Summer 2009

Effects of an Educational and Support Program for Family and Friends of a Substance Abuser

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EFFECTS OF AN EDUCATIONAL AND SUPPORT PROGRAM FOR FAMILY AND FRIENDS OF A SUBSTANCE ABUSER

by

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A Dissertation Submitted to the Faculties of

The College of William and Mary
Eastern Virginia Medical School
Norfolk State University
Old Dominion University

In Partial Fulfillment of the Requirement for the Degree of

DOCTOR OF PSYCHOLOGY

CLINICAL PSYCHOLOGY

VIRGINIA CONSORTIUM PROGRAM IN CLINICAL PSYCHOLOGY
June 2009

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ABSTRACT

EFFECTS OF AN EDUCATIONAL AND SUPPORT PROGRAM FOR FAMILY AND FRIENDS OF A SUBSTANCE ABUSER

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Many family members are adversely affected by their loved ones drinking or drug problem. The aim of the present study was to explore changes in coping and enabling behaviors among family members who attended a community educational and psychosocial group for friends and family of a substance abuser, and to examine the concerns of these family members.

Participants were 32 family members (i.e., parents, spouses/romantic partners, and siblings) who attended one of four consecutive Family and Friend (FF) programs between fall and spring of 2008. Participants completed the Behavioral Enabling Scale (Rotunda & Doman, 2001) and Brief COPE Inventory (Carver, 1997) at pretreatment, posttreatment, and 30-day follow-up.

Results of a series of repeated measures ANOVAs were conducted to assess changes in enabling and coping over time. Participants reported significantly less enabling behavior from pretreatment to posttreatment and from pretreatment to 30-day follow-up. Participants also reported significant improvements on three of the Brief COPE Inventory subscales: Positive Reframing, Instrumental Support, and Behavioral Disengagement.

In addition, verbatim responses from participants were recoded and examined using a Grounded Theory Qualitative analysis of the concerns expressed in the sessions. The following four major themes were identified: 1) Behaviors in association with a loved ones substance abuse issues, 2) Ways of coping with loved one's use, 3) Feelings in association with loved one's use, and 4) Group themes reflecting thoughts about group process and mental health resources.

The qualitative information supported that family members of an active alcohol or drug abuser report the most enabling behavior around: 1) boundary setting, 2) paying their substance abusing loved one's bills, and 3) helping their loved one through a hangover or crisis. The most common coping strategies included: 1) rationalizing why the family members continued support of their loved one was necessary, 2) minimizing the loved one's addictive behavior, and 3) isolating from social support. Group themes most often reported during the sessions related to venting their frustrations and giving advice to other members especially regarding enabling behaviors.

Results indicate that a brief psychoeducational and support group such as the Friends and Family Program appears to be helpful in reducing behavioral enabling among the family members of substance abusing loved ones. Adaptive coping strategies also appear to improve with participation in this type of group over time. These results support the findings of previous literature with the family members of drug and alcohol abusers and highlight the unique concerns of parents, siblings, and romantic partners by using both qualitative and quantitative research methods.

ACKNOWLEDGMENTS

This project is dedicated to the brave family members of substance abusing loved ones. I would like to acknowledge the many wonderful people who supported me throughout this project. First I thank all the members of my committee: Michelle Kelley, Desi-Shipp Hacker, Karen White, Richard Handel, and Brian Porter. Their patience and dedication to helping me think more critically about research has contributed greatly to my professional development. A special thanks to my dissertation chair, Michelle Kelley, for her tireless efforts in supporting all aspects of this project from its design, follow-through, and finishing touches. Her zealousness for helping others in the community through research has been inspiring throughout my graduate career. I thank the many family members and friends who have supported me throughout the rigors of this project. To my husband in particular, I thank you for your patience and for being my strongest ally and role model for hope. Finally, to the clients and staff at the Community Services Board, I offer my gratitude for your willingness to collaborate on this project. A special thanks to Nora Hamel for graciously allowing me to sit in on her groups for a year. Her commitment to helping family members struggle with the pain of helping a substance abusing loved one is truly admirable. A special thanks to Dr. Jeffrey Shelton for making this project possible and for supporting our mutual research goals. It is my sincere hope that our work together can truly benefit the brave individuals who struggle with caring for substance abusing loved ones.

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INTRODUCTION

Alcoholism and Substance Abuse Disorders are serious diseases that affect the health and psychological well being of the user as well as their loved ones. According to recent estimates, substance abuse related problems account for over 220 billion American tax dollars per year (Office on Disability, 2006).

Traditionally, substance abuse has been viewed as a health concern for the alcohol or drug abuser alone. However, most substance abusers live with a family member or have at least weekly contact with a family member (Stanton & Shadish, 1997). It is estimated that every alcoholic negatively affects at least four other people (World Service Office, 2004). Specifically, over 8 million children are believed to live with at least one parent that abuses alcohol (US Department of Health and Human Services, 2005). With respect to drug use, Singleton, Bumpstead, O'Brien, Lee and Meltzer (2001) estimated that each year one million family members are affected by a close family member's drug use. As might be expected, one out of every five individuals who are drug or alcohol dependent create significant stress for family and friends (Velleman & Orford, 1999); however, this estimate does not include the effects that a parent's substance abuse may have on their children.

Family members and friends affected by a loved one's alcohol and substance abuse represent a large but under-researched population (Orford, Templeton, Patel, D, & Velleman, 2007). Although considerable research has focused on how family members influence treatment prognosis for their substance-abusing loved ones, the present study examines the concerns, coping, and enabling responses of family members and friends

(i.e., concerned significant others-CSO) and the effectiveness of a community treatment program for family members and friends of drug and alcohol abusers.

Literature Review

The present review examines the literature on current prevalence rates for substance and alcohol-related disorders. In addition, a large and growing body of literature suggests that many CSO's are affected negatively by a loved one's substance abuse (Orford et al., 2007). Therefore, the literature is reviewed on the psychological impact of a family member or friend's substance abuse on others. In particular, in an attempt to help their loved one remain abstinent, many family and friends of substance abusers manifest enabling behaviors and experience coping difficulties (Meyers & Wolfe, 2004). Thus, the literature on enabling and coping by those affected by a substance abuser is also considered. In addition, the types of treatment and effectiveness of these treatment options for CSO's of a substance abuser are reviewed. Because the present study focuses on the effectiveness of a community-based program for CSO's, the effectiveness of community-based treatments for family members is examined in detail.

Prevalence of Alcohol and Drug Abuse in the United States

Approximately 21.6 million people are estimated to abuse or be dependent on drugs or alcohol (Substance Abuse & Mental Health Services Administration [SAMSHA], 2004). Substance abuse refers to maladaptive substance use over a 12-month period, whereas substance dependence refers to the continued use of a substance despite significant problems with tolerance, withdrawal, and compulsive drug-taking behavior (American Psychiatric Association [APA] 2000). The lifetime risk for alcohol dependence is currently estimated at 5% for the general population (APA, 2000).

Estimates of illegal drug use are more difficult to obtain; however, in the National Household Survey of Drug Abuse, 8.1% of the population aged 12 yrs or older reported illicit drug use within the month prior to the survey interview (SAMSHA, 2008).

Psychological Effects of Alcoholism and Substance Abuse on the Family

Drug and alcohol disorders pose significant psychological and health concerns not only for substance abusers themselves, but for family members and friends who live with these individuals or for those who maintain close contact with a substance abuser. CSO's often report feeling excessive worry for the health and well being of the user (Orford et al., 2007), financial difficulties (Grueber & Taylor, 2006), relationship dissatisfaction (Fals-Stewart, Birchler & Kelley, 2006), lack of social support (Harden, 1998), dysfunctional family relationships (Hien & Honeyman, 2000), and child or spouse maltreatment (Howells & Orford, 2006; Kumpfer, Alvarado, & Whiteside, 2003). Moreover, in psychiatric studies on the origins of depression and anxiety, living with a drug or alcohol abuser is cited as a common factor associated with these mental health disorders (Brown & Prado, 1981; Smith, 1969). Living with a substance-abusing loved one has also been associated with long standing stress symptoms and financial strain (Orford et al., 1998).

Partners of Substance Abusers

It is important to recognize that the type of relationship to the substance abuser may be associated with the stress that the family member experiences (Orford, 1994). Partners of substance abusers often experience depression, anxiety (Meyers et al., 2002; Velleman et al., 1993), and sleep difficulties (Orford & Dalton, 2005). Moreover marital difficulties (Moos, Finney & Cronkite, 1990), financial worries (Orford, 1994), feelings

of helplessness (Andrade, Sarmah, & Chanabasuanna (1989), trauma and stress-related symptoms (e.g., Moos et al., 1990; Svenson, Forster, Woodhead, & Platt, 1995) are often reported stressors among the partners of substance abusers. In an early study on chronic stressors related to caring for a substance-abusing loved one, Bailey (1967) found that the wives of problem drinkers showed a proportional decrease in psychological and physical symptoms in relation to the time that had elapsed since separation from their husbands or their husband's recovery. In a similar study, wives of men with drinking problems reported stressors related to threats and arguments, their husband's poor health, their husband's withdrawal from family activities, and their husband's penchant towards possessiveness and jealousy (Orford, 1994).

In addition, high rates of marital distress and domestic violence occur in couples in which one partner is a substance abuser (Amato & Previti, 2003; Fals-Stewart, O'Farrell, Birchler, Cordova & Kelley, 2005). As might be expected, the divorce rate among heavy drinkers and their partners is several times greater than that of the general population (Fals-Stewart et al., 2005; Moos et al., 1990). Changing residences frequently and high levels of family conflict characterize these families and may contribute to the high rates of divorce as well (Grueber & Taylor, 2006).

Children of Substance Abusers

Approximately 1 in 4 children in the United States are exposed to family alcohol or substance abuse before the age of 18 (Grant, 2000). Children who reside with an alcohol-abusing parent are more likely to experience unpredictable home environments, low parental bonding (Kelley, 1992) and abandonment (Davis, 1994). In fact, neglect and abuse related to parental substance abuse are the leading factors related to a child's

removal from the home (Kelley, 1992). Particularly when the mother is a substance abuser, children may experience parental insensitivity to developmental needs, harsh discipline, and intolerance to age appropriate misbehavior (Hien & Honeyman, 2000). In Orford's (1994) study, children of parents with drinking problems reported family stressors that included parents' arguing and fighting, a parent as moody or critical, a parent as drunk or humiliating, and poor social life experiences. Furthermore, these stressors were described as chronic and long lasting. Specifically, children of alcoholics report that their average length of exposure to a parent's drinking is seven years (Orford et al., 2007).

Children of alcoholics also evidence higher rates of internalizing behaviors (e.g., anxiety, depression), externalizing disorders (e.g., aggression) (Moos et. al, 1990), and histories of physical and emotional abuse (Locke & Newcomb, 2004). Research examining the cumulative stress-related effects on children of substance abusers and alcoholics has found that living in close association with an addicted parent is related to a greater likelihood of sleep problems (Velleman & Orford, 1999), maladaptive attachment to romantic partners (Craig, 1993; Kelley, Cash, Grant, Miles, & Santos, 2004), anxiety and externalizing behaviors (Kelley & Fals-Stewart, 2002), psychiatric disorders (West & Prinz, 1987), and later propensities for substance abuse as an adult (Velleman, Bennet, Miller, Orford, Rigby & Todd, 1993).

Parents of Substance Abusers

Parents of children with drug problems report that their children's manipulations, stealing, running away, self-neglect, and threatening behaviors are all chronic stressors for the family (Orford, 1994). More specifically, Howells and Orford (2006) found that

parents of substance abusers often experience intense feelings of anger, frustration, and despair. In addition, many parents of children who misuse substances report feeling responsible for their substance-abusing child and have difficulty maintaining appropriate boundaries with them. Even when the substance-abusing child is an adult, parents of substance-abusing children often experience difficulty in distancing themselves emotionally and financially from their children (Orford et al., 2007). In a more recent longitudinal examination of stress among parents of problem drinkers, parents reported concern for their child's health, reduced closeness, and sleep disturbances due to their child's substance use (Orford et al., 2005). In Orford and colleagues most recent study of family members, parents reported feelings of helplessness and ambivalence in association with their child's substance abuse (Orford et al., 2007).

Enabling Behavior Versus Codependency Among Friends and Family Members of Substance Abusers

Family members and friends often respond to a loved one's drug or alcohol abuse by utilizing enabling behaviors (Rotunda, West, & O'Farrell, 2004). Enabling behaviors are actions that inadvertently perpetuate a loved one's continued drug or alcohol abuse (Meyers & Wolfe, 2004). Furthermore, these are often natural coping reactions to the stress created by the abusers' continued alcohol or drug abuse (Rychtarik, Cartensen, Alford, Schlundt, & Scott, 1988). Common types of enabling behaviors include taking over household responsibilities, buying and using drugs with the addicted loved one, and covering up drug-related incidents to other family members and friends by lying or minimizing the problem (Edwin, Yoshioka & Ager, 1996, Grueber & Taylor, 2006; Orford et al., 2007).

The terms used to describe enabling behavior, however, have been an issue of debate in the substance abuse literature (Shorkey & Rosen, 1993). The term "codependent" has been the focus of much of this controversy. Codependency is often referred to in the context of "a family disease" or a disease from birth (Rotunda & Doman, 2001). According to the codependency model, enabling results from dysfunctional family of origin patterns in which children never develop a coherent self-identity (Ackerman & Pickering, 1989). However, some researchers disagree with this view of codependency. For example, Holmila (1997) argues that codependency labels are often described by behaviors commonly exhibited by females regardless of having a substance-using partner (i.e., caretaking and empathizing with illness). As compared to men, women may be more sensitive to a family member's drinking or drug problems. Therefore, women may be over-diagnosed as codependent because enabling roles may reflect gender roles that characterize female behavior (Jackson, 1954).

