Affected family member coping with a relative with alcohol and/or other drug misuse: A cross-sectional survey questionnaire

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ABSTRACT: *Families have a crucial role supporting a relative with alcohol and/or other drug misuse, but the role has adverse implications for family members' coping, which in turn, affects their ability and willingness to support the relative. The aim of this study was to assess the coping behaviours of affected family members of relatives with alcohol and/or other drug misuse, and to assess if there was a relationship between the level of coping and family member type and support-giving experience. A cross-sectional survey design was used and 90 respondents completed the questionnaire. Results suggest the following associations: that 'Other' family members made more frequent use of maladaptive coping strategies than intimate partners (p=0.012); family members whose role had a negative effect on their physical health made more frequent use of maladaptive coping strategies than those whose role did not have this effect (p=0.014); and family members whose role had a negative effect on their ability to socialise used maladaptive coping strategies more often than those whose role did not have this effect (p=0.003). Engaged and tolerant-inactive maladaptive coping strategies had a significantly greater adverse influence on family members' physical health and/or socialising than withdrawal coping strategies. Affected family members should be supported to use adaptive coping strategies to mitigate the detrimental effects of their support-giving role, and* *to sustain them in this crucial support-giving role. Family and friends, mental health nurses and other clinicians in the alcohol and other drug field have an important role in supporting family members in this context.*

KEY WORDS: family members, clinicians, coping, mental health nurses, substance misuse

INTRODUCTION

Affected family members (AFMs) (intimate partners, parents, siblings, offspring, relatives or friends), those directly affected by a relative's alcohol and other drug (AOD) misuse, make a key contribution to the support of their relative (Orford *et al.* 2013; World Health Organization 2014; Gethin *et al.* 2016). Harms are not limited to the person with AOD misuse, but have adverse implications for family dynamics and specifically for the well-being of AFMs (Orford *et al.* 2010; Orford *et al.* 2013; Casswell *et al.* 2011; Wilson *et al.* 2017a). Harms also have detrimental implications for AFMs' coping and their ability and willingness to carry out their support-providing role (i.e., provision of emotional, social, instrumental and informational support) (Orford *et al.* 2013), and can compromise their important role in the recovery of the relative (Copello *et al.* 2009b).

AFM harm is affected by their ability to cope in these circumstances (Templeton *et al.* 2007). Coping is an activity in which people use a range of cognitive and behavioural strategies to deal with, moderate or endure, situations that are demanding or surpass their routine ways of dealing with these situations (MacNeill *et al.* 2016). There are two types of coping: emotion- or problem-focused (Lazarus & Folkman 1984), which can be classified in accordance with their purpose (MacNeill *et al.* 2016). Zuckerman and Gagne (2003) conceived a five-factor model of adaptive and maladaptive coping, where coping measures adopted range from complete involvement to avoidance of, in this situation, the relative with substance misuse. Adaptive coping, such as self-help, help-seeking and engaging various forms of support, is more beneficial to AFMs, as they try to minimise the effect of the relative's behaviour. In contrast, maladaptive coping may include avoidance of the situation and self-criticism (Zuckerman & Gagne 2003; MacNeill *et al.* 2016). Adaptive coping is aligned with beneficial outcomes, whereas maladaptive coping is associated with emotional and behavioural difficulties (MacNeill *et al.* 2016).

Orford et al. (2013) proposed a non-pathological stress-strain-coping-support model, analogous to other stress-coping models such as that expounded by Lazarus and Folkman (1984). In contrast to other coping models in the addiction field, the Orford et al. (2013) model focuses specifically on AFM stress, strain, coping and support within the context of the experiences and outcomes of supporting a relative with AOD misuse. Central to this model, no blame is attributed to AFMs for the onset or continuation of the relative's behaviour, or for their thoughts, emotions and behaviours toward the relative. AFMs use one or more of three coping approaches to deal with the problem: *put up with* the behaviour (e.g., accept things as they are, inaction, resignation), *withdraw from* the relative and the immediate situation (e.g., gain independence from the problem, become involved in other activities), and *stand up* to or confront the behaviour associated with the problem (e.g., set boundaries for unacceptable behaviour; protect other family members, especially children, from the relative's behaviour; insist on the relative seeking treatment; seek assistance from the police and judiciary). Decision-making about which coping approaches to adopt is influenced by various factors such as concern for the relative, gender, personal, familial and socio-cultural considerations, and the level of informal and formal support received (Orford *et al.* 2013).

