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## living with addiction: exploring the issues for families

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## EXECUTIVE SUMMARY

### Introduction

This report explores and exposes issues that have arisen for New Zealand family members as they have supported a family member through an alcohol and/or other drug addiction problem. It builds upon a growing body of knowledge within national and international literature about the impact of addiction problems on families.

For the purpose of this project, 'family' of an individual is defined as the collective group of people who hold the greatest interest in that individual's welfare.

Prior research focused mainly on the most visible and well-known addiction-related family phenomena such as child and partner abuse, substance-fuelled domestic violence, Foetal Alcohol Spectrum Disorder (FASD), drunk-driving and drug-driving. Less visible phenomena include interpersonal problems, educational and employment failure, mental health and physical health conditions and socio-economic disadvantage. These appear to be common in families living with addiction but, in the presence of other adverse life influences, it can be very difficult to accurately attribute causation to addiction. It is also difficult to quantify some of these outcomes or consequences. Measurement of the impacts of addiction on family is further complicated by the extent and unpredictability of the consequences of addiction, and also by the diversity of family groupings: the addiction of one person may variably influence the lives of many other people.

There is a growing interest in the role of families in the recovery of an addict, with developing evidence from international literature, that engaging those closest to and most concerned about the substance user can lead to better engagement of the substance user in treatment. Internationally, there is also heightened interest in the interface between health and social services and the family. Emerging local and global government policy in the social development, health, education and justice arenas places a new focus on service co-ordination for improved family wellbeing. In New Zealand, the parallel concept is the recently introduced whānau ora concept.

New Zealand information about the impact of addiction on families is still quite limited, although increasingly

found in the body of literature known as 'grey' literature, which consists of collated information published within commissioned papers, institutional reports, government documents, book chapters and research theses rather than the original research papers that are published in peer-reviewed scientific journals. These 'grey literature' information sources are accessible electronically to those who know where to find them, but are possibly not as well publicised or widely read as they deserve to be. The New Zealand-based original research has confirmed that disruption of normal family relationships is one of the most common and destructive consequences of addiction. However, a recent systematic review has noted a scarcity of New Zealand-based research data about families affected by heavy drinking.

A good understanding of the extent and potential impact of family problems would be most helpful in finding practical ways to minimise that impact on family. This is especially timely because, in addition to the development of a policy for whānau ora as mentioned above, a review of delivery of services for mental health and addiction is currently underway in New Zealand. Some District Health Boards recently announced service reductions as a result of budget cuts directed by government. Within traditional addiction treatment services, the impact of addiction on family was an area largely overlooked, with the emphasis instead placed on treating the individual.

This project takes particular interest in the less-visible impacts on New Zealand families living with addiction: those that may be overlooked in the shadow of higher-profile impacts. The project also seeks to understand the barriers and incentives when families seek and gain assistance, including the attributes of the support agencies, family members and wider community, and other factors that may facilitate or hinder family coping strategies.

The concept of coping through adversity is linked to that of family resilience.

Resilience is the demonstrable ability to continue a relatively normal trajectory through life despite adversity. It is considered a key concept in both individual and family therapy, especially in strengths-based counselling which focuses on characteristics that might provide some protection from the devastating aspects of addiction. Thus, it is important to identify

resilience factors that might protect New Zealand family members from the impact of living with addiction, and deter them from also following that addiction pathway.

The project was designed to address the following specific research questions:

1. What are the key issues for families living with addiction? Do the issues facing New Zealand families differ if there is a drug use, compared to an alcohol problem? If so, how does illicit drug use influence the issues, compared to alcohol?
2. What are the particular barriers that New Zealand families encounter when trying to help a family member with a drug problem, alcohol problem or problem with both?
3. What are the barriers and incentives for family members to seek and gain help for themselves?
4. What are the resilience factors for families (rather than for individuals)?
5. How do the characteristics of support services contribute to the family experiences?

## Methods

Ethical approval for this project was obtained from the Central Regional Ethics Committee. This project represents the voices and wisdom of many contributors, identified in the report as Key Stakeholders, Family Participants and Informal Informants.

Potential Key Stakeholders were identified from a variety of services and contacted about the planned research. Approximately 50 Key Stakeholders gave their insights into: how families become aware of an addiction problem, main impacts on families, substance-specific issues for families, how family needs change over time, how services currently respond and their view of the ideal service. A total of 10 formal Key Stakeholder interviews were recorded and transcribed, with consent. Others contributed their thoughts and comments by email, by telephone and face-to-face discussion.

Family Participants were adult members of families affected by addiction (aged 18 years or over), recruited through health and social services. Family Participants signed a consent form and undertook a recorded interview with consent for transcription for further analysis. Interviews were held in person or by phone (according to the preference of the family member).

Family Participant interviews were conducted in greater Wellington and in Christchurch. A total of 19 Family Participants were interviewed and they provided insights into: becoming aware, impacts on families, substance-specific considerations, time and resilience, help for the addicted individual and help for the families.

Informal Informants were people who had heard about the research and wanted to share their perspectives and contribute their wisdom and insights into New Zealand families living with addiction. These ad hoc informants contributed to the project in a less formal manner, giving advice and opinion, and were not consented as research participants or formally interviewed. Overall there were well over 100 Informal Informants to this project, including delegates at various consultation meetings. Informal Informants contributed their insights to assist with clarity and interpretation of findings.

Findings from review of the literature and Key Stakeholders informed the development of an interview schedule used with the Family Participants. Informal Informants provided additional information for clarification and validation of the findings.

In keeping with a grounded iterative research process, interview questions evolved over time, particularly as new information was gathered, and subsequent interviews were informed by issues raised in earlier interviews.

The analysis is described in detail in the Methods section of the main report. In brief, this was a qualitative study utilising principles of naturalistic enquiry through iterative semi-structured interviews. Analysis sought to identify key themes and/or critical elements that underpinned those themes. The research team members each brought different perspectives and skills (from psychology, sociolinguistics, primary care and addiction medicine backgrounds) to the analysis. In addition, an in-depth analysis was undertaken on a few selected transcripts (it was beyond the scope of the study to conduct this on all interviews) to provide further insight into the underlying meaning in the way that participants described their experiences. In particular, the analysis looked for verbal cues to the emotion within the interactions. These findings assisted in overall interpretation, helping to address the research questions, and served to pilot the scope of an additional methodology for future analysis.

Key Stakeholders and Informal Informants were consulted on the draft report to discuss findings and interpretation. In particular, the opportunity was taken to present preliminary findings to a research audience to seek feedback at a primary care research forum.

## Results

The main findings are summarised below under each of the research questions:

### **What are the key issues for families living with addiction? Do the issues facing New Zealand families differ if there is a drug problem compared with an alcohol problem? If so, how does illicit drug use influence the issues, compared with alcohol?**

New Zealand families living with addiction are directly affected by the addiction that contributes to widespread and ongoing problems for non-addicted family members. Family Participants reported a range of impacts including: low self-esteem; behavioural and social withdrawal; parental unavailability; difficulty developing trust in adult relationships; concerns about own possible addictive tendencies; and becoming comfortable with dysfunction. The impacts of addiction on family are complex, role and situation specific. Reported impacts varied, dependent on the closeness of the relationship to the addicted person. The families of these participants experienced a similar spectrum of difficulties regardless of whether the problems were related to alcohol or drug abuse.

### **What are the particular barriers that New Zealand families encounter when trying to help a family member with a drug problem, alcohol problem or problem with both?**

Families trying to help an addicted family member mentioned particular problems when raising the issue of addiction with the addicted loved one. Families may also be dealing with addiction-related financial, legal and/or justice crises at the time of discovery and confrontation. There was sometimes an element of family denial or of choosing to overlook, not wishing to become involved in someone else's problem and reluctance to apply an addiction label. Family members mentioned gaps in accessibility and timeliness of services, and particularly administrative and confidentiality barriers when trying to obtain help for a third party.

### **What are the barriers and incentives for family members to seek and gain help for themselves?**

Key Stakeholders commented that families might deny their own need for support at the time when they ask for support for the addicted person. Family Participants and Informal Informants confirmed this reaction, in part attributing this to families experiencing the societal stigma surrounding addiction that becomes evident when a problem of addiction is exposed. Families perceive that they are currently underserved by services in New Zealand. The services that are dedicated to assist families with addiction are not particularly well known, and are not always easy to access for families in need.

### **What are the resilience factors for families (rather than individuals)?**

Resilience is an interesting theoretical concept that these family members themselves found hard to explain. Family Participants were asked about this concept using lay words such as 'protective', 'cope' and 'family strengths'. These family members described various strategies undertaken to adjust to and cope with their past or present realities of living with addiction, but their descriptions lacked the positive connotation that the word 'resilience' implies. On the contrary, there was an absence of relatively normal trajectory through life despite adversity in some descriptions. Some Family Participants described coping not as an adaptive survival strategy but as maladaptive, using words such as 'madness' or 'insanity' and 'chaos', by which they meant that they believed they had exhibited chaotic behaviour rather than actual madness or insanity.

The coping strategies that Family Participants had described have been categorised in the main report as: minimising; making allowances; turning away; and carrying on. Minimising allowed the family members to see addiction as less of a problem than it really was. The addictive behaviour may even have been normalised. Making allowances enabled families to carry on with daily tasks and interact with society. It was described by some participants as a form of self-deception, and others had explained how their family members had drawn themselves into living an elaborate bluff, fooling only themselves about the true nature of the problems that they were facing. Turning away may have involved a physical relocation or a decision about emotional distancing. Carrying on meant putting aside

the unpleasant experiences, managing life without the addicted family member, striving to show strength to rise above adversity, acting as if the prior experiences were forgotten and (for some) seeking work within the health and social services.

### **How do the characteristics of the support services contribute to the family experiences?**

The Key Stakeholders and Family Participants confirmed that although families are an important part of getting help for the individual, families may also need help for themselves. The extent of help offered to families living with addiction varies enormously between existing services, but family support is not usually linked to treatment of an individual in mainstream addiction treatment services in New Zealand. As family needs are similar for both alcohol and drug-related problems, generic supportive family services are appropriate. Important characteristics of a health or social service were the provision of funded family counselling and education.

The transcript analysis piloted on a few selected interviews revealed the depth of emotion underlying descriptions of experiences of living with addiction. Family Participants and Key Stakeholders advised that health and social services should give greater recognition to the emotional injury to members of families, as this may be more ongoing than physical injury. Particular gaps were identified for services dedicated to helping children from families living with addiction, family needs assessment at the point of treatment intake and family residential services.

## **Discussion**

This project begins to fill some gaps in knowledge and understanding of the experiences of New Zealand families living with addiction. Our findings are largely in accordance with international research. The effects of addiction on New Zealand families are widespread, regardless of whether the underlying problem relates to misuse of alcohol or drugs.

The Key Stakeholders and Family Participants alike identified lack of awareness of the nature of addiction and advised that inadequate knowledge may misinform family expectations about addiction. The period when the addicted individual enters treatment and counselling may be particularly risky for families, with

the uncovering of problematic issues for families. In addition, since recovery of an individual brings changes that can impact on family life, the family itself needs to be well prepared for change to avert new upheavals.

These findings will assist co-ordination of the health and social services, inform training within those services and highlight wider community factors deserving further attention.

The limited linguistic discourse analysis (as described above) was a novel methodology in the context of this project, piloted here to help identify emotional content and assist in addressing aspects of the research questions related to this issue. In addition, the emergence of New Zealand research centres that focus on family research will also help to fill the knowledge gaps about the roles and functions of families in society.

Interest in the concept of family resilience is growing in international literature. Family Participants in this study were asked about resilience using lay terms such as 'protective', 'cope' and 'family strengths', but many did not give descriptions of behaviours with the positive connotations of resilience. It is unclear if that reflected a lack of understanding by the participants of what resilient behaviour is, or a lack of importance of the concept to the families living with addiction. It is possible that family members who lived with addiction do not perceive that their life followed a relatively normal trajectory after that particular adversity, and hence cannot relate to a feeling of resilience. This finding deserves further exploration.

This also raises the interesting question of popular semantics, particularly the importance of ensuring that there is a shared understanding of intended meaning for commonly used words, especially when used in a therapeutic context. The term 'resilience' was initially coined by research communities to refer in an academic sense to the characteristics of an individual coping under adversity. It found its way into common usage and is now increasingly used by health and social services in a collective context (family resilience), somewhat removed from the initial connotation of the strengths of an individual. If this term is to be used routinely in the collective context, such as with family groupings, then it should be re-defined for that purpose. Family resilience should recognise family strengths, including collective family capacity to resist

risk factors and the particular permutation of multi-factorial protective factors for each family: a mixture of nature and nurture, and personal and interpersonal strengths. It may prove difficult to objectively measure family resilience because these collective characteristics are not readily measurable.

The finding that some family members cope by entering the health and social services workforce draws attention to the lack of guidelines for the training of such professionals who might themselves have lived with addiction. Particular considerations here include the way in which that person may have coped psychologically with prior experiences. This reinforces the importance of maintaining additional psychological supervision over and above the mentoring-in-role (also known as professional supervision) which assists professionals with difficult issues arising primarily from their clients. Professionals working within the addiction treatment workforce, who also have prior personal experience of living with addiction, may also require assistance handling their own vulnerabilities and to ensure that they do not transfer personal legacies to their clients.

More work is required to better characterise the implications of the findings for clinical practice and other health and social services, and also for public health and social policy.

## Limitations and gaps

This study did not set out to include experiences from families of all nationalities currently residing in New Zealand. The results are presented with the caveat that the findings of a small qualitative study should not be used to generalise for all families. There is a notable absence of some ethnic groups among the Family Participant interviews, in particular, the voice of New Zealand Pacific Family Participants. Stakeholders explained that these voices were difficult to obtain for this project because, in general, addiction is an issue heavily clouded by personal and societal shame for Pacific peoples; not something to be talked about readily. In addition, many Pacific nations are represented in the New Zealand population and therefore there can be no single representative Pacific voice. These reasons necessitate a careful

look at addiction treatment services' delivery models for Pacific communities, perhaps using community leaders as agents of change. There is a possibility that the damage brought by addiction may be most hurtful to communities with cultural traditions of family cohesion. This project highlighted a need for a research framework best suited to understanding issues pertinent to Pacific peoples in New Zealand.

There is also a need to explore appropriate reportable outcomes for both Māori and Pacific communities. Outcome measures used to monitor the effectiveness and efficiency of mainstream health services may not apply as well in a collective model of social welfare and health.

Similarly, there is a need to understand why voices of New Zealand Asian families or of refugees, migrants and ethnic minorities were not represented in this project. Stakeholders advised that behavioural addictions appear more prominent within Asian cultures than substance addictions. Traditionally, medical wisdom stated that many people of Asian ethnicities cannot drink alcohol to excess for a biological (metabolic) reason. Experience in New Zealand and elsewhere in the world shows that this is not the case, but instead the pattern of drinking changes: people who metabolise ethanol slowly can become intoxicated by protracted tipping rather than by binge drinking. Tobacco and alcohol addictions are common among Asian families but tend to be normalised. Normalising and minimising constant tipping behaviour could make the drinker just as inaccessible to his or her family as those binge drinking to excess. This is an area requiring further research.

Most of the information provided for this project was about the impact alcohol abuse had on families, with some mention of other substances including opiates, methamphetamine, cannabis and glue sniffing. It is of interest that current and past nicotine smokers did not rate nicotine alongside other family addictions. This raises questions worthy of further exploration: Do New Zealanders regard nicotine addiction as different from other substance addiction? And if so, why? Understanding this may help to provide an inroad to addressing the resistance by tobacco smokers in

New Zealand to public health 'quit smoking' messages, despite a lengthy multifaceted Tobacco Control Strategy.

Behavioural addictions, including gambling, workaholism and eating disorders, might not cause the physical effects and consequential health issues experienced by substance users. But they can be just as destructive with respect to financial, social, legal and mental health consequences for an individual and the extended family. Implications for New Zealand families living with problem gambling and other behavioural addictions are topics deserving future research.

None of the families mentioned FASD, which was perhaps not surprising given the low population prevalence, but this important family health issue is the subject of review by the New Zealand Ministry of Health's Interagency Committee on Drugs to inform the development of a policy to address it.

Recruitment for this project was through health and social services; this was a deliberate precautionary strategy to ensure that support would be available to participants should it be required. However, this built-in recruitment bias led to a gap in the results, in terms of understanding the issues for families not engaged with health and social services.

## Conclusion

Family impacts of addiction are complex, role and situation specific, and there are potential cultural differences, but the results clearly show that similar problems arise regardless of the substance(s) being abused. Families in this study were living with addiction but perceived that they were not well served by the health and social services. Participants spoke about various adaptive and non-adaptive coping strategies. The life stories told by family members in this study lacked the positive connotations of resilience, as some coping strategies had proved maladaptive in the longer term. 'Resilience' is a problematic term that is measured only by looking at the outcome, a normal life trajectory despite adversity. Further studies may help to better understand family risk factors, protective factors and family resilience after the adversity of living with addiction. There is a need to better understand addiction issues pertinent to New Zealand Pacific peoples, Asian families and those of refugees, migrants and other ethnic minorities. Implications for New Zealand families living with behavioural addictions require further exploration. In particular, further research is required to better characterise the implications of the findings for clinical practice and other health and social services, and also for public health and social policy.



## 1. INTRODUCTION

This report explores issues arising for New Zealand families as they support a family member or members through an alcohol and/or other drug or behavioural addiction. Alcohol and other drugs contribute enormously to the burden of health and welfare problems in New Zealand (Connor, Hoorn, & Rhem, 2004). The impact of drug and alcohol use is very visible in our society (New Zealand Law Commission, 2009, 2010), and family members can be affected by addiction in many ways. This report builds upon a growing body of knowledge about addiction-related family issues, adding a New Zealand perspective to fill a previously identified knowledge gap (Girling, Kuralin, Casswell, & Conway, 2006).

### 1.1 Who is family?

Families are very diverse and often fluid social structures. There may be one, two or more parent-figures (the latter in the case of reconstituted families and step-parenting) and with or without children (who may include stepchildren, adopted or fostered children). Families also encompass various extended family members such as grandparents, aunts and uncles, and family friends with honorary titles of that nature. The term ‘family’ need not necessarily imply any direct blood link. A recent Australian report sought to address “what constitutes a family”, but stopped short of any definition, except to agree that families have diverse structures (Frye, Dawe, Harnett, Kowalenko, & Harlen, 2008).

The individual(s) who take personal interest in the welfare of a person with addiction may be closer to the addicted person than any direct blood relatives. Individuals with personal interest in another person’s welfare may also assume the nurturing role normally the domain of family. Therefore for the purpose of this project, ‘family’ of an individual is defined as the collective group of people who hold the greatest interest in that individual’s welfare.

### 1.2 Importance of family support

For the purposes of this report, ‘family support’ was given three-pronged consideration: the support that a family might wish to give to their addicted family member; the support that might be needed by a family

member who takes on the role of supporter; and the support that families need for themselves because they live with addiction.

The role of families in the recovery of an individual has also received increasing attention in recent years. There is a developing awareness that working directly with those closest to and most concerned about the substance user can lead to better treatment engagement by the user (Copello, Velleman, & Templeton, 2005).

