had lived with their relative at some point but at the time of interview seven were not. Family members reported effects which continued when they were not living together. This reflects Newton and colleagues' (2016) findings and contradicts previous research which has found that living together was associated with a greater severity of impact of alcohol use on family members (Berends et al., 2012) and family members who live with a relative who uses drugs or alcohol report greater ill health (Orford et al., 2005). However, family members in the current study were all in regular contact with their relatives which meant they were in close proximity in that regard.

The financial troubles reported by participants in the current study mirrors existing evidence from the UK which found that family members reported to have had arguments over money or to be disadvantaged by financially helping their relative who uses drugs, for example providing accommodation (Copello et al., 2010) or assisting when a relative loses their job (Burton-Phillips, 2007). Family members in the current study also sometimes provided financial assistance which went towards their relative accessing drugs or alcohol and this reflected one of the many dilemmas that family members expressed around struggling to resist succumbing to the pressure to do so.

The impact that relative's drinking and drug use had on family member's work is also supported by existing evidence (Berends et al., 2012). For example, not being able to concentrate or being in a non-relaxed frame of mind at work.

The 'ruptures in relationships theme' reflects affected family members reports that relationships with their relative who was using drugs and alcohol had changed. They would behave in ways that were unwelcomed and often out of character such as lying, letting them down, stealing, being aggressive. Anger and arguments in family relationships were reported which corresponds with findings

from existing research (Barnard, 2005; Berends et al., 2014). Family members experienced actual loss in relationships like relatives moving out or spouses separating and feared potential loss.

With regards to affected family members' social networks, there was a strong emphasis by family members in the current study on not wanting to burden their friends. They explained that their friends had their own lives to live, they should not be expected to listen to the affected family members' problems, their friends would not understand and they emphasised the importance of having people in their lives who have been through a similar experience. Disconnection with social networks resulted in family members feeling alone with the problem. Social support is a key component of the SSCS model and 5-step approach, as good social support has been found to be important for family members' wellbeing (Cohen & Wills, 1985). However, past research (Orford, et al., 2005; Orford et al., 2010) has emphasised affected family members finding help unsupportive or unhelpful, not wanting to be criticised for the way they were coping, blamed or shamed by their networks rather than on not wanting to burden them and therefore preferring to talk to someone who has also been through something similar. There appears to be a difference in the emphasis in past research findings on family members not having the support that they needed from others, whereas the participants in the current study seemed to value their friendships and were considerate of not burdening their friends. Other reasons for ruptured relationships with friends in the current study included being less in the mood to socialise with their wider networks and less interested in other people as they were consumed with their own problem.

The 'guilt and blame' sub-theme of the overarching theme of 'responsibility' relays that many affected family members felt guilt and blame about their relative's drinking or drug use believing that they were responsible for it either because they could not prevent it or they did not pick up on it sooner. This finding was unique to parents in the study and may be tied to dominant societal discourses around parent blaming (Burman, 1996). Barnard (2005) similarly found that parents in Scotland felt responsibility for containing their son or

daughter's drug problem and maintaining a 'normal' family life. However, this responsibility was not shared by siblings. The current study's findings suggest that affected family members go through a process of resolving their guilt and reflect on being in a better position to support their relative when this happens.

The above findings in relation to the first research question highlight the multi-layered impact that having a relative who uses drugs or alcohol can have on affected family member's lives as well as the dilemmas and uncertainty and powerless that they often feel. Relationship breakdown is likely to have further adverse effects on family member's wellbeing (Cohen, Gottlieb & Underwood, 2000) and they may feel alone with the problem, emphasising the importance of support services being available to them.

4.2.2. Question Two: What have been affected family members' experience of seeking help for themselves? (motivations, barriers and facilitators)

To answer the second question, I will refer to the themes 'responsibility' and 'routes to receiving help.'

Motivations for seeking help were reflected by the theme 'responsibility,' captured by the 'duty to protect' sub-theme. A strong motivator for affected family members seeking help was to find out how they could help their relative who was drinking or using drugs because of the negative impact it was having on their lives.

Taking on responsibility for getting help for their relative appeared to be linked to their feelings of guilt and responsibility. Interestingly, despite only parents expressing feelings of guilt, both parents and spouses exhibited a 'duty to protect' their relative. This may be because they view their spouse as being vulnerable due to their drinking and drug use (Aday, 1994) and therefore unable to help themselves. Similarly, Barnard (2005; 2006) found that parents would ask advice from the GP about their son or daughter's drug or alcohol use but generally not seek help otherwise possibly focussing on their son or daughter's problems over their own wellbeing. In a study evaluating an intervention for partners of 'problem drinkers,' Howell and Orford (2006) also found that over half of partners reported

they were seeking help for their 'problem drinking' relative alone. Family members not being aware of their own needs could be a barrier to seeking help.

In line with existing research into help-seeking (Brown et al., 2011) worry also seemed to be a significant motivator in the current study for affected family members seeking help. However, family members sought help to protect their relative from the harms associated with their drinking or drug use rather than to get help for themselves.

Due to the desire to get help for their relative and resolve uncertainty about the 'right' thing to do, affected family members were often looking for practical rather than emotional advice and valued being kept informed about their loved one's care. The 'routes to receiving help' theme denoted that affected family members sought advice from their GP and had a mixture of positive and negative experiences of this. Some affected family members were referred to IAPT for their own mental health and two participants were sign-posted to the FPF service by IAPT and two by their GP. This highlights that primary care services could be a facilitator to affected family members receiving support and coincides with recent literature findings that many affected family members receive help from IAPT for their own mental health (Newton, et al., 2016).

The "routes to receiving help" theme reflects that many family members ended up receiving help from the FPF service unintentionally because they did not know the service existed until their relative started using the attached alcohol service. Other research has found that affected family members reported uncertainty about where to find help (Sakiyama et al., 2015). Some affected family members reported that they only discovered the FPF service existed because they had asked about whether there was someone they could talk to. These affected family members expressed a wish to have been picked up by the FPF service earlier on. Similarly, other research has found that care-givers expected drug services to involve them when their relative went into treatment and were surprised when this did not happen (Orr et al., 2013). Therefore, a potential

challenge to receiving help identified by affected family members was either not being acknowledged by family support services or GPs not having knowledge of local services to sign post them to.

The above findings highlight the motivations for affected family members seeking help predominantly from primary care services for practical advice about how to help their relative. Affected family members expressed a wish to have been sign-posted to the FPF service sooner or to have been acknowledged by the FPF sooner. The constraints of the current research sample mean the experiences of family members who do not end up engaging with the FPF service are still unclear in terms of what barriers there might be, what would facilitate help-seeking and whether or not they have sought help elsewhere.

4.2.3. Question Three: What were the helpful and unhelpful aspects of help received?

To answer the third question, I will refer to the theme 'relieving the pressure'

The 'relieving the pressure' theme reflects that in the context of ruptured relationships and feeling alone, affected family members reported that they valued being able to talk and off load. Support from other people who are in a similar position and understand what the family member is experiencing was important as well as normalisation of their situation, which corresponds with existing research (Orford et al., 2010), reassurance and learning the 'right' and 'wrong' things to do. Previous findings that many family members experienced uncertainty helped to inform the 5-step intervention (Copello et al., 2010).

Findings from this study show that affected family members originally seek practical advice. However, through the process of talking about the intense emotions they feel, they experience a relief of pressure and benefit from learning to let go and not hold all the responsibility for their relative's drinking or drug use. Family members report to have found this to be a useful outcome of the help that they received. Subsequently, they withdraw and re-engage with their own life.

The process of letting go that affected family members described corresponds with the 'withdrawing' coping' (distancing oneself, distraction, focussing on one's own needs) method of coping within the SSCS model (Orford et al., 2010). Previous research has found that family members oscillate between engaging and disengaging coping methods.

Considering the findings of the current research correspond with aspects of the SSCS model, it seems that the 5-step approach could aid the offloading process and process of not feeling alone as the first step is 'listening to family members' experiences'. The SSCS model has been tested and found to be feasible in primary care and specialist drug and alcohol services (Templeton, 2009; Templeton et al., 2007).