Adaptive and maladaptive coping have contrasting implications for AFMs' own well-being and their ability and willingness to maintain their support-providing role. Limited formal services are designed specifically to help AFMs cope with their situation (Kelly *et al.* 2017). Furthermore, when the relative is receiving treatment from AOD services, AFMs frequently perceive that AOD clinicians prevent them from contributing to treatment and are insensitive to their day-to-day difficulties (Orford *et al.* 2013). Of the limited number of psychosocial interventions for AFMs, most lack a distinct focus on improving AFM coping. Essentially, there are three categories of interventions in this situation: (i) those focusing primarily on the relative's treatment, with AFM involvement; (ii) those involving AFMs as a means to encourage the relative to engage in treatment; and, to a lesser extent, (iii) those specifically designed to increase AFM coping (Orford *et al.* 2013). High levels of help-seeking by AFMs to AOD helplines justify the need for tailored programs to enhance their coping (Garde *et al.* 2017; Wilson *et al.* 2017b); hence, it is essential to adopt a family-wide view when addressing a relative's AOD misuse (Brown *et al.* 2011; Ahmedani *et al.* 2013).

Only a limited number of studies have focused on AFMs' coping and how they manage in this situation, and few resources are available to increase their coping (Copello *et al.* 2009a; Kelly *et al.* 2017). Copello et al. (2009a) conducted a cluster randomised comparative trial of two interventions (up to five intensive sessions with a healthcare professional plus a self-help manual versus a single session with a healthcare professional during which the self-help manual was introduced), for AFMs in England. The findings showed significant reductions in stress and improved coping in both clusters, but no significant differences in these outcomes between the clusters. Kelly et al. (2017) evaluated a learning to cope program for family members of relatives with opioid addiction in northeastern United States, comprising attendance at meetings, access to online resources, and peer support. The findings indicated that families reported increased understanding and coping with addiction, greater ability to communicate with their relative, and decrease in stress and self-blame.

In light of the harms encountered by other family members due to a relative's AOD misuse, and high levels of help-seeking by AFMs to AOD service helplines (Garde *et al.* 2017), research is needed to examine how AFMs cope. Findings could augment the approaches mental health nurses and other clinicians in the AOD field use to increase AFM coping. The aim of this study was to assess the coping behaviours of AFMs of relatives with AOD misuse, and to assess if there was a relationship between the level of coping and AFM type and support-giving experience. The study was nested within a larger, mixed methods (sequential explanatory design: quantitative then qualitative (Creswell 2009)) study of AFMs supporting relatives in this circumstance. Findings from the qualitative part of the study reported on AFMs' experience of aggression and violence (McCann *et al.* 2017), stigma experience (McCann & Lubman 2018c), adaptive coping strategies (McCann & Lubman 2018a), and help-seeking barriers and facilitators (McCann 2018b) are reported elsewhere.

METHOD

Design

A cross-sectional survey design was used, incorporating a structured questionnaire, which was completed online once by each respondent using Qualtrics survey software. Data collection occurred from January to December 2015.

Participants, recruitment, and sample size

Recruitment took place through state-wide AOD helplines (Ice Advice Line, Directline and Family Drug Help) and associated social media accounts (Twitter), in the state of Victoria, Australia. When AFMs accessed the helplines for support they were also given details about the study by helpline counsellors and how the survey could be accessed. AFMs recruited through social media communicated directly with the researcher, who also advised them how to access the survey. In light of the indirect methods of recruitment, it was not possible to determine how many participants were approached and the response rate. Inclusion criteria for respondents were: AFMs, aged between 18 and 65 years, and in the support-giving role (providing emotional, social, instrumental and informational support) for at least a year.