In contrast to the view of the loved one as a promoter of the problem, the stress-coping model view proposes that family members and friends experience stress as a result of caring for someone that abuses alcohol and other drugs and their way of coping with this stress often manifests in the form of enabling behaviors (Orford, Rigby, Miller, Bennet, & Velleman, 1992). In contrast to the codependency model (Edwards & Steinglass, 1995), the stress-coping model proposes that the loved one is considered a victim of the stress rather than an active contributor to the drug or alcohol problem.

Regardless of which theoretical model is used as a framework for understanding the behavior of friends and family members of substance abusers, enabling behaviors are believed to be responses to a loved one's substance abuse that can be unlearned when

understood in the context of education and support (Edwin et al., 1996; Rotunda et al., 2001). Although enabling behaviors may be more common among women, male partners of substance-abusing women also engage in enabling behaviors (McCrady & Epstein, 1998). Moreover, enabling behaviors are now conceptualized as common responses in relationships with an addicted love one that may result from the overwhelming stresses incurred from loving and caring for someone with these issues (Fals-Stewart et al., 2005).

Specific Types of Enabling Behavior

Although specific enabling behaviors may vary as a function of the type of relationship to the substance abuser (i.e., partner, parent, child), the majority of research has examined spouses of alcohol-abusing men. Therefore, the literature reviewed in this section centers on the enabling behaviors of partners of substance-abusing men.

Behavioral responses to stress can take many forms and may be mediated by the loved one's relationship to the substance abuser as well as the cultural context of their interactions. In an early study of enabling behaviors among 124 wives of alcoholics, nine general coping strategies were significantly correlated with their husbands' reduced treatment success (Orford et al., 1975). These were: discord, avoidance, indulgence, competition, assertion, sexual withdrawal, fearful withdrawal, intervention, and threats of marital separation. Although wives attempted to rebalance the disharmony created by the user's behavior, Orford et al. concluded that they only succeeded in perpetuating the continued imbalance of roles.

In a more recent examination of 42 alcohol-abusing clients and their partners, the non-alcohol abusing partner reported that they often took over chores for their alcohol-abusing loved one, used drugs with the addicted loved one, and minimized the severity of

the problem to others. Partners who endorsed more enabling supportive beliefs (e.g., perceiving that their partner could not get along without their help) reported more behavioral enabling (e.g., giving their partner money to buy drugs) as measured by the Behavioral Enabling Scale (BES) (Rotunda et al., 2004).

In a similar study, Rotunda and Doman (2001) found that wives of alcohol-abusing husbands who reported enabling behaviors typically used a trial and error approach in trying to cope with their partner's alcoholism. For example, in an effort to encourage abstinence, many women would directly confront their spouse by nagging, pleading, and threatening to leave. After their initial direct attempts failed, these same women resorted to ignoring the drinking behavior, drinking with the husband, or initiating activities that would prevent the husband from drinking excessively.

Maladaptive enabling responses can increase the frequency of a loved one's continued drinking and substance abuse behavior directly (e.g., purchasing alcohol for the drinker or drinking with the user at social activities) or indirectly (e.g., cleaning up an alcohol-related mess). Furthermore, some enabling behaviors result in a return to drinking or drug abuse behavior by the substance abusers even after a period of abstinence. For example, the spouse acts in a way that frustrates the drinker (e.g., yelling) and may contribute to subsequent relapse. Alternatively, she may convince her partner not to attend a treatment session so that they can spend more time together (Yoshioka, Thomas & Ager, 1992).

Other common enabling behaviors include preparing drinks or drugs for the user, socializing with them in places where the problem behavior is likely to occur, and helping the loved one find things that are lost or destroyed as a result of the substance-

abusing behavior. In the process, other family members (e.g., children or grandparents) may be enlisted to help with these responsibilities (e.g., providing transportation). Although enabling is meant to help their loved ones, it succeeds only in reducing or eliminating the user's responsibilities in the home and aids in minimizing the consequences of the behavior of the addict (Johnson, 1990). As a result, enabling behaviors often lead to an increase in their loved one's substance use.

Although friends and family members of alcohol and drug abusers report many types of enabling behaviors (e.g., Orford et al., 2007; Rotunda et al., 2001), common forms of enabling behavior include assuming family responsibilities and roles for the substance abuser and tolerating the substance abuse.

Personal and Cultural Characteristics that May Result in Diversity in Enabling Behaviors

The nature of enabling behaviors may be mediated by the unique characteristics of the individual (Shorkey & Rosen, 1993). For instance, enabling behaviors may differ as a function of a loved one's personal and cultural characteristics (i.e., gender, sexual orientation, race/ethnicity). From a treatment perspective, recognition of the diverse ways in which enabling behaviors can manifest is essential for effective intervention. Therefore, each of these characteristics is examined below.

Gender

As noted above, women have been found to display more sensitivity and conscious awareness of a significant other's substance abuse as compared to men (Holmila, 1997). Specifically, Holmila found that as compared to men, women reported a

greater frequency of relationships with individuals who abuse substances and more negative psychological consequences associated with these relationships.

Sexual Orientation

The nature of enabling behaviors may also be affected by sexual orientation. For instance, Shorkey and Rosen (1993) found that in the case of a lesbian couple, as the recovering user pursued new activities and friendships, the partner perceived an increased sense of loss and resentment because her family of origin had rejected her due to her sexual orientation. The non-substance abusing partner reported that she experienced increasing levels of interpersonal discord with her partner and felt resistant to participation in sobriety-related activities. Although this is only one case, it highlights the need for consideration when examining non-traditional relationships in the context of substance abuse and enabling.

Cultural Diversity

Enabling behaviors may also differ within the context of a family's cultural beliefs. For example, in Mexican-American families, family cohesion and dependence on one another are often valued over individual needs (McRoy, Shorkey, & Garcia, 1985). As a result, behaviors aimed at maintaining the family unit may involve extended family members moving into the home to assume responsibilities for the substance abuser. Family members may also deny the seriousness of the substance abuse to non-family members. In addition, as compared to White families, for Mexican-American families, the cycle of caring for the substance abuser and denying the seriousness of the substance abuse may be prolonged. Again, this tendency may be the result of very close-knit families, common in Mexican-American families, in which family members prefer to rely

on internal family resources versus external supports (Dillard, 1987). For instance, a wife of an alcohol-abusing husband living in Mexico reported difficulty obtaining independence from her husband's drinking because it was not customary to leave the home without the husband's permission in Mexico (Orford, 1994). According to Medina-Mora (1994), obtaining permission from the husband or father for independent activities is common in Mexican families regardless of the male member's mental or physical state. Therefore, Mexican women in these families may perceive the decision to enter personal treatment as willfully disobeying their husband and/or cultural belief system. Moreover, disobeying her husband may create additional conflict in an already difficult situation.

The enabling behaviors of African-American families of substance abusers have been found to differ as compared to White families as well (McRoy, 1990). According to McRoy, because African-Americans often value the ability of family members to adapt to different roles, extended family members and friends may adopt new roles within the family to compensate for an active substance abuser. For example, a grandparent may take over for a substance-abusing granddaughter (e.g., help with household responsibilities or contribute financially). Although White families also engage in these same enabling behaviors, the close-knit interdependence found in many African-American family members may increase the likelihood that grandparents, siblings, and friends engage in enabling behaviors (McRoy, 1990). While the research on cultural differences in enabling behavior among friends and family of substance abusers is sparse, it is generally accepted that cultural factors may influence enabling behavior. Specifically, interdependence found among many minority families (e.g., Mexican-American and African-American) may result in differences in enabling behavior and

should be considered when making conclusions about appropriate treatment or research conclusions.

Coping Behaviors among Family Members and Friends of a Substance Abuser

The way in which a CSO copes with a loved one's substance use is also important to consider. Many researchers have found that the ways in which a CSO copes, "the cognitive and behavioral efforts to master, reduce or tolerate the internal and/or external demands that are created by the stressful interaction" (Muller & Spitz, 2003, p. 508), with a loved one's substance abuse has important psychological and health implications and may impact treatment outcomes for the substance user (Copello, Orford, Hodgson, Tober & Barrett, 2002; Orford, 1994). The CSO's process of coping may also mediate the relationship between psychological and health outcomes.

Early research on the nature of coping by Lazarus and Folkman (1984) postulated that three phases of coping often occur when an individual experiences anxiety: 1) primary appraisal of a perceived threat, 2) an evaluation of potential responses to the threat, and 3) a coping response to the threat. In the third coping phase, individuals tend to use either problem-focused or emotion-focused coping. The use of problem-focused coping involves the individual planning ahead for the stressful event, actively coping (e.g., seeking social support) and confronting the stressful event directly (e.g., confronting the substance abuser about their use).

In contrast to confronting the stressor, the use of emotion-focused coping involves efforts to reduce or manage the stress associated with the event (Carver, Scheier, Weintraub, & Kumari, 1989). According to Folkman and Lazarus (1984), the latter

approach, emotion–focused coping, is the primary strategy used when events are seen as uncontrollable as in the case of a family member's substance abuse.

Examples of emotion- and problem-focused coping can be seen in Orford et al.'s (2005) longitudinal analysis of family members of alcohol-abusing relatives. He found that the family members of a substance user often use one of three basic strategies to cope with the stress of a relative's addiction: tolerant coping, a form of emotion-focused coping that involves putting up with the stressor, standing up to the problem in an effort to regain control (e.g., problem-focused coping), and withdrawing to gain independence from the problem (e.g., emotion-focused coping). In the latter strategy, family members of the substance abuser focus on their own quality of life and distance themselves from the relative's addiction. Orford argues that family members tend to choose one of these types of coping strategies using a trial and error problem solving approach. In addition, tolerant coping (i.e., putting up with the problem) is associated with higher anxiety for these family members. Coping strategies were also characterized by consistent ambivalence over the four-year period (e.g., referring to both the positive and negative aspects of their loved one's drinking).

In Orford's (1994) earlier study of coping in family members of substance abusers in treatment, he argued that there were several advantages and disadvantages to different forms of coping. For example, emotional coping (e.g., yelling at the substance abuser), may benefit the family member by releasing emotional tension, but may also result in later feelings of guilt when the emotion has subsided. In the case of tolerant coping, conflict is avoided and a harmonious atmosphere is maintained. However, at a later time the family member may feel manipulated and angry because the conflict has not been

resolved. In the case of avoidant coping, Orford argued that the CSO may perceive a greater sense of control, but they also may perceive more isolation towards the substance user. In this same analysis, Orford demonstrated that coping by attempting to control the substance abuser (e.g., taking money away from the user) was associated with resentment when the strategy used to control the substance abuser was not effective. Inactive coping (e.g., ignoring the problem) was associated with greater independence for the CSO, but also resulted in greater reported feelings of powerlessness when the situation did not improve. Confrontive coping (e.g., telling the substance abuser to stop) was associated with effecting greater change in the user's behavior (e.g., decreased substance abuse, greater prognosis for treatment), but also resulted in a greater likelihood of alienation from the user. Supporting the substance abuser (e.g., listening to the substance abuser) had many personal advantages for the CSO (e.g., the loved one felt like they were not rejecting the substance abuser) and was more effective in influencing the substance abuser's treatment outcome. However, supportive coping was also associated with resentment if the user did not get better or confusion if the CSO did not know how much to support the user throughout treatment.

Orford and colleagues (2001) also found that ambivalence (e.g., seeing both the negative and positive aspects of a partner's drug use) and tolerance of a loved one's drinking or drug use behaviors (e.g., allowing them to use with no protest) were associated with poor physical health ratings as compared to other types of coping. Tolerant forms of coping may also be related to feelings of helplessness. A mother of a drug-abusing son explained the following, "It's a really bad life that I've got. He can walk all over me. I can't be strong enough against him." A wife of a problem drinker

stated, "I want to get away from him, but this [treatment] won't help" (Orford et al., 2007).

Across several studies (Grueber & Taylor, 2006; Orford, Natera & Davies, 1994, 1998; 2007), parents, children, and wives of alcohol-abusing loved ones commonly reported feelings of helplessness when interacting with their substance-abusing loved ones. More specifically, parents, children, and wives often believed that they could not control their loved one's excessive drug or alcohol use, and perceived the situation as hopeless. Ambivalence was another common theme identified in the literature on coping with a substance abusers' alcohol or drug use. One teenage son reported that he was indifferent to his father's drinking despite his mother's observation that her son's grades had significantly declined. Her son had also reportedly given his father money on several occasions and was spending an increasing amount of time isolating from the family (Orford et al., 2007). Similarly, in Howell and Orford's (2006) study of partners of alcoholics, CSO's reported considerable ambivalence regarding their role in the family process. Participants often reported that they did not know if they had a right to get treatment for themselves and believed that they would be betraying their partner if they sought help.

The type of coping strategy the friend or family member employs may be related to the friend or family member's attitude regarding the drug use as well. For example, in a study by Orford (1994), the sister of a drug addict reported an optimistic attitude that her brother could change and used both tolerant (e.g., ignoring) and supportive coping strategies (e.g., listening to him) in reaction to his drug use. Although she maintained a

feeling of optimism, she also reported an increase in personal health problems and sleep difficulties.