A recent New Zealand thesis (Severinsen, 2005) explored the benefits of whānau engagement in the recovery of a New Zealand Māori family member affected by drugs and/or alcohol. Although it was a small project based at a single kaupapa Māori Health service in Palmerston North, the outcome raised interesting points about service family responsiveness, deserving of further exploration.

A New Zealand study of pregnant women with opiate addiction found that family factors had a big influence on acceptance of treatment and also on their parenting confidence during subsequent child-rearing years (Chan & Moriarty, 2010). Most pregnant women will naturally turn to their family for support, but this study found that the support from family was not given as expected, perhaps because the families had unmet needs themselves (Chan & Moriarty, 2010).

When the Naturalistic Treatment Outcomes Project (Adamson, 2003) asked people in recovery in New Zealand to identify their barriers to change, the two most prominent barriers identified, alongside health issues, were the perceived lack of support from health and social services for partners and friends. Up to 40 percent of people in recovery sought treatment because family wanted them to, and 26 percent because the partner wanted them to (Adamson, 2003). Therefore, for the majority of those in recovery, support of family and partners was a driving factor for getting them into treatment. However, if the family support is conditional on the addicted person entering or remaining in treatment, some seemingly supportive families may be unwittingly destructive to the addiction treatment experience by exerting pressure on a reticent addict.

Addiction is a chronic and relapsing condition. It is recognised that if unilateral change by the addicted person is not matched by changes in interpersonal

reactions and other behaviours of significant others, it can contribute to treatment relapse. It is therefore important that motivation for change lies with the person seeking treatment. If motivation to change lies primarily with family and significant others, their misplaced advocacy and conditional support can become a potential barrier to rehabilitation. This finding is consistent with the New Zealand project that explored experiences of pregnant women on methadone to treat their drug addiction. The project revealed the (then) unexpected finding that some women encounter attitudinal factors from within their own families including discouragement and resistance to methadone treatment (Chan & Moriarty, 2010).

Studies overseas have also shown that intervention mediated through significant others can be used to help motivate a drug abuser to enter and remain in treatment, and some have tried to reinforce that. The Community Reinforcement and Family Training (CRAFT) programme was developed at the University of New Mexico using a family approach to help significant others to modify both the drug-using and the treatment engagement of an unmotivated family member (Meyers, Miller, Hill, & Tonigan, 1998). The participating significant others all had a first degree relative with a known drug problem whom they wanted to help. A more detailed explanation of the nature of the intervention, the outcome measures and other strengths and caveats of this scientific paper are detailed in Appendix 1.

An Australian study of barriers and incentives to treatment for illicit drug users included a recommendation to “recognise the needs of families who seek to help family members through drug treatment” (Treloar, et al, 2004, p. 110), since supporters themselves may need support. The full extent of the support requirements of the non-addicted family members was largely under-recognised until very recently. The Australian Government Department of Age and Aging and the incorporated society for Family Drug Support jointly supported production of a book of personal reflections from family members coping with addiction. This book tells of the very varied impacts of addiction on families (Sayer-Jones, 2006). It provides insights into personal impacts that lie beyond the more visible influence of alcohol or drugs, and beyond the vicious cycle of unemployment, financial hardship and educational underachievement. These interpersonal stories of Australian families indicate that while

families should be encouraged to assist in recovery of their individual addicted family member, they may themselves need assistance in doing so, both during and beyond the recovery of their loved one.

Recent Australian initiatives to address this treatment service aspect have included the Strengthening Families Programme, a project currently in development under the auspices of the National Drugs Strategy (Australian Government), along with other government agencies including the Department of Families, Housing, Community Services and Indigenous Affairs (FACSIA). The ultimate aim is to improve service responsiveness to families. An initial step in this project was a survey of stakeholders, conducted by the Australian National Council on Drugs, about their current approach to support families. The National Centre for Education and Training on Addiction (NCETA) is also conducting a survey of Parent and Child Sensitive Practice (NCETA, 2009) in conjunction with the Australian Centre for Child Protection (ACCP). The aim of that survey is to identify training needs of the addiction treatment workforce to improve their work with families.

Another aspect of importance in family support was highlighted in a United States study of mothers entering a methadone programme. Parental substance abuse is the most common reason for children to be removed from parental care and placed out of their home. This study revealed that cumulative risk factors acting at multiple levels had influenced the decision to remove a child from living with the substance-abusing parent, but mothers who perceived their own mothers as uncaring and intrusive were more likely to have lost custody of their own child (Suchman, McMahon, Zhang, Mayes, & Luthar, 2006). Details of the research tools, outcome measures, strengths and caveats of this research can be found in Appendix 1. These findings were not only consistent with attachment theory predictions, but also help to explain the intergenerational family disruption that addiction can cause (Suchman, et al, 2006). To be effective supporters of their children, parents going through addiction treatment services may themselves need support to first overcome the intergenerational legacy from their own family of origin.

Along similar lines, a PhD research project at London City University (Bradding, 2009) explores the psychological wellbeing of domestic partners of alcoholics, on the premise that these partners might themselves need support.

Barriers to families seeking help may include a lack of awareness of available services or problems with access to these services. An Australian study from 2008 revealed exactly that, but also found additional barriers due to awareness of, or fear of, societal exposure and stigma (Frye, et al, 2008).

### 1.3 Known impacts of addiction on families

A literature search confirmed the findings of an earlier Families Commission report, based on a systematic review of published evidence about families affected by heavy drinking (Girling, et al, 2006), that there is a lack of New Zealand data available on the impact on family members of living with addiction. However, there is now an increasing interest in the impacts of addiction on families, found not in the expanding 'grey' literature, which consists of collated information published within commissioned papers, institutional reports, government documents, book chapters and research theses rather than original research papers which are published in peer-reviewed scientific journals. These 'grey literature' information sources are accessible electronically, but are possibly not as well publicised or widely read as they deserve to be, with the consequence that these information sources are most available to those who know that they exist and know where to find them and are not readily available for those without ease of internet access.

Some addiction-related family issues are very well documented. The international literature focuses on the most well known of addiction-related family phenomena: child and partner abuse, substance-fuelled domestic violence, FASD, drug and drunk driving. These are highly researched topics.

FASD (Roberts, Graham, & O'Brien, 2007) is currently subject to government review in New Zealand. FASD is a preventable cause of central nervous system (CNS) neuro-developmental abnormalities caused by maternal drinking during pregnancy. New Zealand prevalence of FASD is not known, but estimates are of two to three per 1,000 babies born with the full syndrome, and four to five per 1,000 with a partial syndrome. The total incidence of FASD is estimated to be 600 affected babies born in New Zealand each year (by applying the overseas rate of 1 percent of live births). The actual

number may be higher, as we know that 20 to 36 percent of New Zealand women drink in pregnancy (Alcohol Healthwatch, 2007). It is a sobering statistic because that percentage is a much higher rate than in the United States where, according to the Center for Disease Control, just one in eight women still drink during pregnancy<sup>1</sup>. Drinking during pregnancy represents a major threat to the health of New Zealand families and to future New Zealanders. It somewhat tempers the hope that heightened public awareness might bring about behaviour change to reduce FASD incidence. In addition, FASD diagnoses and case findings are expected to increase in the short term with heightened public awareness and detection of previously unrecognised cases through active screening.

Family violence, perhaps the most visible impact of addiction on families, is the subject of a new government strategy for New Zealand (Ministry of Social Development, 2009). In New Zealand, incidences of child abuse, domestic violence, assault and motor vehicle accidents occurring under the influence of alcohol are well documented (New Zealand Law Commission, 2009). In 30 percent of cases, parental alcohol and drug problems and childhood maltreatment go hand in hand (Locke & Newcomb, 2003). Other countries also reported on related issues, including the United Kingdom (Advisory Council on the Misuse of Drugs, 2003) and Australia (Dawe, et al, 2007). These indicate that youth are placed at risk by parental substance misuse (New Zealand Law Commission, 2010).

Addiction also disrupts family relationships, social networks, personal education or work goals, as well as contributing to financial and legal problems (Copello, et al, 2005). There is an overlapping body of knowledge about family homelessness, physical and psychological maltreatment of children in families and domestic abuse that is beyond the scope of this report. The contributing causes of these conditions are multi-factorial, and although it is difficult to tease out the contribution of any one factor, one important underlying consideration is that some of these families live with addiction.

International studies have identified many behavioural impacts that can occur within families living with

<sup>1</sup> <http://www.cdc.gov/Features/dsAlcoholChildbearingAgeWomen/>

addiction, including unfavourable role modelling and unconventional family interactions: siblings adopting parental roles, family members exhibiting anti-social and behavioural difficulties, emotional problems, and control issues (Copello & Orford, 2002). Other possible effects on immediate family members living with addiction are often overlooked, partly because the influences on extended families can be difficult to identify or measure (Copello, et al, 2005) and partly because, in a dysfunctional family situation especially, it can be difficult to attribute the effects to just one contributing factor; for example, that family members were living with addiction.

Much of the existing family-oriented research has been from overseas, with a particular focus on alcohol. International data might not apply to the New Zealand setting. New Zealand society differs from that in other countries not only in its unique mix of cultural identity, but also in the illicit substances available. Geographic isolation and effective border control make hard drugs such as heroin and cocaine less accessible in New Zealand compared with other countries. Consequently, substance abuse in this country involves more misuse of prescription drugs (morphine, methadone, codeine, benzodiazepines, stimulants) and manufacture of substances (methamphetamine and 'home bake' opiate derivatives) to a greater extent than other countries. Patterns of illicit drug use vary between close neighbouring countries such as Australia and New Zealand (Royal Australasian College of Physicians, 2009), in addition to other international ethnic and socio-cultural differences. Successive drug use surveys reveal population trends in alcohol and drug use in New Zealand, including decreased cigarette smoking but increased alcohol and drug use (Wilkins & Sweetsur, 2008). Because of all of these differences, it is important to source information from New Zealand to apply to New Zealand communities wherever possible.

One particular literature review from New Zealand (Hapori, 2008) recognised the strong association of alcohol and substance abuse with partner or child abuse. Consequently, the report recommended alcohol and substance abuse interventions as one of six primary approaches to preventing child maltreatment in New Zealand.

Other New Zealand studies have confirmed that disruption of normal family relationships is one of the most common and destructive consequences of

addiction (Adamson, 2003). This team studied 107 clients undergoing treatment for addiction. Of those clients who had children, only 28.2 percent lived with them for more than three days a week. They were well outnumbered by the 63.3 percent of clients who had none of their own children living with them. However, although they did not have care of their own children, 15.5 percent lived with children who were not their own. The emotional and physical distancing of the person with addiction from immediate relatives results in both social isolation and fragmentation of family units.

Alcohol use or drug use in families does not necessarily occur in isolation. Addiction has impacts on families, but families also influence the patterns of addiction. Some individuals may experience addiction to more than one substance sequentially or at one time. Such co-morbidity between substance use disorders was found to be common in one New Zealand survey, with 45.3 percent of those with a drug use disorder also meeting criteria for alcohol abuse and 30.7 percent meeting criteria for alcohol dependence (Oakley Browne, et al, 2006). Similarly, addiction does not necessarily strike one single individual within a family. Some families will contain multiple family members experiencing alcohol or drugs problems and also behavioural addictions such as gambling and eating disorders.

A New Zealand PhD thesis (Nosa, 1997) explored the impact of alcohol on social status, social connectedness, family conflict and violence, in particular for Pacific Island males. A recent New Zealand book, *Fragmented Intimacy: Addiction in a social world*, by P. J. Adams, discusses the impact of addiction on intimacy within the context of relationships within a social world. The book looks at addiction in relationships and family systems and advocates a new approach to the problem of addiction. It advocates moving away from the 'lets get in and fix it' attitude, to an acknowledgement of the scale of the problem of addiction, considering how much it affects partners, parents, children and friends in the wider social environment. It recognises the complex nature of social relationships and explores possible dynamics at the social interaction level, and how each individual caught up in that might respond. The book uses hypothetical dialogue boxes to demonstrate how changes in relationships may be expressed by individuals (Adams, 2007).

However, the New Zealand peer-reviewed research that does exist does not cover the less visible phenomena very well, compared to the more visible impacts of addiction on family. These less visible impacts remain relatively overlooked by researchers, and are sparsely represented in the peer-reviewed literature. In particular, the research cited earlier was based on treatment services where the emphasis is placed on treating the individual with addiction, not on the influential environment of that individual; that is, the family and social environment. This project takes particular interest in the less visible impacts on New Zealand families living with addiction: those that may be overlooked in the shadow of higher profile impacts. The project also seeks to understand the barriers and incentives when families seek and gain assistance, including the attributes of the support agencies, family members and wider community, and other factors that may facilitate or hinder family coping strategies.

Nearly a decade ago, an Australian report recommended good practice principles for the health and social services working with families living with addiction (Mitchell, et al, 2001), but uptake of that idea was slow. Until very recently there has been a gap in addiction treatment workforce development in New Zealand and an associated gap in addiction service staff skilled in family-inclusive and family-responsive practice, and capable of implementing good practice principles. This workforce scarcity undoubtedly has contributed to the gap in provision of family-inclusive and family-responsive addiction treatment services. Organisations such as the Drug and Alcohol Practitioners Association of Australia and New Zealand (DAPAANZ) and Matua Raki have since helped to develop expectations and training frameworks for the addiction treatment workforce. Matua Raki established the Kina Trust which uses a workforce development approach to help to fill the gap in family responsiveness of New Zealand addiction treatment services (KinaTrust). However, many of the tools and outcome measures used internationally in this field are yet to be validated for New Zealand use.

#### 1.4 Health and social service responsiveness to families

Until recently there has been relatively little in the international literature about services that are available to meet needs of the families in these circumstances. A

recent report from the United Kingdom demonstrated that results of addiction treatment and long-term rehabilitation could be improved through increased support for families of those involved in drug and alcohol misuse (Madill Parker Research and Counselling, 2008). The report found that existing family-oriented services are limited, with uneven geographical distribution, and recommended further development of these services. Such development may include: help for families in healing impaired family relationships; addressing conflicts with trust and love; assistance with help-seeking; family engagement in therapy for addicted individuals and beyond; and addressing any need for help from within the family themselves (Madill Parker Research and Counselling, 2008).

The National Centre for Substance Abuse and Addiction at Columbia University developed a novel inter-agency programme called Caseworks for Families, with the primary aim to assist substance-abusing unemployed women coming off welfare. This was a three-year project designed to address the problematic compartmentalised way that services are generally offered to low-income substance-abusing women. The project was implemented at 11 sites throughout the United States and agencies were co-ordinated rather than compartmentalised at site level. The evaluation showed improved Addiction Severity Index scores, at six and 12 months, with decline in drug use after six months and uptake of employment. See Appendix 1 for further details on the outcome measures and results of this research project, including strengths and caveats on the conclusions. In particular, lack of a comparison group ultimately meant that a causative link could not be proven between the favourable results and the Caseworks for Families intervention, but the authors concluded that the model of site-level co-ordination of inter-agency services delivery itself had proved to be very appropriate for the target population (McLellan, et al, 2003).

A recent Australian report identified support to families dealing with problematic drug use as a critical area, deserving of targeted funding (Frye, et al, 2008). Current funding models for addiction-related health services are directed mainly at the individual in recovery, and thus do not always permit the flexibility to engage immediate or extended family or wider community support for an individual.



Health and social services in New Zealand, however, are beginning to show an increased awareness of, and responsiveness to, family issues. There is growing interest in the multi-faceted interface between family and health and social services. There are a number of examples of emerging government policy focused on family in the health, education, social development, law and order and justice arenas in New Zealand and correspondingly there has been a recent increase in accompanying 'grey' literature. The New Zealand Ministry of Health has recently undertaken a review of delivery of addiction treatment services (Ministry of Health, 2009) which has highlighted the current gap in encouragement of family participation in addiction treatment provision. The New Zealand Ministry of Health's Interagency Committee on Drugs is working on a policy to address FASD, and has released a systematic review of the subject (Health Services Assessment Collaboration, 2008). In the education arena, the Families Commission website contains New Zealand publications and research reports examining the changing typography of families and the impact of public policy on families<sup>2</sup>. The Ministry of Social Development has the Family Violence Strategy and other related social policy documents on the website. Youth affairs in New Zealand fall under the jurisdiction of the Ministry of Youth Development, administered by the Ministry of Social Development, which takes an interest in youth risk factors including the family environment.

Another recent development is the Māori Mental Health and Addiction National Strategic Framework which expresses the overall aim of *whānau ora*, a prioritised action "that Māori families are supported to achieve their maximum health and wellbeing". This is now recognised as "an overarching principle for recovery and maintaining wellness" (Ministry of Health, 2008, p. 14). However, the recently released report of the Whānau Ora Task Force, generated a public debate over the realisation that problematic experience with social service delivery is not unique to Māori families (Espiner, 2010).

In terms of policy delivery, the past decade saw the development of some New Zealand services directed at families. Many of the kaupapa Māori services are already family-inclusive in their way of working and the Kina Trust, mentioned earlier, was established to address the lack of services that included families and

social networks of addiction clients. Kina Trust has on its website information and tools for services to use to help the addiction treatment services work better with families. In particular, the approach of Kina Trust is to use a strengths-based approach to identify and strengthen possible resilience factors. The Familial Trust website not only includes member services, but also hosts a New Zealand report on adolescent counselling for parental alcohol abuse (Boon, 2007). Family First is a New Zealand lobby group that speaks out, on behalf of families, about a variety of topical political issues that impact on family life. The Family Courts provide counselling for families who have had contact with the justice system, and organisations such as Prisoners Aid and Rehabilitation can provide family support when a family member goes through the prison system.

In conclusion, information about the impact of addiction on families in New Zealand is still very limited, and most services are not yet well oriented to family inclusiveness (encouraging family involvement in the treatment of their addicted family member) and family responsiveness (offering help to meet needs of family as well as the individual in treatment). Existing family-oriented services are not widely spread throughout the country and they are not well known. This may be partly due to constrained funding and consideration of competing demands to favour service provision over advertising the service, and also partly due to pragmatic considerations of matching service capacity to demand. In addition, some of the existing family-oriented services in New Zealand are restricted to geographically circumscribed, have a catchment defined by a District Health Board or by enrolment in a Primary Health Organisation (as is the case with kaupapa Māori health services). It is possible too that, as mentioned above, since much of the emerging information is located within the 'grey' literature and accessible electronically, the New-Zealand-centric information sources about family-oriented practice in addiction treatment services are most readily available to those who know that they exist and know where to find them. For services that are yet to establish family-oriented practices these examples of good family-inclusive practice may not come readily to hand, and it will also be relatively inaccessible to needy family members with limited internet access.

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<sup>2</sup> [www.nzfamilies.org.nz](http://www.nzfamilies.org.nz)



## 1.5 The role of resilience

The concept of family resilience has its origins in the study of resilience of individuals. Resilience is the demonstrable ability to continue a relatively normal trajectory through life despite adversity. Initially the concept was used for research purposes rather than for therapy. It is now considered a key concept in both individual and family therapy, especially in strengths-based counselling that focuses on characteristics that might provide some protection from the devastating aspects of addiction.