With regards to what was unhelpful about help that was received, some family members mentioned that it was disappointing not being offered help early enough. Some family members disliked formal, structured group environments which they found in al-anon and preferred informal, unstructured environments where there was room to talk about other topics besides drugs and alcohol. This preference likely reflects the sample of people in the study who had continued to engage with the service. However, this does not reflect samples of people who engage with 12 steps groups like al-anon and may prefer the structure of those as has been found by previous research (Timko et al., 2013; Young & Timko, 2015).

Reflecting on Cornally and McCarthy's (2011) theory that help-seeking follows a process of defining a problem, deciding to seek help and actively seeking help, affected family members arguably had not fully identified the problem they were seeking help for in the sense that they benefited from talking and relieving the pressure but were not initially seeking that.

The findings outlined above highlight that family members benefit from speaking to people who are understanding which breaks the isolation that often results from ruptured relationships. Many family members felt they would burden their friends by speaking about their problems but felt comfortable speaking to people

who were in a similar position to themselves. A useful outcome of receiving help is learning to let go of holding all the responsibility for their relative's drinking or drug use. Feeling a responsibility for their relative often motivates family members to seek help in the first place.

4.2.4. Summary of New Contributions to the Literature

The themes generated in this study correspond largely with previous research findings. However, some nuances were found. The finding that family members' relationships with their social networks are often disrupted when affected by their relatives' drinking or drug use echoes previous findings. However, the current findings appear to contribute a novel understanding of breakdowns in relationships. Previous findings suggest family members find their social networks unhelpful, non-understanding and critical. However, the emphasis on not burdening their friends with their problems in the current study, suggests family members are concerned about the negative impact of talking about their distress on the wellbeing of other people in their lives. Participants' perception of being a burden may be influenced by the individualistic culture of the western world whereby society promotes the ideals of autonomy and independence and not relying on other people (Triandis, 1995). Messages such as media portrayals of an increasing ageing population being a 'burden' on public resources (Jowit, 2013) only serve to relay the message that to be in need of support is to be a burden. This is problematic because research (conducted mainly in the health field) has found feeling like a burden to be a source of psychological distress amongst people with chronic pain (Kowal, Wilson, McWilliams, Péloquin & Duong, 2012).

The finding that family members seek help for their relative rather than themselves is not a new one. However, the current study expands on this and provides some context to this behaviour as seeking help for their relative seemed to be driven by a sense of guilt and responsibility and a motivation to resolve uncertainty by finding out what the 'right' and 'wrong' thing to do to help them was. This coupled with the emphasis on not burdening other people highlights that many family members focus of concern was on the wellbeing of other people

rather than themselves. These unexpected findings highlight the importance of research into this under-acknowledged group. Further research into the factors which motivate and hinder family members talking to their social networks and professionals would give insight into ways support services could engage with family members.

4.3. Implications

4.3.1. Service Level Implications

The 'routes to receiving help' theme highlighted that family members value having their experience normalised and taken seriously as well as being offered support by drug and alcohol services when their relative is in treatment. Family members benefited from speaking to people who were in a similar position to themselves as they perceived these people to be more likely to understand what they were experiencing. This suggests that affected family members would benefit from services providing adequate resources to enable peer support groups to operate.

The finding that some participants wished they had been offered support sooner by the FPF service highlights and is likely reflective of the challenges faced by third sector organisations within the drug and alcohol sector. With the recent closure of the National Treatment Agency and it becoming part of Public Health England, the state of the sector report (Recovery Partnership, 2015) reported that we are in a climate of frequent re-commissioning of services with the responsibility for budgeting and commissioning of substance use services being transferred to local authorities. With this brings serious concerns about the effects of funding cuts to drug and alcohol services with 38 per cent of community drug services reporting a reduction in funding resulting in high caseloads and limited resources and inability to meet service users' needs. This will only lead to services relying more heavily on volunteers such as the person who runs the peer-led group at the FPF service.

This study highlights the challenges for services engaging with affected family members when they are pre-occupied with helping their relatives and perhaps not

always open to receiving support for themselves. Family members' experiences could be understood as a journey or a process in a similar way that drug and alcohol use is understood as moving through stages of change (Prochaska & DiClemente, 1983). This would encourage services to be sensitive to the fact that it might not be the right time for family members to receive help but still create an environment which has easy and open access for when it is.

The findings suggest that drug and alcohol services that offer support to family members work in partnership with GPs to aid affected family members in being aware that support is available so that they can make a decision to access it. Given that many affected family members appear to visit their GPs, it makes sense that GPs are aware of what support is available in the local area and give people leaflets when they come in with their family member who is using drugs or mention psychological distress related to someone else's drug use. A strong theme was around family members wanting advice about the 'right' and 'wrong' thing to do. Affected family members appeared to go to their GP requesting factual advice. Thus, if the GP advises affected family members to look after their own wellbeing, this advice is likely to be taken on board. However, there is a danger that family members become pathologised much like they were within the co-dependency movement (Rothberg, 1986; Schutt, 1985).). To eradicate this prospect completely would be a challenge. However, in order to minimise this eventuality, local drug and alcohol services could consult with GPs about the stresses and strains often experienced by family members and ask them to provide family members with leaflets which describe family support in non-pathologising language.

The findings suggest that affected family members may access primary care psychological therapy services for their own mental health if they are feeling anxious or low in mood. When family members are in contact with primary care psychological therapy services, they can be a facilitator for family members accessing help from drug and alcohol services that offer support to family members like the FPF service by sign-posting them to it. However, this can only occur if primary care services ask questions that will elicit information about the family member being affected by a relative's drug or alcohol use. The FPF

service and services like them could consult with local psychological therapies services to encourage them to ask relevant questions to people accessing the service and ensure all local primary care, drug and mental health services have pamphlets describing the service which can be given to family members when sign posting.

4.3.2. Policy Level Implications

The findings add weight to the growing body of evidence that affected family members are significantly impacted by their relatives drinking or drug use in many areas of their lives. The findings have important policy implications because although recent policy does acknowledge the needs of family members in their own right, there is still a policy focus on supporting family members to help improve treatment outcomes for the person using drugs (Velleman, 2010). There is also variation in what services are offered to affected family members across the UK (Copello & Templeton, 2012; Fals-Stewart & Birchler, 2001). Given the level of distress experienced, more emphasis should be placed on the benefits of supporting family members regardless of the treatment status of their relative as well as guidance for providing consistent and effective support.

The findings indicate that national and local guidance around 'harm reduction' and recovery should include how services can work in ways that reduce harm to affected family members. The results of the current study strengthen the findings of previous research that family members experience distress benefit from support for their own wellbeing. An investment in support services for affected family members in their own right is likely to put them in a better position to support their relative in treatment for drugs or alcohol should they wish to do so.

4.3.3. Implications for Clinical Psychology Practice

The current research findings suggest that family members would benefit from a culture where drug and alcohol services routinely ask service users when they enter treatment for drug and alcohol problems if they have any affected family members. This would enable more affected family members to be identified and offered support. However, it is acknowledged that not every person using drugs

or alcohol will want to share information about their family. Clinical psychologists within services that come into contact with people who use drugs and alcohol are in a position within multi-disciplinary teams to help foster a culture where the needs of affected family members are routinely considered. This can be achieved through multi-disciplinary team meetings, providing supervision, training and reflective practice.

Specifically, clinical psychologists within drug and alcohol services are well placed to provide training and consultation with staff around family oriented ways of working. The 5-step intervention is an accessible way for health care professionals to routinely ask family members about their experience in a systematic way and it is flexible to service demands (Templeton, 2009).

Team reflective practice, meetings or team formulation sessions can be an opportunity for psychologists to support staff to formulate how family members' may be feeling such as worry, stress and isolation. Thus, when family members attend drug and alcohol services with their relatives or phone staff asking about how their loved one is doing in treatment, staff can inform relatives about support services available to them.