Although there has been a tendency to assert that psychological and health difficulties are common among CSO's, a friend or family member's method of coping may also be affected by their own levels of psychological distress. For example, in Orford's (1975) study of coping, self-reported experiences of depression were associated with increased escape avoidance and withdrawal coping behaviors. In a study examining alcohol-specific coping behaviors among 157 non-alcohol-abusing spouses (Love, Longabaugh, Clifford, Beattie, & Peaslee, 1993), four categories of coping behaviors were identified: enabling behaviors that occur simultaneously with the drinker's behavior (i.e., drinking with them), enabling behaviors that occur in the absence of the drinker's use (i.e., making excuses for them when they miss work), punishment related to partner's drinking (i.e., threatening to leave), and support related to the drinker's continued use (i.e., arranging social activities where drinking is present). The authors found that these types of coping behaviors greatly interfered with the effectiveness of the substance abuser's concurrent treatment.

In a seminal study, Krishman et al. examined the substance user's perception of their family member's coping (Krishman, Orford, Bradbury, Copello, & Velleman, 2001). Participants were recruited if they were living with a drug- or alcohol-abusing loved one and reported significant stress. The substance user characterized the coping of their family members as: emotional (e.g., making them feel guilty for their drug use), inactive (e.g., ignoring the problem) and avoidant (e.g., refusing to have contact with them). Emotional coping was found to be the most common and ineffective form of

support. On average, drug and alcohol users preferred supportive coping actions and tolerance when they had no intention of discontinuing their use. The authors concluded that the ideal coping strategy for family members would be supportive coping (e.g., discussing feelings) and assertive coping (e.g., showing support for the user) unless the user has no desire to discontinue use.

Although the literature on coping in friends and family member's of substance abusers highlights the diversity in which family members express and adapt to the stress of caring for a substance-abusing loved one, it is generally understood that the primary forms of coping include both problem- and emotional-focused strategies. Common examples of problem-focused coping include: active coping, planning, suppression of competing activities, restraint coping, and seeking instrumental support. Common types of emotion-focused coping include: seeking emotional support, acceptance, denial, and turning to religion as a means of coping with the family member's substance abuse (Carver et al., 1989).

The present study examined emotion- and problem-focused coping in individuals who are parents or adult children of an active alcohol or drug abuser. Because the literature is inconclusive regarding the most effective forms of emotion and problem-focused coping, and how these forms of coping may be affected by attending an educational and support program designed for loved ones of a substance abuser, the present study examined specific types of emotion and problem-oriented coping that are assessed on the Brief COPE Inventory (Carver, 1997). It was believed that as opposed to more general categories of coping (i.e., emotion-oriented or problem-solving), assessing

specific forms of coping that may be targeted and improve as a function of attending a community-based program would be more revealing.

Barriers to Treating Enabling Behavior

Barriers in treating the enabling loved one factor greatly in recovery rates for both the user and the loved one of the user. For example, a friend or family member often is unaware of their efforts to circumvent the substance abuser's progress in treatment (McCrady, 1989). Friends and family members may refuse to drive the user to medical or therapeutic appointments. The reaction may derive in large part from the increasing levels of depression or resentment associated with the user's recovery as they begin to rely less on the enabling behaviors of their family members (Shorkey & Rosen, 1993). In addition, some family members underestimate the frequency and severity of a relative's addictive behavior. In this case, family members may enable the substance abuse without acknowledging the extent of the substance abuse (Connors & Maisto, 2003).

Moreover, some partners may view the discontinuation of certain behaviors (i.e., buying alcohol for their addicted partner) as extremely disruptive to the relationship or personal feelings of well being and refuse to discontinue the behavior even when suggested by the treating clinician (Edwin, Yoshioka & Ager, 1996). Edwin et al. clarify that the enabling loved one may also fear financial distress and safety considerations at the thought of discontinuing their enabling roles. These studies also indicate that the reduction in enabling behaviors may also lead to a dramatic change in the family lifestyle. For example, the non-using spouse may no longer be able to attend parties and may be reluctant to change their behavior because they believe that they are being punished because of their partner's problem. Another barrier to treatment concerns the

defenses often associated with caring for someone who is struggling with an alcohol or drug addiction. Denying the seriousness of the loved one's addiction (e.g., "everyone gets high once in a while") and denying their own role in contributing to the loved one's behavior is common. According to early research on the issue of denial, family members and friends of substance abusers often deny the seriousness of the substance user's problem. The family member may believe that the problem will mysteriously go away or that life circumstances will intervene and mitigate the problem behavior eventually (Whitfield, 1984). In some cases, CSO's may be unaware of their enabling behaviors, or aware, but not ready for treatment. The dysfunctional cycle often begins when denial leads the substance-abusing partner to rely on the family member's tendency to deny the severity of the problem and assume additional roles to compensate for the shift in family role performance.

In Orford et al.'s (2005) analysis of relatives caring for problem drinkers, the perceived benefits of heavy drinking on the mood of the user, relaxation, and improved interpersonal relations, were reported as barriers to recovery from the majority of those sampled. Several family members reported that their relatives drinking had positive effects on the users' ability to socialize and relate in intimate ways. For example, wives reported that their husbands deserved to relax after a hard day's work. Others wives reported that their husbands were more kind and cheerful while drinking. Drinking with the family member or being heavy drinkers themselves was also reported as a barrier to their partner's recovery. Similarly, Haber (2000) found that allowing family members to drink may facilitate communication and intimacy between members in a way that is not possible when the user is sober. For example, the author explained, "family members

may become addicted to emotional crises because crises are the only route to getting in touch with and expressing otherwise repressed or suppressed feelings (p. 316)."

The role of social support may influence an enabling family member's readiness to change. According to Orford and colleagues (1998), the family member's level of social support factors greatly in their experience of stress and receptivity to treatment. In his examination of family members of substance abusers living in Mexico, England and Australia, family members did not seek social support due to feelings of loyalty to the substance abuser. Orford and colleagues also found that family members reported feeling judged by others within their social circle.

Enabling Roles a from a Family Systems Perspective

Many researchers have found that certain roles that facilitate harmony in the family or the marital relationship (e.g., cleaning up the drinker's alcohol-related mess, providing nurturance and warmth when the substance abuser has an alcohol-related illness) may be the only way in which the partner knows how to express feelings of love and concern for their partner (Meyers & Wolf, 2004). As a result of the need to show love for their partner, these behavioral roles can often circumvent the user's progress in treatment. The types of enabling behaviors that a loved one engages in are usually associated with the roles assumed by each partner. This process later becomes a function of the larger marital or family subsystem. The "Family Trap" ultimately occurs in these situations when family members become so enmeshed (e.g., emotionally reactive to the behaviors of the other member) in their roles, that they act out in dysfunctional cycles of interaction that perpetuate the continued substance abuse among the addicted family member (Wegscheider, 1976).

Family roles and maladaptive family structure within these substance-abusing families have received considerable attention in the literature. In general, particular roles within the family have been associated with poor communication regarding the problem behavior as well as poor treatment prognosis for the user (Haber, 2000). For example, a father's problem drinking may have become a part of an established family routine or ritual that now dictates the structure of the family (e.g., after work, it is mother's job to pick up beer and children's job to be quiet so father does not get upset, Steinglass, Bernett, Wolin & Reiss, 1987). Similarly, in families characterized by substance or alcohol abuse, children often take on adult roles in caring for their addicted parent at the expense of age appropriate activities (Haber, 2000). According to Stevens-Smith (1998), within the substance-abusing family, family roles serve the function of protecting the substance abuser from conflict and rejection. However, this process often results in reciprocal patterns of interaction that lead to maladaptive relational patterns. For example in Stewart and Stewart's (1993) examination of this reciprocal family process, adolescent drug use was conceptualized as a reaction to the pattern of drug use in the nuclear family and served the function of diverting attention away from the family to focus on the needs of the adolescent. The diversion in these families resulted in improved communication between the family because all the members had to work together to help the adolescent.

A review of the literature also indicated that family members of substance abusers often adopt specific roles in the family. These roles have been identified as the Dependent Personality, the Chief Enabler, Family Hero, Scapegoat, Mascot and the Lost Child (Denzin, 1993). Each role serves the purpose of providing a particular balance to the family unit. For example, "The Dependent Person" is often the substance abuser of

the family and becomes the center of attention in the family due to his or her problematic behaviors. The Chief Enabler is the one who commonly focuses on "rescuing" the substance abusing loved one and engages in behaviors that make it easier for the family member to continue using. The Family Hero is the over-achiever and workaholic. The hero has difficulty saying no and often struggles with feelings of insecurity, confusion, and guilt. Family members who adhere to the 'hero' role in the family also may struggle with addiction and dependency issues as a result of the role that they maintain within the family. According to the author, the family Scapegoat often takes the "heat" for the family and is at risk for being blamed for the source of family problems. The Mascot of the family is usually thought of as the comic relief. They will often engage in behaviors that bring laughter or distraction to a tense situation. This role is also prone to later feelings of insecurity, loneliness, and guilt. Finally, the Lost Child is often the role that is associated with a shy or quiet member of the family.

Recognition of the types of roles assumed by family members in response to one member's substance abuse may be especially important from a treatment perspective. For example, in their review of the literature on substance abuse, Grueber and Taylor (2006) argued that many treatment interventions focus on the situational episodes that bring a substance abuser and concerned family member to seek help. Knight and Simpson (1996) propose that it may be more important to understand how the substance abuse problems have created a unique family structure and how the functional characteristics of the family (e.g., roles, rules of the family, alliances) contribute to the perpetuation of the substance abuse behavior in a reciprocal manner. Although the present review examines general theoretical approaches to intervention with the family members of substance

abusers, it is generally understood by most clinical practitioners that an evaluation of family structure and role adaptation is a necessary consideration for family-based treatment (Grueber & Fleetwood, 2004).

Treatment Programs for non-Substance-Abusing Family Members and Friends of Substance Abusers

Treatment for drug and alcohol abuse has focused almost exclusively on help for the user as opposed to the family members and friends affected by their use (Meyers et al. 2002; Orford et al., 2007). Part of this neglect may be related to the professional bias towards seeing the family member as codependent and a contributor to the substance abuse problem (Orford et al., 1992). Primary health care providers may also see the situation as hopeless if the user is not interested in treatment or may lack confidence in treating family problems related to substance abuse. As a result, the family and friends of problem drinkers and drug abusers remain a large but relatively untreated population (Howells & Orford, 2006; Velleman et al., 1999).

One of the earliest treatment studies designed for family members of problem drinkers was the psychoeducational and individual therapy approach designed by Yates (1988). Treatment involved individual therapy and educational support for the family member. In the first session, family members were listened to, but the therapist did not label any enabling behaviors. In subsequent sessions, family members were given advice about ways to cope with their loved one's addiction and encouraged to tell their problem drinking loved one of their involvement in the program. The most common form of enabling reported in this study was minimization of their loved one's problem drinking. At the end of the study, family members reported that the most helpful aspect of the

intervention was validation from the therapist that their concerns for the problem drinking loved one were legitimate. Although the measure of success focused on whether or not the substance abuser initiated treatment, the CSO's reported relief and positive feelings following treatment.

Cognitive Behavioral Therapy

Although many treatment programs follow a single theoretical approach to treatment, recent studies have highlighted the importance of using diverse techniques and models in treating loved ones of substance abusers. Cognitive Behavioral Therapy (CBT) is one such technique that often incorporates the use of one or more approaches in treating substance abusers and their loved ones. Education is provided prior to implementation of the skills and collaborative goals are set between the therapist and the family member. Homework sessions follow as related to the unique agreed upon goals between the family member and therapist. CBT typically employs a short-term problem-focused approach to treatment with the underlying assumption that individuals are capable of learning and unlearning certain behaviors. The process involves identifying particular cognitions and beliefs associated with the enabling behaviors that are specific to the relationship with the substance abuser. Therefore, the overall goal of treatment is to help individuals recognize the severity of their problem, avoid behaviors that contribute to the substance abuse, and cope more adaptively (Anthony, Ledley, & Heimberg, 2005).

In a recent evaluation of CBT among family members of substance abusers, six skills were identified as particularly effective in helping family members with a substance abusing loved one. These were detaching from the problem as opposed to the substance abuser, setting boundaries appropriate to the substance abuser's developmental level (i.e.,

restricting an adult substance abuser from returning to his parents home while under the influence), showing consistency in decisions, supporting sobriety (i.e., attending 12-step program with family member), and selecting realistic goals and focusing on personal physical and mental health (Ligon, 2004).

The Community Reinforcement Technique (CRT) is a cognitive behavioral approach that focuses on treating both the substance user and the concerned significant other (Meyers & Smith, 1995). CRT teaches the significant other how to identify their unique enabling behaviors and to support behaviors that encourage abstinence in the home. Treatment typically begins with collaboration between the therapist, substance user, and family member, on agreed upon goals and behaviors of concern. Following the initial session, the substance user begins individualized treatment. The CSO is taught how to engage in non-confrontive (e.g., no nagging, pleading, or threatening) responses when faced with substance-related relationship stresses. In a recent study examining the efficacy of CRT for engaging loved ones in treatment and improved affective adjustment, loved ones were assigned to one of three groups: Community Reinforcement and Family Training (i.e., CRAFT, an enhanced version of CRT), CRAFT with aftercare support, or a 12-step Narcotics Anonymous group. The CRAFT with aftercare support group showed the greatest success in the improvement of symptoms as well as engaging the loved one in later treatment (76%) as compared to the CRAFT alone (58%) and Narcotics Anonymous (29%) conditions (Meyers, Miller, Smith, & Tonigan, 2002).