Resilience is considered a key component for therapy for individuals. Resilience of individuals growing up in a family affected by substance use has been explored, especially in the North American literature (Edwards, Das Eiden, & Leonard, 2006; Pilowsky, Zyber, & Vlahad, 2004). The literature gives less guidance on how the concept would apply to a collective, especially a larger grouping such as an extended family, and how well the resilience approach to individual therapy transfers over into family therapy.

The scientific literature on resilience of individuals is very complex. Much of the literature on coping, social support under stress, and resilience, dates from the 1980s and 1990s. It uses multiple tools to measure parameters that in themselves are not necessarily good or even direct measures of resilience. Indeed there is a lack of shared understanding of resilience within the literature itself. Resilience may be framed in positive terms; for example adaptive coping (Pilowsky, et al, 2004), or in mixed terms such as a relative lack of mental problems and evidence of social competence (Werner, & Smith, 1992). However, some studies have found that some coping strategies of the resilient are largely negative (denial, avoidance and disavowal rather than acceptance) (Buetow, Goodyear-Smith, & Coster, 2001).

Time and space do not permit a detailed analysis of all of the resilience literature. However, two recent papers published in peer-reviewed scientific journals, on the topic of resilience for families living with addiction, are considered here. Both papers were published by research teams with considerable experience researching resilience factors in families touched by addiction. The papers demonstrate some of the complexities and challenges in interpreting research on resilience, and in applying it to the New Zealand setting.

A paper entitled “Resilient children of injection drug users” from the School of Public Health at Columbia University, New York (Pilowsky, et al, 2004) had studied child-parent pairs recruited from HIV services. The team used a parent-report questionnaire of social competencies and reported behaviours, the Child Behaviour Checklist, to separate resilient and non-resilient children on the basis of their score on the checklist. For details of the strengths and caveats in the research methodology, the outcome measures and analysis of results, see Appendix 1. The recruitment tactic in itself has applicability problems for the New Zealand setting where HIV positivity is rare even amongst injecting drug users.

This study found little difference across a wide range of parameters between the children designated as resilient and non-resilient. However, the parents of resilient children perceived their social support to be better. The resilient children were also reported to exhibit better school behaviour than their non-resilient peers, although the teachers of these children were not consulted and their school functioning data were not presented.

Another research paper from New York State looked at behaviour problems in children of alcoholic fathers specifically to ascertain if a secure mother-infant attachment was a protective factor for these children (Edwards, et al, 2006). This team used the same Child Behaviour Checklist to identify children with more internalising and externalising behaviours than their age-group norm. The participants were a highly select group of families as the rigid selection criteria set up to control for possible factors confounding on maternal attachment had excluded many children from the study. Appendix 1 includes further discussion of the strengths and caveats on the methods, results and analysis in this study.

The findings were that children with an alcoholic father, who also had insecure mother-infant attachment at age one year, exhibited significantly more internalising and externalising behaviours than children with secure maternal attachment, but this finding held regardless of paternal alcoholism status. Insecure alcoholic-exposed children behaved very differently from insecure but non-alcoholic exposed children. However, the authors acknowledged that children who exhibit less or more internalising and externalising behaviours than their

age-norms at age 18-36 months, may not necessarily grow up with lower or greater resilience later in life. A longitudinal prospective study is required to definitively prove or refute the hypothesis.

Although the resilience literature is unclear, a pivotal definition of family resilience is “a dynamic process encompassing positive adaptation within the context of significant adversity” (Luthar, Cicchetti, & Becker, 2000). The concept of family resilience should recognise family strengths, including collective family capacity to resist risk factors and the particular permutation of multi-faceted protection factors for each family: a mixture of nature and nurture, of personal and intra-personal strengths. Certain aspects of family functioning, such as strong emotional bonds, effective methods of communication and intact family belief systems, are important means by which families cope with adversity (Mackay & Kalil, 2003).

Resilience itself is a somewhat problematic term when applied to families. The concept of family resilience must also recognise that within a family some individuals will exhibit more resilience than others. However, it is important to understand the resilience factors that are important for New Zealand families; factors that enable families to positively adapt and continue to function well as families, and those that might protect other individual members from the impact of addiction or even deter them from taking a pathway to addiction.

## 1.6 Identifying knowledge gaps

The emergence of dedicated research centres with a focus on family research will help in future to fill the knowledge gaps about roles and functions of families in New Zealand society. The Roy McKenzie Centre for Family Studies at Victoria University of Wellington<sup>3</sup> and the recently established Centre for Research on Children and Families, under the guidance of Professor Gordon Harold at University of Otago, Dunedin<sup>4</sup> are important initiatives that aim to address this knowledge gap. However, neither of these research centres has current research projects focused on families living with addiction (email correspondence with Sue Bradford, 3 September, 2009).

There is a particular gap in the national and international literature about the specific impact of different addictions in families. For instance, it is

not known whether the issues facing families might differ when a family member is affected by alcohol abuse alone, illicit drug use alone or drug and alcohol problems in combination, or by a behavioural addiction (such as a gambling or eating disorder). There are also knowledge gaps about the New Zealand-centric experience for families living with addiction, what family help is needed, the availability of help and the family experience of seeking and obtaining help from the health and social services in New Zealand.

This project seeks to look in particular at the less visible effects of addiction on families in New Zealand, factors that are not easily counted or readily included in health and social statistics. The project also seeks better understanding of family resilience factors, factors that facilitate or hinder family coping strategies and the incentives and barriers to families when seeking and gaining assistance.

This information could be useful at many different levels. Firstly, a good understanding of these issues is a key factor for directing appropriate and responsive public policy. Secondly, a better understanding of the effects of living with addiction on New Zealand families may also assist in highlighting factors within the wider community that deserve further attention. This will facilitate development of support services and help to build the inter-service relationships required for best possible outcomes for New Zealand families. Thirdly, a good understanding of the potential impact and extent of family problems is essential in order to identify practical ways to minimise that impact on family. Awareness of the barriers and incentives facing families is also important for all field workers, including those involved with education, justice and health, to facilitate their engagement with families and build their capacity to encourage family support for family members immediately affected by addiction. Finally, New Zealand-based information may also assist in development of, or improvement of, tools to measure the effectiveness of the services dedicated to helping families. This project seeks to contribute to filling these gaps.

## 1.7 Research aims and objectives

The specific objective of this project was to explore key issues for New Zealand families supporting a family member through alcohol and/or other drug problems.

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<sup>3</sup> <http://www.victoria.ac.nz/mckenzie-centre/news/pastevents/index.aspx>

<sup>4</sup> <http://www.otago.ac.nz/crcf/>

This project addressed the following specific research questions:

1. What are the key issues for families living with addiction? Do the issues facing New Zealand families differ if there is a drug problem compared with an alcohol problem? If so, how does illicit drug use influence the issues, compared with alcohol?
2. What are the particular barriers that New Zealand families encounter when trying to help a family member with a drug problem, alcohol problem or problem with both?
3. What are the barriers and incentives for family members to seek and gain help for themselves?
4. What are the resilience factors for families (rather than for individuals)?
5. How do the characteristics of the health and social services contribute to family experiences?

It is anticipated that the findings of this study will assist co-ordination between the health and social services and government agencies, inform the training of health and social services and highlight factors within the wider community that may deserve further attention.

## 2. METHODS

The research questions being addressed required a qualitative methodology that would provide access to the richness of personal experience. Therefore this project represents the voices and wisdom of many contributors, identified as Key Stakeholders, Family Participants and Informal Informants.

### 2.1 Ethical approval

Ethical approval for the study was sought and granted from the Central Regional Ethics Committee (reference number CEN 08/09/057). A major ethical issue was to ensure that the research processes protected the confidentiality of personal data, especially data that would be gathered within family groupings. This was a particularly sensitive consideration for recruitment within Māori families, Pacific families and participants from smaller or otherwise identifiable communities. Early advice was also sought from the University of Otago Māori Consultation Committee.

In discussions with the Ethics Committee the possibility was raised that family members might, during the interviews, recall trauma previously repressed or not adequately managed. Therefore a decision was made to recruit through addiction-related services for this project, ensuring that participants would have access to further counselling with those host services if that was required. The chosen methodology (talking to family members about their experiences of living with another family member's addiction) required that some information might be collected about that third party without their knowledge, consent or any means of rebuttal. This was also discussed with the Ethics Committee. It is not dissimilar to the circumstances under which health and social services such as Al-Anon and Familial Trust work in their support of family members. Processes to ensure anonymity of participants and their loved ones were duly agreed to.

An additional concern raised by the Ethics Committee was that processes should be in place to ensure the safety of the interviewer, particularly if domiciliary visits were made to families under stress or experiencing ongoing substance use. To this end, safe but appropriate interview locations were negotiated with participants in a transparent fashion.

### 2.2 Key Stakeholder interview process

Researchers identified Key Stakeholders who represented health and social agencies and other organisations with interest in the wider issues of social and family support and addiction. Key Stakeholders were initially approached to set the scene and by snowball methods assist in the identification of other stakeholders. A wider pool of potential Key Stakeholders was identified and then contacted about the planned research. This included people working within: Māori and Pacific Island health services; community-based organisations and self-help organisations; mainstream primary care and hospital-based services, especially those for addiction and child and family health; Government departments; and university teaching and research centres. The services are among those listed in Appendix 2. Initial contact was established with these Key Stakeholders and services to help frame the parameters of enquiry. Stakeholder interviews were conducted in person, by telephone or email. Face-to-face interviews were recorded and transcribed with consent for further analysis, and a paper record of phone and email conversations was generated. The purpose of consulting these services was two-fold: to ascertain the stakeholder perspective on the key issues to be explored with participants; and also to understand the stakeholder viewpoint on accessibility, affordability and attitudinal attributes of services for families living with addiction. Interested stakeholders were also offered an opportunity to review the draft report.

### 2.3 Family Participant interview process

The Family Participants were adult members of families affected by addiction (aged 18 years or over). The initial intention was to interview up to 15 self-identified participants semi-purposefully selected from a large urban region and a semi-rural smaller town (greater Wellington region and Masterton). The number of Family Participants was intended to achieve a cross-section of perspectives while keeping the qualitative data set to a manageable size. The initial aim was to recruit approximately one-third of Family Participants from members of families respectively affected by alcohol alone, illicit drug use alone and alcohol combined with other drugs.

The actual Family Participant interviews proceeded somewhat differently from these initial intentions for several reasons. Firstly it became evident from early interviews that the intended strategy to recruit five persons from an alcohol-affected family, five from a drug-affected and five from a mixed family experience represented a very artificial division into substance of choice. It did not reflect the lived realities of families in New Zealand. Family Participants reported that the substance of choice for an individual and the patterns of use might change over time. These family members often reported a mixture of substance-use experiences within their extended family: with multiple family members addicted to a variety of substances of abuse over time. Therefore the decision was made not to select Family Participants solely by substance of choice.

The geographic coverage was also modified because of the high interest in the project expressed by members of Familial Trust based in Christchurch, and also because of initial delays experienced in engaging with the Masterton service. This subsequently impacted upon researcher availability. Consequently, the interviews were conducted in the greater Wellington region and in Christchurch, gaining some North Island and South Island representation at the expense of semi-rural or small-town representation in this exploratory study.

Most Family Participants were identified by word of mouth from self-help organisations such as Al-Anon, Familial Trust and case workers in mainstream addiction treatment services. They were also identified through an informal snowball technique via other participants or Informal Informants. A recruitment poster was designed for display at premises of addiction clinics, the needle exchange and other support services. Appendix 2 lists services from which participants were recruited and the family-focused services that participants mentioned during their interviews. Family Participant interviews were recorded and transcribed with consent for ease of further analysis.

## 2.4 Informal Informant interview process

This project resonated with many people who had insights into New Zealand families living with addiction; people who had heard about the project and wanted to share their perspectives and contribute their

wisdom to it. In this way many Informal Informants shared personal stories to inform the project in a less structured manner. These discussions were not tape-recorded, but did give valuable insights to the data collected via the formal Family Participant and Key Stakeholder interview process. Informal Informants were located in a variety of situations: in community consultations and conferences, in the health and social services, in meetings of addiction-related health service providers and in academic settings. Delegates at the 2008 Cutting Edge Conference in Christchurch, the 2009 ALAC Working Together Conference in Wellington and the Wellington and Christchurch 2009 ALAC Youth and Māori stakeholder consultation meetings were particularly interested in the project and keen to engage and share insightful contributions to the project. Informal Informants initially helped to set the scene early in the project and assisted in establishing the framework for this research. Later on, different Informal Informants helped to shape the emerging themes and finally to confirm interpretation of findings. The experiences and wisdom of these Informal Informants provided additional data gathered in an opportunistic manner, and both confirmed and helped to clarify contributions from the Key Stakeholders and the Family Participants. The insights gained from the Informal Informant contributions were incorporated throughout this report, but care was taken to omit specific details of their experiences to protect anonymity.

## 2.5 Design of interview schedule

The design of the Family Participant interview schedule was informed by the literature review update and findings from the Key Stakeholder interviews. The literature review update followed previously successful search strategies undertaken in the earlier Families Commission systematic reviews on families affected by heavy drinking (Girling, et al, 2006), the project on methadone and pregnancy (Chan, 2008) and the thesis on whānau engagement in treatment (Severinsen, 2005) previously mentioned.

The indicative list of questions for the Family Participant interviews is included in Table 1. In keeping with a grounded iterative research process, the actual questions evolved over time, particularly as new information was gathered and earlier interviews informed the subsequent interviews. Family Participants signed a consent form and undertook a recorded

interview. The interviews were conducted either by a registered medical practitioner with special training and experience in addiction medicine, or by a research assistant with prior psychology training, who was also a medical student. The recordings were transcribed, with consent, to ensure reporting accuracy and for future in-depth analysis. Interviews were mostly held

in person, but some were conducted by phone (where requested by the family member). Most of the face-to-face Family Participant interviews were conducted at the premises of a health or social service. One interview was conducted on the medical school premises and another in a downtown business location, at the specific request of those individuals.

**TABLE 1: Family interview questions**

Note: These were indicative questions for the semi-structured interviews. Actual questions differed according to interview context and questions evolved over time.

Family scene setting	Duration living with a family member with a problem with addiction, how the family became aware, how many known family members have addiction problems and the nature of their addiction.
Family-specific issues	What was the biggest impact on the family (hardest for the family to cope with) and what less so? How have the issues changed over time? What has helped the family through?
Substance-specific issues	Does a drug-use problem rather than an alcohol problem change the issues for some families? Has that (substance type) affected how well this family has coped?
Individual seeking help	Was help offered to the individual family member(s) with addiction? Did that person accept help for their own drug and/or alcohol problem? Why, where and how? Did that also help the family, or cause more difficulties? How/what? If your family could give some advice to drug and/or alcohol treatment services in New Zealand what would that be?
Families seeking help	Did the family seek help for itself or for individual non-addicted members? Why? What? Where? What is good and not so good about the health and social services? If you could design a service to help New Zealand families in this situation, what would it be like, what help would it offer?
Resilience	What do they see as protective factors for the family? How did they cope and what helped the individual to get through all this? What do they see as individual and family strengths as a result of this experience?

## 2.6 Data handling and analysis

Interviews were transcribed verbatim and transcripts were coded and stored using data banking software belonging to the Applied Research in Communication in Health (ARCH) research group. The data bank was developed by and is currently used in ARCH studies of communication in health interactions. It is capable of an appropriate level of encryption to provide confidential safeguards for qualitative data storage derived from personal health-related interactions. The data are searchable by theme, code or by specific words and this also facilitated preliminary steps of the thematic analysis.

The qualitative analysis firstly used a grounded theory approach using principles of naturalistic enquiry through iterative semi-structured interviews. A comprehensive thematic content analysis of the transcribed interviews was undertaken. The analysis sought to identify key themes and/or critical elements that underpinned those themes. The results were interpreted from a range of perspectives within a multidisciplinary research team (with members from psychology, sociolinguistics, primary care and addiction medicine backgrounds). The use of transcription enabled a closer look to be taken at selected interviews to better understand the way in which participants



had described their experiences. Selected excerpts from verbatim interactions, which were analysed from a sociolinguistic perspective, have been included in this report. These indicate the ways in which in-depth interaction analysis might make an additional contribution to the findings of a qualitative project of this nature. In-depth interview analysis across the whole interview data set was not undertaken for this report, as this was beyond the scope of the present study. Sociolinguistic analysis focuses interest not just on what is said but also on how it is said, including the length and position of pauses and dysfluencies such as incomplete sentences, rephrasing, stammering and other punctuating articulations. Interactions analysis is becoming a common methodological approach

in research on health care interactions, adding additional research insights by looking at the nature of encounters between services and service users. (Díaz, 2000; Heritage & Stivers, 1999; Hutchinson, Read, & Sharrock, 2008; Seale, Chaplin, Lelliott, & Quirk, 2007.)

Key Stakeholders, interested Family Participants and Informal Informants were again consulted on the draft report to discuss findings and confer on interpretation. In particular, the opportunity was taken to present preliminary findings to a research audience at the 2009 RNZCGP pre-conference research forum at which contributions were received both from audience discussion and from individual Informal Informants. Selected Key Stakeholders were also invited to undertake a preliminary peer review of the draft report.

## 3. RESULTS

### 3.1 Key Stakeholder interviews

Preliminary interviews with Key Stakeholders were very helpful in framing the parameters of the enquiry. The stakeholders gave their insights into:

- > how families become aware of an addiction problem
- > what the main impacts are on families
- > the substance-specific issues for families
- > how family needs change over time
- > how services currently respond
- > the ideal health and social service.

#### 3.1.1 How families become aware

These stakeholders described various ways that a person may become aware of substance addiction within the family. Stakeholders explained that the process of becoming aware can be a very traumatic time for families, especially if it is associated with immediate law or justice complications. As one stakeholder explained:

...having the police turn up, and tell them [family members] they're looking for things that suggest manufacture, or distribution, this and that, really is quite horrifying for the family.

However, the full extent of addiction problems is often not recognised at first, or even in the longer term. Stakeholders identified the need to look deeper into the family of a new client for problems with the same or different substance of abuse. For health and social services, managing the family impacts can become more complex where more than one member of the family/whānau has an addiction. One service described how helping one family member with addiction had raised awareness of an additional family member with a substance abuse problem:

I know of one mother whose son ... went on to become a very big dealer in Wellington, and the mother was happily using, injecting with the son.

#### 3.1.2 Main impacts on families

Services indicated that the emotional impact on families may be greater than the physical impact. The emotional impact is less visible and more insidious. It may not be immediately recognised or confronted and therefore may be ongoing:

The psychological stuff can be a lot worse than the physical stuff ... the physical stuff was at least up front.

One of the most common impacts identified by these services was the self-blame taken on by non-addicted members of affected families:

It all comes back to blaming themselves ... what have they done wrong? What could they have done better?

Individuals can be seen to blame themselves for failure to better manage the impact of the addiction-related problems on the family:

...thinking 'I'm no good at this'.

Services can see family members who do not know what has happened to relatives:

A lot of people that we have contact with have no contact, no relationship (with their family).

Family members might worry, in the absence of direct information from the user, about what is happening with his or her life and drug or alcohol use:

I guess not knowing whether they were going to get that call saying he's been found in a gutter dead.