Sample size was determined based on the maximum expected number of independent variables to be tested in a multiple regression analysis of the overall coping score. A sample size of 64 would achieve 80% power to reject the null hypothesis at the 5% significance level (alpha) when the actual value of the squared multiple correlation coefficient is 0.2, representing a medium effect size. Allowing for 20% attrition, we aimed to collect data from a minimum of 80 AFM respondents: in reality, 90 AFMs completed the questionnaire.

Instruments

A sociodemographic questionnaire was developed from the literature and expert contribution. It contained 18 items focusing on general (n=9) (e.g., age, gender, education, main language spoken at home) and support-giving role (n=9) (e.g., relationship with member with AOD misuse, effect of support-giving on employment, physical health, socialising, assistance from AOD services) characteristics.

The coping questionnaire (CQ) (Orford *et al.* 2001; Orford *et al.* 2005) was used to assess the ways AFMs coped with the harmful impact of a close relative's AOD misuse in the past three months. It has been used extensively in studies of AFM coping with a relative's AOD misuse (Gethin *et al.* 2016; Orford *et al.* 2017), and has been adapted for AFMs of relatives with problematic gambling (Brooks *et al.* 2017). The CQ contains 30 items on a four-point Likert scale: 0 (no), 1 (once or twice), 2 (sometimes), and 3 (often). It contains three sub-scales: engaged coping (CQ-E) (standing up to the problem) (14 items), tolerant-inactive coping (CQ-TI) (putting up with the problem) (9 items), and withdrawal coping (CQ-W) (withdrawing and becoming independent from the problem) (6 items and subtract scores for items 5 and 22). The CQ can be scored by summing all items to give a total coping score, or by calculating each sub-scale score separately. Higher CQ-E scores = more frequent engaged coping. Higher CQ-TI scores = more frequent tolerant-inactive coping. Higher CQ-W scores = more frequent withdrawal coping. Most coping behaviours included in the CQ are unhelpful to AFMs' experience and health, especially engaged and tolerant-inactive coping. Overall, lower CQ scores are more positive, indicating less attempts at (maladaptive) coping and fewer adverse events impacting on AFMs' experience and health (Velleman *et al.* 2011; Copello *et al.* 2009a; Orford *et al.* 1998).

There are two versions of the CQ; one for use when the substance misusing relative is male, the other when the relative is female. Both versions were used in the present study. Cronbach's internal reliability for the total scale (α=0.85) and sub-scales (CQ-E, α=0.85; CQ-TI, α=0.74, CQ-W, α=0.60) is satisfactory (Orford *et al.* 2005). In the present study, the Cronbach alpha for the total scale indicated very good internal consistency (α=0.87), very good for the CQ-E (α=0.88), good for the CQ-TI (α 0.72), and moderately good for the CQ-W (α=0.61). Preferably, Cronbach's alpha should exceed 0.7 (DeVellis 2003).

Ethics

Ethics approval to conduct the study was given by Eastern Health Human Research Ethics Committee (LR59/1314). Completion of the survey was interpreted as consent.

Data analyses

Data were analysed using IBM® SPSS® for Windows, Version 24.0 (IBM Corp., Armonk, NY). Data screening was undertaken prior to analyses. Cases were assessed for missing data amongst the outcome scores. Cases providing few or no responses to items (i.e. less than 5 valid responses to the CQ), and socio-demographic variables with a large proportion of missing values, were deleted from the analysis. This amounted to the deletion of 2 cases. Missing data amongst the remaining cases were assessed for missingness (the pattern and extent to which data are missing from a data set). About 1.4% of data was missing, with no evidence revealed that missing data were not missing completely at random in the overall CQ or any of its sub-scales according to Little's test for missing completely at random and separate variance t-tests. Correspondingly data imputation was conducted, using the expectation maximisation algorithm, and subsequent analyses were conducted on imputed data sets.

