

Family Stress, Well-being and Hope for the Future when Supporting a Relative with AOD Misuse: A Cross-sectional Survey

Running title: Family well-being and hopefulness AOD misuse

ABSTRACT

While families have a central role supporting relatives with alcohol and other drug (AOD) misuse, this can undermine their own well-being and hopefulness. The aims of this study were to assess the effect of supporting a relative with AOD misuse on affected family members' (AFMs) psychological and physical well-being and hope for the future about their relative, and to identify factors associated with AFMs' well-being and hope. A cross-sectional survey design with 90 AFMs. Over three-quarters of AFMs had not received any assistance from AOD services recently, nearly 80% experienced adverse effects on their physical health and ability to socialise with relatives and friends, and just over 50% reported detrimental effects on their paid employment. AFMs living with their relative with AOD misuse experienced more harmful stress than those who were not residing with their relative. Intimate partner AFMs experienced more mild-to-moderate physical and psychological ill health than non-partner AFMs. No socio-demographic factors were significantly associated with AFMs' levels of hopefulness-hopelessness. Measures are needed to increase AFMs' access to mental health nurses and other AOD clinicians for their own needs. Services and AOD clinicians should target, but not be restricted to, reducing stress and strengthening their physical and mental well-being and hopefulness.

Introduction

Alcohol and other drug (AOD) misuse can have detrimental effects on families, including significant physical and psychological harm (Kelly, Fallah-Sohy, Cristello, & Bergman, 2017; T. V. McCann, Polacsek, & Lubman, 2019; Orford, Velleman, Natera, Templeton, & Copello, 2013). Emotional and instrumental (financial, material and practical assistance) support given by affected family members (AFMs; such as intimate partners, parents, children, siblings, other relatives) can often have beneficial effects on the course and outcome of the relative's AOD misuse (McPherson, Boyne, & Willis, 2017; Templeton & Copello, 2012). However, harms can undermine their willingness and capacity to fulfil this important support-giving role as well as their hope for the future about the relative, both of which, in turn, can adversely affect the relative's recovery (Copello, Templeton, & Powell, 2009; Frye, Dawe, Harnett, Kowalenko, & Harlen, 2008; T. V. McCann & Lubman, 2018b).

A combination of internal and external factors contribute to the physical and psychological harms experienced by AFMs as well as their outlook about the relative's AOD misuse. Internal factors emanate directly from the relative and the AFM. One relative-related internal factor is the unpredictable nature of their AOD misuse, which can amplify harms to AFMs (Kelly et al., 2017; Werner & Malterud, 2016). Another relative-related internal factor is the high rate of aggression (verbal, physical, emotional) by the relative towards persons or objects within the household (Dowling et al., 2014; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Pasquali & Simonelli, 2015), which is stressful and emotionally draining to AFMs (T. V. McCann, Lubman, Boardman, & Flood, 2017). One AFM-related factor is AFMs frequently have to endure considerable personal (e.g., reduced or lost opportunity for paid employment) and family-wide costs associated with the relative's AOD misuse (Orford et al., 2013). Another AFM-related factor, is the harm AFMs may experience as a result of the way they cope with the relative's behaviour (Templeton, Zohhadi, & Velleman, 2007). In practice, AFMs use a

combination of adaptive (or positive) and maladaptive coping. Adaptive coping is associated with beneficial outcomes for the AFM; in contrast, maladaptive coping is associated with adverse effects on AFMs' physical health and socialising (T.V. McCann, Stephenson, & Lubman, 2019).

External factors add directly and/or indirectly to the harms experienced by AFMs. Stigma can exacerbate harms to AFMs and is considered to have three dimensions: public stigma (negative attitudes of the public towards people with a reprehensible characteristic [e.g., AOD misuse] (Corrigan, Roe, & Tsang, 2011)) and self-stigma (internalisation of public stigma and consequential lowered self-efficacy and self-esteem (Corrigan & Watson, 2002)). The third, but less commonly recognised dimension of stigma, is 'courtesy stigma' (Goffman, 1963), where families, and AFMs in particular, experience shame and blame resulting from their relative's AOD misuse (Corrigan, Watson, & Miller, 2006), increasing their social isolation from others (T. V. McCann & Lubman, 2018c).