Some services reported that they had heard indirectly, perhaps through other health and social services, about the substance user's neglect of children, pending criminal or financial or other family problems. Financial strains can be particularly trying on families. Financial impacts can occur regardless of the substance used. As one stakeholder explained:

It becomes a crisis situation, when the family has become impacted on the money aspect, which may of course include some criminal behaviours – stealing, taking money from the family that they didn't know was being taken for quite a while, until it built up and built up.

Services will try to help lessen these impacts by offering simple interventions. For instance, simply acknowledging family members' thoughts, concerns and feelings about addiction provides a positive contribution to family wellbeing:

...what might help a family get through is from the external agencies, when they become involved, having someone validate the concerns of the family.

Providing objective information about addiction is also helpful. As one service provider explained: understanding addiction as a disease of the brain seemed to help many families to accept the behaviour as a health problem and therefore try to remain engaged with their addiction-affected individual as a family:

...having the impact of the [substance-induced] injury, of the [substance] abuse, noted; and the organic changes that can happen in the brain. And often just knowing this, and having it documented, can be of use, not only to the family, but also to the individual. The fact that it's a reality check: that the brain may have been affected, the memory, attention and executive functioning are often impacted by ongoing alcohol or drug abuse.

The extent of family problems that can be identified will of course depend upon just how widely whānau/family is defined. The more embracing the definition of family the more widely the net can be cast. More individual family members with personal problems of substance or behavioural addiction may be identified in the extended family. More non-addicted but nonetheless affected whānau members may also be found within the extended family.

### 3.1.3 Substance-specific issues for family

Stakeholders agreed that the impacts of addiction on families seen mostly, appear similar irrespective of substance of choice. In particular, legal status of the substance, (for example, alcohol vs cannabis or other illicit drug use), appears not to be a discriminatory factor for families. This may at first seem counter-intuitive, but the fact is that communities also attach stigma to excessive abuse of alcohol, despite its legal status in New Zealand.

As the Māori Health service provider explained, the legality of alcohol use means that associated violence and drunk-driving is very visible. This visibility is in part intrinsic to alcohol intoxication. Society has come to expect visible consequences of alcohol excess and alcohol-related problems are reported in the New Zealand media on a daily basis:

Drug abuse is more covert, and families are less willing to perhaps acknowledge there's a drug abuse issue, rather than alcohol. And I guess that may be because alcohol is more widely available, and more accepted within society.

Al-Anon, for example, generally sees people from families who identify alcohol as the main problem substance, but accept that the person with an addiction may also use other drugs as a secondary phenomenon.

As one stakeholder explained, alcohol abuse is also more problematic for families simply because it is by far more prevalent in society than the use of any other drug:

In terms of the drug use, illicit drug use is more likely to be [affecting] one member of the family, whereas in my experience the alcohol abuse is more likely to be rife [sic] throughout the family.

Health and social service stakeholders observed that in families with more than one addicted individual or more than one substance of abuse, it is alcohol that is most visible. The positive aspect to this is the existence of better access to alcohol treatment than for drug treatments, and seeking help is encouraged and somewhat less stigmatised.

Stakeholders explained that families generally don't view alcohol problems as being quite as bad as drug problems. Drug use on the other hand is often perceived to cause more severe disease presentations than alcohol, and (depending on substance used) drug use might bring a more accelerated risk of addiction. Drug use carries added risk due to uncertainties about the purity of black market purchases. Similarly, drug use might be more actively hidden if it is illegal: the need for treatment more difficult to recognise, and it is likely to be something that families do not wish to have to explain to their associates. An interesting viewpoint,

as explained by a volunteer worker in the addiction field, was that some families may not be aware of differences between illicit drugs, seeing them all only as substances of abuse:

My family would put marijuana probably in the same category as injecting heroin. It's all terrible. But getting smashed ... getting drunk as a skunk is quite acceptable.

#### **3.1.4 Changes over time**

These stakeholders provided differing insights into family adaptation and how issues of importance for families may change over time. The family problems arising from addiction may seem to get worse, until the crisis is reached and some health or social service responds to family awareness of need:

The issues change over time, I guess, because they get worse. The impact of the difficulties becomes more problematic.

For instance the needle exchange described how, in their experience, families will gradually adjust, but to become more accepting they must be open to informing themselves about substance use and about the phenomenon of addiction. Some stakeholders considered that the time taken for the addicted person to come to services' attention and first receive help was a particularly difficult time for family members. It was also an opportune time for health or social services to facilitate and engage with family members. In addition, Al-Anon recognises a continuum of family awareness that may eventually result in relatives, who were facilitating help for a loved one, coming to realise that they too have also been part of the problem. Families will then find a way of dealing with that realisation about themselves.

Key Stakeholders predicted that because the burden for families does lessen once the crisis has passed, Family Participants in this research project may not necessarily recall or even want to recall the full extent of the family pain that was associated with past events.

#### **3.1.5 How health and social services respond**

The extent of help offered to families and individuals living with addiction varies enormously between services; from none to management of a crisis such as Family Court assistance once the situation comes

to the attention of the legal system. Differences in the approach of some health and social services towards families is highlighted in the following passages; comparing and contrasting the approach of Al-Anon, a community-based needle exchange service, a private therapist, a mainstream hospital-based addiction service and a kaupapa Māori Health service for families living with addiction.

Al-Anon makes contact with family members through self-referral, supporting individuals who seek help to become the support person of another family member with addiction. Family members are drawn to Al-Anon when they become aware that they cannot deal emotionally with the problem they are facing alone and they may find the group through word of mouth. Al-Anon works directly with those individual family members to empower them to recognise the opportunity to intervene, and then implement a management plan (usually contact with a member of Alcoholics Anonymous (AA), who will visit the alcohol-impaired relative). The Al-Anon approach, while not family-centred, is a form of family group work where individual members of different families discover they are not alone in tackling family-related addiction problems. Al-Anon is a self-funding organisation but there are no dues or fees; members are asked to contribute what they can afford.

The needle exchange comes to hear about family members through personal contact, when extended family members come to support a needle exchange user or come to use the services themselves. Families may also seek help because they have become aware of possible drug-use problems through witnessing behaviours associated with injecting drug use, or when the police arrive at their home. The needle exchange helps families indirectly, by recommending on-referral to the police Victim Support service, Family Court counsellors or GPs for counselling or treatment. The needle exchange finds that encouraging clients to invite family members to become involved helps individuals in their recovery:

By taking away a lot of the secrecy, hiding, it's just brought down a lot of the barriers.

At the needle exchange, advice to families is free, but not all the services to which families may be referred are free of charge.

The private therapist saw family members seeking help for themselves, when problems arose from underlying family addiction. Individuals might be referred, or self-referred, into a private clinic. Private therapy will usually be self-funded (unless as a result of an accident or physical injury). The stakeholder explained that cost is not necessarily seen as a barrier but as a measure of motivation: individuals who are highly motivated to accept help will be prepared to pay for that help. This particular private therapy clinic was, like Al-Anon, based on an AA-type 12-step recovery model.

Mainstream addiction treatment services are provided free to New Zealand residents, but most of these services do not have particular processes in place to identify the family members of their client, or the needs of that family:

Treatment is tagged to the ID of the patient and NHI [individual patient identifier the National Health Index], so we don't have any way of including families at the outset.

Mainstream services do recognise family services as a current gap and would like to see the services become more family focused, funding structures permitting:

There's no routine identification of dependent children [meaning: the children who are the dependants of an adult client]. We don't gather information on any others. If at the point of intake or allocation there could be a list of dependent children's names then [we] could be funded for some family sessions.

In contrast, the Māori Health service is proactive, setting up special opportunities for families to engage with the service, such as a family week or waanaga (intensive learning activity) where families are invited. Sometimes this is organised in response to a particular need identified by the community, such as need for a women's waanaga. Often an outside service, such as a counsellor seeing a family member about relationship problems, will refer clients to the Māori Health service if it seems culturally appropriate to do so. The Māori Health service uses group work, especially to expose the issues, and then provide information and direction where more specialist assistance is required. If family become better informed, that is considered key to recovery and this enlightenment approach may also lead to some family members later becoming involved

in the health sector themselves, as helpers after

“getting answers for yourself and getting comfortable with the setting”.

Family/whānau inclusiveness is typical of the therapeutic approach of kaupapa Māori services, in keeping with the Whare Tapu Wha model of Māori Health outlined by Mason Durie (Durie, 2001). Kaupapa Māori Health services are generally low cost or free.

Health services have all witnessed changing times. Help may now be sought not just by their main clients, the individuals with addiction, but also by members of that client's family. However, in general, families do not come to services in the first instance to seek help for themselves and for non-addicted members. They first try to get over the problems in their own way and not all family members readily accept help when it is offered. The Māori Health service experience was that families often do not accept help until years later, or at a crisis point. This was echoed by Al-Anon who will often see families only when they feel ready – often at 'rock bottom'. The needle exchange explained that some families can be quite resistant to accepting that their problem does need some help. Even a dramatic family event such as having the police appear on the doorstep may not be enough to cause a change in family attitude toward seeking help for themselves.

Services said that the time when the addicted person seeks help can bring great stress for the family as rules of family engagement can change, behaviour can be unpredictable and the family situation can become dangerous, especially for women in relationships. Some people with an addiction problem fear telling their families that they are seeking help because that might bring unrealistic pressures from the family for them to change substance-use behaviour faster than they can achieve it. However, if one or more family members are already connected with a service to support significant others, such as Al-Anon, that will have helped the family to be better prepared for these changes when they happen.

### 3.1.6 The 'ideal' health and social service

These stakeholders each offered advice to drug or alcohol treatment services in New Zealand about the needs of families. The stakeholders said that an ideal

service would offer advocacy to help families, and would have a frontline counselling service to organise further appropriate help. The ideal service would:

- > tailor treatment to individual needs
- > cut down waiting times for treatment so that family problems do not accelerate whilst in waiting
- > be open to families of the addicted individual
- > listen to the family stories and see them for what they are
- > help families and loved ones to understand that abstinence may not always work
- > help the individual with addiction to integrate back into family life
- > be funded to also help the families, and especially children.

Key Stakeholders emphasised that children might need extra support and that specialty services for children from families living with addiction are scarce. As one service provider explained, the gap is:

An add-on to the adult service, for the kids, the counsellor to see their kids ... the kids are sort of an afterthought a lot of the time.

Several stakeholders suggested that an ideal service would also provide educational material to counter-market what they describe as the 'misinformation' and 'scare stories' about drug use that abound in popular parlance. Written material also has a role for some family members for whom the alternative technique of seeking information through support groups or individual counselling is not appropriate. Good websites were suggested as one means to provide information to families: a website can be remotely accessed, and does not require the same courage as seeking out and consulting a service in person. New Zealand examples include the New Zealand Drug Foundation<sup>5</sup> and Pacific Life<sup>6</sup>. However good, this form of information can be relatively inaccessible to families without web access.

Currently, residential addiction treatment and rehabilitation services in New Zealand encourage family engagement on an outpatient basis. Residential services are generally not available for families in New Zealand. Some key informants saw the absence of a family residential provision as a current service gap. The

women's refuges offer residential shelter and counselling for women and their children, but only when they have left their partner/family father figure. Women who access refuge services often do so because of substance abuse-fuelled family violence. However, there is no equivalent shelter service available for men with children in their care. In large cities, night shelter services provide temporary accommodation for single men at low cost (NZ Council of Christian Social Services, 2009), but a night shelter is not a family-appropriate environment. As one key informant explained, speaking also from personal experience as a family member, the gap is that:

In an ideal world, a service to help New Zealand families that are experiencing addiction would provide a live-in, 24-hour service that would support them through the many facets of their functioning that are impacted. Daily living habits need to be broken. A rehab model also needs to take into account the preventative aspects for when the person would go back into society. And of course, short- and long-term follow-up would be essential.

## 3.2 Results from family interviews

Table 2 summarises the characteristics of 19 Family Participants interviewed for this project: seven men and 12 women. Of these, two identified as Māori, 17 as New Zealand European. Two were youth (aged 18-25 years). In this report the balance of Māori, Pacific and youth perspectives were obtained from Informal Informants, as explained previously. In the following sections of this report, comments quoted from the interviews with the 19 individual Family Participants have been identified by the notation P.1 to P.19.

The following key ideas were expressed at Family Participant interviews, and also mentioned by Informal Informants:

- > becoming aware
- > impacts on families
- > substance-specific considerations
- > time and resilience
- > help for the addicted individual
- > help for the families.

<sup>5</sup> [www.nzdf.org.nz](http://www.nzdf.org.nz)

<sup>6</sup> [www.pacificcitizen.org.nz](http://www.pacificcitizen.org.nz)



**TABLE 2: The family member participants**

Number & gender	Relationship of the participant to the addicted family member(s)	Substance of abuse	Self-addiction?	Involved in treatment provision now?	Other family members had known substance addiction problem?
P.1, F	Daughter, ex-wife, mother	Alcohol	No	No	Yes
P.2, F	Wife, mother	Alcohol, marijuana, IV drug use	No	Counsellor	Yes
P.3, F	Daughter	Alcohol	Yes	Social worker	Yes
P.4, F	Daughter, wife	Alcohol, IV drug use	No	Counsellor, management	Yes, and eating disorder, gambling
P.5, F	Daughter	Alcohol	Yes	No	Yes
P.6, F	Ex-wife	Alcohol	No	No	Yes
P.7, F	Mother	Opiates and cocaine	No	No	Yes
P.8, F	Mother	Mixture of illicit drugs	No	No	No
P.9, M	Son	Alcohol	Yes	Counsellor	Yes, and workaholism, gambling
P.10, F	Wife	Alcohol, methamphetamine and marijuana	No	Counsellor, management	Yes
P.11, F	Ex-wife	IV drug use and marijuana	Yes	Management	Yes
P.12, M	Extended family	Alcohol, IV drug use and marijuana	Yes	Volunteer at D&A service	No
P.13, M and son	Brother	Opiates, esp. heroin, marijuana, tobacco and alcohol	No	No	Yes
P.14, M	Husband	Alcohol	No	Educator	No
P.15, M	Son	Alcohol	No	Counsellor	Yes
P.16, F	Mother	Glue sniffing, cannabis, methamphetamine	No	No	No
P.17, M	Husband	Opiates	Yes	No	Yes
P.18, F	Mother and grandmother	Marijuana, methamphetamine	No	No	Yes
P.19, M	Son and sibling	Alcohol, tobacco, marijuana, party pills	Yes	No	Yes

### 3.2.1 Becoming aware

Many Family Participants had lived with the addicted family member for a long time, quite unaware of the problem. Sometimes a sudden change in family circumstances had forced a discovery or a confrontation. Some family members in this study reported that they had been shocked to be first informed of their loved one's problem by the hospital, the police or drug and alcohol services. Discovery may also have been triggered by emergence of family financial problems:

...often most common times that we'd spend time together is when he was basically asking for money. Initially I actually was giving him money because I kind of was fooled into the usual lies of 'Um I've spent it all on um tobacco' or 'I've spent it all on rent and I've got all these debts I've got to pay off' and when I sort of woke up a bit and realised that I was simply feeding his drug habit I started refusing P.13

One described confronting the reality of that addiction with an ultimatum to the addicted family member:

Do something, or you'll lose your family. He was given a pretty heavy ultimatum. P.2

The presence of addiction in the family might especially go unrecognised by the children for a long time, because for them it seems normal:

I didn't actually know anything as a child. It was hidden from me. We sort of put up with the hangovers and associated behaviour of it. P.5

However, some did experience awareness, even as a child, that something remained unspoken, but was not right:

...there were things that were sort of um [tut] it's that weird thing when you hear about things that aren't actually talked about. P.13

Eventually, some consequence of the addiction might draw the family's attention to the fact that there could have been a problem that was successfully hidden for some time:

He got caught drink-driving. And that was pretty intense, and yeah, he just started drinking every day. But it took a long time for us to realise, because he used to work at home, and he would drink by himself. P.15

One participant explained how, as an adult in a new relationship, the realisation that the spouse was alcoholic dawned very gradually:

...um [quietly, surprised] I don't really know it sort of you know it happens by stealth, you don't really realise when it happens you know. P.14

Another participant described how as he grew up he became aware of underlying addiction as the basis of the problems faced by the family and he later sought to understand addiction better in order to become closer to the affected family member:

It was in later years when I actually knew that he was a drug addict that I started to find out more about it... P.13

There may be an element of family denial, or of choosing to overlook, not wishing to become involved in someone else's problem:

When you're a family member, it's really, really difficult, because you don't... Because it's not your problem. P.1

Just as the Key Stakeholders had mentioned earlier, some Family Participants expressed reluctance to apply an addiction label, not just at the time of awareness, but also on a continuing basis:

I just knew that she um went through an awful lot of sherry. P.13 [The underlined words were said with the participant's own emphasis.]

Eventually most of our interviewees gained insight through obtaining external help or information. This might have been expected as a result of the strategy to recruit through health and social services:

I am a recovering alcoholic addict. So I guess it was by doing the work on myself that's given me the awareness to see what was going on in my childhood. P.3

Awareness also came through self-reflection:

I hit a place in my own life where I just didn't want to do life any more ... started looking at my life and putting pieces together, and getting a bit of insight into [husband's] addiction, more than anything. But mapping it back, I saw my father's behaviours were very similar. P.10

### 3.2.2 Impacts on families

Participants reported a range of impacts on family members, of both the awareness of addiction and the addiction itself. Low self-esteem and behavioural, socialising and/or withdrawal problems were commonly reported. Perhaps predictably, some impacts were dependent upon position in the family.

Those who were **children** at the time may have lived with parental dysfunction and experienced parental aggression:

I think because I was a really fearful kid... I had real problems with socialising in school. I still do now. P.5

Childhood fear was commonly described. Fear also added to impaired socialisation as the child strove to ensure that friends would not discover the family secret:

Fear, just simple fear. Fear of when your father doesn't come home straight away from work... You were scared of peers finding out about what happened in your family ... so it affected all your relationships. P.1

Participants also described fluctuating parental availability during their childhood:

Some weekends he'd be drunk when you turned up, so you didn't see him then. And then some weekends he'd be fine, so then we'd go see him. P.15

They recognised their addicted parent's emotional unavailability during their childhood as a factor contributing to their own relationship problems as an adult:

My dad was emotionally unavailable, as ... you know. Well, he still is, actually. And so I'm not really good at communicating in relationships with men. P.3

The emotional turmoil for a young person was explained by one participant:

...every time he promises you that he's going to stop and he never does, and every time he promises you that he'll be sober when you go visit him, and he isn't: you kind of get numb to it all. So you don't want to be hurt when you go and find out. So you always expect the worst. And when it does happen, you're just like, 'Well, I expected it'. P.15

For some, socialising difficulties developed into problems with trust in adult relationships:

I struggle a lot to trust people. Because yeah, when you're younger, and I sort of ... my dad was my world, and I loved him so much, and then he sort of just left me... I've just ... I don't let many people close to me, because I don't want to be hurt. P.15

In **growing up**, children noticed changes in the nature of their relationship with a parent as that parent developed an addiction problem:

...he changed heaps over time, because he was real loving, and real ... awesome. Always looking after me. ...he pretty much went from a focus on me, when I was younger, and then pretty much became very self-absorbed, because he was just really into alcohol, and how to get it, and drinking... So yeah, when I go see him now, it's just pretty much focused on him and his life. And there's no real time for me, which is pretty hard. P.15

Some **adult** members of affected families said that they became concerned about possible addictive tendencies in themselves:

I'm a terribly introspective person and I had become aware that I have certain [inhales] addictive tendencies. For example, at one point I was I won't say addicted to the pokie machines but [inhales] um I could feel myself getting very, very wrapped up in it. P.13

Others reflected that dysfunction had become very familiar, almost comfortable, and as one participant intimated, life expectations are set up:

And you know, chances are the family members have grown up in dysfunction, and that's why they end up in relationships similar to the upbringing they've had. P.3

Several adult participants, members of one support group in particular, quoted a phrase, "Don't talk, don't trust, don't feel" (Kroll, 2003), that they considered was symbolic of what they believed they learnt as a child.