Socio-demographic data were summarised descriptively. Parsimonious (i.e., explaining as much of the outcome as possible with as few predictor variables as possible) regression models were derived, relating participants' socio-demographic characteristics to the overall coping score (the primary outcome), via a set of simpler screening models designed to identify and eliminate confounding variables and those of no importance to the outcome. A multivariate regression analysis of the three coping sub-scale scores, with follow-up univariate analyses, were also conducted to assess the source of any associations as a secondary analysis; considering the same predictors as in the analysis of overall scores. Related levels of categorical variables were combined as necessary where frequencies of particular categories were too low for individual analysis, to avoid the use of multiple indicator variables or to reduce collinearity effects.

RESULTS

Socio-demographic

Socio-demographic data were collected on 90 AFM respondents; complete or near-complete response data were collected on 88 individuals (Table 1). The mean age of AFMs was around 44 years, and most were female (86.7%). The amount of time they had been in the support-giving role with the relative with AOD misuse was approximately 10 years. Almost two-thirds of AFMs lived in the same household as the relative, and English was the main language spoken at home. Just over half of AFMs responded that supporting the relative had a detrimental effect on their employment, and a large majority indicated that it had adverse effects on their physical health (79.8%) and ability to socialise with others (76.4%). Moreover, just over three-quarters (76.4%) were not receiving any support from AOD services.

TABLE 1: *Sociodemographic characteristics of respondents (N=90).*

	n	%
Gender		
Male	12	13.3

Female	78	86.7
Relationship with relative with AOD misuse		
Parent	31	34.4
Intimate partner	30	33.3
Other (adult child, sibling etc.)	29	32.2
Home status		
Living with relative with AOD misuse	55	61.8
Not living with relative with AOD misuse	34	38.2
Country of birth		
Australia	70	68.0
New Zealand	3	2.9
South Africa	2	1.9
United Kingdom	5	4.9
Other	8	7.8
Main language spoken at home		
English	83	94.3
Other	5	5.7
Highest level of education		
Primary school	5	5.6
Secondary school	16	18.0
Technical and further education	16	18.0
Tertiary education	52	58.4
Occupation		
Professional/Business/Management	51	58.6
Administration/Clerical	15	17.2
Trade/Factory work	7	8.0
Home duties	6	6.9
Other	8	9.2
Current employment status		
Employed	74	83.1
Not employed	15	16.9
Has your support giving role affected your employment in this occupation?		
Yes	45	50.6
No	35	39.3
Not applicable	9	10.1
Over the past 3 months, has your support giving role affected your physical health?		
Yes	71	79.8
No	18	20.2
Over the past 3 months, has your support giving role affected your ability to meet and socialise with relatives and friends?		
Yes	68	76.4
No	21	23.6
AFM receiving assistance from AOD services		
Yes	21	23.6
No	68	76.4
	Mean	SD†

Age (years)	44.4	13.6
Years lived in Australia	35.7	19.7
Time (years) relative has had AOD misuse	13.0	11.6
Time (years) supporting relative with AOD misuse	9.57	10.0
Number of contacts with AOD services in previous 4 weeks	0.99	2.7

†Standard deviation.

Overall and sub-scale coping

Mean overall and sub-scale CQ scores were analysed (Table 2). Mean overall coping score was 43.9, indicating moderately frequent use of coping strategies by AFM respondents in their support-giving role. Regarding engaged coping, AFMs had a mean score of 21.4, suggesting moderately frequent use of coping strategies, such as standing up to the problem and actively engaging with the relative with AOD misuse. Concerning tolerant-inactive coping, AFMs had a mean score of 12.0, indicating moderately frequent use of coping strategies, like putting up with or accepting the relative's behaviour. Regarding withdrawal coping, AFMs had a mean score of 7.4, suggesting occasional-to-moderately frequent use of coping strategies, such as taking measures to become independent from the relative's behaviour. Overall, the moderately frequent use of coping strategies suggests that the relative's AOD misuse had an adverse impact on AFMs' support-giving experience.