Another external factor that can exacerbate the harms experienced by AFMs is limited access to support from AOD services. AOD service helplines, which are usually 24/7, enable easy access to support, and are convenient for AFMs who feel stigmatised or desire anonymity. However, while some AFMs have frequent contact with AOD services (Garde, Manning, & Lubman, 2017), many experience numerous barriers accessing them (T. V. McCann & Lubman, 2018b). In addition, when access does take place, it is frequently of short duration (Orr, Barbour, & Elliott, 2013) and limited to crisis situations (Kim & Salyers, 2008). What is evident overall, though, is that AFMs who are able to access support for themselves are more likely to maintain their support-giving role (T. V. McCann & Lubman, 2018b).

It is unclear, however, what effect support-giving has on AFMs' well-being and hope for the future when they have limited or no access to AOD services. To bridge this gap, the aims of this study were to assess the effect of supporting a relative with AOD misuse on AFMs'

well-being and hope for the future about their relative. Our hypotheses were that socio-demographic factors associated with support-giving would change AFMs' stress, physical and psychological health, and hopes for the future. The study was situated within a larger, mixed methods study (qualitative interviews, survey) of AFMs' experience supporting relatives with AOD misuse.

Methods

Participants and procedures

A cross-sectional survey design was used involving a structured questionnaire. The survey was carried out online using Qualtrics survey software, and each respondent completed the questionnaire once. Recruitment was undertaken through state-wide AOD telephone helplines (Directline, Ice Advice Line and Family Drug Help) and related social media accounts (Twitter), in the state of Victoria, Australia. After AFMs contacted the helplines for support they were provided with information about the study by helpline counsellors and how to access the survey. AFMs recruited through social media spoke directly with the researcher, who also gave information about how to access the survey. As a consequence of the indirect methods of recruitment, it could not be ascertained how many participants were approached and the response rate. Inclusion criteria consisted of participants being aged between 18 and 65 years, and being in the support-giving role for at least one year.

Sample size was ascertained founded on the maximum expected number of independent variables to be assessed in a multiple regression analysis of AFMs' well-being and hope for the future. A sample of 64 would realise 80% power to reject the null hypothesis at 5% significance level (alpha) when the actual value of the squared multiple correlation coefficient is 0.2, equating to a medium effect size. In making provision for 20% attrition, we set out to recruit at least 80 AFMs: in practice, 90 completed the survey.

The study was approved by Eastern Health Human Research Ethics Committee (LR59/1314), and completion of the survey was interpreted as consent.

Measures

A *sociodemographic questionnaire* was generated from literature and expert contribution, comprising 18 items. Nine items centred on general issues (e.g., age, gender, education) and nine centred on AFMs' support-giving role (e.g., relationship with relative with AOD misuse, effect of support-giving on AFMs).

Primary outcome measures were the *Family Member Impact* (FMI) Questionnaire (Orford, Templeton, Velleman, & Copello, 2005), the *Symptom Rating Test* (SRT) (Orford et al., 2005), and the *Hopefulness-hopelessness* (Hope) *Scale* (Orford et al., 2005). The FMI Questionnaire (Orford et al., 2005) assesses the degree and type of harmful stress on AFMs or on the family as a whole, in the past three months, attributable to the relative's AOD misuse-related behaviour. The FMI contains 16 items, on a four-point Likert scale, ranging from 0 (Not at all) to 3 (often) (e.g., Does your relative steal or borrow money and not pay it back? Has your relative sometimes threatened you?). It has two sub-scales: Worrying behaviour (WB) (10 items) and active disturbance (6 items). Higher scores are indicative of a higher level of impact on the family. The scale validation study (Orford et al., 2005) reported high internal reliability (Cronbach's $\alpha = 0.77$). In the current study a Cronbach's α -value of 0.81 was obtained, also indicating high internal reliability (internal consistency of items).

The SRT (Orford et al., 2005) assesses AFMs' level of mild-to-moderate physical and psychological ill health in AFMs in the last three months. The SRT contains 30 items, on a 3-point Likert scale, ranging from 0 (never) to 2 (Often) (e.g., AFM feeling guilty. AFM feeling pressure or tightness in the head.). It contains two sub-scales: Psychological symptoms (18 items) and physical symptoms (12 items). Higher scores are suggestive of greater frequency of

symptoms experienced. Very high internal reliability was observed in the Orford et al. study (2005) ($\alpha = 0.93$) and in the current study ($\alpha = 0.96$).