**Parents** of an addicted person described self-blame and guilt, a sense of responsibility for what happened to the life of their child:

I think any parent tries to accept responsibility for making their child well, if they're ill, and to think that love will cure all. I think we're induced to

believe that, that it's a mother's love that will save any child. P.8

These parents tried to at first fix the problem themselves, not wanting to engage outside help:

And [named offspring] really spiralled, and she attacked me with a pair of scissors. And I called the police, and they sent the armed offenders' round, which really shocked me. I just ... you know, I just ... this is my daughter, my baby, I love her, you know ... there's no need for this. But I guess there was a need for it, and you do try and just close off, and try and do it yourself. You know, try and fix the situation yourself. But you can't. P.16

The parental desire to fix the problem meant that they themselves risked co-dependency or another maladaptive behavioural response:

I realised that I was exhibiting all the similar symptoms that he was displaying, in terms of controlling behaviour, and lying, and sneaky behaviour: trying to find drugs in his room, following him, doing everything I could to try and control his behaviour, which was totally pointless. And it wasn't until I realised that it wasn't in my control. P.8

Parents had also tried to protect their children from the worst of the impacts of another parent's drinking:

My mum, I think, helped a little bit, because she would always make sure that I was looked after at dad's place, and that I wouldn't be living there when he was drunk, or anything. P.15

**Siblings** of an addicted person described how, as non-addicted siblings, they may be at risk of taking on self-pity and/or putting up a brave front:

...they [the non-addicted siblings] have traits, attitudes I suppose, that have influenced their lives ... reacting to other people's behaviour, feeling sorry for themselves and prone to feeling bad. But always putting on a good front, and surviving in the world. P.1

One sibling later expressed regret over the response of his parent to a brother with a drug problem:

...the police rang up and said 'We got your son here and he had a joint with him. You wanna come and pick him up?' and dad's response was 'Nah leave him there'. P.13

**Peers** had watched the self destruction of a loved one, helplessly: "most of my friends have died from drug overdoses".

**Spouses and significant others** had experienced repeated deceit and attempts to manipulate them:

...people with addictions become so self-centred, and so kind of compulsive-obsessive stuff about getting their drug of choice, no matter what, everything else in their life just gets put to the side, and that includes people, places and things. That's the biggest character defect thing. And with that goes the lying and the deceit, and the broken promises, and control and manipulation. All of that. P.6

And, as one Family Participant admitted, this is taken personally:

I thought I was a rotten wife. P.10

Partners felt the need to be protective, as they would of dependent children. One participant experienced difficulties travelling overseas with a spouse with a drinking problem:

...[going through] customs or whatever it is you know [inhales sharply] and um it's difficult er to protect somebody who is [inhales] liable to do something [laughs] indiscreet, you know. P.14 [Underlined words were participant's own emphasis.]

This particular excerpt demonstrates the dysfluency associated with describing the prior experiences, a finding explored further in 'Describing discomfort', p.38.

This protectiveness also extended to a reluctance to apply the label of addiction. In the following example the word "probably" and the phrase "those kind of" were deployed by the Family Participant to moderate the full impact of the statement.

Two sisters who had grown up with addiction in the household had both later chosen to marry men with a drinking problem:

...both my sister and I probably married people who had those kind of patterns [alcoholic]. P.10

The non-addicted partner might also be faced with the responsibility for sheltering other family members, managing the impact on others as well as themselves as a result of an addiction-related breakdown of the relationship:

...the unit just broke down, really. Stopped communicating. We'd had problems with kids' behaviour. P.6

Some **extended family** participants were surprised by their own reactions to the addiction within the family:

...extended members of my family ... were alcoholics too ... and then their behaviour began impacting on me, [I] actually hit my rock bottom over one of those ... and it was interesting, because it wasn't even a partner or my father, or anybody else (no-one very close). P.1

Family Participants found themselves facing not only the realities of one member with an alcohol or drugs problem, but also the complications of youth risk behaviours, including undesirable peer associations or even gang affiliations, and the strain that added to internal family relationships:

...when things happened I know that he was basically with the [named gang] when [inhales] um that was before mum and dad split up so that would've been when he was 15 or 16. P.13

The family might be so busy with their coping that possible underlying factors were not recognised or addressed. One participant described an unspoken family secret that was left untold because the interpersonal bitterness and mistrust resulting from the substance abuse destroyed many of the opportunities to reveal it. Only in retrospect was the family secret recognised as a factor contributing to the addiction and an associated depression:

...he always wanted to tell me, but he didn't tell me, because he'd get drunk just before, because he was just really nervous, and thought that I'd just dismiss him, and not want to see him again, and ... but yeah. So that (telling the secret) never happened. P.15

Physical distancing may result:

...just probably got worse, really, until ... you know, he wasn't allowed on the property, he was not considered ... he was considered beyond help, I guess, by most of the family. P.7

Reconciliation might become very difficult once the family have distanced themselves:

I know that he wants to see me, and he wants to get to know me, and still have that relationship, but yeah, he just can't make that first move. P.15

### 3.2.3 Substance-specific considerations

Family Participants and Informal Informants agreed that issues facing families of an alcoholic and a drug addict will be much the same. The main difference lies in the prevalence of preferred substance use, as drug use is less common than alcohol. There was, however, a perception that alcohol breeds more violence, as one family member explained:

Alcoholics are nasty. P.19

Drinking alcohol is socially acceptable in New Zealand, which enables alcohol problems to be more successfully hidden until at an advanced stage. That can have serious consequences for the family members. In this following example, the spouse kept the family problem hidden from society, living secretly in fear, until a crisis occurred and emotions were stirred that she felt she could no longer hide:

...we came to the point where he pulled a knife on me and I can remember actually I'd gone beyond fear at that stage to anger. P.10

On the other hand, the social acceptability can make it easier for families to acknowledge an alcohol problem compared with a drug problem, and families may be more open to seek help for alcohol than for illicit drug problems. Illicit activity can foster greater secretiveness by the user:

...the more illegal the more secretive the addict becomes. P.2

Secrecy can allow an addiction problem to continue until the behaviour becomes severely dysfunctional and the index person with addiction becomes quite impaired. By this stage, difficulties for families will also have progressed. Fifteen of the 19 Family Participants mentioned that the addiction was not limited to just one person in their families. Within these families, there was a mixture of drug and alcohol problems and behavioural addictions such as gambling, eating disorder, obsession with work (Table 2).

### 3.2.4 Time and resilience

Participants had great difficulty explaining their resilience or the positive aspects of family functioning that had got them through. It is not clear that they even believed that they had demonstrated resilience over time. Instead, the examples they gave of adaptive strategies tended to have somewhat negative

connotations: carrying on through chaos; switching off emotions; temporary insanity; putting on a brave front; struggling to continue on; and mentally separating the person they loved from the addicted behaviour that was exhibited. Coping, defined as the process of dealing with problems, can be adaptive or maladaptive. The way in which this coping was described often emphasised perceived family weaknesses, rather than family strengths and collective family capacity to resist risk factors. Family Participants did not seem to believe that they were following a relatively normal trajectory through life despite the adversity, which is a standard definition of resilience as discussed earlier:

Insanity was probably the biggest thing that kept us going through it. [laughing] You know ... just staying ... no healthy things helping us get through. P.4

The following participant recognised that coping well was adaptive up to a certain point:

I just coped. I just learned to cope well, and it was only when I hit my rock bottom, when I couldn't cope any more. P.1

These Family Participants made allowances for the individual whom they knew was still there, behind the addiction. They stayed in an unsatisfactory situation for the sake of memories of prior good times:

The reason that I stayed mainly was because I could still see this person, and I knew he had huge potential... Like we had times when it was fun. So all of that stuff, just remembering that stuff, got us through. P.1

In some cases, families turned away from the addicted individual and the resulting disruptive behaviour. Their mechanism to cope with adult life was to switch off emotionally and shut past emotions away:

I turned off. I switched off from emotion, and stuff like that. Which was good for me, because if I'd tried to go through it back then, I would have become really ... [laugh] because it was really hard. But I kind of didn't think about it at all ever. P.15

The quotation above indicates how hard it was for that Family Participant to even articulate any consequences of going through the emotions back then. The sentence was left incomplete and instead, as a displacement activity, the person laughed. That person also recognised that the coping mechanism of emotional

avoidance could be maladaptive in the long term, because it may have consequences later in life:

Because then when you come to build relationships with others, when you have no real emotions, or anything like that, it's hard to relate to people. P.15

Some family members reacted to the addiction problem by exhibiting unhealthy behaviours themselves, such as co-dependency or taking on an obsessive work ethic. One participant, in describing behaviour patterns and coping, called a sibling a workaholic:

...which you could call an addiction, I think it fits the same sort of role. P.9

These descriptions of coping and adaptive reactions are an apparent mismatch with the positive connotations of resilience as a successful engagement with life despite adversity. On looking back, one Family Participant explained that coping skills may be good for short-term survival, but are not as good in the longer term:

A lot of people come up with coping skills, growing up in a dysfunctional, addicted family, that are great at the time; they actually kept them alive, and manage to survive it, but they're not so great in adult life. P.9

### 3.2.5 Help for the addicted individual

Some participants said that help had been available for their addicted family member when it was needed. Others said that that help was available at the time but it was not accepted, because for both the addicted person and their family, members:

Denial is a wonderful thing. P.1

Family Participants described frustrations experienced when trying to get their family member into help when they, the family, wanted to:

...we tried AA [Alcoholics Anonymous]. I went with him for about a couple of months, but yeah, that didn't work either, because, you really have to know that you have a problem, to do well at AA. P.15

For some it had taken a major crisis in health status or a family ultimatum, such as the immediate family threatening to break away, for their family member to accept help for their problem:

I don't know what the turning point was but there was a very definite point at which [named brother]



realised that if he carries on the way he's going he's gonna die, um and I think that might have been when he was diagnosed with a severe liver disease. P.13

Waiting lists for entry into an addiction treatment service had meant that families experienced delays in getting help. However, for some the waiting list had given the family space to think about their circumstances and consider options.

Rules for entry for some treatment services had created barriers for some families as they tried to get the loved one some help:

There is nothing ... if they're on methadone; they're not welcome at meetings for people who are drug-free. So there's no support there, so they can't go to drug support groups. P.8.

Encouraging a family member into engagement with services had, for some families, ended, with their addicted family member declining help, time and time again:

...it's emotionally draining on you. And unless you feel that you're going to get somewhere with it, and having had the experience where you've gone to all of these organisations, counsellors, you know, everything, and you don't get anywhere, you get to the stage where you think you don't think anything works. And the reality is it doesn't. It doesn't. So I don't know where I go from here. P.16

Help sometimes had come through law and justice intervention, court enforcement, the General Practitioner (GP), following encouragement from someone else in the family. But even then, some treatments were not necessarily acceptable to the individual with addiction:

...he said that, you know, I'm never gonna go into the methadone programme because I know so many people that've gone in there and they've just killed themselves. P.13

Some of these family members had felt very emotionally engaged in the uptake of help:

...you buy into their recovery and so if they fail, you fail, and that's the problem. P.8

Making allowances had led some family members into unwanted situations:

I was so intent on saving him, I guess. I did things that were not healthy or helpful, either for [him] or for me. So I allowed myself to get dragged into all sorts of stuff that I wouldn't normally go ... where I'd not normally go at all. P.7

The period of entering treatment had caused particular problems for some. These included changes to family functioning on return, marital separation, the burden of managing alone and a:

...false sense of okayness. P.1

Some families had experienced particular frustration with the restrictions of the privacy laws and the Privacy Act, especially when seeking assistance on behalf of a young person who was no longer deemed a minor in law:

Saying 'We can't talk to you now [named relative] is 16'. just like that, cut and dried. P.16

My dad would try and ring up and say ... 'What can I do to help my son?' (and) they'd say things like 'Ooh that's confidential. We can't even tell that he's even here.' P.19

For some families their ultimate option had been to turn away and try to carry on. Sadly this could also have the effect of isolating the affected family member even more from the family unit. In the instance below, a sibling recalled the loss of a brother to the family unit:

I think the hardest thing was probably the fact that the addiction combined with the way he was treated by my father meant that he wasn't really part of the family. P.13

### 3.2.6 Help for the families

As a result of the recruitment strategy used in this project, most Family Participants had already had contact with health and social services and many had already received some help. These Family Participants could articulate the nature of the help that they received and the benefits of that help. Collectively, they had accessed many services (see Appendix 2). As mentioned earlier, the decision to recruit from health and social services was deliberate: to ensure access to psychological intervention was possible if needed. However, this recruitment strategy introduced a selection bias, and as a consequence there will be less information from and about families who were unable or unwilling to access help.

One participant said that she didn't want to seek help from her doctor because she feared that the GP would put her on anti-depressants and she knew that that wouldn't help, given her circumstances.

Participants had experienced difficulties explaining their own distress. One recalled the frustrations and dilemmas during the period before their addicted family member obtained some help with the addiction problem:

I tried to be honest with my GP and I tried to be honest with the counsellor, but the GP didn't really pick it up any depth. P.10

In retrospect these participants recognised that they needed health or social services to come forward to them, because they were not in a good position to actively seek assistance or lobby for some help:

...if you are seeking help as a family member you might need a bit of advocacy. P.10

The enormity of the situation that the family members found themselves in may have become somewhat rationalised over time as a result of obtaining some help. However, some of these families also retrospectively acknowledged that, at the time, they had minimised or denied the impact that the circumstances had on themselves:

...you know we knew we were affected by it but we didn't really accept that we actually had a problem as well. P.13 [Underlined word was participant's own emphasis.]

For extended family members who had taken over the responsibility of raising children of addicted parents, support was difficult to find. The participants who were in this situation advised that although there are government social services that provide assistance in these circumstances, they do not always succeed in doing so. These Family Participants indicated that timely, appropriate help had, at times, been lacking. They cited staff turnover and young or inexperienced officers who might seem to have interpreted institutional instructions too literally:

Case managers not equipped to deal with what they have to deal with. They follow the book. They change all the time. P.16

In particular, frustration was expressed with service delays in recognising a change of caregiver, and the

need to respond to and support the caregiver. This was attributed to excessive emphasis on client confidentiality and other institutional red-tape.

Some Family Participants in this situation had found advice and support through the organisation Grandparents Raising Grandchildren.<sup>7</sup>

### 3.2.7 Describing discomfort

Some of these Family Participants experienced and expressed emotions when recounting family events; some had become tearful during the interviews. The interactional analysis of transcripts also revealed a degree of personal discomfort for other participants. This was manifested as some long pauses and shorter, strategic hesitations in the interactions, marked dysfluencies including rephrasing, sentences that were left incomplete and clustering of utterances such as um, ur, yeah, well, sort-of and like.

Some dysfluency of this kind is to be expected in normal spontaneous conversation. However, a greater degree of dysfluency was evident not only when participants were talking directly about their family addiction-related experiences, but also when making suggestions for improvements to health and social services. Most of the extracts included in this report so far have been stripped of the dysfluencies, displaying just the actual spoken words. The following extracts are given as examples of the interactional dysfluency that had been exhibited in talk about family impacts of addiction. The three extracts below are from one Family Participant (P.15) who had become progressively dysfluent when talking about emotionally laden topics as follows:

- a. the importance of a father figure to a child:  
"Because yeah, when you're younger, and I sort of ... my dad was my world."
- b. returning to the family home as an adult:  
"now that I've left ... I left home ages ago ... like it's harder to bring yourself to go back"
- c. handling some personal issues better in recovery:  
"Yeah, to explore stuff, because yeah, I'm more alive now, and can ... yeah. Mmm."

This dysfluency can be one indication of underlying vulnerability to the topic on a personal level. It comes

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<sup>7</sup> <http://www.raisinggrandchildren.org.nz/>

to the fore when the speakers find themselves in a position where they are required to voice their own feelings as family members personally affected by addiction. The following three excerpts are all from one Family Participant (P.14) who had exhibited considerable dysfluency when talking about how addiction affected the relationship with the spouse:

...well um usually pretty good but um er as far as the addiction is concerned th- [inhales] er w- when she's – when she's having a bad time of it um it means that um [inhales] er things we could do together w- we can't really you know those sort of – communication's a bit more difficult.

Not only is communication with the spouse difficult for this particular participant, but also working life has been very much harder to plan with any certainty, as the unpredictability of addiction may cause last-minute changes:

[inhales] which means that planning for anything you know th- a- any sort of planned [inhales] things are a- are subject to not being required [inhales].

For this person, living with addiction also meant becoming a caregiver somewhat unexpectedly in midlife, not only when travelling (as outlined in another quote from this participant on page 34 of this report). This created difficulties with holding down a responsible job in a setting where the reason for caregiving could not be explained to work colleagues, as that reason (addiction) was not perceived to be socially acceptable. This interview was particularly noteworthy because this interviewee is accustomed to talking fluently for a living.

This person expressed the conflicts that the disruption of personal life had created for someone holding down a responsible job:

...something else is happening too so [inhales] I'm torn really um [inhales] between – because being in a responsible position where other people er er er you know p- a res- responsible job where people're actually relying on me and where [inhales]...

The added element of in-depth transcript analysis has provided additional insight into the emotionality and at times intense discomfort of this interviewee. The need to explain very personal dilemmas placed this participant in a very different situation, compared with the day-to-day command and control that person

usually has over conversations in the responsible work role. At work, the personal vulnerabilities of this person can and must be kept out of sight.

### 3.2.8 What would have helped

When asked what should be included in a service for families, the Family Participants echoed the thoughts of the Key Stakeholders; that obtaining information about addiction was a helpful first step. This included a need for more New Zealand-relevant information about the nature of addiction, the role that family take on during recovery, the changes family could expect and support they might need through the recovery process:

It would be nice to see some New Zealand literature... Families are treated like an add-on to the addict. They're always like an afterthought. And it would be nice to see some voices from the families. P.9

In retrospect, These Family Participants think that frank information could have assisted their interpretation of the situation. As one participant described, what most helps with this stage is:

...better quality education, and back off the scaremongering. P.12

They could also see that personal strength was needed at the time in order to do something to ease their family situation:

...the family can actually stop playing the game. P.9

These Family Participants suggested that such information and strength might come from attending self-help groups (AA, Al-Anon, Familial Trust, Rational Recovery, NA, Nar-Anon) and from reading their books and pamphlets. Information and strength might also come from undergoing counselling for depression or relationship or child development problems; counselling for addiction itself; from undertaking courses in self-esteem, self-care and assertiveness; or even, for some, from taking up professional training to later become a social worker or alcohol and drug counsellor themselves.