TABLE 2: *Total and sub-scale CQ scores.*

Scale	Mean (SD†)
Total	43.9 (15.4)
Sub-scales	
Engagement	21.4 (9.81)
Tolerant-inactive	12.0 (5.72)
Withdrawal	7.4 (4.87)

†Standard deviation

Relationship between level of coping and AFM type and support-giving experience

Uncontrolled (univariate) screening models of overall CQ scores indicated that the following variables exhibited an association of some substantive importance: AFMs' gender, relationship with the relative, home status, effect of supporting the relative on AFMs' physical health and ability to socialise with others, AFMs' age, and duration of time (years) the relative had AOD misuse. These indicator variables were carried forward into a multiple model. Categories in the variable corresponding to 'relationship' were merged into 'intimate partner' or 'other' to avoid issues of collinearity. AFM gender, home status, age and time (years) the relative had AOD misuse were not significantly associated with overall CQ scores in a multiple model and were excluded from further analysis. This left a final parsimonious model, which included the variables corresponding to AFM type (intimate partner versus other AFMs) and effect of support-giving on AFMs' physical health and ability to socialise with others. The results (parameter estimates, 95% confidence intervals and p-values) of the model on overall CQ scores are shown in Table 3.

TABLE 3: *Univariate multiple model parameters: Overall CQ scores.*

Variable	Parameter estimate	95% CI†	p-value
AFMs' relationship with relative			
Intimate partner (reference category)			
Other (parent, adult child, sibling etc.)	2.90	(0.642, 5.16)	0.012
Effect of supporting relative on physical health			
Negative effect (reference category)			
No negative effect	-3.38	(-6.04, 0.716)	0.014
Effect of supporting relative on socialising ability			
Negative effect (reference category)			
No negative effect	-4.02	(-6.59, 1.44)	0.003

†Confidence intervals.

Controlling for other variables, 'other' AFMs of relatives with AOD misuse scored 2.90 points higher (i.e., worse) on the overall coping scale than intimate partner AFMs, indicating that the former group of AFMs made more frequent use of maladaptive coping strategies than the latter; AFMs whose role had a negative effect on their physical health scored 3.38 points higher (i.e., worse) on the coping scale than those whose role did not have a negative effect on their physical health, suggesting that the former used maladaptive coping strategies more frequently than the latter; and AFMs whose role had a negative effect on their ability to socialise with others scored 4.02 points higher on the coping scale than those whose role did not have a negative effect on their socialising ability, indicating that the former adopted maladaptive coping strategies more often than the latter (Table 3).

The adjusted-R^2 statistic for this model was 0.266. Multivariate statistics for these variables (Wilk's lambda, F-ratios [with degrees of freedom (df)], parameter estimates and p-values) in the corresponding multivariate model of the CQ sub-scales are presented in Table 4.

TABLE 4: *Multivariate statistics: CQ sub-scale scores.*

Variable	Wilk's lambda	F-ratio	df†	p-value
Relationship with relative				
Intimate partner (reference)				
Other (parent, adult child, sibling etc.)	0.886	3.53	3,82	0.018
Effect of supporting relative on AFMs' physical health				
Negative effect (reference)	0.907	2.79	3,82	0.046
No negative effect				
Effect of supporting relative on AFMs' socialising ability				
Negative effect (reference)				
No negative effect	0.874	3.96	3,82	0.011

†degrees of freedom

All included variables were significantly associated with a linear combination of engaged, tolerant-inactive and withdrawal sub-scale CQ scores. Statistics from follow-up univariate analyses (parameter estimates, 95% confidence intervals and p-values) of a multiple multivariate model on the sub-scale CQ scores are summarised in Table 5. The significance of the relationship between the relative with AOD misuse and sub-scale CQ scores was evidenced primarily in the tolerant-inactive sub-scale (p=0.012), but was substantive in all three sub-scales. 'Other' AFMs of the relative with AOD misuse scored higher on the three sub-scales (3.23, 2.90 and 1.93 points more on the engaged, tolerant-inactive and withdrawal respectively) than intimate partner AFMs, indicating that the former group made more frequent use of maladaptive coping strategies than the latter. This suggests that the relative's AOD misuse had a more detrimental effect on 'other' AFMs' support-giving experience.