Behavioral Couples Therapy

One of the most empirically supported cognitive behavioral treatments for alcoholism and drug abuse is Behavioral Couples Therapy (BCT). BCT is a partner-

involved treatment for substance abuse that teaches skills that promote partner support for abstinence and emphasizes reduction of common relationship problems in these couples (Klostermann, Fals-Stewart, & Gorman, 2005). The rationale in using BCT with enabling significant others derives in large part from the growing recognition that substance abuse and relationship discord often mutually influence the other and contribute to the ongoing cycle of addiction (Dunn, Jacob, Hummon & Seilhamer, 1987; O'Farrell & Fals-Stewart, 2006). Furthermore, BCT recognizes that common coping strategies related to conflict avoidance with the drug abuser often reinforce psychological distress for the partner as well as the substance abuser (O'Farrell & Fals-Stewart, 2000). In BCT, significant others are taught how to reward abstinent behaviors as well as conflict resolution strategies that target enhanced relationship functioning skills.

Alternative Approaches

Unilateral Family Therapy (Yoshioka et al., 1992), Network Therapy (Galanter, 2004), the Pressures to Change Method (Barber & Crisp, 1995), and Social Behavior Network Therapy (Copello et al., 2002) are additional clinical intervention programs that emphasize treating the whole family or the partner and substance user as opposed to treating the drug or alcohol abuser alone. However, one limitation of these types of interventions is the emphasis on engaging the substance abuser in treatment and improving relationship satisfaction rather than directly treating the non-substance-abusing partner (Bowers & Al-Redha, 1990).

Community Based Programs

Although these previously described substance abuse treatment programs offer positive secondary outcomes for the family members of alcohol and drug abusers, they

tend to be expensive and not widely available (Fals-Stewart & Birchler, 2001). Moreover, because these types of programs tend to focus on the substance abuser as opposed to the family member's well being, community programs that offer psychoeducational support tend to be more common treatment options for family and friends of substance abusers. Community-based treatment programs typically offer 6-to 8-week group sessions. Sessions involve education regarding drug abuse, description of enabling strategies, and teaching coping strategies for the non-substance abusing family member, as well as referral options for individual treatment.

Alcoholics Anonymous for the non-alcohol abusing loved one (Al-Anon), counseling through primary health care professionals, and the 5-Step Approach are some of the community-based treatment interventions currently in place that have been effective with these concerned significant others. Al-Anon is one of the most common forms of treatment for loved ones of substance and alcohol abusers. Al-Anon sessions typically follow a group format that emphasizes the recognition of enabling behaviors and maladaptive coping strategies in an effort to decrease the frequency of these behaviors among participants. The goal of Al-Anon is to help the family and friend of the substance abuser stay detached from their loved one's addiction while maintaining a loving connection with them (Ablon, 1982). Al-Anon treatment also emphasizes self-esteem building and personal self-growth independent from the substance abuser's success in treatment. Although Al-Anon programs are not directed toward increased abstinence among the substance abusers themselves, they have been consistently associated with greater happiness, family cohesion, and relationship satisfaction among the family members of substance abusers (Fernandez, Begley, & Marlatt, 2006). In a

similar study, individuals who attended Al-Anon reported significantly higher levels of adaptive coping skills as compared to baseline (Rychtarik et al., 1988).

The 5-Step approach developed by Copello and colleagues (2002) is another community program that was created to help affected family members cope with the stress of a substance dependent loved one. The 5-Step approach is primarily used in health care settings. The 5-Step Approach is based on the Stress-Strain Coping Model (Orford et al., 2005) in which the family member is seen as a victim rather than a codependent contributor to the problem. Affected family members are given a 58-page self help manual and meet with a primary healthcare professional, health visitor, or practicing nurse, over multiple sessions (e.g., four sessions) or within a single session. The manual focuses on five steps: listening non-judgmentally, education about drugs or dependence, counseling on adaptive ways to cope, increasing social support, and how to consider further options for health and support. Exercises and case examples are also provided throughout the text. Positive outcomes (i.e., reductions in tolerant and engaged coping) were found both in full (n = 51) and brief (n = 92) 5-Step intervention approaches (Copello et al., 2002).

Interestingly, in the posttreatment assessment phase, only 61% of the sample reported that the intervention was favorable in improving their life situation (i.e., 64% of participants in the full treatment; 60% of participants in the brief treatment). The authors also examined qualitative data obtained during posttreatment sessions to examine ways to improve the intervention. Participants were asked to explain their unique family situation within the context of their loved one's drug use, their experience during treatment, and changes in relating to the substance-abusing loved one since the intervention. Family

members reported that they experienced improvements in talking more openly about family difficulties. In addition they reported decreases in feelings of shame and guilt, increased assertiveness, and the ability to react with less emotion to the substance-abusing loved one. When asked about perceived strengths and weaknesses of the program, participants reported a preference for professional contact and being listened to instead of told what to do.

Community programs that focus on helping family members through their primary health care providers have also become popular (Orford et al., 2007). In the Empowering Family Members and Friends via Primary Health Approach, health care workers are trained to advise a family member or friend who is closely associated to an alcohol or drug abuser. Four main goals characterize this approach: listening in an objective manner, providing educational information on the nature of substance abuse and coping, counseling about coping strategies, and encouraging support within the family. According to the authors, family members and friends who completed all aspects of the program reported improvements in being able to listen to their substance abusing loved one objectively.

In a recent study by Howells and Orford (2006), a community program designed specifically for the partners of substance-abusing relatives attended by 47 women and 3 men, showed positive results for coping, self-esteem, and substance abuse related behavior. In each intervention session, volunteer counselors were instructed to center the treatment plan on the partner rather than the substance-abusing relative. Perceived stress, accepting or sacrificing coping (i.e., giving up own needs for needs of substance abusing partner), and self-esteem significantly improved throughout the treatment. Alcohol-

abusing husbands also reduced their drinking. It is interesting to note that only three non-substance-abusing partners were males; however, Howells and Orford reported that male partners of alcohol women showed significantly less stress and 'sacrificing coping' as compared to the female partners of alcoholic men.

Psychoeducational Groups

Dittrich and Trapold's (1984) early treatment intervention program for wives of alcoholics arguably set the stage for many community programs to follow. Treatment consisted of 8 weekly sessions designed to provide psychoeducation on the disease concept of alcoholism, dysfunctional family organization, common enabling behaviors, and rational approaches to coping (i.e., dealing with the stressor directly and assertively). As compared to the control group that received a manual addressing the treatment objectives, the treatment group showed significant decreases in self-reported ratings of anxiety and enabling behaviors and increases in self-concept. Dittrich and Trapold's early study led to the development of ongoing group sessions for concerned significant others of substance abusers.

The present study examined changes in enabling and coping strategies following participation in a local psychoeducation group (i.e., the Family and Friends program). The Family and Friends program is a free local community group that offers educational materials and social support to family and friends of substance abusers. Six sessions are offered over a 6-week period. Each involves education about different aspects of drug use (e.g., symptoms of drug abuse, the addiction process, and effects of addiction on brain functioning) as well as education about how substance abuse affects family members (e.g., the development of dysfunctional family roles, enabling behaviors, and maladaptive

coping). The facilitator encourages members to help each other problem solve within the sessions (e.g., encourages members to make suggestions on how to deal with an enabling or coping difficulty that another member is experiencing). Moreover, the format of the group emphasizes the importance of loving detachment from the substance abuser and increased focus on personal well-being. The following goals are projected after completion of the six week session: 1) improvement in boundaries with a substance-abusing family member, 2) reductions in enabling behaviors (e.g., buying drugs or alcohol for the user), 3) decreased feelings of loyalty and shame, and 4) increases in adaptive coping strategies (e.g., talking about feelings, active coping, seeking social support, confrontive coping, and maintaining realistic expectations of the loved one).

Present Study

Interventions are needed to help the loved ones of substance abusers recognize and decrease their enabling behaviors and learn positive coping behaviors. Affordable treatment is often limited to revolving community groups. Therefore, it is difficult to understand the frequency of these enabling behaviors (e.g., making excuses for a substance-abusing loved one, denying the severity of a loved one's addiction) and the possible impact that these behaviors have on the well being of friends and family members of substance abusers. Furthermore, research in these settings is difficult due to the small number of participants in these programs and the high attrition rates.

The present study utilized both qualitative and quantitative methods to understand the experience and concerns of family members that took part in a six session community-based psychosocial group for friends and family members of substance abusers. Specifically, using the Grounded Theory Approach, the author examined the

self-reported concerns, needs, and behavior of individuals who participated in a voluntary community-based program for those with friends or family members with substance abuse problems. The Grounded Theory Approach involves the analysis of interactions among the target population in an effort to develop a theoretical explanation for the behavior of individuals in their group. As compared to quantitative approaches, grounded theory is derived from the existing data rather than fitting data into a preconceived theory (Hill, Thompson, & Williams, 1997). Although qualitative methods have become more widely used to study health-related experiences, few studies have used this approach in alcohol and drug treatment settings.

Hypotheses

1. The self-reported use of enabling behaviors would decline from pretreatment to posttreatment and from pretreatment to 30-day follow-up in terms of overall enabling behavior score (e.g., purchasing drugs for the alcohol or substance abuser, cleaning up alcohol or drug related messes, and changed or cancelled family plans because family member or friend was drinking, using drugs, or hung over).

2. It was expected that coping behavior would change from pretreatment to posttreatment and from pretreatment to 30-day follow-up in the following ways:

2a. Active coping strategies (e.g., active coping, planning, behavioral disengagement, seeking instrumental/emotional support, and positive reframing) would *increase* from pretreatment to posttreatment and from pretreatment to 30-day follow-up.

2b. Emotion-focused strategies (e.g., denial, venting, substance use by CSO and self blame) would *decrease* from pretreatment to posttreatment and from pretreatment to 30-day follow-up.

2c. Because acceptance of a loved use (i.e., accepting reality of loved one's addiction) and Self Distraction has been associated with positive mental health outcomes in previous studies (Carver et al., 1997; Lazarus et al., 1984), these factors were also expected to increase. No specific expectations regarding Religion and Humor were hypothesized.

In addition, using a Ground Theory Approach, qualitative data (i.e., verbatim responses from the participants as reported during the sessions) were examined for thematic content. Based on a previous study examining qualitative responses among family members of substance abusers (Orford, 2007), the following qualitative categories were expected: nature of drug/alcohol problem of the SA loved one, psychological and health issues reported by family members of substance abusers, perceived effects on the family, reactions to drug/alcohol abuse (i.e., enabling behaviors), and perceived thoughts of the user on the family's members treatment outcome. Consistent with a Grounded Theory Approach, hypotheses regarding specific themes were not formulated prior to inspection of the data.

METHODOLOGY

Participants

Participants were 33 family members/romantic partners of adults addicted to alcohol or drugs. All members were referred by the facilitator of the group through postings at a local community services board or through a personal invitation to participate. All participants volunteered to be a part of the group if they had a loved one struggling with an alcohol and/or drug abuse problem. Of these, 15 (46.9%) of the respondents were biological mothers, 5 (15.6%) were stepparents, 5 (15.6%) were spouses, 3 (9.4%) were biological fathers, 2 (6.2%) were sisters, 1 (3.1%) was a brother, and 1 (3.1%) was a girlfriend.

The participating CCSB did not allow the author to ask participant's their age, due to concern that if information were revealed, it might be possible to identify the respondent. Therefore, the author estimated the approximate age of the participant. The majority of respondents appeared to be between 36 and 55 years of age. Approximate age was categorized as follows: 2 (6.2%) were between 18-25 years of age, 3 (9.4%) were between 26 and 35 years of age, 6 (18.8%), were between 36 and 45 years of age, 12 (37.5%) were between 46 and 55 years of age, 7 (21.9%) were between 56 and 65 years of age, and 2 (6.2%) were between 66 and 75 years of age. It should be noted that in order to participate in the Friends and Family Program, all participants must have been 18 years of age or older. There were no other exclusionary criteria other than age.

Ethnicity was as follows: 27 (84.4%) were European-American and 5 (15.6%) were African-American. Demographic information on the participants is reported in Table 1.

Table 1

Demographic Information for Friends and Family Participants and their Substance-abusing Family Member

Variable	n	%
Gender		
Female	22	68.8
Male	10	31.2
Relationship of Friend and Family Member Participant		
Mother	15	46.9
Father	3	9.4
Sister	2	6.2
Brother	1	3.1
Spouse	5	15.6
Boyfriend or Girlfriend	1	3.1
Stepparent	5	15.6
Race/Ethnicity of Friend and Family Participant		
White	27	84.4
Black	5	15.6

Table 1 (continued)

	n	%
Age of Friend and Family Member Participant (in years)		
18-25	2	6.2
26-35	3	9.4
36-45	6	18.8
46-55	12	37.5
56-65	7	21.9
66-75	2	6.2
Concurrent Counseling Attended by Friend and Family Participants		
Al-Anon	1	3.1
Nar-Anon	1	3.1
Faith Based	3	9.4
Other (e.g. psychologist)	1	3.1
None	26	62.5

Table 1 (continued)

	n	%
Past Counseling Attended by Friend and Family		
Participants		
Al-Anon	3	9.4
Faith Based	4	12.5
Other	5	15.6
None	20	62.5
Number of Sessions Attended by Friend and Family Participants		
1	0	0
2	1	3.1
3	1	3.1
4	7	21.9
5	12	37.5
6	11	34.4

Table 1 (continued)

	n	%
How Long Family or Friend Participant has Experienced		
Distress from Loved One's Substance Abuse		
Less than 1 year	9	28.1
1-2 years	5	15.6
3-5 years	5	15.6
6-10 years	4	12.5
11-15 years	3	9.4
Over 15 years	5	15.6
Missing	1	3.1

Table 1 (continued)

	n	%
Type of Alcohol/Drug by Substance Abuser		
Cocaine/Crack	10	32.2
Alcohol	8	25.0
Polydrug Use	5	15.6
Heroin	4	12.5
Speed	2	6.2
Missing	3	9.4
Comorbidity in Substance Abuser		
Depressive Disorder	10	31.2
ADHD	8	25.0
Two or More Axis I Disorder	5	15.6
Bipolar	3	9.4
Anxiety Related Disorder	2	6.2
Schizophrenia	1	3.1
Eating Disorder	1	3.1

The Friends and Family Program is a free voluntary, one evening per week, 6-week psychoeducational and support program offered for adult men and women who are family members or friends of individuals who misuse alcohol or other drugs. The purpose of the program is to educate adults who have a family member or friend that actively abuses substances. Specifically, the program educates the participants about addiction, enabling behaviors, and coping behaviors. The substance user does not take part in this program; rather, this program is for Concerned Significant Others (CSOs) that may be affected by addiction.