Findings from the current study indicate that many family members become isolated due to not wanting to burden people in their social network. This could further impact negatively on their wellbeing and discourage family members from asking for help. Psychologists could help to design service leaflets which normalise affected family members talking about their difficulties and empathise with how difficult it can be to talk to others.

Psychologists are also skilled in conducting service evaluations to assess whether there is adequate local service provision for affected family members in line with the national drug and alcohol strategy guidelines. They could also build relationships with local services for affected family members, ensuring smooth and effective referral pathways for affected family members and encourage staff to signpost family members that they come into contact with.

4.4. Limitations

4.4.1. Sample Limitations

The sample in the current study was susceptible to a selection bias (Maxwell, 2012) as it was a convenience sample of people known and approached by the group facilitator. The fact that the people who took part were receiving support from the service implied that they expressed a more favourable view of the service than those who did not, especially considering that they agreed to take part on the request of the group facilitator. Arguably the sample does not capture the experience of those who have had a negative experience of receiving help. However, I believe the findings still provide important information about the challenges people had faced before getting to the service or even within the service before getting the help they received.

In line with previous research in the area, the current sample was mainly made up of female partners and mothers. This under-represents the experience of men and other forms of family relationship, such as siblings.

I was unable to interview any friends who were affected by someone else's drug or alcohol use because the peer led group facilitator was not aware of any who were actively using the FPF service at the time. People affected by a friend's drug or alcohol use had used the FPF service in the past. They potentially stopped using the service because they did not feel they were the same as other types of affected other. This highlights a need for research into the help-seeking experiences of friends affected by someone else's drinking or drug use.

A potential limitation of the research is that data was collected from one service in one area of London. People who attend although not a homogenous group may have more similarities than people who attend different services and people from different parts of London.

Interviewing the affected family members who are not engaged with services and who have never sought help would reveal a lot about the barriers or reasons for not seeking help. However, research into family members who are seeking help is also useful because their journey to seeking help was not always smooth.

4.4.2. Interviews

During interviews, it was challenging steering many of the participants away from talking about their relative's drug or alcohol related behaviours and towards talking about themselves. This may be because they were not used to talking about themselves as the drug or alcohol use took centre stage. Also, I got the sense that they wanted someone to really hear how bad things had been for them and this was enabled by giving them space during the interview to talk about their relative. Consequently, some of the interviews contained less information about help-seeking experiences compared to others. However, all of the interviews together provided rich information.

It is worth noting that many of the participants knew each other because they attended the same group and were aware that I had interviewed other members of the group. Although participant anonymity and confidentiality was assured, this may have impacted their answers.

Another potential study limitation is that participants spoke about their help-seeking experiences retrospectively and for some it was a long time ago that they had initially sought help. This means that their accounts are susceptible to memory biases.

Interviews were conducted within an ethnically diverse borough of London yet the sample does not reflect this. This could be reflective of people who are more likely to seek help or people more likely to find the service accessible.

4.4.3. Power

It is important when carrying out qualitative research that the researcher is attentive to the power differential between themselves and the participants. Efforts were made to reduce power differences to encourage participants to be open in their responses. Despite my efforts to foster an atmosphere of reciprocal disclosure and authenticity (Karnieli-Miller, Strier, & Pessach, 2009) by inviting participants to ask me questions, they did not. I wondered if the participants felt uncomfortable to ask me questions and how this may have influenced the content of the interviews. If I were to conduct this research again I would make further attempts to minimise the power differential between myself and participants by

inviting them to have a more active role in the research process. I would ask participants to comment on the validity of the findings to ensure their credibility. I would do this by offering participants the opportunity to read a draft of the analysis section and comment on whether they felt it was a good reflection of their experiences (Braun & Clarke, 2013).

Finally, the findings showed that there were many similarities between the experiences of family members affected by drugs and alcohol use. However, it is possible that the behaviours associated with specific types of drugs and with alcohol do result in subtle differences in the experiences of affected family members.

4.5. Evaluation of the Current Research

It is important for qualitative researchers to demonstrate that their research is sound and rigorous. There are many different approaches to evaluate the quality of qualitative research, I used Yardley's (2008) evaluation criteria as outlined below:

4.5.1. Sensitivity to Context

Sensitivity to context is defined as researchers being explicit about the context of theory and literature using similar methods and/or analysing similar topics; the socio-cultural setting of the study; and the relationship between the researcher and participants. I provided a review of the existing literature in chapter one. Earlier in this chapter, I placed this research within the context of what is already known about the topic, highlighting where findings echo previous work and offering new ways of conceptualising affected family members' experiences when the findings differed from previous work. Data was analysed bearing in mind the socio-political context the participants and myself as the researcher were operating within.

4.5.2. Commitment and Rigour

Commitment refers to demonstrating prolonged engagement with the research topic and rigour refers to the completeness of the data collection and analysis. As

outlined in chapter two, my longstanding interest in the research topic developed through my research and clinical experience demonstrates my commitment to the topic. Prior to collecting data, an appropriate sample to answer the research questions was selected and the interview schedule was practiced with my supervisor. The research rigour is demonstrated through the description of the data collection and analysis in chapter two and demonstrations of the analysis process and reflections provided in appendices H to N.

4.5.3. Transparency and Coherence

Transparency encompasses disclosing every aspect of data collection and analysis. Transparency is shown through examples of coded data extracts and thematic maps in appendices J to M which demonstrate to the reader what my analytical interpretations were based on. Coherence denotes the quality of the research narrative. I asked open-ended questions to encourage participants to respond freely uninhibited by my pre-conceptions as the researcher. However, consistent with the critical realist approach adopted I was also aware through reflexivity at all stages of the research, of my potential influence over the findings. For example, power differentials between myself and the participants were acknowledged and commented on throughout the write up of this research. A coherent description of data collection and analysis were outlined in chapter two.

4.5.4. Impact and Importance

The research findings have implications at a policy level, service level and for the work of clinical psychologists. They provide novel insights into understanding some of the challenges that family members face in accessing support for themselves when affected by a relative's drinking or drug use. A summary of this research will be disseminated within the third sector organisation the data was collected from.

4.6. Critique of Thematic Analysis

Thematic analysis was deemed to be an appropriate method of data collection to answer the exploratory questions posed by the current research. The flexibility of thematic analysis can be both advantageous because the range of themes

generated are broad but also disadvantageous because it can be difficult to narrow the analysis down to the most salient points (Braun & Clarke, 2006).

When doing a thematic analysis, there is a danger of describing themes which fit with the researcher's pre-conceived ideas, resulting in the analysis being deductive rather than inductive. To ensure the current study's analysis was inductive, themes were cross referenced for coherence with my supervisor and reflective notes ensured I was aware of how my own thoughts and assumptions could influence the interviews and data analysis process.

4.7. Recommendations for Future Research

Given that many family members reported that they attempt to contain the problem themselves and that they often feel guilty about their relative's drug or alcohol use, it is highly likely that many other family members are affected but not engaging with services. It would be beneficial to research the experiences of family members who are not actively receiving help but may still be affected by their relative's drinking or drug use. This would give insight into whether there are any specific barriers or reasons they do not seek help. They may get support in other ways such as social or religious support. The challenges of collecting data in this way would need to be considered. Family members who are not known to services could potentially be contacted through their relative who is using drugs or alcohol, through primary care services or through a public domain. Information about the study may get lost being transferred between relatives and their affected family members and people may be more reluctant to talk if they are not used to engaging with services.

The participants in the current study did not generally benefit from 12 step fellowship family groups. Although some of the participants reflected on it maybe having not been the right time for them to attend. Research into the help-seeking experience of family members who actively attend 12 steps groups would implicate whether there is anything qualitatively different about the experience of people who benefit from that approach.

The current study only included the experiences of family members. The experiences of affected friends within the social networks of people who use drugs and alcohol is under-researched. Research into the help-seeking experiences of friends affected by somebody else's drug or alcohol use could highlight barriers to this group seeking help but also help to understand their experiences and the ways that they are affected. Research into help-seeking with more ethnically diverse samples could provide insight into potential cultural and socio-economic factors which could improve accessibility to services.