The significance of the relationship between the effect on AFMs' physical health and socialising ability in supporting the relative with AOD misuse and sub-scale scores was evidenced primarily in the engaged and tolerant-inactive coping sub-scales. AFMs who reported that their physical health and/or ability to socialise was affected adversely by their support-giving role scored higher in both these sub-scales than those who did not report this effect; hence, the former group made more frequent use of these coping strategies than the latter. There was no evidence of a relationship between the effect of AFM support-giving on their physical health and/or socialising ability and scores on the withdrawal coping sub-scale.

The adjusted-R^2 statistics for the models of engaged, tolerant-inactive and withdrawal sub-scale scores were, respectively, 0.176, 0.266 and 0.026. Hence the model of withdrawal sub-scale CQ scores is less well-fit to the data than the other models.

TABLE 5: *Follow-up univariate model parameters: CQ sub-scale scores.*

Variable	Sub-scale	Parameter estimate	95% CI†	p-value
Relationship with relative				
Intimate partner (reference category)				
Other (parent, adult child, sibling etc.)	Engaged	3.23	(-0.881, 7.33)	0.122
Relationship with relative				
Intimate partner (reference category)	Tolerant-inactive			
Other (parent, adult child, sibling etc.)		2.90	(0.642, 5.16)	0.012
Relationship with relative				
Intimate partner (reference category)				
Other (parent, adult child, sibling etc.)	Withdrawal	1.93	(-0.289, 4.14)	0.087
Effect of supporting relative on AFMs' physical health				
Negative effect (reference category)	Engaged	-5.34	(-10.2, -0.504)	0.031
No negative effect				
Effect of supporting relative on AFMs' physical health				
Negative effect (reference category)	Tolerant-inactive	-3.38	(-6.04, 0.716)	0.014
No negative effect				
Effect of supporting relative on AFMs' physical health				
Negative effect (reference category)	Withdrawal	1.59	(-1.02, 4.20)	0.230
No negative effect				
Effect of supporting relative on socialising ability				
Negative effect (reference category)	Engaged	-6.20	(-10.9, -1.52)	0.010
No negative effect				

Effect of supporting relative on AFMs' socialising ability				
Negative effect (reference category)	Tolerant-inactive	-4.02	(-6.59, -1.45)	0.003
No negative effect				
Effect of supporting relative on AFMs' socialising ability				
Negative effect (reference category)	Withdrawal	1.41	(-1.11, 3.93)	0.269
No negative effect				

†Confidence intervals.

DISCUSSION

The aim of this study was to appraise the coping behaviours of AFMs of relatives with AOD misuse, and to assess if there was a relationship between their level of coping and AFM type and support-giving experience. There were three main findings in this study. First, AFMs experienced various forms of harm associated with their support-giving role. More than half claimed it had a damaging effect on their employment, and over three-quarters reported it had unfavourable effects on their physical health and capacity to socialise with others. These findings are consistent with those of other studies of AFMs' well-being (Orford *et al.* 2010; Orford *et al.* 2013; Casswell *et al.* 2011). The implication of these harms is they can have detrimental effects on AFMs' ability and willingness to carry out their support-giving role (Frye *et al.* 2008), and can compromise their important contribution to the relative's recovery from AOD misuse (Copello *et al.* 2009b). Furthermore, in the present study more than three-quarters of AFMs indicated they were not receiving any assistance from AOD services. Even though they are regarded as having a key role in supporting and as change agents for their relatives, AFMs experience significant gaps in support and education (Orford *et al.* 2010; Copello & Templeton 2012; Orford *et al.* 2013; Kelly *et al.* 2017).