Several Family Participants mentioned that family residential services were lacking from amongst the current service options. This situation has worsened as the residential treatment centres were progressively restructured into day services or even closed:

...it's a pity that so many treatment centres have been closed. P.11

There once was a week-long residential programme for family members within the now discontinued Queen Mary Hospital rehabilitation programme at Hanmer Springs. This was highly regarded by those families lucky enough to use its service before the closure. That programme was considered very supportive to family members and beneficial for both the family members and for the addicted individual:

He went to Hanmer, which was probably the most amazing place, and offered the best support, but when he went there, that's when he was clean for nine months after that. P.8

In addition to the mainstream service, Queen Mary Hospital also offered a dedicated Taha Māori programme, embracing family engagement as part of best practice for Kaupapa Māori services. Family Participants mentioned that the family engagement in recovery, and also family therapy itself, were important components of the rehabilitation services offered at Queen Mary Hospital. This facet of family assistance has not been replaced.

Ashburn Hall encourages family to attend courses during the residential rehabilitation of their addicted family member. As the Ashburn Hall rehabilitation service is largely self-funded, it is not readily accessible without health insurance policies that cover family therapy as part of addiction rehabilitation. Women's refuges will offer residential care, counselling and support to women and children fleeing from addiction-related violence, but no similar service exists for men or youth who need to escape from a domestic environment made untenable by addiction. Family Participants explained that this can create particular problems for men wishing to remove their children away from violence in the family home.

These Family Participants called for better availability of family services nationwide: more family counselling, upskilling of GPs and nurses, access to psychiatrists and psychologists interested in child and family therapy and availability of residential facilities. They also asked that help from health or social services should be available in a timely fashion:

...when people go and ask for treatment, they really need it then, not in a year's time. P.12

Family case conferencing was also suggested as a way of helping families and professionals to see the multiple strands of addiction rehabilitation that need to be drawn together for a successful outcome:

...a focus on family conferencing having the relevant medical and psychological specialists attending a case conference, multidisciplinary, where the family are in attendance and ... trying to get people to realise how everyone is affected. And how things aren't as simple as here is one person with a drug addiction ... someone will want something done and you try and get people to realise that things are never that simple that it's not just doing this one thing it's the consequences of that one thing and who that who is impacted by it. P.13

Many Family Participants also emphasised the gap in mainstream service responsiveness to family, which necessitated families in distress seeking understanding and help elsewhere.

The main message from families about mainstream addiction service provision could be summed up in this quote from one participant:

Don't just focus on the addict, but the person you are asking to support the addict in recovery. p.11

### 3.2.9 Addressing the research questions

The collated information provided by Key Stakeholders, Family Participants and Informal Informants does go some way toward addressing the research questions listed earlier:

#### **What are the key issues for families?: Do the issues facing New Zealand families differ if there is a drug use, compared with an alcohol problem? If so, how does illicit drug use influence the issues, compared with alcohol?**

New Zealand families and extended whānau groupings are directly affected by the disease of addiction. It causes widespread and ongoing problems for non-addicted family members. Families experience a very similar spectrum of difficulties regardless of whether the underlying problems are alcohol- or drug-related:

I think they're just as bad... [but] ... alcohol is readily available. P.6

Behavioural addictions include eating disorder, workaholism and gambling and one participant also saw similar problems arising for families in relation to gambling:

The same things happen because of it [gambling]. I think the only thing that's different is people's perception that it's different. P.9

Non-addicted family members also reported struggling with trust after living with lying and deceit: finding difficulty in developing adult relationships, especially where the adult relationships were with adults of the same sex as the addicted parent, and self-blame and emotional unavailability of other family members.

Interestingly, only two Family Participants mentioned tobacco smoking as part of the family experience of living with addiction. During the interviews, it became apparent that some of these 'non-addicted' Family Participants were current smokers or ex-smokers. There appeared to be an incongruity in the non-report of self tobacco dependence as an addiction experience.

**What are the particular barriers that New Zealand families encounter when trying to help a family member with a drug problem, alcohol problem or problem with both?**

Families raised particular problems with knowing how to raise the issue of addiction with their loved one, finding gaps in services and also with experiences with legal and administrative barriers.

There was dilemma in knowing when and how to raise the issue of a possible problem of addiction with a family member. Some families came to expect denial, which is part of the disease spectrum of addiction, but other families also bought into the denial themselves, until the family secrets could no longer be kept hidden. Some families had not recognised the gravity of the situation until the addiction caused extreme behavioural disruption or until external agencies became involved. Families then faced delays while waiting for the addicted person to acknowledge the need for help.

The gaps in services meant that resources were not always immediately available when the addicted person was most motivated. There was a sentiment that for the affected individual help comes too late. The dual diagnosis of mental health and addictions might create an additional burden for families to bear:

...there's a gap, a huge gap. Some services won't treat mental health without treating the alcohol and drug, some alcohol and drug services won't take clients with mental health issues. So where do they go? There's nowhere. P.3

This assertion above (by participant P.3) may seem extreme, but it was reflected by Informal Informants. Dual diagnosis service provision, for both mental health and addiction, is a long-recognised gap (Todd, Sellman, & Robertson, 1999) which has yet to be resolved across the country, despite localised experiments in service reconfiguration and funding streams.

In some instances, caregivers encountered legal barriers, such as the Privacy Act, and administrative barriers, when approaching government and other health and social agencies for assistance, especially when it was for a young person no longer deemed in law to be a minor.

**What are the barriers and incentives for family members to seek and gain help for themselves?**

Family Participants and Key Stakeholders commented that at the time when families ask for services to support the addicted person, they might deny their own need for support; a view also supported by Informal Informants. In addition, the services that are available to assist affected family members are not well known and not always easy to access. Therefore help for the families is perceived to be sparse and hard to find and also difficult to access, particularly at times when families are actually motivated to seek help. Societal stigma about addiction is also evident for families who need help. That stigma is associated not only with illegal drug use, but also with alcohol abuse. It impacts directly on the non-addicted family members, giving a strong incentive to keep their problem a secret. In this way dysfunction becomes familiar and self-perpetuating, as explained earlier. In particular, these families felt vulnerable when children were involved in the family addiction experiences:

...kids need their own support. I think the kids need a place where they can work through that stuff together, and get some education about addiction, so that they don't take it on board that any of the stuff that's happened in their lives is their fault. Because that's a horrible sort of thing to carry from childhood into adulthood. P.4

### **What are the resilience factors for families (rather than individuals)?**

Resilience is an interesting theoretical concept and one that these Family Participants themselves found hard to reconcile with or attribute to their own experience. Family Participants in this study were asked about this concept using lay terms such as ‘protective’, ‘cope’ and ‘family strengths’. Participants spoke about various adaptive and non-adaptive coping strategies. The life stories told by family members in this study lacked the positive connotation of resilience, as some coping strategies had proved maladaptive in the longer term. These families lived with denial but also with hope, wanting the problem to resolve, knowing of the actual human potential of their loved one, having to deal with the behavioural disruption on a day-to-day basis but wanting to keep the problem a family secret. This generated mental and emotional strain that one participant described as “insanity in the chaos”.

For some, coping may for some have included covering up the problem or minimising it. One Family Participant described a tactic of offering excuses to save associates of the family from the discomfort of recognising the addictive behaviour:

...some of the excuses I would've given, that people would've just accepted because they want to because it's easier. P.10

Some families might alternatively prefer to be more open about the presence of addiction problems, to ensure that others understand what they are experiencing. The brave statement following does not expose any underlying personal feelings:

I've never, ever believed in hiding the fact that my son's an addict. If people ask me, I will tell them, because I think it's important that people know that addiction strikes at everyone. I think that

recognising that, that it is a constant sore, is really important. P.8

The apparent mismatch between the theoretical importance of resilience and the lack of common understanding or sense of importance placed on this concept by participants deserves further investigation. Participants did talk about coping strategies, but although these strategies may have appeared to be favourable adaptive behaviours in the short term, participants did recognise that in the long term these now appeared to them to be less protective or less favourable. Consequently, their coping strategies had not instilled in them any enduring sense of resilience. This issue is explored further in the ‘Discussion’ section of this report.

### **How do the characteristics of the health and social services contribute to the family experiences?**

These Family Participants, Key Stakeholders and Informal Informants alike indicated that families may feel most threatened and most in need of support when their loved one begins addiction treatment. In particular, the period when the addicted individual enters addiction treatment and counselling may be an especially risky period for families, uncovering problematic issues for the family group. Since recovery of an individual brings changes that can impact on family life, the family itself needs to be well prepared for change to avert new upheavals including relationship break up. In mainstream health services, the funding streams are tied to reportable outputs that drive services to focus on care of an individual, rather than take a holistic perspective on treatment. This means family support is not usually linked to individual addiction treatment. Hence, although a few exceptions such as Māori Health services are family inclusive, these families reported that they felt currently underserved by mainstream services in New Zealand.



## 4. DISCUSSION

The findings of this study are largely in accordance with international research: they verify that families play an important part in getting help for an individual (Copello, et al, 2005), but that in addition there is a need to offer help for the family themselves. This study identified that New Zealand families and whānau living with addiction can be directly and indirectly affected by the disease of the affected family member. Overseas studies suggest it can contribute to ongoing problems for the other family members. The effects on families are widespread, regardless of whether the underlying problem relates to alcohol or drugs. This was an unexpected finding. The research team expected that, due to the illicit nature of drug abuse, families living with drug abuse would experience different issues compared with families living with alcohol abuse. The impacts of addiction on family are very complex. Although the impacts of different substances appear similar, they may be different for individuals holding different roles within the family (role-specific). Some impacts could be culture-specific or situation-specific. The impacts can also be quite varied; they may be multiple and family problems may be interrelated.

Prior research experience from both the whānau support project based in Palmerston North (Severinsen, 2005) and the Wellington-based methadone and pregnancy project (Chan, 2008), indicated that members of New Zealand families do appreciate the opportunity to discuss addiction-related issues. This finding was confirmed in this study by the numbers of Informal Informants willing to discuss their experiences and perspectives. It was also confirmed by the willingness and by the generosity of Family Participants to discuss their personal and family experiences of living with addiction. One reason for this could be a lack of outlets at which there is an empathetic ear to listen to the situation of families living with addiction. For example, recent New Zealand research shows that uptake of the opportunities to discuss drug and alcohol issues with GPs does not occur as often as might be expected (Moriarty, Stubbe, & Bradford, 2009).

Silence and avoidance also fit the rule echoed by Family Participants who grew up as children in families living with addiction: “don’t talk, don’t trust, don’t feel” (Kroll, 2003). That rule, when instilled in families, allows addictive behaviour to continue unchallenged.

In addition, some family members may be at risk of co-dependent behaviour (needing to be needed). The possibility of this risk arises in the context of partners who feel obliged to take responsibility for adult spouses, and parents who continue to assume responsibility for the behaviour and recovery of their adult children, even to the extent of taking over the parenting roles from their adult children.

In this present study, the limited interactional analysis highlighted, in the manifestation of dysfluency, the unspoken difficulties in coping with emotions that may be faced by family members coping with a loved-one’s addiction (Linell & Bredmer, 1996; Markova, 1989). Management of the emotional burden may be a therapeutic approach worth exploring with families living with addiction.

Grief is a recognised part of the spectrum of co-existing disorders complicating the treatment of substance abuse for some substance users. Family issues contribute to the very chronic and debilitating grief experienced by users, and it is possible that family members living with addiction also experience unrecognised grief. A small study in America used a validated self-report instrument, the Inventory of Complicated Grief, to study complex grief in a sample of substance users (Zuckoff, et al, 2006). That study was unable to show that talking about grief improved the substance abuse, but consequently their treatment programme was modified to place an emphasis on developing skills for coping with emotionally laden situations (Zuckoff, et al, 2006).

Relationship counselling, self-esteem and assertiveness courses may have a role in helping families at the time of getting help for the addicted person. Not only does addiction counselling of an addicted individual bring up underlying issues for families, but recovery of that individual also brings changes that can impact on fitting back into family life. If the family itself is not well prepared for change, this can lead to new upheavals including relationship break up.

Good information is also important, delivered when required and appropriate to need. Key Stakeholders, Family Participants and Informal Informants alike identified issues with the lack of awareness of the nature of addiction and inadequate knowledge misinforming family expectations about addiction.

## 4.1 Families living with the impact

This project demonstrates that New Zealand families adopt a variety of adaptive and maladaptive strategies to cope with their past or present realities of living with addiction. The coping strategies identified by this project can be categorised as: minimising, making allowances, turning away, carrying on and the protective concept of resilience.

## 4.2 Minimising

Minimising allows the family members living with addiction to see it as less of a problem than it really is. The addictive behaviour may be normalised. One informant explained that growing up as children they did not regard the parent figure as alcoholic, but rationalised the heavy drinking as an acceptable behaviour. Heavy drinking was considered normal in working families where the bread-winning adults drank in binges after work and through most weekends. Early hotel closing on workday evenings in the 1960s meant that binge-drinking was, then, a predominant male drinking pattern. Women could drink at home alone and largely undiscovered. As the children of these families reached their late teens or early adulthood, this 'norm' came to be seen in a different light.

Minimising also allowed the family some denial, but this could also have the effect of postponing the day of realisation when the person living with addiction would come to see the behaviour as others did. For some families in this study that realisation occurred when a very public crisis brought to the family the double shame of addiction stigma and justice problems in a single blow.

Minimising can take many shapes. Associates of the family may, for reasons of their own, wish to accept the family minimisation at face value. Accepting the minimisation may represent the associates' hope that life really could be just as good as it is being painted. Alternately, accepting minimisation may become a means to avoid conflict in an already highly charged situation. One family member explained how minimisation can be used to save face with family associates. This makes it easier for outsiders to accept the proffered minimisation than to openly confront the gap between what is said and what is seen in reality.

The addicted person may also use minimisation as a denial tactic. Therefore, the family and associates may become unwittingly complicit with the addicted person.

Minimising or denial can have subsequent unexpected consequences. Three Informal Informants described how psychological barriers suddenly failed when they were exposed to an addiction recovery story as part of professional training. Memories of the family environment that were minimised, long repressed, but clearly not forgotten, were suddenly brought to the fore. Similarly, two participants in this project were taken aback by sudden emotionality when recounting past events during their interviews. Each had thought themselves beyond any sensitisation.

## 4.3 Making allowances

Making allowances may seem adaptive because it enables families to carry on with daily tasks and continue to interact with society. It, too, is a form of self-deception or denial where the family members may be drawn into an elaborate bluff that fools no-one but themselves. One informant explained that life just carried on until the affected parent eventually sought help with the addiction. Then the rules of family engagement changed and the attitude of family members toward that affected person moved from resentment and compensation to respect and admiration as family members became better informed about addiction. As one Family Participant also explained, making allowances can be maladaptive as it might lead other family members into unwanted situations.

## 4.4 Turning away

Turning away can be through physical relocation or emotional distancing. Partners, children or extended family living with a person with an addiction can face many destructive effects: deceit, control, manipulation, powerlessness, assault and self-neglect issues. These in themselves may or may not cause the partner, spouse, child or family member to leave the environment. It is well known that women in particular can be reluctant to remove themselves from a physically or emotionally abusive environment due to fear, manipulation, and physical or emotional restraint. This reticence may also be due to an unwillingness to accept their own inability to change the behaviour of a loved one, co-dependency, transference and other psychological vulnerabilities, not wanting to admit defeat or simply reluctance to leave their own home. Women's refuges provide residential services for families of men who are abusive because of an addiction problem, but can

only help women once they have left their partners. This can limit the reach of the service to families in strife. There is no equivalent service for male partners or extended family members of abusive women with an addiction problem. Men in that situation might feel obliged to stay on for the sake of the welfare of the woman or their children, as more than one participant clearly articulated. The decision to move away will be tempered by concerns for the unpredictability of the partner left to fend for him or herself, fears for stability of his or her mental health and the safety and custody of any children.

Children of such families face similar emotional problems including experience of living with parental dysfunction, anger and parental aggression. For children there is often no option to escape, except to run away or disengage, turning to truancy, drug and alcohol abuse or premature sexual relationships and antisocial behaviour. Indeed even if the children of these families can remain with one or more responsible parent figure, some are likely to turn to drugs and alcohol, premature sexual relationships or antisocial activity (Pilowsky, et al, 2004). That response could be seen as the child's equivalent of turning away.

Turning away may appear to be an adaptive coping strategy in the short-term but at least one participant explained how it subsequently proved maladaptive.

## 4.5 Carrying on

Those who distanced themselves from the behaviour of the addicted person, or the person themselves, attempting to carry on with their lives by setting the unpleasant experiences behind them, actively striving to show that they could manage without the influence of that addicted family member in their lives, and were strong enough to rise above any such adversity.

Carrying on in the face of family dysfunction may bring some short-term survival advantage but as participants explained, that advantage may not persist and family dysfunction could hinder individuals from successfully carrying on later in life.

For some, carrying on meant living life as if the prior experience was forgotten, although subliminally still present. Informants recalled occasions when their life path later led them back to another encounter with the estranged family member, and recounted the mixed

emotions that such a reunion could cause. Some informants expressed surprise at their reaction-anger that the family member would have the audacity to make contact after all these years and disappointment at realising that a renewed encounter or even a different life event that was reminiscent could revisit some of the hurt – but they also recognised that this sentiment was tempered with curiosity about the way that life had treated that relative, and some concern for their welfare.

Carrying on seems to be especially hard for parents of addicted children, as they continue to assume responsibility, even after the offspring have grown up and left home. For them, the feelings of grief, self-blame and guilt are commonly experienced when a child develops a substance addiction (Sayer-Jones, 2006). It is especially hard for any parent to let go when offspring do not grow up through their normal teenage and young adult years to become independent. Our study shows that letting go to carry on is particularly difficult when there is ongoing welfare concern. Grandparents may take over the nurturing role of their own adult children with addiction, including caring for grandchildren, and a partner of an addicted spouse may take on protection roles resembling parent-child interactions.

In contrast, for some, carrying on meant sharing their experiences with others in a similar predicament. Hence, many of our Informal Informants and some Key Stakeholders had also had a personal experience of living with addiction.

Many of the individuals who provided information to this project are themselves now employed in addiction-related health roles. This was an unexpected finding, but perhaps should not have come as a surprise. Addiction is common in New Zealand. Almost all families will have some experience of at least one extended family member affected by addiction. In addition, since the project was based within health and social services, active participant bias was a distinct possibility, as professionals with a personal experience of living in a family with addiction might have selectively chosen to participate. It is possible that this research project itself provided a novel outlet to help health and social professionals who were open to talking about their experiences and to explain how that past is important to them now, as professionals.

The finding does carry some implications for the development of this relatively new addiction treatment workforce. Particular considerations could be the way in which a person coped with their past experiences. Were their issues truly resolved, rather than remaining suppressed but still lying just beyond the day-to-day level of awareness? The ethical design of this project was underpinned by consideration of this very possibility of resurfacing emotions. That this theoretical possibility actually occurred reinforces the importance of maintaining a mentoring-in-role (known in counselling services as professional supervision) for the addiction treatment workforce in particular.