The findings of the current research indicate that family members perceive themselves to be a burden to their support networks. Future research could further explore affected family members' experiences of social support and its impact on their wellbeing.

Future research could include both affected family members and their relatives who drink or take drugs. This could provide insights into dynamics of responsibility and blame within relationships.

There is strong evidence for the need to provide support for family members affected by their relative's drinking or drug use. More can be known about these needs within different sub-groups of affected others. However, there is also a need for further research into what kind of support is effective.

4.8. Researcher Reflections

4.8.1. Interview questions

I noticed that as anticipated and despite my efforts to normalise that some people find support unhelpful, participants did not mention much about what they found unhelpful about the support that they received when asked directly. I hypothesised this may be due to a social desirability effect whereby participants wanted to present a favourable view of themselves by not appearing to be complaining or ungrateful (Eysenck, 2004). In an effort to minimise this effect during interviews I asked an indirect question (Fisher, 1993) about what

participants would have liked to be different about the help they received. This elicited more information from participants than just asking them about the unhelpful aspects of support they had received.

4.8.2. Reflexivity

On reflection, the interviews were carried out in close succession over a short period. As such, I did not have time to reflect in between interviews about how I was feeling or my thoughts about the interview process. Although I kept a record of reflective notes throughout the research process (see appendix N), I did not keep a consistent diary after each interview. Therefore, I ensured that I kept more consistent reflective notes when it came to conducting the analysis. If I were to do the research again I would pay closer attention to individual interview processes and the influence of my participation within the dynamic. This may provide important learning for subsequent interviews.

4.9. Conclusion

This aim of this research was to provide contributions to the growing understanding about the experiences of adults affected by a relative who uses drugs or alcohol. Furthermore, it aimed to contribute to the thin literature specifically focussing on help-seeking experiences. Themes were identified and considered within the context of the literature, with the use of thematic analysis. In summary, results indicate that services can be made more accessible by letting family members know they exist, GPs encouraging access to services, services acknowledging that it might not be the right time for family members to engage and joined-up working between primary care, substance use services and mental health services. Clinical psychologists can help foster a culture where the needs of affected family members are routinely considered within services. Findings from this study provide further support for family oriented interventions and policy for this group.

CHAPTER FIVE: REFERENCES

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CHAPTER SIX: APPENDECIES

6.1. List of Appendices

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Appendix A Literature Search

The following terms were used to search the literature about the experiences of family members affected by somebody else's drug or alcohol use. Terms were separated with an "AND." Searches of PsycINFO, PsycARTICLES, CINAHL Plus were carried out between January and March 2017. The search parameters 1980- March 2017.

Table 3. Literature Search

Search term 1	Search term 2	Search term 3	Number of Articles	Number of Articles included in the review
Family	Affected	Substance use	283	16
Family	Affected	Substance misuse	59	12
Family	Affected	Addiction	579	26
Family	Affected	Drug dependency	59	1
Family	Affected	Drug misuse	18	1
Family	Affected	Drug use	245	0
Relatives	Affected	Substance use	107	0
Significant others	Substance use	-	563	5
Significant others	Affected	Substance use	17	0
Relatives	Affected	Substance misuse	34	0
Carers	Substance use	-	175	8
Carers	Substance Misuse	-	77	5
Carers	Addiction	-	72	0

Family	Affected	Alcohol use	264	0
Family	Affected	Alcohol misuse	114	0
Family	Affected	Alcohol dependency	181	0
Family	Affected	Alcoholism	433	2
Carers	Alcohol use	-	122	0
Carers	Alcohol misuse	-	41	0
Carers	Substance use	Help seeking	1	0
Carers	Substance misuse	Help seeking	1	0
Carers	Alcohol use	Help seeking	1	0
Carers	Alcohol misuse	Help seeking	6	0
Family	Substance use	Help seeking	1	1
Family	Substance misuse	Help seeking	17	2
Family	Alcohol misuse	Help seeking	7	0

Article Exclusion Criteria

Some of the reasons articles were not included in the review were:

- duplicates
- about a non- relevant population of study e.g. children, adolescence or parental substance use.
- were investigating family factors which cause and maintain drug use
- published before 1980
- not published in English

Appendix B

Interview Schedule

The following is a rough guide to the interview questions. As the interview is semi-structured, the exact way that the interview unfolds will be influenced by the participants' responses.

Questions that screen for eligibility:

To check if you are eligible for the study I need to ask everyone a couple of questions:

Are you affected by someone's drug or alcohol use or both?

Do you have your own drug or alcohol use problems?

Demographic information (recorded by hand):

Age

Gender

Ethnicity

Relationship to person using Drugs/Alcohol (and their age)

What is their primary substance(s)?

Are they receiving support?

What support are you receiving?

Audio Recorded Interview Questions:

What is the impact of somebody else's drug/alcohol use on your life? OR How has the drug/alcohol use affected you?

When did you decide to seek help?

What motivated you to seek help for your own wellbeing?

How did you go about seeking help?

What has been your experience of seeking help? (e.g. challenges and facilitators)

What has been your experience of the help received? (helpful and unhelpful aspects)

Would you change anything about the help you received?

Is there anything that I haven't asked you that you would like to say?

Prompts

Can you tell me more?

Can you give me an example?

What do you think has influenced those decisions/behaviours?

Debrief

How was it taking part in the interview?

Do you have any questions?

Is there anything that you would like to discuss further?

You can contact me if you have any questions and here is a sheet with organisations you can contact if you feel you would like to talk to someone later on.

Appendix C Research Flyer



Are you an adult affected by someone else's drug or
alcohol use ?

**Would you like to take part in a research study and share your
experiences of seeking support for yourself?**

What is the study about?

The aim of the study is to better understand the experiences of people affected by the drug or alcohol use of someone close to them. I hope that this will improve professionals' knowledge of how to support you.

What would participation involve?

- * One interview with me (Fiona) the researcher lasting approximately 60 minutes.
- * The interview will take place at [Name of Service] at a convenient time for you.
- * The questions will depend on what you choose to talk about but may include things like; what is the impact of somebody else's drug or alcohol use on your life? What has or would motivate you to seek help?

**If you would like to be involved in this study, or would like more
information, please contact:**

Fiona Dowman, Trainee Clinical Psychologist, University of East London

Email: u1438298@uel.ac.uk

Or Phone: XXXXXXXXXXXX

Thank you!

Appendix D
Participant Information Letter and Consent Form



UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator: Fiona Dowman
Email: u1438298@uel.ac.uk

Family, friends and partners affected by somebody else's drug or alcohol use.

If you are an adult (aged 18+) and are affected by someone else's drug or alcohol use, I would like to invite you to take part in a research study. The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of my doctorate in Clinical Psychology at the University of East London.

Project Title

Exploring the help-seeking experiences of family, friends and partners affected by somebody else's drug and/or alcohol use.

What is the purpose of this research?

This research study is important because previous research has highlighted that an individual's drug or alcohol use can impact the people close to them. Research has found, supporting family and friends of drug and alcohol users not only improves their own wellbeing but often leads to positive change in the drug or alcohol user. As such, National policy encourages drug services to involve family and carers in the treatment process. However, there has not been much research into family, friends and partners' experiences of seeking help for

themselves. The findings of this research will help services to understand better ways of supporting people.

Unfortunately if you are having your own drug or alcohol use problems, you will not be able to take part in this study. This is because it will be difficult to separate your own experiences of drug or alcohol use from the impact of someone else's drug or alcohol use.

What would participation involve?

If you agree to take part, I will invite you for a recorded interview lasting up to one hour. You will have the opportunity to ask me any questions that you might have before beginning the interview. During the interview you will be asked to talk about your experiences. The questions will depend on what you choose to talk about but may include things like; what is the impact of somebody else's substance use on your life? What motivated you to seek help?

Do I have to take part?