Similar to other community programs, the Friends and Family Program is designed to be small. Therefore, in the planning stages of the study, it was determined that data collection would take place during consecutive programs until a sufficient number of participants (approximately 30) were obtained. A total of 32 participants took part in this study. All participants took part in one of four Friends and Family Program that took place in the fall of 2007 or spring of 2008. There were 12 participants in Group one, 7 participants in Group two, 6 participants in Group three and 8 participants in Group four.

Measures

Behavioral Enabling Scale. The Behavioral Enabling Scale (BES; Rotunda & Doman, 2001) was developed to assess specific enabling behaviors among the partners of substance dependent clients. The BES is comprised of two 20-item scales: the Enabling Behaviors subscale and the Enabling Beliefs subscale. Items were generated from the Dr. Rotunda's clinical experience and combined with items from Dittrich and Trapold's (1984) Enabling Behaviors Inventory. Due to time limitations regarding the length of

survey administration imposed by the participating CCSB, only the 20 items that assessed Enabling behaviors were administered.

Behavioral items reflect behaviors as opposed to cognitions associated with their loved one's substance abusing behavior (e.g., "I assured my family member or friend that his/her drug use wasn't that bad," "I gave my family member or friend money to buy alcohol or drugs"). Response codes are as follows: 0=not at all, 1=rarely, 2=sometimes, 3=often, 4=very often, 0=Not Applicable. The sum of the items equals the BES total score, with higher scores indicating higher levels of behavioral enabling. For the present study, the items were slightly modified with permission from the author to reflect that the non-substance-abusing individual could be a spouse, family member, or friend.

Reliability analyses for this subscale in Rotunda's (2004) study were adequate for alcoholic clients ($\alpha = .77$) and their partners ($\alpha = .81$). No additional reliability or validity data is available for this scale at the present time. Internal consistency for the present study is reported in Table 2

Brief COPE Inventory. The Brief COPE Inventory, developed by Carver (1997), is an abbreviated version of the COPE Inventory (Carver et al., 1989). The Brief COPE Inventory is based on Lazarus' 1984 transactional model of stress. The original COPE Inventory and Brief COPE Inventory are both used for populations that are currently experiencing severe stress. However, the Brief COPE Inventory uses a shorter item set, 28 items as opposed to 60 items. The abbreviated form of the COPE was administered in the present study due to the limited time available for survey administration. The 28-item Brief COPE Inventory assesses 14 factors that measure different ways that individuals cope with stress. Carver's (1993) study describes each factor as follows: Active Coping

(i.e., taking action to remove the stressor or reduce its effects, α = .68), Planning (i.e., thinking about how to cope with a stressor, α = .73), Positive Reframing (i.e., reexamining the stressor in a positive way, α = .64), Acceptance (i.e., learning to live with the reality of the stressor, α = .57), Humor (i.e., making jokes about the situation, α = .73), Religion (i.e., finding comfort in religion, α = .82), Using Emotional Support (i.e., getting support, sympathy and empathy from others, α = .71), Using Instrumental Support (i.e., seeking help or advice from others, α = .64), Self-distraction (i.e., doing activities to take mind off stressor, α = .71), Denial (i.e., refusing to believe the reality of the stressor, α =. 54), Venting (i.e., expressing negative feelings, α = .50), Substance Abuse (i.e., using alcohol or drugs to cope with stressor, α = .90), Behavioral Disengagement (i.e., reducing one's effort to deal with the stressor, α = .65) and Self-blame (i.e., assuming cause or responsibility for the stressor, α = .69). These reliability estimates were derived from the original study validated with hurricane survivors (Carver, 1997).

The original COPE Inventory has been shown to have adequate factorial validity and internal consistency on most of the 14 scales; however, Carver's (1997) previous findings with the Brief Cope show low internal consistency for two of the scales (i.e., Venting α = .50; Acceptance α = .57, Carver & Scheier, 1993; Carver, Scheier & Pozo, 1992; Vitaliano, Russo, Carr, Maiuro & Becker, 1985). Participants rate the frequency in which they endorse these strategies on a four point scale from: 1) not at all, to 4) doing a lot. These factors can also be represented by two conceptual categories: Problem focused: active coping, planning, and seeking instrumental support. Emotion focused strategies include: positive reframing, acceptance, humor, turning to religion, using emotional support, self distraction, denial, venting, substance abuse, and self blame. To obtain the

total score for each of the 14 factors, the two item scores for each factor were summed.

Procedure

The consent process was two-part. First, the potential participant indicated whether they would allow the investigator to record by hand (i.e., the qualitative portion of the study) what was said during the sessions. All 32 group members consented to allowing the author to recode the comments and questions by hand. The second part of the consent process involved specifically consenting to completing the quantitative portion of the study which involved completing two study measures (i.e., BES and Brief COPE Inventory) at pretreatment, posttreatment, and 30-day follow-up. One group member did not consent to participating in the quantitative portion of the study.

The present study involved two types of assessment: 1) qualitative analysis of the concerns, needs, and behavior reported during the Friends and Family Program sessions, and 2) quantitative analyses of enabling and coping behaviors as reported by the participants. The questionnaires are as follows: informed consent (See Appendices A & B), Permission to attend group (see Appendix C), Demographic Survey (see Appendix D), Pre-Post Educational Survey (see Appendix E), Brief COPE Inventory (Carver, 1997; see Appendix F), Behavioral Enabling Scale (Rotunda et al., 2001; see Appendix G) and the Follow-up Contact form in order to get in touch with the participant at the 30-day follow-up (see Appendix H). All quantitative measures were completed in person during the scheduled meeting time of the group (see Appendix H).

At the first session, all group members signed a consent form that allowed the author to observe the meetings and record by hand the topics discussed (see Appendix A, Informed Consent). In addition to the consent that allowed the author to recode verbatim

all concerns mentioned during the sessions, the participants signed a second consent form for the quantitative portion of the study.

The qualitative aspect of the study involved observing and recording by hand the concerns, needs, and behaviors reported by the participants. The relationship to the substance user and any relationships between group members were noted. In addition, the author noted the participant's gender, approximate age, and ethnicity. Also, the type of substance abused by the drug or alcohol-abusing family member was recorded (e.g., heroin, crack, alcohol).

The sessions took place in a small comfortable room at the participating CSB. Members sat around a large table. The author sat in during the weekly sessions and recorded participant responses verbatim. In order to develop a more accurate record of respondents' comments verbatim, the author developed a sitting chart. The position of the respondents was outlined on a grid at the top of each note sheet. Participants were assigned a number that represented the individual's sitting position. The date of the session was recorded at the top of each note sheet. Personal characteristics of the participants were also noted for each group member (e.g., male, mid-50s, alcohol-abusing daughter) to increase the accuracy of recording.

The information recorded by the author was analyzed for thematic content following the last scheduled group for the study (i.e., approximately May, 2008). A Grounded Theory Approach (Hill et al., 1997) was utilized to develop themes and sub-themes that reflected the concerns, needs, and behaviors reported by the program participants. To generate common themes and general categories within the data, the author read over each of the statements. General categories and interrelationships were

identified within the recorded statements based on review of the literature. Because data were collected from four consecutive separate groups over the course of eight months, the author and her dissertation advisor continued to review data from later groups and early codes were modified as needed. This initial review provided the template for a coding framework that covered the main four categories observed in the data: behavioral enabling, coping responses, feelings, and process themes related to group. After all the interviews were reviewed and themes and sub-themes were identified by the author and dissertation advisor, a graduate student blind to the study was trained to criterion (i.e., 90%) to recognize categories using sample responses (e.g., similar, but not actual responses from the qualitative data). Following the coding of the data, 25% of the statements were randomly selected and coded for reliability by a second graduate student blind to the study. Periodic retraining sessions were provided to prevent drift and resolve discrepancies. Because data were collected from four samples, 80% interrater reliability was established between the primary and secondary coder for each of the qualitative categories. The author resolved occasional discrepancies between the primary and secondary coder.

Quantitative analysis involved examination of the participants' responses to the Behavioral Enabling subscale and the Brief COPE Inventory over three time points (i.e., pretreatment, posttreatment, and 30-day follow-up). Prior to participating in this portion of the study, the participants signed an Informed Consent Form (see Appendix A). Participants who choose to participate in the quantitative portion of the study were asked to fill out the following measures: The Brief COPE Inventory (Carver, 1997-see Appendix F) and The Behavioral Enabling Scale (modified: Rotunda et al., 2004 see

Appendix G). Participants were asked to complete the measures at: 1) pretreatment (initial group session/first of six sessions), 2) posttreatment (at the end of the last session [sixth session] meeting), and 30-day follow-up.

At the last session (i.e., posttreatment assessment), the author asked the participants whether they would like to be mailed the follow-up questionnaires or, if they would prefer to respond to the follow-up questionnaires during a phone call with the author (see Appendix H). Five participants said they would prefer to complete the follow-up by telephone. These 5 participants completed the 30-day follow-up questions by telephone. All others were mailed the 30-day follow-up and returned the questionnaires to the author by mail. Participants recorded only their initials on the quantitative information. A master list linking the initials to the full names and mailing of the clients were kept on CCSB premises in a locked office.

If the same member was in more than one group, their data was only counted once. This happened one time with the mother of a substance abusing daughter who wanted to attend two of the FF groups. The payment schedule for individuals who participated in all three phases of the quantitative assessments was as follows: one $10 dollar Walmart gift card per individual who completed assessment at pretreatment, posttreatment, and 30-day follow-up. Participants must have completed all three-assessment phases (pretreatment, posttreatment, and 30- day follow-up) to receive the gift card.

Participants were clearly informed of the limits of this confidentiality, which are in cases of suspected child abuse or neglect, and harm to self or others. No such incidents were reported during the groups; however, the group facilitator was a mandated reporter

in the State of Virginia and was available in the case that the primary researcher was informed of, or discovered, suspected child abuse.

Analyses

To address the hypothesis that behavioral responses and coping would change over time, ANOVAs with follow-up trend analyses were conducted. Specifically, within-subject ANOVAs with time as the independent variable and enabling behavior and coping scores served as the dependent variables.

RESULTS

Preliminary Analyses

Prior to hypothesis testing, the data were checked for missing values and outliers. Missing data were checked for by inspecting the completion of each study packet. Of the 32 participating respondents, 3 respondents had missing data for no more than 33% of their responses (i.e. at least 1/3 of the packet was incomplete). Their data was included in the ANOVA's by imputing the mean of the remaining items. Two of these respondents had data missing for the Brief COPE Inventory. One respondent had an incomplete BES packet. For example, this respondent skipped three items on the BES. The missing item scores were imputed with the subject's mean for the remaining completed BES items. After replacing missing data for these three respondents, scores were then tested for linearity, skew, and kurtosis. No outliers, skewness, or kurtosis was observed.

Internal consistencies were calculated for all subscales and are reported in Table 2. The Behavioral Enabling Scale demonstrated adequate internal consistency. Five of the subscale scores from the Brief Cope Inventory had poor reliability. These were: Substance Abuse (range of αs: = .54 - .77); Venting (range of αs = .30 - .63); Acceptance (range of αs = .48 - .57); Active Coping (range of αs = .37 - .52); and Self-Distraction (range of αs= .40 - 47). With the exception of the subscales of Venting and Acceptance, the αs reported in the present study are similar to those reported by Carver (1997). Due to the low reliability of some of the Brief COPE Inventory scores, data from the following five Brief COPE Inventory were not examined: Substance Abuse, Venting, Acceptance, Active Coping, and Self-Distraction.

The dependent variables for these analyses were family member reports on the following subscales from the Brief COPE Inventory: Positive Reframing, Religion,

Humor, Instrumental Support, Behavioral Disengagement, Self Blame, Denial, Emotional Support, and Planning. Only differences observed at a .05 alpha were reported as significant. Although there are 14 Brief COPE scales, five scales were excluded due to low internal consistency (i.e. Substance Abuse, Venting, Acceptance, Active Coping, and Self-Distraction)

Correlational Analyses

A series of Pearson product-moment correlations were conducted to examine correlations between the Behavioral Enabling Subscale scores and the Brief COPE subscale scores for each data assessment time (i.e., Pretreatment, Posttreatment, and 1-month follow-up). As shown in Table 3, at pretreatment, the following significant positive correlations were observed: Self Blame was significantly positively correlated with Behavioral Enabling scores, r (31) = .39, $p < .05$, Substance Abuse, r (31) = .37, $p < .05$, and Denial, r (31) = .47, $p < .01$. Instrumental Support was significantly positively correlated with Venting, r (31) = .44, $p < .01$. Emotional Support was significantly positively correlated with Religion, r (31) = .39, $p < .05$, Instrumental Support, r (31) = .66, $p < .01$, and Planning, r (31) = .35, $p < .05$. In addition, as might be expected, the use of Denial as a coping mechanism was significantly negatively correlated with Behavioral Disengagement, r (31) = -.46, $p < .01$ and Acceptance, r (31) = -.46, $p < .05$. However, contrary to what would be expected, Planning was significantly negatively correlated with Behavioral Disengagement, r (31) = -.41, $p < .01$.