Second, AFMs in the current study made moderately frequent use of maladaptive coping strategies in their support-giving role. In particular, 'other' AFMs made more frequent use of maladaptive coping strategies than intimate partner AFMs. This finding suggests that intimate partners, perhaps because of their emotional closeness with, and commitment to, the relative, were more objective and coped better in this situation than 'other' AFMs. Third, AFMs whose role had a negative effect on their physical health made more frequent use of maladaptive coping strategies than those whose role did not report an adverse effect on their physical health. AFMs whose role had a detrimental impact on their ability to socialise with other used maladaptive coping strategies more frequently than those whose role did not have this impact. Moreover, AFMs who indicated that their physical health and/or socialising ability were affected unfavourably by their support-giving role made more frequent use of engaged and tolerant-inactive coping strategies than those who were not affected in this way. Engaged and tolerant-inactive coping in particular, could be interpreted as forms of maladaptive coping (MacNeill *et al.* 2016), which, potentially, have more unfavourable implications for their physical health and/or ability to socialise with others.

Overall, our findings suggest that AFMs experienced harms from undertaking their support-giving role. Harms are influenced by the maladaptive coping strategies they used in these situations (Templeton *et al.* 2007), have adverse consequences for their ability and willingness to fulfil this important role (Orford *et al.* 2013), and can undermine their critical contribution to the relative's recovery (Copello *et al.* 2009b). AFMs need much greater access to, and support from, AOD services to enhance their adaptive coping (over three-quarters were not receiving support from these services). In particular, measures are needed to encourage, educate and support them to use adaptive coping strategies (e.g., self-help, help-seeking and enlisting various forms of informal and formal support). A wide range of evidence-based information as well as informal and formal support (Frye *et al.* 2008; Copello & Templeton 2012; O'Grady & Skinner 2015), including religious/faith community support (Orford *et al.* 2013), are required to enable AFMs to cope. AFMs need AOD services that accessible, supportive, non-judgemental and respectful (Haskell *et al.* 2016) to enable them to use adaptive coping strategies.

Limitations

As a cross-sectional, self-report study, conclusions about association or causality cannot be inferred. In addition, the sample size limits the representativeness and generalisability of the findings. Nevertheless, the findings provide an important insight into the coping strategies adopted by this cohort. Approximately 87% of AFM participants were females whose coping strategies may differ from males. Around three-quarters of participants were born in Australia or in other developed countries, and for over 94% English was the main language spoken at home. Hence, the coping strategies adopted by immigrants from developing countries, and those whose primary language is not English, may differ (Orford *et al.* 2013). Likewise, just under 60% of respondents were in professional/business/management occupations; hence, further study is needed of AFMs who do not fall within these occupations. These are important considerations as AFMs were recruited through state-wide AOD services, which may have culminated in an atypical group of participants who may not be coping as well as others AFMs.

CONCLUSION

Our findings highlight that AFMs used adaptive and maladaptive coping strategies. 'Other' AFMs use maladaptive coping strategies more often than intimate partner AFMs. Those whose role had adverse effects on their physical health and socialising used maladaptive coping strategies more frequently than those whose role did not report these effects. Engaged and tolerant-inactive maladaptive coping strategies had more detrimental effects on AFMs' physical health and/or socialising than withdrawal coping strategies. It is important that AFMs use adaptive as opposed to maladaptive coping strategies to moderate the harmful effects of their support-giving role on their employment, promote their physical and social well-being, and equip them more so to sustain them in their critical role with the relative with AOD misuse.

RELEVANCE FOR CLINICAL PRACTICE

To enhance adoption of adaptive coping strategies, AFMs need suitable and well-timed access to a wide choice of evidence-based information and informal and formal support. To this end, close relatives and friends, mental health nurses and other clinicians in the AOD field can make a key contribution by offering emotional, instrumental and educational support to facilitate AFMs to use adaptive coping strategies. AOD services need to provide greater access and more tailored services for AFMs. Research is also needed to evaluate measures to promote adaptive coping and minimise or eliminate maladaptive coping.

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