You are not obliged to take part in this study and should not feel coerced. If you do decide to take part, you may withdraw at any time. Should you choose to withdraw from the study you may do so without giving a reason and your withdrawal from the study will not affect the continued support you receive from [NAME OF SERVICE REMOVED]. If you withdraw your participation after the point of data analysis, I reserve the right to use your anonymized data in the write up of my thesis and any future journal publications.

Where will interviews take place?

The interviews can take place at the [NAME OF SERVICE REMOVED] Families, Partners and Friends service or the University of East London in Stratford, whichever is most convenient for you.

Are there any disadvantages or risks to taking part?

I will make all efforts to ensure the interviews feel like a safe and comfortable space to talk. However, you might feel upset talking about something you find difficult or emotional during the interviews. If this happens, you will be offered a break, the opportunity to re-schedule or withdraw. All participants will also be given details of organisations that they can contact for support.

Will the information I provide remain confidential?

Yes, consent forms that contain identifying information will be kept securely in a locked filing cabinet. Your personal information will be stored separately from any interviews you complete. Your real name **will not** be used in the analysis of the interview material or write up of the study, pseudonyms (false names) will be used instead. The interviews will be audio recorded on a password protected

Dictaphone. This audio file and written transcripts will be saved on a computer which will be password protected and only be accessible by me and my supervisor. Audio recordings and transcripts will be deleted ten years after completion of the project write up.

The only time I will need to break confidentiality is if you tell me something that gives me reason to believe that you or someone else is at risk of significant harm. In this situation I may need to inform an agency who can offer support. Where possible, I will inform participants before breaking confidentiality.

What will happen to the results of the research study?

The results of the study will be written up as a doctoral thesis and submitted for publication in an academic journal. In all written material of this study your identity will remain anonymous. The data will be stored for up to ten years, following which time it will be shredded and disposed of.

Who has reviewed the study?

Ethics approval has been obtained from the University of East London.

Who can I contact following the study if I have any questions?

If you have any questions or concerns, please use the following contact details:

The researcher **Fiona Dowman** can be contacted at:

School of Psychology, University of East London, Water Lane, London E15 4LZ.
u1438298@uel.ac.uk.

The academic supervisor **Dr Poul Rohleder** can be contacted at:

School of Psychology, University of East London, Water Lane, London E15 4LZ.
020 8223 6674. p.a.rohleder@uel.ac.uk.

The Chair of the School Research Ethics Committee **Dr Mary Spiller** can be contacted at: School of Psychology, University of East London, Water Lane, London E15 4LZ. 020 8223 4004. m.j.spiller@uel.ac.uk

Thank you for taking the time to read this information sheet.
Please keep for future reference.



UNIVERSITY OF EAST LONDON
Consent to participate in a research study:

Exploring the help-seeking experiences of family, friends and partners affected by somebody else's drug and/or alcohol use.

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw after the point of data analysis, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Appendix E Participant Debriefing Information



Debriefing Sheet

Project Title: **Exploring the help-seeking experiences of family, friends and partners affected by somebody else's drug and/or alcohol use.**

Thank you for participating in this research study concerning your experience of seeking help for the affect that someone else's drug or alcohol use has had on you.

Your participation is greatly appreciated!

I hope that the findings from this research will provide a better understanding of the factors that help and hinder people from seeking help so that services can understand better ways of supporting people.

The support you receive from [NAME OF SERVICE REMOVED] will not be affected by your participation in this research. If you have any questions or concerns regarding this study, please feel free to use the following contact details:

The researcher **Fiona Dowman** can be contacted at:

School of Psychology, University of East London, Water Lane, London E15 4LZ.
u1438298@uel.ac.uk.

The academic supervisor **Dr Poul Rohleder** can be contacted at:

School of Psychology, University of East London, Water Lane, London E15 4LZ.
020 8223 6674, p.a.rohleder@uel.ac.uk.

The Chair of the School Research Ethics Committee **Dr Mary Spiller** can be contacted at:

School of Psychology, University of East London, Water Lane, London E15 4LZ.
020 8223 4004. m.j.spiller@uel.ac.uk

In the event that you feel distressed by participation in this study, here are a list of services that may be able to help:

Adfam

Find information, local support groups and helplines for anyone affected by someone else's substance use.

Website: www.adfam.org.uk

Telephone: 020 7553 7640

DrugFAM

Are you affected by someone else's drug or alcohol addiction? Are you bereaved through drug or alcohol use? Contact their free helpline from 9am-9pm, 7 days a week on **0300 888 3853**.

Carers UK

Charity supporting unpaid carers of family and friends.

Website: www.carersuk.org

Telephone: 0808 808 7777

FRANK

National drug information service with factfiles and FAQs

Website: www.talktofrank.com

Telephone: 0300 123 6600 (24 hours a day, 365 days a year).

Text Message: 82111 Need a quick answer? Text a question and FRANK will text you back

Samaritans

Free listening service for anything that is troubling you, get in touch via phone, email, post, or SMS, 24 hours a day, 365 days a year.

Website: www.samaritans.org

Telephone: [116 123 \(UK\)](tel:116123)

Email: jo@samaritans.org

Write: Freepost RSRB-KKBY-CYJK, PO Box 9090, STIRLING, FK8 2SA

Refuge

Provide domestic violence advice and helpline for women and children (can also provide advice and information for men who are victims of domestic violence).

Website: www.refuge.org.uk

National Domestic Violence Helpline: 0808 2000

Appendix F Transcription Convention

[inaudible] Inaudible section of transcript

Emphasis Word spoken with more emphasis than others

[laughs] Laughter during the interview

[Text] contextual information is included if a part of the extract is ambiguous

Words in brackets () replace potentially identifiable information

Extracts are punctuated to facilitate reading

Pseudonyms are used in place of all names

Where an extract begins in the middle of a longer passage by a speaker, this is indicated by (...) at the start of the extract. (...) also indicates where words have been omitted.

(adapted from Banister et al., 2011)

Appendix G

Ethical Approval Documents from the University of East London and Change of Thesis Title

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational
Psychology

REVIEWER: Mark Finn

SUPERVISOR: Poul Rohleder

COURSE: Professional Doctorate in Clinical Psychology

STUDENT: Fiona Louise Dowman

TITLE OF PROPOSED STUDY: Exploring the help-seeking experiences of family, friends and partners affected by somebody else's drug and/or alcohol use.

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

MINOR AMENDMENTS

Minor amendments required (for reviewer):

This is a thorough and well-considered application but please note the following:

The emails attached to the application just welcome a conversation with the researcher and as such are not evidence of 'permission' to be involved in the proposed research. The application mentions that [NAME OF SERVICE REMOVED] has already given permission but there is no evidence of this. Please provide evidence of permission or state that it will be formally sought – at least through ethical approval from the charity (which will be sought), and similarly with other agencies/organisations that may become involved.

If charity/agency staff is going to be involved with recruitment, please ensure that staff make it clear that continued support from the charity/agency is in no way contingent on participating in the research. This could also be made clear on the invitation and debrief letters.

An exclusion criterion includes potential participants having drug and/or alcohol issues themselves – how will this be determined? It is suggested that this is made clear on the participant invitation letter (in a non-confrontational way).

Do you really want to destroy transcripts after 3 years? You may want to keep transcripts for up to ten years, for example?

Stipulating that data cannot be withdrawn after the end of January 2017 may be too specific at this stage – maybe better to stipulate up until the point of analysis.

The proposed research has been approved by the School of Psychology Research Ethics Committee (not UREC), so please amend

Please add contact details of Dr Mary Spiller (Chair of the School Research Ethics Committee) to the invitation and debrief letters (see staff page)

Please seek permission to amend protocol if possibly accessing online support forums for recruitment purposes leads to changed procedure (e.g. phone/Skype interviews)

ASSESSMENT OF RISK TO RESEARCHER (for reviewer)

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

- | | |
|-------------------------------------|---------------|
| <input type="checkbox"/> | HIGH |
| <input type="checkbox"/> | MEDIUM |
| <input checked="" type="checkbox"/> | LOW |

Reviewer comments in relation to researcher risk (if any):

Reviewer (Typed name to act as signature): Mark Finn

Date: 07/06/2016

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (Typed name to act as signature): Fiona Dowman
Student number: U1438298

Date: 15/06/2016

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: <http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

SCHOOL OF PSYCHOLOGY
UNIVERSITY OF EAST LONDON

Acting Dean: Professor Rachel Mulvey, BA MA DCG PhD FICG FHEA



School of Psychology
Professional Doctorate in Clinical Psychology

Thursday, 16 June 2016

To Whom It May Concern,

This letter is to confirm, as outlined in the Decision Letter, that Fiona Dowman has received ethical approval for the project titled "Exploring the help-seeking experiences of family, friends and partners affected by somebody else's drug and/or alcohol use".