The New Zealand addiction treatment workforce embraces prior consumers (persons who themselves have recovered from addiction) if suitably trained, and the Drug and Alcohol Practitioners Association of Aotearoa New Zealand, DAPAANZ, recently drew up guidelines for 'time beyond recovery' at which entering training for a related health and social profession would be deemed appropriate. However, there are no guidelines for the acceptance of non-addicted individuals from a family who have lived with addiction, and it is suggested that there should be.

Professional supervision provides non-judgemental peer guidance and support, and invaluable assistance in achieving a healthy balance between clinical empathy and professional distance. In some professions, clinical psychology in particular, there is a requirement for health and social professionals themselves to receive psychological counselling, not only during training, but also counselling and psychological supervision in the professional role. Given the small and tight-knit nature of New Zealand society and the prevalence of addiction within our communities, provision of additional psychological supervision would seem to be a good safeguard to be put in place for handling any professionals' vulnerabilities. It would ensure that professionals do not risk a transfer of personal legacies to their clients. Providing professional supervision to all members of the health and social services would be useful to those with personal experience of living with addiction, providing them with appropriate support to carry on within the workforce.

#### **4.6 Protective or resilience factors**

Resilience is considered to be a key consideration that can help families withstand and rebound from

disruptive life experiences (Walsh, 2006). Resilience is fundamental to the approach of many healing agencies. Therefore it was interesting and unexpected that participants did not explain their capacity to endure adversity in a positive way. This was particularly surprising since care was taken to use lay terminology in the interview questions. Notions of coping were instead described rather negatively, such as "insanity in chaos", "putting up a brave front" and "separating the behaviour from the person". These notions seem different from the description of resilience as a positive adaptation to achieve normal trajectory under significant adversity. Participants followed the short-term survival behaviours of minimising, making allowances, turning away, carrying on. These behaviours may have seemed to be solutions to adversity at the time, but our participants recognised that they were not necessarily positive adaptation strategies, and they did not map these to any enduring sense of resilience. As discussed earlier, the literature does not address the additional area of complexity raised in this report: namely that a coping strategy that appeared adaptive or essential for survival in the short term had unfavourable consequences later in that person's life.

There was an apparent mismatch between the theoretical importance and prominence of resilience to the health and social services, and the way in which family members had described their coping strategies. There was evidence that these participants doubted their own survival being a sign of resilience. They also placed little importance on the concept. The questioning about resilience frequently took them by surprise, even though it was couched in lay terminology.

This observation raises important questions about resilience that deserve further investigation. Is this concept of family resilience well proven and truly evidence-based? Why do health and social services appear to be wedded to the idea of strengthening resilience when clients in this context (with a familial exposure to addiction) do not appear to relate to the concept at all? Is it important that clients should relate to the concept of resilience, in order to benefit from it? If so, should therapists try to better communicate the concept of resilience to their clients, so that any lack of understanding about the content does not undermine the value of the concept to the families? Is it possible that families who have experienced living with addiction

may be so hurt by that experience that they cannot perceive the actual resilience of their subsequent life trajectory? The apparent belief in the importance of resilience to health and social services and the lack of it with family clients, implies that the real importance of resilience might lie in the general concept of good outcomes despite adversity, even though these families did not often describe good outcomes.

It is acknowledged that the reality of family life is less neat and tidy than the use of the words themselves, resilient or non-resilient, seem to indicate. Resilience may exist in shades of grey rather than a black-or-white concept of it being absent or present.

'Resilience' was a term initially coined for research purposes, especially to describe the strategies employed by an individual coping with adversity. It is now largely used outside of that research context. In respect to family resilience, the meaning of the word now takes on positive connotations and refers to the characteristics of a group of people rather than an individual person. A recent New Zealand literature review identified that there was insufficient literature to adequately define whānau resilience (Moke, 2009). Despite this conflicting literature about resilience, the concept of resilience retains its importance in therapy; in particular, resilience is generally regarded as a key characteristic that helps families withstand and rebound from disruptive life experiences.

This raises the interesting question of semantics, especially the importance of ensuring that there is a shared understanding of intended meaning for commonly used words. There is recent precedence in New Zealand for taking a circumspect approach to popular semantics; being clear about what is really meant, even when there is no doubt about intrinsic value (Espiner, 2010). Perhaps the term 'resilience' became so popular within these services that its use became almost fashionable. It has become a catchphrase, meaning different things to different people. A good idea, without a good definition, becomes subject to criticism if it draws different expectations from different audiences.

The unexpected finding that the concept of family resilience was not described by participants in their accounts of their life trajectory, but rather that they had spoke of actions and feelings that did not sound particularly resilient, raises questions about the

importance of this concept to families themselves. The family member may have had what appeared to observers to be a subsequently normal life trajectory, but they still carried a sense of vulnerability and damage from the experiences of living with addiction. Judging by participants' reactions to questions about resilience, resilience is not something that a person can necessarily see while they are still grappling with daily sequelae of living with addiction. 'Resilience' is a problematic term, measured only by looking at the outcomes; a normal life trajectory despite adversity. Further studies could help to better understand family risk factors, protective factors and family resilience after the adversity of living with addiction.

#### 4.7 The Pacific voice

This project does not represent any participants' voices from New Zealand Pacific families living with addiction. This noticeable gap in the data represents an important finding as Pacific Key Stakeholders explained. For the Pacific peoples in general, addiction is an issue heavily clouded by personal and societal shame. Pacific nations live in a society in which the church plays a large part in everyday life, and also a society that is predominantly matriarchal. These guiding influences hold true not only for people still living on their ancestral lands, but also represent a deeply ingrained cultural tradition that is adhered to even by those who have moved their families to a new life in New Zealand. Many Pacific peoples choose not to drink alcohol at all, but some drink in excess (Huakau, et al, 2005). As one Pacific medical practitioner said, reporting on the 2009 Pacific Medical Association meeting in Rarotonga, routine screening for addiction in a community with a high proportion of abstainers, seems inappropriate especially if that screening also uses Pākehā screening tools (Kim Mai'a'i, personal communication, 14 August 2009). However, when addiction strikes a family member, this is seen as not only a betrayal of all that the church has taught, but also a manifestation of huge hurt in the community: the addicted person has let down everyone. In particular, this is seen as a slight on the women who take a lead societal role. In Pacific communities, addiction is not something readily talked about.

However, all this may be changing. A 2004 research project into the drinking behaviours of Samoan nationals living in New Zealand, indicated the younger

generations' attitudes toward alcohol were evolving away from that of older traditional generations. This was particularly notable where younger generations have started to assimilate New Zealand cultural ways (Lima, 2004). The evolution included increased alcohol consumption; especially the adoption of high-risk binge-drinking patterns that were more typical of non-Pacific New Zealand youth (Kypri, et al, 2009; Paschall, Grube, & Kypri, 2009).

There are six major Pacific groupings living in New Zealand: Samoan, Cook Island Māori, Niuean, Fijian, Tokelauan and Tuvaluan and hence there can be no single Pacific 'voice' in New Zealand. Each Pacific nation has its own culture, language and sense of identity, and the uniqueness of these national distinctions remains despite the intermingling and intermarriage common among sea-faring island nations. For those families now living in New Zealand, Pacific life remains very much communal and within each community there is a shared view of life, common values and common understanding of how society should function.

It is a commonly accepted generalisation: New Zealand Europeans are regarded as living more individualistic and competitive lives than Pacific peoples. Pacific peoples tend to make decisions for the benefit to the wider community over and above benefit to any individual: decisions are made collectively for the common good. For Pacific people, an individual's health problem is a communal problem and requires a community response. This finding implies a need to look carefully at service delivery models to these communities, perhaps using women as agents of change (Robinson, et al, 2006).

In recent years, dedicated Pacific Health services were established throughout New Zealand in recognition of that cultural norm. Dedicated addiction treatment services were established more recently in Auckland, where the Pacific population is most concentrated. These services operate in a very different manner from mainstream health and addiction treatment services. Evidence from anti-smoking initiatives also suggests that a family-based model works well for indigenous populations (Grigg, Waa, & Bradbrook, 2008). Therefore this may also apply to other substance-related addictions. An initiative currently underway in Auckland trains Niuean community volunteers in

alcohol issues and these trainers will then work within families. The outcome of this initiative is yet to be reported (ALAC, personal communication, date ?).

It is also recognised that reportable outcomes used to monitor the effectiveness and efficiency of mainstream health services might not apply as well to a collective model of social welfare and health (Ministry of Health, 2009).

### **Specific services seek to address the barrier to delivering viable health and social services to Pacific peoples**

A good example of this is the Taeaomanino Trust (Taeaomanino Trust) operated by the Porirua City Council. The website [www.pacificcitizen.org](http://www.pacificcitizen.org) is a recent electronic initiative to reach out to all Pacific nationals. It offers a mix of topical Pacific news items along with useful information about Pacific life in New Zealand. It includes items about addictions, in particular gambling. Web-based material is made accessible to individuals with a need who not readily convey that need to their wider community.

This consideration raises particular implications for research into Pacific peoples living in New Zealand. It is culturally inappropriate to expect any individual to present a personal opinion on the communal way of life or cultural viewpoint, especially if that opinion might be interpreted as being representative of the Pacific viewpoint in general.

For all of the reasons above, the main methodology of this project, individual interviews with affected family members and Key Stakeholders, is a methodology that is understandably less successful with recruiting members of the Pacific communities to talk about addiction. A community-based meeting, or fono, to discuss issues might be an appropriate method to explore Pacific views on certain issues. For this particular project, that approach is also problematic because for Pacific people, addiction is not a topic for free and open discussion. The need for a research framework best suited to understanding issues pertinent to the Pacific peoples in New Zealand was recognised. This is currently a topic of a PhD thesis (Lanumata, 2009). This finding also implies the need to look carefully at delivery models of addiction treatment services to these communities, perhaps using Pacific women, the community opinion leaders, as agents of change.



## 4.8 Voices from the families of the Asian countries

As with the finding for Pacific families, the voices of New Zealand families who originated from Asian subcontinent countries were underrepresented. Not all nationalities residing in New Zealand were included in the study. People of Asian descent represent a small proportion of New Zealand society. In addition, the known proportions of ethnic groups in the New Zealand population are under question, due to inherent flexibility within the Census question (Health Utilisation Research Alliance, 2006). Asian families living in New Zealand may have initially come from the Indian subcontinent or south-east Asia, or may be Chinese, Korean or Japanese. In this regard the word 'Asian' is possibly an even less unifying category than use of the term 'Pacific peoples'.

The impacts of biomedicine and culture on Asian families living with addiction deserves special mention, because addiction may take on a different profile compared with New Zealand Māori and Pākehā peoples (Wall, et al, 1997).

It is known fact that the metabolic make-up of humans differs from person to person. The impact of these differences is especially visible in the case of alcohol metabolism (Wall, et al, 1997). In some, the enzyme that metabolises alcohol and its breakdown products is very efficient, and these people are known as rapid acetylators. People with this enzyme can drink large quantities of alcohol in binges without experiencing immediate unpleasant effects from the otherwise toxic effects of the alcohol break-down products. The legendary drinking capacity of people of Irish and Scots heritage is in some measure attributable to the prevalence of rapid acetylator genes in the gene pool shared by people of those ethnic origins. In contrast, people who possess a slow acetylator enzyme cannot drink alcohol in large quantities at any one time because they feel the toxic effects of alcohol metabolites quite quickly.

Many Asian populations have higher prevalence of the slow acetylator gene (Wall, et al, 1997). Traditional medical wisdom stated that for this biological reason, Asian people could not drink alcohol to excess. Experience in New Zealand, and elsewhere in the world, shows that this is not the case. Indeed alcohol (and tobacco) addictions are common among Asian families but tend to be normalised. Slow acetylator status does not prevent drinking to excess; instead it

impacts on the pattern of drinking. In a society such as New Zealand where a drinking culture is the norm, slow acetylators can get drunk by protracted tipping rather than binge drinking. Normalising and minimising constant tipping behaviour could make the drinker just as inaccessible to his or her family as the drinker who binge drinks. This is clearly an area requiring further research.

In New Zealand, behavioural addiction (such as gambling), takes on a more prominent role in Asian society than in other cultural groupings. Problem gambling is now recognised as behaviour in the nature of addiction ([www.pgfnz.org.nz](http://www.pgfnz.org.nz)). In New Zealand the Asian community is renowned for an affinity with gambling (Adams, 2004), and problem gambling is both socially acceptable and minimised in these communities. Problem gambling fits the diagnostic criteria for addiction and is often associated with other mental health and addiction problems (Petry, Stenson, & Grant, 2005). The impact of behavioural addiction such as problem gambling is predictably somewhat different from that of substance addiction, since it will not include the physical effects of intoxication and consequent physical health sequelae (disease or disorder caused by preceding disease) of substance users. However, problem gambling can be just as destructive in respect to financial, social, legal and mental health consequences for an individual and the extended family. Asian informants to this study explained an emerging trend of more and more females engaging in gambling activities as recreation. In addition, the minimisation of a problem results in friends and families becoming aware only when a huge debt is involved.

The implications for New Zealand families living with problem gambling are another topic very deserving of future research.

## 4.9 Missing addictions

This study initially set out to interview a sample of family members selected by their experience of living with either solely alcohol addiction, solely illicit drug addiction or a combination of alcohol and drugs. This substance-based differentiation did not reflect the reality experienced by New Zealand families living with addiction. Instead, a pragmatic approach was taken of including narrative about alcohol or drug use as it was offered by the participants. This strategy resulted in an interesting mixture of stories about families living with

addiction. These families had experienced abuse of a variety of substances: alcohol; marijuana; glue sniffing; speed or methamphetamine; and opiates. There were experiences within families of individuals using a combination of substances of abuse and of multiple family members each with a different addiction. In addition to substance abuse, the behavioural addictions of gambling and workaholism were mentioned by participants.

Notably missing from this list were stories about families struggling with tobacco addiction and other forms of behavioural addiction. Nicotine addiction remains very common in New Zealand society with approximately 19 percent of the adult population still smoking (Ministry of Health, 2005). Despite intensive public health initiatives as part of the Ministry of Health's Tobacco Control Strategy, many of the residual smokers are now recalcitrant smokers who tried unsuccessfully to stop or who succeeded but then relapsed. The prevalence of smoking is known to be even higher among population groups with mental health problems and addiction. Despite this, only two participants in this project mentioned smoking addiction in the family. One participant experienced understanding from a parent who had acknowledged addiction as a result of developing tobacco-related emphysema. Given the known prevalence and links of smoking to addiction and mental health problems (Action on Smoking and Health), it is anticipated that there would be many more smokers within the extended families of our 19 participants. Some participants who were smokers did not list that as a personal addiction. This observation raises some interesting questions about the status of nicotine addiction in New Zealand society: that tobacco smoking might be regarded differently from (legal) alcohol and/or (illicit) drug use; that tobacco smoking might be so normalised within New Zealand that families do not consider it to be a real addiction. These are questions worthy of further exploration, and could in turn further an understanding of residual resistance to public health anti-smoking messages.

#### 4.10 Service responsiveness

The wide range of responsiveness to families' needs in existing addiction treatment services was cleverly demonstrated at a workshop at the 2008 national addictions conference Cutting Edge (McLean & Gledhill, 2008). Delegates created a physical line-up representing where their own service lay along the

entire spectrum of family responsiveness criteria. Health and social services range from mainstream health services in the medical model, where the focus is on an individual therapy and family are acknowledged as significant others. Mainstream services do not regard family engagement as core business. At the other extreme is a more holistic approach, seen with Pacific or marae-based services, where the underlying problems that manifest as addiction behaviour and family are both regarded as key to healing. Another model, entirely family focused therapy and support, is found in organisations working directly with families such as Al-Anon and Familial Trust, and in Kina Trust which upskills the workforce to work with families. Kina Trust launched a resource to upskill health professionals to better assess and respond to the needs of family of their addiction clients (<http://www.kinatrust.org.nz/practice-assessment.asp>).

However, health funding resources do not usually extend to family and carers. The organisations mentioned above tend to be non-government organisations funded outside of mainstream health services, through charitable trusts or even user self-funded (in the case of accessing private counselling or joining Al-Anon). Mainstream drug and alcohol services generally focus on providing care to the addicted individual client, and from the family perspective communication between mainstream agencies and the client's family is perceived as minimal. This very fact initially made it difficult to recruit family members into the study through mainstream treatment services, as services did not have established channels of communication to families of their clients. Where mainstream sessions include families, the focus often remains on the needs of the addicted person rather than the needs of the family. The therapeutic environment might not be sufficiently supportive to also benefit family members.

Family Participants in this study repeatedly called for improvement in the support and education available for such families in New Zealand. Participants identified that the prevailing need for families was education: education about the nature of addiction; the role they take on as a family member; and the changes that are needed for recovery to occur. This seems an achievable objective.

Other suggestions included nationwide availability, more services and especially residential services for family members. Residential services could cover several

models: refuge care, family therapeutic community and a holiday facility. Family involvement in residential therapy is most common in cases where the client is an adolescent (Madill Parker Research and Counselling, 2008). Queen Mary Hospital in Hanmer Springs had a family residential week, fondly remembered by some participants in this study, but that service is no longer operating. Whānau-based models of care are available through some Māori Health service providers, but these are largely outpatient family support services.

Addiction is one component of the complex logistic requirements in trying to target service delivery to the hard to reach. Persons with addiction are by definition hard to reach because denial and continuing use despite problems are characteristic of the disorder. Families living with addiction can find it hard to gain the agreement of their loved one to obtain help or might deny that they need help themselves. It is well described in New Zealand and elsewhere (Crampton, Dowell, & Woodward, 2001) that the role of addiction is a difficult piece to fit into the hard-to-reach puzzle. These families living with addiction perceived that they had been underserved by health and social services in New Zealand, especially though the lack of funding arrangements and variable family responsiveness.

#### 4.11 The protective umbrella of family

An overriding concept that arises from this project is the image of the protective umbrella role of family. When huddled under an umbrella, a group can benefit from the collective warmth and wind shelter of others as well as protection from the rain. Similarly, family members benefit collectively from the closeness of the others: caring, warmth and protection from adversity. At the risk of generalisation, and in recognition that not all Māori and Pacific families enjoy a close family unit, it is true to say that these are examples of ethnic communities who intuitively know and highly value family cohesiveness, more so than those with a culture of nuclear families.

Family members living with addiction carry the brunt of the effects: desperation, conflict, turmoil, violence, financial ruin, unemployment, missing the person they know who hides underneath the addictive behaviour and whom they still love; hoping for recovery but afraid of what additional trials that might bring. Many of these New Zealand families living with addiction described a

family unit with one or more family members left literally out in the cold, leaving the remainder emotionally chilled, socially bereft, more exposed and less protected. There is a distinct possibility that the damage brought by addiction may conversely be most hurtful for communities with cultural traditions of family cohesion. It is possible that this deserves further research. Noting the important role family play when an individual seeks help for addiction, Māori and Pacific families may be in double jeopardy when addiction strikes a family member. This is another important focus for future investigation.

#### 4.12 Limitations and gaps

As an exploratory study, this project was necessarily small and geographically restricted, as well as limited to majority ethnicities. The findings of this study cannot be generalised because of their qualitative nature. Therefore a larger and more inclusive study would be useful to expand upon the findings and identify additional important factors for New Zealand families living with addiction.