The Hope Scale (Orford et al., 2005) assesses how hopeful AFMs are regarding the future of the AOD misuse problem. The Hope comprises 10 items, on a 5-point Likert scale, ranging from 1 (Strongly agree) to 5 (Strongly disagree) (e.g., I believe that out of this will come something really good for my relative. I worry that my relative's going to go on drinking/taking drugs until the end.). The scale is comprised of positively and negatively worded items. The total scale score is obtained by reversing the scores for positively worded items (5-1) and adding them to the scores for the negatively worded items (1-5). High internal reliability was observed in the Orford et al. study (2005) ($\alpha = 0.86$) and a good level was observed in the current study ($\alpha = 0.73$).

Data analysis

IBM® SPSS® for Windows, Version 24.0 (IBM Corp., Armonk, NY) was used to analyse the data. Data screening was carried out prior to analyses. Cases were assessed for missing data in the outcome measures (FMI, SRT, Hope). Those containing few or no responses to items (i.e., less than 5 valid responses), and socio-demographic variables with a considerable proportion of missing cases, were omitted from the analysis (a total of 2 cases). Missing data in the remaining cases were evaluated for missingness (the extent and pattern in which data are missing from a data set). Approximately 1.4% of data was missing; however, there was no evidence to indicate that this data was not missing completely at random in the outcome measures or their sub-scales, as assessed by Little's test for missing completely at random and separate variance t-tests. Hence, data imputation was undertaken, using the expectation maximisation algorithm, and subsequent analyses were carried out on imputed data sets.

Socio-demographic data were summarised descriptively. Parsimonious multiple regression models were obtained, assessing the relationship between participants' socio-

demographic characteristics and the total score of each outcome measure, through a set of straightforward screening models designed to identify and exclude confounding variables and those of no consequence to the outcome under consideration. Dichotomous variables, such as the primary language used at home, that did not adequately discriminate between cases were excluded from this process. Associated levels of categorical variables were combined, as necessary and feasible, where occurrences of specific categories were too low for individual analysis, avoiding the use of multiple indicator variables or reducing collinearity effects. Corrections for multiple comparisons were applied informally. As the comparisons were considered to be largely complementary, formal corrections such as Bonferroni corrections, could result in loss of power to detect real effects of substantive interest. In this case specifically, anticipated correlations between outcome scores measured on the instruments are likely to be correlated, so formal correction for multiplicity is not appropriate. Effect size was measured by the partial- η^2 statistic. Regression analyses of sub-scale scores were not conducted to avoid over-inflation of Type I error rates.

Results

Sociodemographic characteristics

Sociodemographic data were obtained from 90 AFMs, with complete or near-complete responses being obtained from 88 respondents (Table 1). The mean age of AFMs was just over 44 years (SD=13.6 years), with most being female (86.7%). The mean duration of time they had undertaken the support-giving role with their relative was just under 10 years (SD=10 years). Approaching two-thirds resided in the same home as their relative, and English was the primary language used in this setting. Almost 80% of AFMs indicated that supporting the relative had adverse effects on their physical health and ability to socialise with relatives and friends, and slightly over half responded that it had an adverse effect on their paid employment. Regarding

assistance from AOD services in the past four weeks, slightly more than three-quarters indicated they were not receiving any assistance from these services.

****Insert Table 1 about here****

Total and sub-scale FMI, SRT and Hope scores

Respondents' scores in the FMI, SRT and Hope scales are summarised in Table 2 below. On average, AFMs' scores tracked towards the negative side of the FMI scale, denoting they sometimes experienced harmful stress from their relative's AOD misuse. Respondents' scores on the SRT were approximately in the middle range of the scale, indicating they sometimes experienced physical and psychological ill health as a consequence of their relative's AOD misuse. Their scores on the Hope were in the middle of the range for the scale, suggesting they were somewhat ambivalent in their beliefs about the future prospects of the relative's AOD misuse.