Yours faithfully,

A handwritten signature in black ink, appearing to read 'M. Spiller', is written over a light grey, semi-transparent rectangular box.

Dr Mary Spiller
Chair of the School of Psychology Research Ethics Committee

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ResearchUEL

Dear Fiona

[Change project title - Ms Fiona Dowman](#)

The Psychology Research Degrees Sub-Committee on behalf of the University Quality and Standards Committee has considered your request. The decision is:

Approved

Your new thesis title is confirmed as follows:

Old thesis title: Exploring help-seeking experiences of family, friends and partners affected by somebody else's drug and/or alcohol use

New thesis title: Exploring the Help-Seeking Experiences of Family Members Affected by Someone Else's Drug and/or Alcohol use.

Your registration period remains unchanged.

Change project title - Ms Fiona Dowman

Appendix H Coded Transcript

<p>I Is there any other people in your family or in her circle that you've noticed has been affected as well?</p> <p>P4 Yeah my son was affected to begin with.</p> <p>I Is he older or younger?</p> <p>P4 He's a couple of years younger. Yeah he was affected because he tried to help her and support her at times when I was too angry to talk to her he would try and be there for her. But then obviously if someone is not willing to help themselves there's only so much you can do.</p> <p>I And how do you know that she's not willing to help herself?</p> <p>P4 We tried to talk about it and she says oh she's gonna do this and she's gonna do that but it never happens.</p> <p>I ok. So she says she's going to...</p> <p>P4 She says going to try and get help and she'll go to the alcohol..... go to the GP and get an appointment but then she won't go to appointments and I think the commitments not there.</p> <p>I Yeah. Ok so you mentioned a few emotions. Anger, depressed, stressed. Are you able to describe some of the things that you have done to help her, so how have you tried to help her?</p> <p>P4 I've tried to listen to her, be there for her. I've gone to appointments with her. A couple of years ago I even went to meeting with her at her alcohol thing to try and support her with it. I tried so much. I've let her stay with me.</p> <p>I So you've been an emotional support, helped her with appointments, let her stay with you for a little while.</p> <p>P4 Yeah</p> <p>I ok. Has it impacted anything in terms of your day to day activity? practically impacted on your life?</p> <p>P4 well yeah because when I used to stay with her I didn't see my friends and I was anxious 'oh my friends are going to be upset with me' but at the same time I wanted to keep my daughter safe and it's also impacted on me because the depression sometimes I don't want to get up. Sometimes I can't do my practical things because of how it makes me feel.</p> <p>I Yeah. You said when you were living with her you didn't see friends. Why was that?</p> <p>P4 Because I was worried that if I left her she would turn to drink or drugs</p> <p>I Ok. So you felt like you had to be with her.</p>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Friction, tension in the relationship.</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Acceptance that she is powerless to help daughter.</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Disappointment, let down,</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Let down</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Attended FPF service appointments with loved one</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Important to protect and keep her daughter safe?</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Impacting her relationship with other people</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Emotional impact: Depression</div> <div style="border: 1px solid black; padding: 5px;">Wanting to protect her, control her behaviour</div>
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Appendix I

Initial Codes and Frequencies

This table illustrates the initial codes identified within the 11 transcripts. The frequency column denotes the number of participants each code was mentioned by.

Code	Frequency
1. Emotional impact of relative's drug/alcohol use	9
2. Worry about relative 's safety	6
3. Impact of drug/alcohol use on family members' Behaviour	9
4. Physical Impact	1
5. Regression	4
6. Dependency	1
7. Loss	6
8. Impact on work	7
9. Boundary Setting	2
10. Reaching Limits	2
11. Right and wrong thing to do	8
12. Powerlessness	5
13. Shame/Embarrassment	3
14. Secrecy	4
15. Friction in relationships	6
16. Less time for friends	1
17. Lost relationship with friends and family	1
18. Impacted relationships with other people	5
19. Disappointment/Let down	5
20. Draining	5
21. Important that other people understand/relate/are in a similar position	7
22. Not wanting to burden friends	4
23. Feeling alone/isolated	5
24. Seeking help for relative rather than themselves	6

25. Sought help through primary care	6
26. Sought help through social services	2
27. Looking online for help	3
28. Sought help from a private counsellor	2
29. Sought help from friends	1
30. Sought help through 12 step fellowship family support group	5
31. Found out about FPF service through word of mouth	2
32. Found out about FPF service through IAPT	1
33. Found out about FPF service through relative using the service	2
34. Found out about FPF service through a local drug service	1
35. Found out about FPF service through social worker	1
36. Found out about FPF service through the manager at carers event	1
37. Talking Helps	5
38. What makes support helpful is informality/unstructured	3
39. What makes support helpful is reassurance	3
40. Practical support is helpful	1
41. Receiving support makes you feel less alone	3
42. Educational support was helpful	1
43. Letting go	6
44. Change of attitude after receiving help	3
45. Less family arguments after receiving help	1
46. Lies/Mistrust	4
47. Stealing	2
48. Guilt & responsibility	4
49. Passing responsibility	4
50. Want their relative to take responsibility	2
51. Several trips to GP before getting help for relative	1
52. GPs were not knowledgeable about local drug services	2
53. Disruption	5
54. More effected when relative is in close proximity	1
55. Dilemma about how to respond	5

56. Long process/might never end	1
57. A good service has approachable staff, comfortableness & cleanliness	1
58. Transparency about relative 's care is important	3
59. Health and social services should know what help is available	1
60. Support for family member was not offered by FPF service	4
61. Heard about FPF service through relative using the service	1
62. FPF service provides a space to emotionally offload	1
63. Wanted support locally	1
64. Likes workshops that are structured and provide materials.	2
65. Group support: my situation isn't as bad as other peoples	1
66. Prefers big groups	1
67. Prefers smaller groups	1
68. Receiving help made family member more relaxed/less anxious	1
69. Receiving advice was helpful	2
70. Supported family member's detox at home	2
71. Attended FPF service appointments with relative	2
72. Deterioration of relative's drink and/or drug problem	3
73. Affected family member's mental health triggered help-seeking	1
74. Help-seeking triggered by dissatisfaction in relationship	1
75. Help-seeking triggered by a FPF service leaflet	2
76. Violence towards affected family member	2
77. Lower family income due to relative's drinking	1
78. Found it helpful to know there were people in a worse position	2
79. Did not find al-anon helpful	3
80. Found al-anon too formulaic	1
81. It's not common knowledge that support for family members exists	1
82. It's not easy to find services for family and friends online	2
83. Hypervigilance & constant worry that relative will drink again	1
84. Worried about children's safety in relative 's care	3
85. Found out about al-anon through word of mouth	1
86. Impact on living arrangements	1