As reported in Table 4, at posttreatment, the following significant positive correlations were observed: Humor was significantly positively correlated with Venting, r (31) = .47, $p < .01$. Instrumental Support was significantly positively correlated with.

Table 2

Means, Standard Deviations and Alphas for Behavioral Enabling Inventory and Brief COPE Inventory Subscale Scores at Pretreatment, Posttreatment and 30- day Follow-up

Variable	Pretreatment (T1) *M (SD)*	Posttreatment (T2) *M (SD)*	30-day Follow-up (T3)*M (SD)*	T1 (α)	T2 (α)	T3 (α)
BES	27.84 (9.92)	18.59 (9.32)	18.16 (10.03)	.78	.77	.86
COPE						
Positive Reframing	03.75 (1.58)	04.69 (1.62)	04.66 (1.58)	.60	.76	.62
Religion	05.38 (2.10)	05.66 (1.99)	06.06 (1.79)	.84	.94	.74
Substance Abuse	03.25 (1.59)	03.06 (1.41)	03.41 (1.56)	.77	.65	.54
Venting	05.10 (1.74)	04.75 (1.57)	05.00 (1.87)	.30	.53	.63
Humor	03.16 (1.65)	03.22 (1.31)	03.72 (1.37)	.69	.59	.90
Instrumental Support	04.75 (1.68)	05.09 (1.73)	05.56 (1.90)	.63	.68	.66
Acceptance	05.47 (1.32)	05.88 (1.60)	06.38 (1.43)	.48	.57	.50
Active Coping	06.13 (1.34)	06.00 (1.41)	05.63 (1.56)	.37	.52	.36
Behavioral Disengagement	03.47 (1.54)	03.47 (1.34)	04.22 (1.86)	.63	.80	.62

Table 2 (continued)

Variable	Pretreatment (T1) *M (SD)*	Posttreatment (T2) *M (SD)*	1-mo-Follow-up (T3) *M (SD)*	T1 (α)	T2 (α)	T3 (α)
Self-Blame	4.22 (1.88)	3.94 (1.74)	4.09 (1.61)	.72	.70	.78
Denial	3.41 (1.79)	3.53 (1.80)	3.72 (1.73)	.83	.86	.80
Self-Distraction	4.88 (1.48)	5.22 (1.71)	4.75 (1.68)	.44	.47	.40
Emotional Support	4.98 (1.97)	4.91 (1.87)	4.95 (1.57)	.73	.80	.79
Planning	5.91 (1.63)	5.59 (1.79)	5.56 (1.79)	.62	.63	.75

Note: Brief Cope Inventory subscale scores ranged from 2 to 8 and were derived from two summed item scores per subscale. Items were rated from (1) I haven't been doing this at all, to (4) I've been doing this a lot. Total Behavioral Enabling Scales Scores ranged from (0) Not at all to (4) = Very Often.

Religion, r (31) = .49, $p < .01$, Venting, r (31) = .50, $p < .01$, Emotional Support, r (31) = .77, $p < .01$, and Planning, r (31) = .55, $p < .01$. Acceptance was correlated with Positive Reframing, r (31) = .53, $p < .01$, Venting, r (31) = .45, $p < .01$, Instrumental Support, r (31) = .56, $p < .01$, Self-Distraction, r (31) = .50, $p < .01$, Emotional Support,r (31) = .48, $p < .01$, and Planning, r (31) = .48, $p < .01$. Behavioral Disengagement was significantly positively correlated with Humor, r (31) = .47, $p < .01$, and Venting, r (31) = .49, $p < .05$. Self Blame was significantly positively correlated with Substance Abuse, r (31) = .50, $p < .01$, and Denial, r (31) = .41, $p < .05$. Denial was significantly positively correlated with Substance Abuse, r (31) = .57, $p < .01$. Self-Distraction was significantly positively correlated with Positive Reframing, r (31) = .40, $p < .05$, Venting, r (31) = .55, $p < .01$, Acceptance, r (31) = .50, $p < .01$, and Behavioral Disengagement, r (31) = .39, $p < .05$. Emotional Support was significantly positively correlated with Religion, r (31) = .57, $p < .01$, Venting, r (31) = .41, $p < .05$, Instrumental Support, r (31) = .77, $p < .01$, and Acceptance, r (31) = .48, $p < .01$. Planning was significantly positively correlated with Religion, r (31) = .58, $p < .01$, Instrumental Support, r (31) = .55, $p < .01$, Acceptance, r (31) = .48, $p < .01$, and Emotional Support, r (31) = .50, $p < .01$. One negative correlation was observed at posttreatment, Planning was significantly negatively correlated with Substance Abuse, r (31) = -.41, $p < .05$. The correlations between the variables of interest at posttreatment are presented in Table 4.

At 30-day follow-up, the following significant positive correlations were observed: Humor was significantly positively correlated with Venting, r (31) = .48, $p < .01$. Instrumental Support was significantly positively correlated with Religion, r (31) =

Table 3

Correlations Between Family Behavioral Enabling Total Scores (BES) and Brief COPE Subscale Scores at Pretreatment

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. BES Total	-														
2. Positive Reframing	-.13	-													
3. Religion	-.06	-.01	-												
4. Substance Abuse	-.20	-.11	-.24	-											
5. Venting	-.13	-.22	-.04	-.10	-										
6. Humor	-.04	-.22	-.11	-.34	-.21	-									
7. Instrumental Support	-.05	-.14	-.22	-.10	-.44**	-.25	-								
8. Acceptance	-.02	-.10	-.18	-.09	-.02	-.09	-.14	-							
9. Active Coping	-.30	-.42	-.18	-.15	-.01	-.03	-.23	-.10	-						
10. Behavioral Disengagement	-.05	-.10	-.17	-.25	-.27	-.36	-.32	-.02	-.12	-					
11. Self Blame	-.39*	-.02	-.05	-.37*	-.24	-.15	-.21	-.07	-.22	-.26	-				
12. Denial	-.11	-.03	-.09	-.21	-.25	-.35	-.01	-.46*	-.25	-.46**	-.47**	-			

Table 3 (continued)

Correlations Between Family Behavioral Enabling Total Scores (BES) and Brief COPE Scores at Pretreatment

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
13. Self-Distraction	-.05	-.01	-.26	-.26	-.23	-.03	-.16	-.30	-.33	-.11	-.03	-.13	-		
14. Emotional Support	-.08	-.07	-.39*	-.10	-.17	-.03	..66**	-.27	-.33	-.23	-.18	-.10	-.30	-	
15. Planning	-.16	-.05	-.02	-.28	-.17	-.20	-.31	-.11	-.26	-.41*	-.07	-.34	-.01	.35*	-

Note: n=32, ***p< .001, **p<.01, *p<.05.

.53, $p < .01$ and Venting, r (31) = .53, $p < .01$). Active Coping was significantly positively correlated with Instrumental Support, r (31) = .44, $p < .05$, Behavioral Disengagement was significantly positively correlated with Venting, r (31) = .41, $p < .05$, Humor, r (31) = .40, $p < .05$. Self Blame was significantly positively correlated with Substance Abuse, r (31) = .52, $p < .01$. Denial was significantly positively correlated with Self Blame, r (31) = .55, $p < .01$. Self Distraction was significantly positively correlated with Venting, r (31) = .60, $p < .01$ and Instrumental Support, r (31) = .64, $p < .01$. Emotional Support was significantly positively correlated with Acceptance, r (31) = .75, $p < .01$, and Active Coping, r (31) = .32, $p < .05$. Planning was significantly positively correlated with Instrumental Support, r (31) = .74, $p < .01$, Active Coping, r (31) = .63, $p < .01$, and Self Distraction, r (31) = .48, $p < .01$. Negative correlations were observed between Emotional Support and Substance Abuse, r (31) = -.40, $p < .05$; Denial and Behavioral Disengagement, r (31) = -.44, $p < .05$; and Self Blame with Behavioral Disengagement, r (31) = -.37, $p < .05$. Summaries of all correlations for 1-month follow-up are presented in Table 5.

Hypothesis Testing

It was hypothesized that participants would exhibit lower behavioral enabling scores (BES) from pretreatment to posttreatment and from pretreatment to 30-day follow-up. A repeated measures ANOVA with sphericity assumed was conducted to test this hypothesis. BES scores served as the dependent measure; time (Pretreatment, Posttreatment, 30-day follow-up) served as the independent measure. Due to the low reliability on five of the Brief COPE Inventory factor scores, only nine of the Brief COPE

Table 4

Correlations Between Family Behavioral Enabling Total Scores (BES) and Brief COPE Subscale Scores at Posttreatment

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. BES Total	-														
2. Positive Reframing	-.18	-													
3. Religion	-.16	-.01	-												
4. Substance Abuse	-.13	-.21	-.03	-											
5. Venting	-.09	-.20	-.30	-.28	-										
6. Humor	-.05	-.06	-.09	-.32	.47**	-									
7. Instrumental Support	-.03	-.22	.49**	-.04	.50**	-.13	-								
8. Acceptance	-.17	.53**	-.25	-.06	.45**	-.19	.56**	-							
9. Active Coping	-.02	-.20	-.45	-.20	-.12	-.03	-.01	-.24	-						
10. Behavioral Disengagement	-.04	-.17	-.13	-.38	.49*	.47**	-.02	-.06	-.15	-					
11. Self Blame	-.22	-.10	-.15	.50**	-.39	-.23	-.24	-.38	-.23	-.26	-				
12. Denial	-.01	-.20	-.06	.57**	.26	-.29	-.01	-.02	-.10	-.30	-.41*	-			

Table 4 (continued)

Correlations Between Family Behavioral Enabling Total Scores (BES) and Brief COPE Scores at Posttreatment

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
13. Self-Distraction	-.02	-.40*	-.02	.19	.55**	- .11	-.32	.50**	-.40	-.39*	-.32	-.02	-		
14. Emotional Support	-.02	-.13	.57**	.06	--.41*	-.03	.77**	.48**	-.40	-.05	-.32	-.06	-.15	-	
15. Planning	-.06	-.27	.58**	-.41*	- .18	-.18	.55**	.48**	-.32	-.29	-.18	-.13	-.10	.50**	-

Note: n=32, ***p< .001, **p<.01, *p<.05.

Inventory factor scores were examined. These were: Positive Reframing, Religion, Humor, Instrumental Support, Behavioral Disengagement, Self Blame, Denial, Emotional Support, and Planning. Differences observed at a .05 alpha were reported as significant.

Results showed that BES scores significantly decreased over time, F (2, 62) = 23.30, $p < .001$, partial eta^2 = .43, power = 1.00. Post hoc analysis using Tukey's Honestly Significant Differences Test showed that BES scores were significantly different between pretreatment (M = 27.84, SD = 9.92) and posttreatment (M = 18.59, SD = 9.32) and significantly different between pretreatment and 30-day follow-up (M = 18.16, SD = 10.03).

It was also hypothesized that the ways in which family members coped with their loved one's addiction would change as a function of participation in the Friends and Family Program. Repeated measures ANOVAs were conducted to test this hypothesis. However, Brief Cope subscales with low internal consistency (i.e. α = .60 or higher) were excluded from hypothesis testing. These were: Substance abuse, Venting, Acceptance, Active Coping, and Self Distraction) were excluded from hypothesis testing.

Results of the 9 repeated measures ANOVAs (i.e., Positive Reframing, Religion, Humor, Instrumental Support, Behavioral Disengagement, Self Blame, Denial, Emotional Support, and Planning) revealed significant changes from pretest to posttreatment and pretest to 30 day follow-up on three Brief COPE subscales. Because of the low alphas on Substance Abuse, Venting, Acceptance, Active Coping, and Self-Distraction scales, only 9 of the 14 Brief COPE scales were interpreted. In each of the 9 ANOVAs, three time levels represented the IV. The respective Brief COPE subscales represented the DV. Post

Table 5

Correlations Between Family Behavioral Enabling Total Scores (BES) and Brief COPE Subscale Scores at 30 day Follow-up

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. BES Total	-														
2. Positive Reframing	-.06	-													
3. Religion	.01	-.25	-												
4. Substance Abuse	.01	-.14	-.19	-											
5. Venting	.02	-.03	-.13	-.20	-										
6. Humor	-.07	-.12	-.02	-.19	.48**	-									
7. Instrumental Support	-.16	-.14	.53**	-.05	.53**	-.30	-								
8. Acceptance	-.39*	-.27	-.24	-.07	-.02	-.32	-.23	-							
9. Active Coping	.33	-.03	-.27	-.04	.21	-.02	.44*	-.22	-						
10. Behavioral Disengagement	-.10	-.02	-.12	-.38*	.41*	.40*	-.02	-.13	-.02	-					
11. Self Blame	-.16	-.22	-.04	.52**	-.21	-.19	-.20	-.12	-.16	-.37*	-				
12. Denial	.24	-.22	-.29	-.30	.30	-.24	-.01	-.03	-.30	-.44*	.55**	-			

Table 5 (continued)

Correlations Between Family Behavioral Enabling Total Scores (BES) and Brief COPE Subscale Scores at 1-month Follow-up

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
13. Self-Distraction	-.09	-.03	-.21	- .21	-.60**	-.16	-.64**	-.28	-.52*	-.25	-.33	-.23	-		
14. Emotional Support	-.06	-.10	-.09	-.40*	-.12	-.20	-.01	-.75**	.32*	-.25	-.20	-.07	-.29	-	-.
15. Planning	.07	-.01	-.31	-.20	-.32	-.21	-.74**	-.07	.63**	-.19	-.03	-.15	-.48**		-

Note: n=32, ***p< .001, **p<.01, *p<.05.