****Insert Table 2 about here****

Factors associated with AFMs' harmful stress

Univariable screening analyses conducted on the FMI total measure revealed that home status, age and the length of time that the relative had AOD misuse showed some substantive association with this outcome (Table 3). These variables were fitted into a multiple regression model, and *p*-values, parameter estimates, associated confidence intervals and effect sizes were assessed. The findings showed that, in this multiple model, only home status had a significant effect (at 5% significance level) on AFMs' total FMI scores. At best estimate, and controlling for other factors and covariates, AFMs who were living with their relative with AOD misuse scored 3.95 points higher on the total FMI scale (i.e, they experienced greater harmful stress) than those who were not living with their relative; representing approximately a 10% change

from mean scores. The size of this effect was small ($\text{partial-}\eta^2=0.059$). Amongst factors which were non-significant, but substantively associated with the outcome, older AFMs scored slightly lower than younger AFMs on this measure, with each year of increasing age being associated with a reduction of 0.12 points on average on the measure. Likewise, AFMs who had been supporting relatives with AOD misuse for a longer duration scored lower than those supporting for a duration: each additional year of support was associated with a reduction of 0.13 points on the measure. The factors age and duration of support period are likely to be correlated.

Factors associated with AFMs' physical and psychological ill health

Univariable screening analyses conducted on the total SRT measure revealed that nationality, relationship and profession status, age and duration of time the relative had AOD misuse showed some substantive association with this outcome (Table 3). These variables were fitted into a multiple regression model, and p -values, parameter estimates, associated confidence intervals and effect sizes were assessed. The findings indicated that, in this multiple model, only relationship to the relative with AOD misuse had a significant effect (at 5% significance level) on AFMs' total SRT scores. At best estimate, and controlling for other factors and covariates, AFMs who were intimate partners of the person with AOD misuse scored about 8.2 points higher on the total SRT measure (i.e., they experienced more mild-to-moderate physical and psychological ill health) than those not living with the person; representing approximately a 30% change from mean scores. The size of this effect was moderate ($\text{partial-}\eta^2=0.092$).

Factors associated with AFMs' hope about the future

Univariable screening analyses conducted on the *Hopefulness-Hopelessness* measure revealed that AFM gender, length of time as an AFM, and whether or not support had been received from AOD services showed some substantive association with this outcome (Table 3). These

variables were fitted into a multiple regression model, and p -values, parameter estimates, associated confidence intervals and effect sizes were assessed. The findings showed that, in this multiple model, and controlling for other factors, female AFMs on average scored 1.81 points more on this measure than male AFMs. Those AFMS who received support scored on average 1.10 points more on this measure than those who did not, and each additional year as an AFM was associated with an extra 0.054 points on the measure. However, no variable had a significant effect (at 5% significance level) on AFMs' total hopefulness-hopelessness scores.

****Insert Table 3 about here****

Discussion

The hypotheses of our study were that socio-demographic factors associated with support-giving would affect AFMs' stress, physical and psychological health, and hopes for the future. There were four main findings in this study. First, in terms of total scores on the FMI, SRT and Hope scales, AFMs sometimes experienced harmful stress, physical and psychological ill health and were somewhat undecided in their hope for the future concerning themselves and their relative. These findings are consistent with those of others studies of AFMs, where support-giving in this context can cause mental health problems, such as stress (Orford, Vellemen, Copello, Templeton, & Ibanga, 2010; Rognmo, Torvik, & Roysamb, 2013), anxiety (Dawson, Grant, Chou, & Stinson, 2007) and depression (Homish, Leonard, & Kearns-Bodkin, 2006), physical health problems (Copello et al., 2009) and hopelessness (T. V. McCann & Lubman, 2018b).

Second, regarding socio-demographic factors associated with harmful stress (hypothesis 1), there were significant associations (at the 5% level) between home status and harmful stress. AFMs who lived with their relative with AOD misuse experienced greater stress than those who did not live with the relative. However, the size of this effect was small (partial-

$\eta^2=0.059$). Living in the same household as the relative with AOD misuse may cause harmful stress to AFMs, whereas living in a separate household may provide a protective buffer or a form of respite against this stress (T. V. McCann & Lubman, 2018a).