Analysis was undertaken from the perspective of clinicians and a social scientist working in and with the health services. They used their contacts to develop the data and their perspectives to interpret it. There are several important implications of this approach. In particular there is the risk of taking a predominantly bio-medical stance to try to dissect what is, in reality, a very complex and wide-reaching multidisciplinary topic with closely intermingled personal, economic and socio-cultural elements.

Recruitment of participants through health and social services carries the risk that services will have already exposed clients to counselling, health constructs and concepts that could have shaped some of their answers and perspectives. The rationale to recruit from within services proved to be justified because for several of our participants the act of participation exposed raw emotions and raised awareness of issues that were suppressed. As discussed earlier, choosing to recruit participants from within health and social services was driven by an important ethical consideration: to ensure that participants would have an accessible outlet through which to follow up on their personal reflections following the interviews. However, that strategy left a potential gap in our understanding of issues for families living with addiction, but who have not yet made contact with any of these services.

The project focused on issues for families living with addiction to alcohol and abuse of illicit substances. It was noted that only one participant discussed the experience of living with family members who were addicted to smoking tobacco. It had become evident at interviews that some Family Participants who were smokers did not regard themselves as also having an addiction. As mentioned above, this deserves further investigation to understand if and why New Zealand families regard nicotine addiction differently from other substance addiction.

Some participants had briefly mentioned the behavioural (non-substance) addictions of gambling and workaholism, but not eating disorders. A better understanding of the impact of such behavioural addictions on families is required and this is an area open for further exploration.

These families did not mention FASD but that is not surprising in a small sample. It is also possibly under-recognised as an addiction-related problem. The effects of FASD range from selective learning

difficulties and attention deficit-hyperactivity disorder, right through to the full scale Foetal Alcohol Syndrome (FAS) (Streissguth & O'Malley, 2000). FAS is often associated with low intellectual abilities (IQ around 70–85), growth deficiency, facial abnormalities and behavioural and cognitive dysfunction. These addiction-related developmental factors, especially the neuro-behavioural factors, would have the potential to add to the family stressors.

Foetal abnormalities arising from drug abuse are less well documented, and are still the subject of clinical research. This is a difficult topic to research both ethically and epidemiologically. The effects of illicit drug use on foetal health will be less common than FASD and effects could be more varied, depending on the particular substance abused. Therefore, foetal drug effects could be difficult to recognise as a discrete syndrome. A prospective clinical trial is currently underway to investigate this phenomenon (National Institute on Drug Abuse, 2009).

## 5. CONCLUSION

This project has only just begun to fill the gaps in knowledge and understanding of the actual experiences of New Zealand families living with addiction. In the process of discovery, this project identified many issues

that deserve further exploration. In particular, more work is required to better characterise the implications for clinical practice and other health and social services. More work is also required to characterise the public health and social policy and research that arises from these findings. Table 3 summarises the key findings.

**TABLE 3: Key findings**

- > The impacts of addiction on family are complex, role specific and may differ according to the culture of the people in the specific situation.
- > The impacts of addiction on family appear to be far-reaching, influencing family members beyond the nuclear family.
- > In this study, the family problems arising from substance(s) abuse were similar, regardless of substance type. Family problems can also arise from behavioural addictions and may be of a similar spectrum to alcohol and drug-related problems.
- > Family members living with addiction may experience many negative emotional and social impacts, in addition to the well-known problems of family violence, partner and child abuse.
- > Family members become good at hiding the reality of addiction within the family. They are also good at hiding the emotional and social impacts on themselves.
- > These New Zealand family members did not relate to the concept of resilience but instead reported various coping strategies.
- > Families describe survival or coping strategies such as minimising, turning away, carrying on, but recognise that these may be adaptive or maladaptive in the longer term.
- > These family members living with addiction, especially those not addicted themselves, perceive that they are not well served by the health and social services.
- > In particular, families living with addiction perceived a gap in mainstream service responsiveness to family needs, as family support is not usually linked to individual addiction treatment, and funding is usually targeted to an individual.
- > The health and social services should give greater recognition to, and help for, the emotional injury to family members, as this may be more ongoing than physical injury.
- > These families living with addiction perceived a need to improve the education and support for themselves and other families living with addiction in New Zealand.
- > There is a need to better understand addiction issues pertinent to New Zealand Pacific peoples.
- > The impact of addiction on New Zealand Asian families and families of refugees, migrants and ethnic minorities, requires further research.
- > More work is also required to explore models for delivery of addiction treatment services best suited to the needs of these communities, especially for Māori and Pacific.
- > Implications for New Zealand families living with behavioural (non-substance) addictions require further exploration.
- > More work is required to characterise the implications for clinical practice, health and social policy arising from this study.

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## APPENDIX 1: Strengths and caveats of scientific papers in the body of this report

### Enabling treatment: the CRAFT programme

The Community Reinforcement and Family Training (CRAFT) programme was developed at the University of New Mexico using a family approach to help significant others to modify both the drug-using and the treatment engagement of an unmotivated family member (Meyers, et al, 1998). The participating significant others all had a first degree relative with a known drug problem whom they wanted to help.

The CRAFT programme taught the family members techniques to use to engage their loved ones in treatment. Seventy-four percent of those who participated were able to encourage their relative to seek treatment within a six month study period.

Outcome measures included a Family Environment Scale and a Social Functioning Scale, both measured upon the report of the significant other. The Family Environment Scale explores the perceptions of family members on how things are going currently for the family and compares that with how the family environment might change in the future and the ideal aspirations of family members. The Social Functioning Scale is a scale of social adjustment that was designed for assessing families facing adversity.

A major limitation of the study was that the non-engaged addict did not report on him- or herself.

Consequently the real changes in the unobserved addict's illicit drug use and other behaviours resulting from the programme could not be fully assessed. In addition, there was a possible bias toward inclusion of the most highly motivated of family members, since only 62 (20 percent) participated out of the 303 significant others invited to do so. This research team went on to do a randomised trial of two methods of using significant others to engage their loved ones in treatment. The outcomes of the CRAFT approach compared favourably with the outcomes of the Al-Anon or Nar-Anon 12-step models of peer support by family members.

### Preventing out-of-home child placements

Mothers entering a methadone programme in Connecticut USA were interviewed about their own childhood abuse and neglect histories and the out-of-home placement of their own children (Suchman, et al, 2006). This stance was taken because parental substance abuse is the most common reason for children to be removed from parental care and placed out of their home. Outcome measures included the Addiction Severity Index and Parental Bonding Instrument.

The Addiction Severity Index (Weisner, et al, 2000) measures nine areas: medical status, employment, alcohol use and drug use (over the lifetime and in the past 90 days), legal status, family and social relationships (including satisfaction with the relationships, duration of abuse or emotional problems), survival needs, child care responsibilities and psychiatric symptoms. The interviewer/health professional is required to rate the client's needs as a result of the responses given to questions covering those items. That interviewer rating adds into a combined index score, a step that potentially can result in observer bias.

The Parental Bonding Instrument is a series of questions to the client about how he/she remembers the care and protection provided individually by the mother and father. This retrospective type of instrument may be subject to recall bias and also results can be influenced by the current mental status of the respondent, especially current mood disorders.

Given those caveats, this study revealed that cumulative risk factors acting at multiple levels influence the decision to remove a child from living with the substance-abusing parent. Mothers who perceived their own mothers as uncaring and intrusive were more likely to have lost custody of their own child (Suchman, et al, 2006). These findings were not only consistent with attachment theory predictions, but also help to explain the intergenerational family disruption that addiction can cause (Suchman, et al, 2006). The implication is that to be effective supporters of their children these family members with personal addiction may themselves need support to first overcome the intergenerational legacy that they carry.

## **An inter-agency casework programme**

The National Centre for Substance Abuse and Addiction at Colombia University developed a novel inter-agency programme called Caseworks for Families, with the primary aim to assist substance-abusing unemployed women coming off welfare (McLellan, et al, 2003). This was a three-year project designed to address the problematic compartmentalised way that services are generally offered to low-income substance-abusing women. At site level, agencies were co-ordinated rather than compartmentalised, and the project was implemented at 11 sites throughout the United States. Although there was no formal control or comparison group, a team at the Treatment Research Institute, University of Pennsylvania, performed a proof-of-concept evaluation (McLellan, et al, 2003).

Outcome measures included the Addiction Severity Index (Weisner, et al, 2000), a measure of addiction severity in nine areas: medical status, employment, alcohol use, drug use, legal status, family and social relationships, survival needs, childcare responsibilities and psychiatric symptoms. The Addiction Severity Index combines impacts on family and social functioning into a composite score, and this score improved significantly ( $p < 0.0001$ ) at both the six- and 12-month reviews. See above for potential pitfalls with use of this index score in research.

That caveat aside, the results included decline in reported drug use after the first six months. By 12 months, 46 percent of the women were self-reporting abstinence and 30 percent reported being employed.

Intuitively, some family wellbeing would benefit from maternal abstinence and subsequent employment. It is unclear how those early improvements in family and social functioning had contributed to the mother's success in achievement of sobriety and return to the workforce.

Lack of a comparison group ultimately meant that a causative link could not be proven between the favourable results and the Caseworks for Families intervention, but the authors concluded that the model of site-level co-ordination of inter-agency services delivery proved to be very appropriate for the target population (McLellan, et al, 2003).

## **Resilient children of drug users**

In 2004 a team from the School of Public Health at Colombia University, New York (Pilowsky, et al, 2004) published a study of children (aged six to 11yrs) and their parents recruited from an HIV clinic or via parental participation in a longitudinal study of the lived experience of intravenous HIV positive individuals. The paper was entitled 'Resilient Children of Injection Drug Users'. HIV services proved to be a convenient recruiting ground to find parent-child pairs living with addiction in the United States, but it has applicability problems for New Zealand where HIV positive status is uncommon, even amongst injecting drug users. In addition, in New Zealand active prenatal screening and treatment has resulted in very low HIV infection in children of infected parents. Living with HIV would have added stress to the families, additional to any stress attributable to injecting drug use itself.

The majority of the children in this study were also from single-parent families, a potential additional stressor in itself.

A large group of children who had been assessed as resilient were compared to a smaller group assessed as non-resilient. Levels of resilience were defined by scores in the Child Behaviour Checklist; a widely used measure of children's behavioural and emotional problems, which scores internalising and externalising behavioural symptoms. Intrinsic to this research methodology was an unproven assumption that the Child Behaviour Checklist could be used to differentiate resilient from non-resilient children.

The Child Behaviour Checklist is a parent-report questionnaire that scores parental observations on the child's social competence and social behaviours. This tool was not designed for research but for clinical use, in assessment of children with disorders such as hyperactivity. There are 20 social competence items asking about hobbies, friends etc, and 120 social behaviour items including emotional problems in the past six months, hyperactivity and bullying behaviours, conduct disorder, defiance and violence. Unfortunately the researchers did not corroborate information with the other (non-resident) parent of these children to verify data that had been gathered from the parent who was the injecting drug user.

The study found little difference between the resilient children and non-resilient children when assessed across a wide range of parameters such as parenting distress, dysfunctional interactions, 'difficult child' status and actual child social support. One difference between the two groups was that the parents of resilient children perceived their social support to be better. The paper also reported that resilient children's behaviour at school was superior to their non-resilient peers, but the veracity of this data was unproven since the teachers of these children were not consulted and the school functioning data were not presented.

### **Mother-infant attachment as a protective factor in families with alcoholic fathers**

Another research paper from New York State, published in 2006, looked at behaviour problems in children of alcoholic fathers specifically to ascertain if a secure mother-infant attachment was a protective factor for these children (Edwards, et al, 2006). This team used the same Child Behaviour Checklist as the paper described above (see information given above about the pitfalls of using this tool in research settings) to identify children with more internalising and externalising behaviours than their age-group norm. Children with an alcoholic father, who also had insecure mother-infant attachment at age one year, exhibited significantly more internalising and externalising behaviours than children with secure maternal attachment. This finding held regardless of paternal alcoholism status. Insecure alcoholic-exposed children behaved very differently from insecure but non-alcoholic-exposed children.

At face value the findings of this paper seem very persuasive. It is quite intuitive to believe that resilience

may have something to do with secure early maternal attachment. However, this too was a highly select group of families: all the children in this study resided with both parents and 88 percent of the parent pairs were married. Rigid selection criteria were set to control for possible factors confounding maternal attachment but this excluded many children from the study. To be included in the study, participants had to meet the following criteria: the mother had to be non-alcoholic with no maternal drug use; parents the primary care-givers; no prior mother-infant separations; the child had to be the youngest or only child; and the mother not pregnant at the time of the study. Consequently, although 13,657 families were identified with a child of an appropriate age, only 82 families with an alcoholic father were found to be suitable for inclusion. These were compared with a control group of 94 matched families with a non-alcoholic father.

In addition, the researchers took a rather selective view of addiction, carefully selecting for alcoholism in the fathers, as that was a focus of the study, but excluding alcoholism and drug use in the mothers except for 'occasional' maternal cannabis use. There was no mention of screening for, or analysis of, addiction to nicotine (cigarette smoking) in the mothers. In reality, it is likely that the confounding factors that had excluded so many children from the study would be present in the lives of most families that live with addiction. Aside from this very practical limitation, the authors acknowledged that those children who had exhibited less or more internalising and externalising behaviours than their age-norms at age 18-36 months, may not necessarily grow up with lower or greater resilience later in life. A longitudinal prospective study is required to definitively prove or refute that hypothesis.

## **APPENDIX 2: Health and social services mentioned by stakeholders, participants, informal informants**

### **Self-help groups**

- > Alcoholics Anonymous, AA
- > Al-Anon
- > Familial Trust
- > Rational Recovery
- > Narcotics Anonymous, NA

### **Peer support**

- > Grandparents Raising Grandchildren
- > Needle Exchange

### **Residential services**

- > Queen Mary, now closed
- > Odyssey House, Auckland
- > Ashburn Hall, Dunedin
- > Women's Refuges
- > Night shelters

### **Outpatient services/counselling**

- > Hanmer Clinic
- > Community Alcohol and Drugs Services, CADS
- > Mainstream GP and hospital services
- > Private therapists
- > Care NZ
- > Welltrust

### **Kaupapa Māori**

- > Ora Toa Health Services
- > Piki Kotuku, Wakapai Hauora, Palmerston North
- > Te Raupuora Health Service, Blenheim

### **Pacific-focused**

- > Teamoana Trust
- > Union Heath Services
- > Ora Toa Health Services

### **Web-based**

- > Drug Foundation
- > Pacific Citizen
- > Teamoana Trust

### **Workforce/educational**

- > Kina Trust
- > Matua Raki
- > Alcohol Advisory Council, ALAC

### **Additional services mentioned only by stakeholders**

- > Alcohol drug helpline
- > Family Court counselling

Counselling and social services available through mainstream Women's Health and Maternal Health services



## Blue Skies Research

- 1/06 *Les Familles et Whānau sans Frontières: New Zealand and transnational family obligation*, Lunt with McPherson & Browning, March 2006.
- 2/06 *Two Parents, Two Households: New Zealand data collections, language and complex parenting*, Calister & Birks, March 2006.
- 3/06 *Grandfathers – Their Changing Family Roles and Contributions*, Wilton & Davey, March 2006.
- 4/06 *Neighbourhood Environments that Support Families*, Witten, Penney, Faalau, & Jensen, May 2006.
- 5/06 *New Communication Technologies and Family Life*, Weatherall & Ramsay, May 2006.
- 6/06 *Families and Heavy Drinking: Impacts on children's wellbeing*, Systematic Review, Girling, Huakau, Casswell, & Conway, June 2005.
- 7/06 *Beyond Demography: History, ritual and families in the twenty-first century*, Pryor, June 2005.
- 8/06 *Whānau is Whānau*, Walker, Ngāti Porou, July 2006.
- 9/06 *Supervised Contact: The views of parents and staff at three Barnardos Contact Centres in the southern region of New Zealand*, Gibbs & McKenzie, August 2006.
- 10/06 *New Zealanders' Satisfaction with Family Relationships and Parenting*, Robertson, August 2006.
- 11/06 *Korean Migrant Families in Christchurch: Expectations and experiences*, Chang, Morris, & Vokes, October 2006.
- 12/06 *The Role of Whānau in the Lives of Māori with Physical Disabilities*, Collins & Hickey, September 2006.
- 13/06 *New Spaces and Possibilities: The adjustment to parenthood for new migrant mothers*, DeSouza, November 2006.
- 14/06 *New Zealand Cultural Norms of Parenting and Childcare and How These Relate to Labour Force Participation Decisions and Requirements*, McPherson, November 2006.
- 15/06 *Towards a Statistical Typology of New Zealand Households and Families: The efficacy of the family life cycle model and alternatives*, Crothers & McCormack, December 2006.
- 16/07 *The Family Court, Families and the Public Gaze*, Cheer, Caldwell, & Tully, April 2007.
- 17/07 *Fairness, Forgiveness and Families*, Evans, Yamaguchi, Raskauskas, & Harvey, April 2007.
- 18/07 *Managing Multiple Sclerosis and Motherhood: Women's stories*, Payne, McPherson, & Crerar, May 2007.
- 19/07 *Diverse Forms of Pacific Families and their Financial Decision-making Approaches*, Koloto & Katoanga, September 2007.
- 20/07 *Lifelines: Young New Zealanders imagine family, friends and relationships across their life-course*, Patterson, Peace, Campbell, & Parker, September 2007.
- 21/07 *Older Adults' Experience of Family Life: Linked lives and independent living*, Breheny & Stephens, November 2007.
- 22/08 *Whānau Socialisation Through Everyday Talk: A pilot study*, Tomlins-Jahnke & Durie, January 2008.
- 23/08 *Strengthening Rural Families: An exploration of industry transformation, community and social capital*, Goodrich & Sampson, April 2008.
- 24/08 *Grandparents in Rural Families: Young people's perspectives*, Keeling, Glasgow, & Morris, July 2008.
- 25/09 *Settling in: Parent-adolescent family dynamics in the acculturation process*, Stuart, Jose, & Ward, February 2009.
- 26/09 *Sent Home: The impact on the family of a child's exclusion from school*, Smith, March 2009.
- 27/09 *An Exploration of the Family Partnership Model in New Zealand*, Wilson & Huntington, May 2009.
- 28/09 *Who Cares for People with Schizophrenia: Family carers' health, circumstances and adjustment*, Collings, August 2009.
- 29/09 *We're a Family: A study of how lesbians and gay men are creating and maintaining family in New Zealand*, Gunn & Surtees, August 2009.
- 30/09 *Discipline in Context: Families' disciplinary practices for children aged under five*, Kirk & Hornblow, September 2009.
- 31/09 *Heart and Head: Explanation of the meaning of fatherhood*, Lawrence & Smith, November 2009.
- 32/10 *Family Food Environment: Barriers to acquiring affordable and nutritious food in New Zealand households*, Smith, Parnell, & Brown, February 2010.
- 33/10 *'Crime Families' in the News: Exploring media reports of young offenders and their families*, Beals & Van Wijk, May 2010.
- 34/10 *Being a Single Mum: Pacific Island mothers' positive experiences of parenting*, Stewart-Withers, Scheyvens, & Fairbairn-Dunlop, May 2010.

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