Hoc analyses using Tukey's HSD Test were used to establish significant differences between mean scores.

Respondents reported greater use of Positive Reframing strategies from pretreatment ($M = 3.72$, $SD = 1.57$) to posttreatment ($M = 4.69$, $SD = 1.62$) and from pretreatment to 30-day follow-up ($M = 4.66$, $SD = 1.58$), $F\ (2, 62) = 5.79$, $p < .01$, partial $eta^2 = .16$, power = .85.

In addition, participants reported higher scores on the Seeking Instrumental Support subscale of the Brief COPE from pretreatment ($M = 4.75$, $SD = 1.68$) to 30-day follow-up ($M = 5.56$, $SD = 1.90$), $F\ (2, 62) = 3.61$, $p < .01$, partial $eta^2 = .10$, power = .65.

Finally, participants reported greater use of Behavioral Disengagement strategies from pretreatment ($M = 3.47$, $SD = 1.54$) to 30-day follow-up ($M = 4.22$, $SD = 1.86$) and from posttreatment ($M = 3.46$, $SD = 1.34$) to 30-day follow-up, $F\ (2, 62) = 4.43$, $p < .01$, partial $eta^2 = .13$, power = .65.

Qualitative Analyses

Four Friends and Family Groups were observed weekly. The author recorded all group members' statements by hand. From the statements generated by the participants, a total of 37 themes/categories were generated. These categories fell into four major themes: 1) Behaviors in association with a loved ones substance abuse issues (see Table 7), 2) Ways of coping with loved one's use (see Table 8), 3) Feelings in association with loved one's use (see Table 9), and 4) Group themes reflecting thoughts about group process and mental health resources (see Table 10).

The themes that emerged from the group discussions are reported in the left hand column of the tables. The number and percentage of participants who mentioned each

theme is reported under its respective column. The number of respondents and percentage reported is based on the total sample. An example of each type of category/theme that emerged during the group discussions is reported in the right hand column of the tables. For each major theme, the types of responses cited by the Friends and Family Program participants are listed from most frequently to the least frequently mentioned.

Behaviors with Substance Abusing Family Member. Six categories emerged under the first major theme: Behaviors with Substance Abusing Family Member. These were: 1) Specific examples of boundary setting (61%) and successful boundary setting (59.4%), 2) Giving a substance abusing loved one (LO) money or paying their bills (56.2%), 3) Helping LO through a hangover (40.6%), 4) Altering LO's access to drugs or alcohol (31.2%), 5) Trying to convince their LO to be proactive in recovery (18.7%) and 6) Lying or making excuses for LO (18.7%). Additional examples are reported in Table 7.

Ways of Coping with Family Member's Substance Use. The next most commonly mentioned themes addressed methods that participants' used to cope with their loved one's substance abuse. Seven themes emerged that addressed coping techniques. These included: 1) Rationalizing why support was necessary (50%), 2) Minimizing loved ones behavior (37.5%), 3) Isolating from social support (25%), 4) Reporting physical problems in association with stress (25%), 5) Yelling or venting negative feelings to loved ones (25.9%), 6) Denying or pretending nothing is happening in relation to loved ones drug abuse (21.9%), and 7) Reflecting on the positive and negative aspects of a loved one's addiction (18.7%). Please see Table 8.

Table 6

Results of Univariate Analyses of Variance of Time (Pretreatment, Posttreatment and 30 day Follow-up) for the Behavioral Enabling Scale Scores and the Brief Cope Inventory Subscale Scores

Variable	Pretreatment *M*	Posttreatment *M*	1-month FU *M*	*F*
BES	27.84[a]	18.59[b]	18.16[b]	23.30***
Positive Reframing	03.72[a]	04.69[b]	04.66[b]	05.79**
Religion	05.38	05.66	06.06	01.95
Substance Abuse	03.25	03.06	03.41	0.572
Venting	05.06	04.75	05.00	0.524
Humor	03.16	03.22	03.72	02.18
Instrumental Support	04.75[a]	05.09	05.56[b]	03.61*

Table 6 (continued)

Results of Univariate Analyses of Variance of Time (Pretreatment, Posttreatment and 30-day Follow-up) for the Behavioral Enabling Scale Scores and the Brief Cope Inventory Subscale Scores

Variable	Pretreatment *M*	Posttreatment *M*	1-month FU *M*	*F*
Acceptance	5.47[a]	5.88	6.38[b]	3.30*
Active Coping	6.00	5.63	6.13	1.43
Behavioral Disengagement	3.47[a]	3.46[a]	4.22[b]	4.43*
Self-Blame	4.22	3.94	4.1	0.51
Denial	3.41	3.53	3.72	0.49
Self Distraction	4.88	5.22	4.76	0.97
Emotional Support	4.94	4.91	4.95	2.15
Planning	5.91	5.59	5.56	0.52

Note: Means having the same subscript are not significantly different from each other as per post-hoc Least Significant Difference Tests, * $p < .05$, ** $p < .01$, *** $p < .001$.

Feelings in Association with Family Member's Substance Use. The next most common major category of events generated by Friends and Family Program participants addressed their feelings in association with their loved one's addiction. The following categories of feelings were reported. These were: 1) Anger (50%), 2) Frustration (50%), 3) Confusion (43.7%), 4) Fears for loved one's safety (40.6%), 5) Anxiety (40.6%), 6) Helplessness (34.4%), and 7) Sadness (22%). Please see Table 9 for additional examples.

Group Themes. At times, group members' responded to other member's concerns with suggestions or challenged one another regarding participants' enabling behavior and so forth. Members also discussed global problems (e.g., lack of services available for their loved ones), that many, if not all member's had experienced. These responses were given their own category under the category, Group Themes, after comparing the primary and secondary coder's category themes. The following themes emerged as independent from the previous three categories (i.e., enabling behaviors, coping, and feelings): 1) Group members vented about their loved one's addiction (90.6%), 2) Group members gave advice to other group members (62.5%), 3) They discussed the importance of drug education and signs of enabling behaviors among themselves and others (59.4%), 4) Group members noted the lack of resources available to loved ones for alcohol and drug treatment (40.6%), 5) They reported a recent crisis regarding the substance-abusing loved one (37.5%), 6) Group member's mentioned to another group member the importance of appealing to a higher power (34.4%), 7) Group members communicated to one another that attendance in the Friends and Family Program was helpful to their recovery (31.2%), 8) Group members mentioned to other group members that the program was not helping (28.1%), 9) Participants' shared their experience of initiating case management for their

Table 7

Family and Friend Participants Enabling Response to their Loved One's Substance Abuse

Type of Behavior	Examples
1. Trouble Setting Boundaries *(n = 19; 59.4%)*	"There is something about my son that I have trouble saying no to. I just worry that he will be hurt if I don't help him." "I cover up for her to her dad, like if she hasn't done her chores, I will. She does things when she feels like it."
2. Gave LO money or paid bills *(n = 18; 56.2 %)*	"I just gave her some money so she [daughter] wouldn't" get arrested."
3. Helped LO through a hangover, rescued from crisis, or gave drug/alcohol paraphernalia *(n = 13; 40.6 %)*	"I cleaned up his [son] mess after the party because he was too drunk to get out of bed."
4. Altered LO's access to drugs or alcohol *(n = 10; 31.2%)*	"I threw all the bottles of wine away, even an old bottle of champagne, because that girl [sister] will drink anything."

LO: Substance Abusing *Loved One* of Family or Friend

Table 7 (continued)

Family and Friend Participants Enabling Response to their Loved One's Substance Abuse

Type of Behavior	Examples
5. Trying to convince LO to pay bills or being proactive in recovery *(n = 6; 18.7%)*	" I told him [son], if you don't pay, they are going to take your car."
6. Lied or made excuse for LO *(n =6 ; 18.7 %)*	" I told my husband that she [daughter] was doing better when I knew she really wasn't because I didn't want him to worry.

LO: Substance Abusing *Loved One* of Family or Friend

substance-abusing loved one (25%), 10) Group members recounted a loved one's behavior before the onset of their addiction (25%), 11) Group members communicated acceptance that he or she is not to blame for their loved one's drug use (21.9%), 12) Participants discussed conflicts with other family members in relation to their loved one's drug or alcohol use (21.9%), and 13) Participants expressed disapproval to regarding another group member's behavior and interactions with their substance-abusing loved one (21.9%). See Table 10 for additional examples.

Narratives Depicting Enabling Behaviors

Setting Boundaries with Substance Abusing Loved Ones. Significant others of substance abusers reported several behavioral reactions to their substance abusing loved one. Difficulty setting boundaries with their substance-abusing loved one was the most frequently reported experience. In most cases, family members explained this difficulty within the context of feeling responsible for the family member in some way or confused about how to best handle their interactions with the substance-abusing loved one (e.g., "I have filed for divorce three times and every time, I take him back.", "His business is my business because he is my son. That is why I can't stay out of it.", "I have trouble saying no to her [drug-abusing daughter] and I don't know why.").

Participants also reported the experience of success with boundary setting (e.g., "It is a hard thing to do to have your son arrested, but you have to do it. I did this last time too and have stayed in touch with his probation officer.", "My son is not allowed to be in the house when we are gone."; "She was smoking crack in the bedroom, 6 months pregnant, crying, and we called the police for the baby's sake."). Setting boundaries was

Table 8

Categorization of Coping Strategies Reported by Family and Friends of Substance Abusers

Type of Coping Strategy	Examples
1. Rationalized why support was necessary *(n = 16, 50%)*	" I am his main support because his doctors aren't going to drive him to his appointments."
2. Minimized LO's addiction behavior *(n = 12; 37.5 %)*	" It is not like he [son] is using everyday and can't hold a job like some of these people."
3. Isolated from social support *(n = 8; 25 %)*	"My daughter doesn't want me to tell anyone about it so I don't tell my family. I don't even see them much anymore because I don't know what to tell them about her."
4. Physical problem in connection to stress of caring for LO *(n = 8; 25 %)*	"He [referring to husband] has almost had a heart attack two times worrying about this kid."

LO: Substance Abusing *Loved One* of Family or Friend

Table 8 (continued)

Categorization of Coping Strategies Reported by Family and Friends of Substance Abusers

Type of Coping Strategy	Examples
5. Denied or pretended nothing happened *(n = 7; 21.9 %)*	"I remember when I would just ignore the used needles in the bathroom. It was like they weren't really there.
6. Yelled negative feelings/disapproval *(n = 9; 25.9 %)*	"I told him the last time he relapsed that his [son] literally sickens me."
7. Reflected on positive and negative of LO addiction *(n = 6; 18.7 %)*	"She has been sober longer now than the last time she [daughter] relapsed."

LO: Substance Abusing *Loved One* of Family or Friend

Table 9

Categorization of Feelings Reported by Family & Friends in Connection to Caring for a Substance Abusing Loved One

Type of Feeling Reported by Family Member or Friend	Examples
1. Anger *(n = 16; 50 %)*	"He [husband] shouldn't be doing this at his age. I smoked pot once. We all did. I feel like hitting some sense into him or something."
2. Frustration *(n = 16; 50 %)*	"Yeah, my husband drank all the NyQuil one night. You know, I feel like a mother to my husband. He is so smart, which makes me so mad."
3. Confusion *(n = 14; 43.7 %)*	"Why can't she [sister-in-law] stop after all the trouble she has caused?"
4. Fear for LO's safety *(n = 13; 40.6 %)*	"When I don't know where she is, I worry that she [daughter] is off shooting up somewhere."

LO: Substance Abusing *Loved One* of Family or Friend

Table 9 (continued)

Categorization of Feelings Reported by Family & Friends in Connection to Caring for a Substance Abusing Loved One

Type of Feeling Reported by Family Member or Friend	Examples
5. Anxiety *(n = 13; 40.6 %)*	"I remember feeling like I was having a panic attack every time the phone rang – thinking if he was dead or in jail." "This will kill you. It will actually worry you to death."
6. Helplessness *(n = 11; 34.4 %)*	"Sometimes I just don't know what to do, I just feel stuck."
7. Sadness *(n = 7; 22 %)*	"I don't understand why this has to be happening [crying]. I just lay in my bed and cry myself to sleep."

LO: Substance Abusing *Loved One* of Family or Friend

the second most frequently reported category. Although the low *n* prohibited statistical analyses, boundary setting appeared to be more common among members who had attended previous community group counseling. This suggests that developing the ability to set boundaries with a substance-abusing family member may be a process that occurs over time and with repeated coverage. Please see Table 7 for additional examples.

Helping Substance-Abusing Loved Ones. Giving a substance-abusing loved one (LO) money or paying their bills was the third most frequent category reported (e.g., "I paid his [drug-abusing son] attorney fees and helped his case get dismissed.", "I am letting my daughter live with me and am paying all the bills because now she is pregnant."). Helping a LO through a hangover in various ways was a significant concern and primary form of giving assistance to LO or cleaning up drug related messes (e.g., "After his [drug-abusing son] party, I had to get him back to normal and clean up the house.", "He [drug-abusing son] couldn't even stand up, we had to drive him to the doctor", "I didn't hear him when he came in, but in the morning, he was bouncing off the walls, opening the closets, etc. It was four in the morning and I told him I had to go to work. He had ripped the downstairs apart. He had defecated all over the living room. He had thrown his pants on the patio and I was furious. He was still so out of it that he had no idea what I was talking about. He was looking for his cell phone and he accused me of hiding it. He took one of the doors at that point and had thrown it off the hinges. I became panic stricken because I had lived with an abusive husband and that is when I called the police. When they arrived, he was sobered up and went with them without complaint. He called to pick up some of his clothes, came home, and began to cry. He apologized and I ended up letting him stay. I ended up cleaning up the mess of course." Refer to Table 7

Table 10

Categorization of Group Themes Reported by Family & Friends in Connection to Caring for Substance Abusing Loved One

Type of Feeling Reported by Family Member or Friend	Examples
1. Venting to other group members on nature of loved one's addiction *(n = 30; 96.6%)*	"She started using crack in high school and it just progressed from there."
2. Giving advice to other group members *(n = 20; 62.5 %)*	"You have to let your daughter make decisions on her own. Believe me, I've been through it."
3. Awareness of drug education and signs of enabling *(n = 19; 59.4 %)*	"An enabler is the responsible adult, the peacemaker."
4. Frustration with lack of resources for addicted loved one *(n = 13; 40.6 %)*	"They send him [son] out of jail with no resources. I mean, no one will hire him. So how is he supposed to beat this thing?
5. Reporting a recent crisis involving loved one *(n = 12; 37.5 %)*	"Last night, my daughter almost died from a heroin overdose."