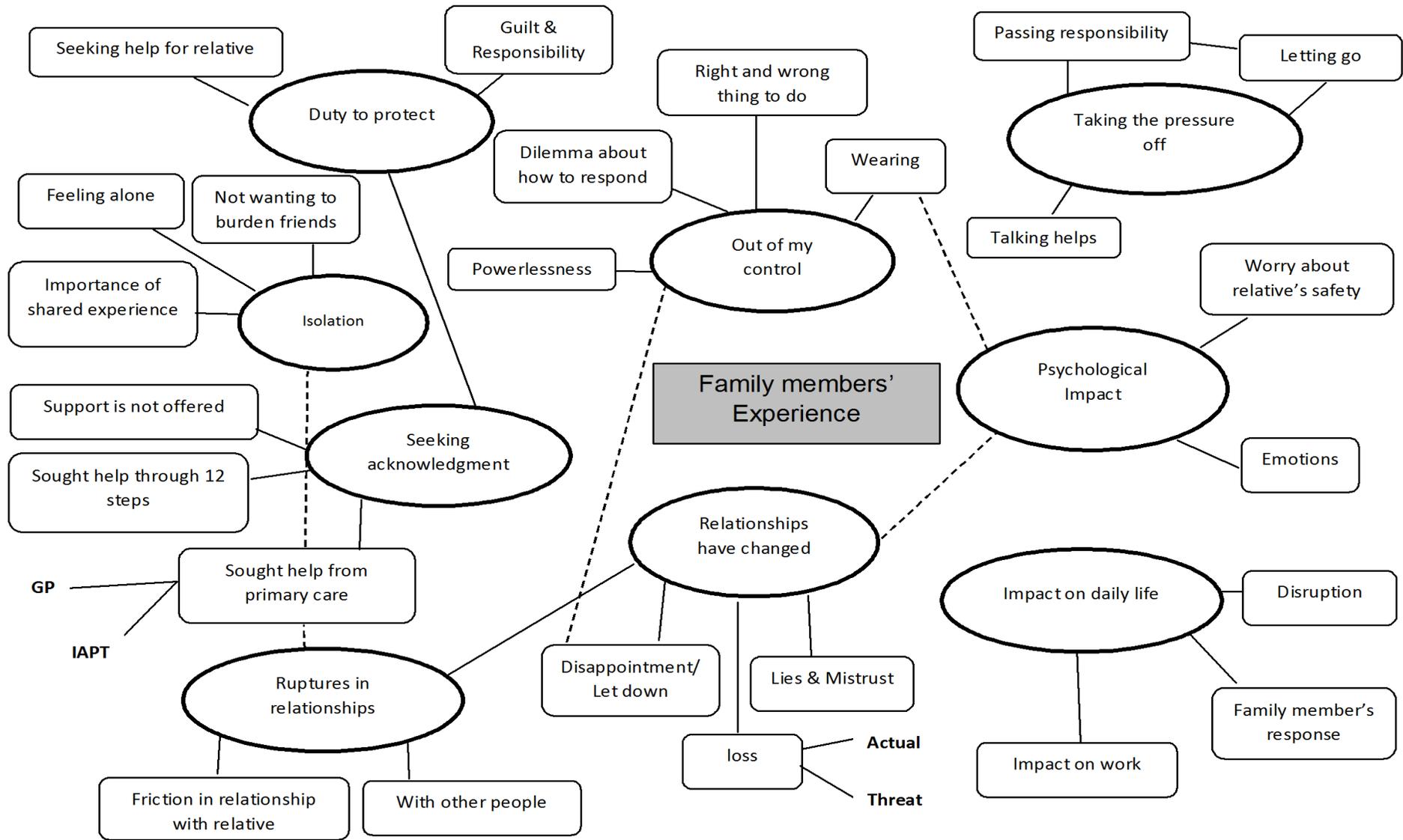
87. Affected family member's demeanour	1
88. Outreach service would help	1
89. Prefers groups to have permanent members	1
90. Other people's stories in the group puts situation into perspective	1
91. Regret	2
92. Sought help through residential family and friends course	1
93. Being in a group can be emotional	1
94. Sex life has diminished due to partner's drinking	1

Appendix J
Example Coded Extract

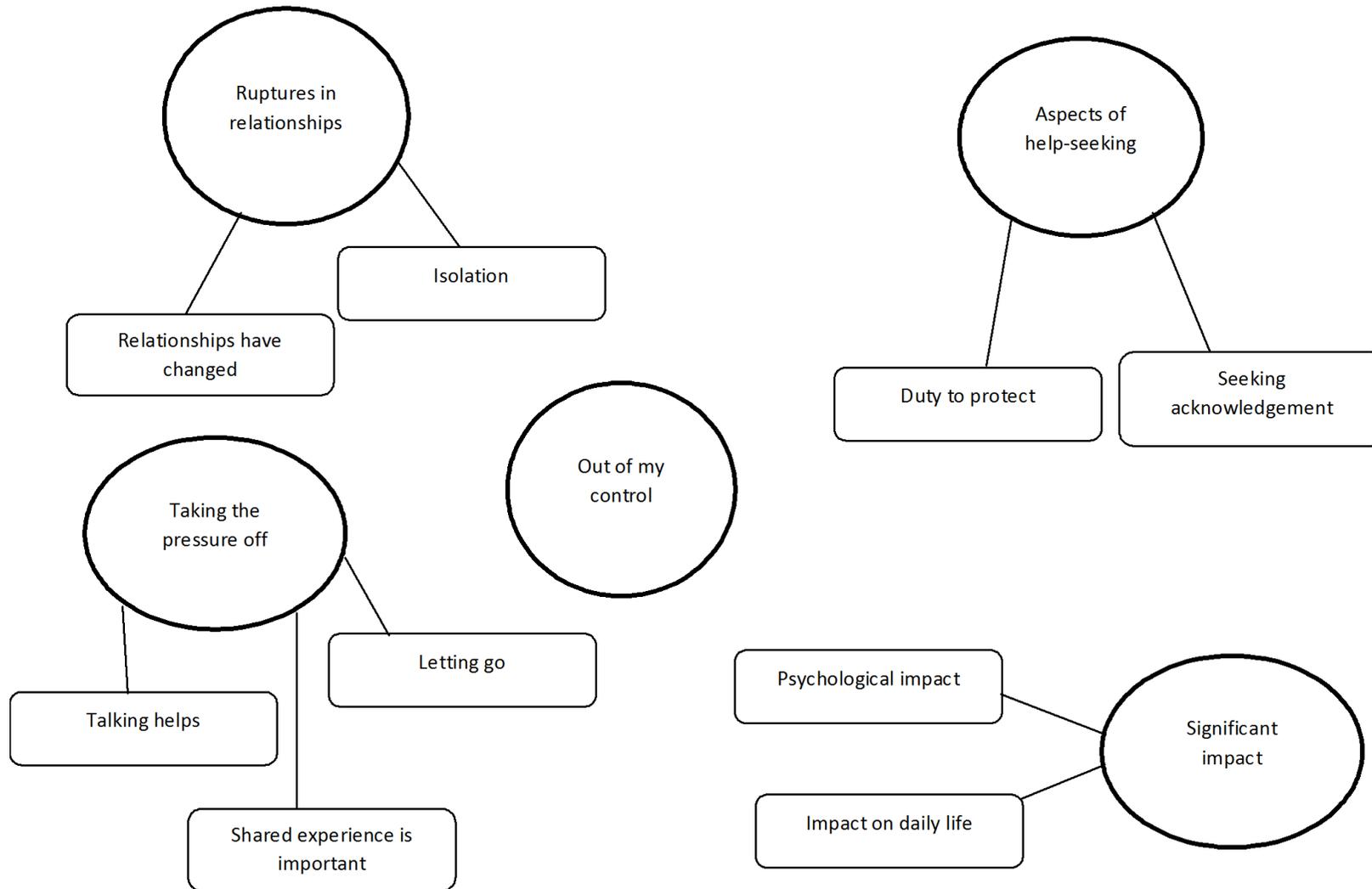
Code	Extracts
Right and wrong thing to do	I <i>And what did the leaflet... can you remember roughly what was in it? What appealed to you?</i>
	P1 it was more that...it said it was for friends and family and I just felt at that time that I needed to be able to...that I wasn't sure that I was doing the right things. And I wanted someone to say to me "erm yes what you're doing is right or no you shouldn't be doing that"
	P1 You do things in the beginning which are totally wrong .and I think I've learnt through here [FPF SERVICE], through the workshops, through reading generally erm about it, what you should and perhaps shouldn't do. So I have changed my behaviour.
	P2 My intention wasn't to try and seek help for myself. When I came here it was to... for his benefit really. Just to have a professional opinion about whether what I was doing with him was the right thing to do.
	P2 (...) I only envisaged having one discussion and that was more to find out whether what I was doing was the right thing and whether there was anything not to do which would have an adverse effect on my son. That was with Mel and I didn't know they had a family service here as well.
P3 (...)But then it was more about oh my god what am I supposed to do with her now? And I think particularly over the time that she was on these really awful drugs that reacted so badly with drink. It was like what was I supposed to do with her. How was I supposed to interpret these comas she seemed to go into? Where they actually dangerous? Should I have been bothering to take her to casualty? Because they weren't doing much really when I did. I just would have wanted to be reassured about the danger to her health and how seriously to take it and stuff like that.	