Third, and in particular, concerning socio-demographic factors associated with physical and psychological ill health (hypothesis 2), there were significant associations (at the 5% level) between relationship to the relative and experience of mild-to-moderate physical and psychological ill health. AFMs who were partners of individuals with AOD misuse experienced more physical and psychological ill health than those who did not reside with the relative. The size of this effect was moderate (partial- $\eta^2=0.092$). This finding is understandable given that partners are particularly vulnerable to experiencing aggression and violence from their AOD misusing partner (T. V. McCann et al., 2017). They also face having to protect their children and cope with the financial costs and other issues related to their relative's AOD misuse in this situation (T. V. McCann et al., 2017; Orford et al., 2013).

Fourth, regarding socio-demographic factors associated with hope (hypothesis 3), no factor was associated (at 5% significance level) with AFMs' total hopefulness-hopelessness scores. Possible explanations for this non-significant result are that hopefulness-hopelessness is a measure of an independent construct that is not affected by these factors. This lack of association was also reported by Orford et al. (2005), in a UK study of close relatives with AOD misuse and in Mexico with families with members with AOD and misuse and problem gambling, and in a study in Italy by Arcidiacono et al. (2010), of families living with relatives with AOD misuse. In addition, changes identified in harmful stress, physical and psychological ill health in our study were issues directly related to the AFMs' immediate circumstance rather than more global changes in perceptions of hopefulness-hopelessness. This is unsurprising as AFM well-being is closely associated with the circumstances of their relative (T. V. McCann et al., 2019).

Overall, the findings of our study indicate that nearly 80% of AFMs reported that their support-giving role had detrimental effects on their physical health and ability to socialise with relatives and friends, and just over half indicated it impacted adversely on their paid employment. Those residing with their relative reported more harmful stress than those living elsewhere, and partner AFMs experienced more physical and psychological ill health than non-partner AFMs. AFMs were somewhat ambivalent in their beliefs regarding the future prospects of the relative's AOD misuse.

Implications of these findings are that harms can compromise AFMs' coping (T.V. McCann et al., 2019) and commitment to continuing this critical support-giving role, which, as a consequence, can undermine the relative's recovery (Copello et al., 2009; Frye et al., 2008; T. V. McCann & Lubman, 2018b). It is noteworthy that just over three-quarters of AFMs had not received any assistance from mental health nurses and other AOD clinicians in the preceding four weeks. This finding is similar to reports elsewhere of low levels of help-seeking to AOD services by partners seeking support for their own needs (Orford et al., 2013). Furthermore, even when help-seeking occurs it is often of short duration (Orr et al., 2013) and restricted to crisis circumstances (Kim & Salyers, 2008).

Limitations

The findings and interpretations of our study should take account of the following limitations. As a cross-sectional, self-report design, no inferences are made about causality or association. Another limitation is that the sample size limits the representativeness and generalisability of the findings to this and other settings. Nonetheless, the findings provide important information about the well-being of AFMs, and their hope for the future concerning their relative's ongoing AOD misuse. A final limitation is, because AFMs were recruited through state-wide AOD services, this may have yielded an atypical sample of respondents whose well-being and hope for the future may differ other AFMs.

Conclusion

We explored the effect of supporting a relative with AOD misuse on AFMs and sociodemographic factors associated with their well-being and hopefulness. The findings highlight the harms to AFMs' stress levels, physical and psychological health and hope for the future, and the need to address the gap in service provision specifically for AFMs' own needs. Additional and focused measures are needed to increase provision for, and access to, mental health nurses and other AOD clinicians, for AFMs. Those who are able to obtain support from these clinicians are more likely to maintain their critical support-giving role (T. V. McCann & Lubman, 2018b). Clinicians should also target, but not be limited to, enhancing AFMs' well-being and hopefulness, and coping (T.V. McCann et al., 2019), as those who are able to obtain wide-ranging and ongoing support for themselves are more likely to continue to support their relative (T. V. McCann & Lubman, 2018b). In addition, as AFMs who live with their relative experience more stress than those who do not live with the relative, and as partner AFMs experience more physical and psychological ill health than non-partner AFMs, partner AFMs in particular require additional emotional support and referral to other services for medical and financial support as well as provision of alternative accommodation and/or respite. As partners AFMs are especially susceptible to aggression and violence from their AOD misusing partner, as highlighted in qualitative findings from this study (T. V. McCann et al., 2017), it is important that mental health nurses and other AOD clinicians are open to, and supportive of, the former in this situation and of the need to refer them to family violence services and support groups. More research is needed to focus on the relationship between partners and non-partners and physical and psychological ill health, and to establish for certain its significance or otherwise.