P4	I could talk privately about things that I couldn't bring to the group and get advice on the way I was dealing with things. Like in the beginning when I was giving her money for food and they advised me not to.
P5	um so it was like living on a helter skelter or a merry-go-round where you never knew whether it was going to be up or down and I now know that I did all the wrong things you know to try and counteract it but I didn't know that at the time.
P6	(...) it's good to talk to somebody about it and also somebody who can give you a perspective about what's right.
P10	(...) the carer's do a thing every year, carers week and I was up [road name] and there was this woman, I never did see her after but apparently she's left now, Mel. Everyone speaks about her now and I duno why she looked at me, she said "you ok?" I said I'm worried about my son, I said but I think something's going on. So she took my email I think it was and she said "oh give me a ring" you know. I said but I don't wana, in case he's not or I don't wana do the wrong thing. And so I had an inkling then.
P11	So I bought him a new couch, new bed, new flooring. Washer and fridge freezer. And we done the place up. So, he'll move back at the end of the week when the bed turns up and I know I've done all the wrong things, and I'm meant to let him hit rock bottom but to me that was rock bottom that flat [laugh]

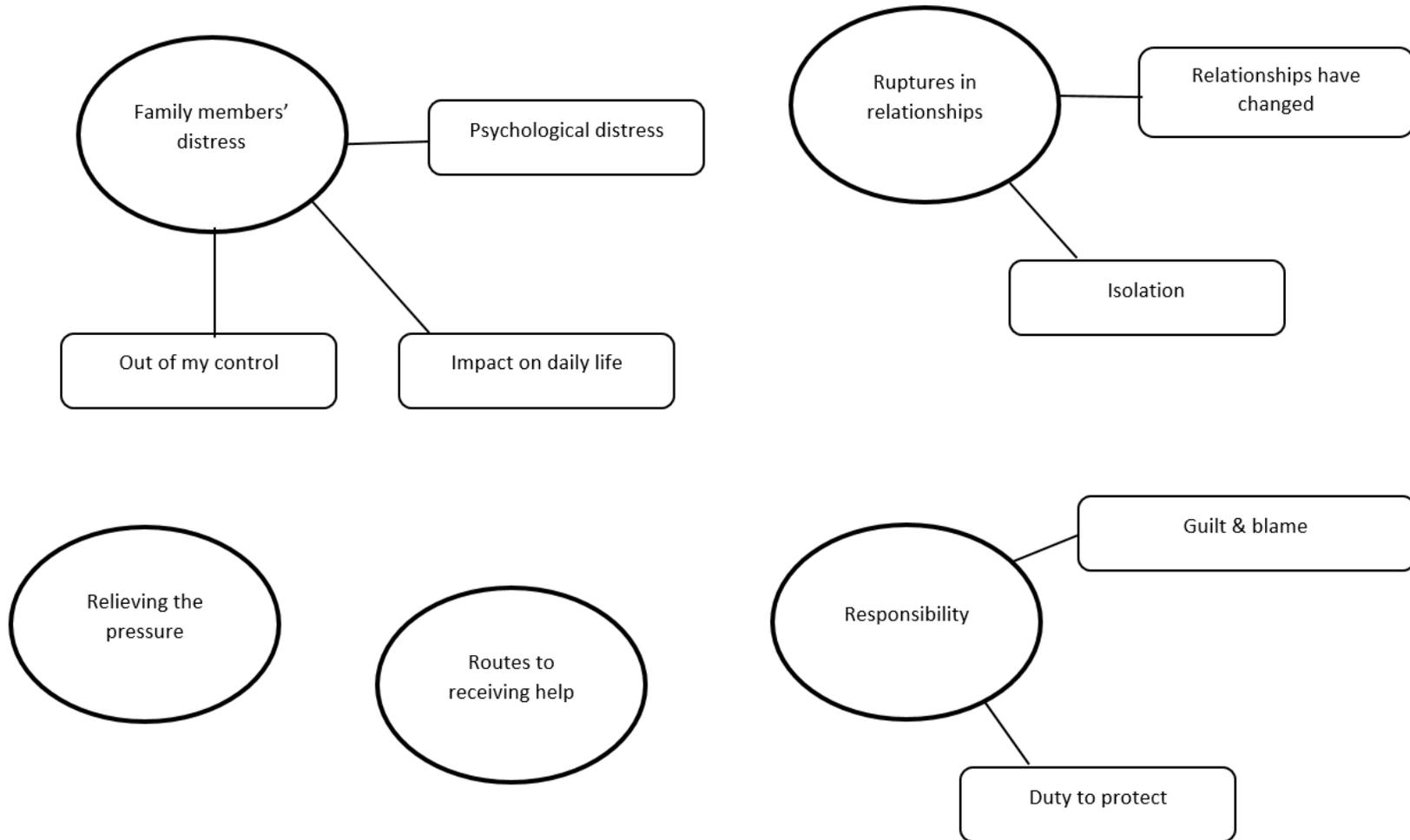
Appendix K - Initial Thematic map



Appendix L
Thematic Map (2)



**Appendix M
Thematic Map (3)**



Appendix N: Reflective Diary Extracts

Extract 1 – Reflections on an interview

During the interview today the participant assumed that I had personal experience of being affected by someone else's drug or alcohol use. I found this to be an interesting assumption given the participant chose not to ask me any questions about myself when invited to before the interview began. I wondered what function holding that belief about me served. Perhaps it was an invitation for me to share with her whether I did have any personal interest in the topic. Perhaps it helped her to feel like I really understood where she was coming from and would therefore not be surprised about what she was telling me. Or perhaps it was a way of expressing that she could not believe anyone would be interested in this topic unless they were personally affected which made me wonder about what topics get viewed as being 'worthy of research'. The way it was framed as a rhetorical question meant that she did not leave the assumption open to be dispelled. I considered issues of power dynamics and whether it was an opportunity for me to disclose whether or not I had been affected but then I also wondered if the question was intentionally framed rhetorically. As she had not asked me a direct question and the conversation moved on swiftly, I decided not to interject. The participant's assumption followed my question about how she had found one to one support at the FPF service. The assumption preceded her response saying they were useful but: "Um I think the awful thing is you realise that there's very little... there's nothing that really can be done. So, you're just constantly faced with this reality that you can't control it. You can't really do anything. You've got to look after yourself and while they're in your head. It's so difficult to look after yourself."

I wondered if she was almost giving herself permission to say that the one to one help did not solve her problems. I wondered if she would have found that difficult to tell me as professional but easier to tell me as someone who could relate. This makes me wonder, as I have done after previous interviews about how easy participants find it to tell me about the unhelpful or negative aspects of their help-seeking experience. I am also curious about assumptions other participants might have made about me. Going forward I will continue to acknowledge during interviews that experiences of seeking help are not always positive. This will hopefully indicate I am open to hearing about all elements of participants' experience.

Extract 2 – Reflections on the analysis

Why is the theme about the 'right and wrong thing to do' standing out to me so much? Is it because I find it surprising that participants place so much emphasis on 'expert' opinion? This could tap into my beliefs about people being the 'experts' in their own lives and believing that my participants' efforts to cope with their situation are ordinary responses to adverse circumstances. It seems people are assuming they are doing something wrong for simply attempting to manage a difficult situation. I need to ensure that this code is salient (i.e. repeated and emphasised throughout the entire data set) and not just something I find interesting or surprising.