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Table 1. Sociodemographic summary of respondents ($N=90$).

	<i>n</i>	%
Gender		
Female	78	86.7
Male	12	13.3
Relationship with relative with AOD misuse		
Parent	31	34.4
Intimate partner	30	33.3
Other (adult child, sibling etc.)	29	32.2
Residential status		
Residing with relative with AOD misuse	55	61.8
Not residing with relative with AOD misuse	34	38.2
Primary language used at home		
English	83	94.3
Other	5	5.7
Highest level of completed education		
Primary school	5	5.6
Secondary school	16	18.0
Technical and further education	16	18.0
Tertiary education	52	58.4
Current paid employment status		
Employed	74	83.1
Not employed	15	16.9
Support-giving role adversely affected AFM's paid employment*		
Yes	45	50.6
No	35	39.3
Not applicable	9	10.1
Support-giving role adversely affected AFM's physical health in the past 3 months		
Yes	71	79.8
No	18	20.2
Support-giving role adversely affected AFM's ability to meet and socialise with relatives and friends in the past 3 months		
Yes	68	76.4
No	21	23.6
AFM receiving assistance from AOD services in previous 4 weeks		
Yes	21	23.6
No	68	76.4
	Mean	SD [†]
Age (years)	44.4	13.6
Time (years) relative has had AOD misuse	13.0	11.6
Time (years) supporting relative with AOD misuse	9.57	10.0

*Due to the large proportion of invalid responses to the variable corresponding to the effect on paid employment of supporting a relative with AOD misuse, no further analysis of this variable was undertaken.

[†]Standard deviation.

Table 2. Family Member Impact, Symptom Rating Test and Hopefulness-hopelessness total and sub-scale outcome scores of AFMs ($N=90$).

Scale	Mean (SD [*] ; range)
Family Member Impact (total)	32.3 (8.54; 7-45)
Family Member Impact (worrying behaviour)	22.0 (5.95; 3-30)
Family Member Impact (active disturbance)	10.2 (3.81; 1-18)
Symptom Rating Test (total)	30.4 (13.6; 1-58)
Symptom Rating Test (psychological)	20.3 (8.80; 1-36)
Symptom Rating Test (physical)	10.1 (5.42; 1-22)
Hopefulness-hopelessness (total)	31.2 (3.57; 22-41)

*Standard deviation.

Table 3. Regression parameters of total Family Member Impact, Symptom Rating Test and Hopefulness-hopelessness Scale scores.

Parameters	P-value	Parameter estimate	95% CI [*]	Effect size (partial- η^2)
<i>Family Member Impact</i>				
Home status				
Not living with relative with AOD misuse (reference)				
Living with relative with AOD misuse	0.044	3.95	(0.108, 7.78)	0.059
Time (years) that AFD has had AOD misuse	0.135	-0.126	(-0.291, 0.040)	0.029
Age (years)	0.097	-0.120	(-0.263, 0.022)	0.036
<i>Symptom Rating Test</i>				
Occupation				
Not professional, business or management (reference)				
Professional, business or management	0.177	-3.85	(-9.47, 1.78)	0.024
Relationship to relative with AOD misuse				
Parent or other non-partner (reference)				
Partner	0.006	8.24	(2.38, 14.1)	0.092
Time (years) that AFD has had AOD misuse	0.134	-0.185	(-0.427, 0.058)	0.029
Nationality				
Non-Australian (reference)				
Australian	0.213	4.43	(-2.60, 11.5)	0.020
<i>Hopefulness-hopelessness</i>				
Gender of AFM				
Male (reference)				
Female	0.114	1.81	(-0.443, 4.06)	0.033
Assistance received from AOD services				
No assistance received (reference)				
Assistance received	0.230	1.10	(-0.709, 2.91)	0.019
Time (years) spent supporting relative with AOD misuse	0.183	0.054	(-0.026, 0.133)	0.023

*Confidence interval