LO: Substance Abusing *Loved One* of Family or Friend

Table 10 (continued)

Categorization of Group Themes Reported by Family & Friends in Connection to Caring for Substance Abusing Loved One

Type of Feeling Reported by Family Member or Friend	Examples
6. Appeal to higher power *(n = 11; 34.4 %)*	"I just put these troubles in God's hands and that gets me through."
7. Group education is helping in some way *(n = 10; 31.2 %)*	"It makes me feel better being here and just knowing that I am not the only one going through this." "I am starting to understand all these worksheets and am finally starting to apply it to my life."
8. Frustration that group is not helping *(n = 9; 28.1 %)*	"I don't really understand what we are supposed to do with this information. I want answers and solutions."
9. Taking action towards case management for loved one *(n = 8; 25 %)*	"So I called his [son] doctor and set up an appointment to get the ball rolling."

LO: Substance Abusing *Loved One* of Family or Friend

Table 10 (continued)

Categorization of Group Themes Reported by Family & Friends in Connection to Caring for Substance Abusing Loved One

Type of Feeling Reported by Family Member or Friend	Examples
10. Recounting loved one's behavior before the onset of their addiction *(n = 8; 25 %)*	"When she was a child, she was happy and loved to exercise."
11. Acceptance that group member is not to blame/doing their best *(n = 8; 25 %)*	"You are handling this the best way that you know how."
12. Disputes with other family members about how they are *handling* situation *(n = 7; 21.9 %)*	"My husband yells at me sometimes, but I can't control him [son] either."
13. Expressing disapproval of another group member's behavior *(n = 7; 21.9 %)*	"It is just my opinion, but I think you are being too lenient with your son."

LO: Substance Abusing *Loved One* of Family or Friend

for more examples.

Altering LO's Access to Drugs/Alcohol. Concern for a LO's use also manifested in altering LO's access to drugs or alcohol (e.g., "I had to bring him [drug-abusing son] his Xanax medication because the doctors wouldn't give it to him."; "I have to hide his pills to make sure he doesn't take the whole bottle."). Because many of the group members lived with their substance abusing loved one, this often required them to remove all drugs and alcohol from the home (e.g., "I had to throw away expensive wines that I have saved for myself because my daughter will just drink anything, even Nyquil."). Additional examples are reported in Table 7.

Convincing LO to be Proactive in Recovery. The experience of trying to convince their LO to be proactive in recovery was another prominent behavioral category (e.g. "When he is laying around, I tell him to keep moving so he doesn't get bored and start using again.", "I told her to go to rehab, but she wouldn't."). This desire to help the substance abusing LO often manifested by giving LO advice or taking behavioral steps to ensure LO's recovery (e.g. "I made him [son] get the car and told him, we are going to beat this."; "I want my daughter on birth control. I can't even get her to go to a doctor's appointment. I try to get her to pay the bills, but she doesn't care." For additional examples, see Table 7.

Protecting LO by Lying or Making Excuses. Lying or making excuses for LO was frequently mentioned by group members (e.g. "I would protect my husband by not telling him about her [drug-abusing daughter] addiction.", "I used to hide my son's addiction. When he first started, I remember he took my daughter's violin and pawned it for money. I didn't tell on him and helped him sneak it back up to her room after I bought it back

from the pawn shop.", "She [daughter] can't help it, she has Attention Deficit and an eating disorder."). See Table 7 for more examples.

Making LO Feel Guilty. Making LO's feel guilty was also commonly endorsed (e.g., "I pretend to feel sorry for myself so she'll quit.", "I sometimes exaggerate my feelings to try to make her [drug-abusing daughter] stop. I asked her later if that works when I try to make her feel guilty and she says it is better for me to just not answer the door or phone if she is using."). Please refer back to Table 7 for additional examples.

Coping Responses in Relation to Substance Abusing Loved One

Group members also discussed in detail their strategies for coping with their family member's addiction. The coping behaviors in order of most to least endorsed included rationalizing, minimizing, social isolation, reporting physical symptoms in response to stress, yelling negative feelings, denying or pretending nothing is happening in relation to a loved one's drug or alcohol abuse, and reflecting on the positive and negative aspects of a loved one's addiction. Table 8 depicts the following forms of coping that were expressed during the weekly meetings.

Rationalization. Rationalizing why support of their loved one was necessary was the most frequently endorsed coping category (e.g., "I am afraid not to give him money. Who wants to walk around with no money in their pocket?", "If I don't help her, she will lose her kids.", "Her family was never there for her. I can't be another person that just turns their back on her – even if she is using).

Minimization. Minimizing a loved one's behavior or characterizing the drug use as less significant in comparison to LO's other life stressors was also mentioned frequently (e.g., "Compared to last year, he [husband] is not drinking nearly as much as

he used to. I mean, last year, we used to fight all the time because he was always drunk. "; "So, he [son] went into rehab last week and he is already begging to come home. He walked out without permission once, but then came back. The counselor said that he is trying to get himself kicked out, but I think they just need to be patient with him.").

Isolating from Social Support. Participants often mentioned withdrawing from supportive family and friends in an attempt to keep the LO's substance abuse a secret from others (e.g., "I can't tell anyone about this, not even my sister, she [drug-abusing daughter] forbids it.", "I don't like to tell my friends and family because I am embarrassed.", "I don't really relate to other wives sometimes. It is not very visible. No one knows about it. My family doesn't know about it and it is easier if we keep this between us.")

Reporting Physical Problems in Association with Stress. Many mothers and fathers of substance abusers in particular reported exacerbation of existing physical symptoms in association with loved one's substance abuse (e.g. "I have got a bad heart over all this.", "My arthritis has gotten worse since she [drug-abusing daughter] went back to using.", "I stay quiet about it and my blood pressure goes up.").

Yelling Negative Feelings. Several participants reported yelling or venting their negative feelings towards their substance abusing loved ones. For instance, one brother of a cocaine abuser said, "I don't tip-toe around this issue like my parents, I told her [sister] she was making a mess of her life." Similarly, several fathers of adult drug-using children mentioned confronting their children regarding their use: "I finally told my daughter I can't do this anymore.", "I was screaming at him [drug-abusing son] and asked him how he could do this.").

Denying LO's Addiction. Denying or pretending nothing was happening in relation to a loved one's drug abuse was also common (e.g., "When there is a confrontation, I avoid it.", "I used to pretend I didn't see her [daughter] taking my diabetes syringes from the trash.", "I was in denial, I would let him [husband] have a couple of drinks, but then it just progresses and it becomes more and more.").

Reflecting on the Positive and Negative Aspects of a Loved One's Addiction. Some participants mentioned the positive and negative aspects of a loved one's addiction/recovery process (e.g., "She used to use [drugs] everyday, but her last drug screen was negative. She is doing better." "Well, he is back in rehab, but at least he is sticking it out this time."). Additional examples of Reflecting on the Positive and Negative Aspects of a Loved One's Addiction are shown in Table 8.

Feelings in Association with Family Member's Substance Use

The next most common major category reported during the weekly group meetings were feelings regarding their loved one's substance abuse. The most commonly reported to the less commonly reported feelings were: anger, frustration, confusion, fear for loved one's safety, anxiety, helplessness, and sadness.

Anger. Participants frequently mentioned feelings of anger (e.g., "My issue is with my daughter. She is 24 and has a 2 year old, which pissed me off and pushed me over the edge", "Why does he [husband] keep doing this to us? Sometimes I literally want to shake him and say, Wake up!").

Frustration. Frustration was commonly mentioned by group members (e.g., "These facilitators keep telling me to set boundaries, but I can't do that because he [husband] is the financial provider. I mean, do you know how frustrating that is?", "I

want to retire, but I can't because now I have to deal with my daughter. All the money I was saving for me is going towards her kids, which is frustrating because she really should be able to do this for herself.")

Confusion. The experience of confusion in connection with LO's use was also commonly reported (e.g., "It is very confusing because I am trying to read his mind, but I can't figure him out. I feel like his mother, hiding pills, walking on pins and needles. He took our son's antihistamines to get high. He lost his job so we have nothing now. We are just here trying to figure this out. He has more of a drug abuse issue than an alcohol problem I think.").

Fear for LO's Safety. A common concern was fear for the loved one's safety (e.g., "She still sees nothing wrong with her drinking. I am afraid if I can't get her some better help by 18, I am afraid I will lose her.", "Honestly, every time he [son] leaves the house, there is a part of me that wonders if he is going to die.").

Sadness. Feelings of sadness often occurred in conjunction with anxiety and helplessness (e.g., "But I can't let him come back home and haven't found the courage to tell him. I know he will say, I am no good and what am I going to do and I will end up crying and worrying because it breaks my heart to turn my child away, but I feel like I have done everything I can possibly do.").

Less Frequently Endorsed Feelings. Feelings of anxiety, helplessness and sadness were less prominent categories reported among family members. However, mothers in particular reported the experience of constant tension in connection with their son or daughter's drug use (e.g., "I am on edge all the time over this"). See Table 9 for

additional examples of feelings reported in relation to a loved one's substance abuse.

Group Themes Most Commonly Reported

In addition to discussing common behaviors, coping strategies, and feelings associated with their loved one's drug use, group members often shared comments with each other that did not fall into the above categories. These themes included: venting about their loved one's addiction, giving advice to other group members, communication of awareness regarding drug education and signs of enabling, frustration with the lack of resources available to loved ones for alcohol and drug treatment, reporting a recent crisis regarding a loved one, appealing to a higher power, communication to other group members that attendance at this program was helpful to their recovery, communication to other group members that this program was not helping, communication of acceptance that he or she is not to blame for their loved one's drug use, communication related to case management initiated by group member on behalf of their loved one's drug use, recounting a loved one's behavior before the onset of their addiction, discussion about conflicts with other family members in relation to loved one's drug use, expressing disapproval to another group member's behavior about his/her interaction with their drug-abusing loved one. Brief examples for each of these categories are presented below. See Table 10 for additional examples.

Venting about their Loved One's Addiction. "This has been going on for a long time. My wife and I have been in Al-Anon for five years and we don't expect that our son will miraculously recover completely.", "It is hard loving someone with a drug addiction."

Giving advice to Other Group Members. "You need to put your foot down with your son.", "I have been going through this for 10 years, the best you can do is get on with your life and let them figure this out in jail."

Communication of Awareness Regarding Drug Education and Signs of Enabling. "I know that I have been the family hero and I see how it has become an issue in my own family. I am still trying to help everyone else. Looking fine on the outside, but feeling scared on the inside."

Frustration with the Lack of Resources Available to Loved Ones for Alcohol and Drug Treatment. "What is he [son] supposed to do when he gets out of jail? The system is set up for them to go back to what they are good at.", "These doctors don't really listen or read their histories. Why are they giving her [daughter] more drugs when she already has a drug problem?"

Reporting a Recent Crisis Regarding a Loved One. "My daughter tried to commit suicide last night. She almost overdosed on heroin.", "We thought we were going to lose our daughter this weekend. We came home and she was in the backyard, just sitting in a chair. She drank God knows what and we had to rush her to the emergency room."

Appealing to a Higher Power. "I just put this in God's hands and pray that it will all work out.", "I give my stress to the Lord."

Communication to Other Group Members that Attendance at this Program was Helpful to their Recovery. "It is hard to come here sometimes, but I am glad I came. It gives me comfort to know that I am not alone.", "I am starting to understand all this stuff and I am finally using it in my life!"

Communication to Other Group Members that this Program was not Helping. "I don't understand what we are supposed to do with all this information. I want to know where to go from here. What is the next step?"

Communication of Acceptance that he or she is not to Blame for a Loved One's Drug Use. "I can't control what my son does. I can only say that I tried my best as a parent and I think I did a good job."

Communication Related to Case Management Initiated by Group Member on Behalf of Loved One's Drug Use. "I got [son] him connected to a new rehab facility that will take him next week.", "I am going to drive her [daughter] to her doctor's appointments because she doesn't have a car."

Recounting a Loved One's Behavior Before the Onset of their Addiction. "She [daughter] used to do so many sports. My daughter was very active and had a lot of nice friends.", "Our son used to be the manager of a mortuary and he was making good money. He could have had a very nice business."

Discussion about Conflicts with other Family Members in Relation to a Loved One's Drug Use. "My husband and I have argued over this because sometimes we disagree about how to handle the situation.", "I used to lie to my husband because I didn't want him to get angry at her [daughter]. But now, I realize that I was only making the situation worse."

Expressing Disapproval to Another Group Member about their Behavior with their Drug-abusing Loved One. "I think you are being too easy on him [group member's son]. He is just going to keep walking on you." See table 10 for additional examples.

Across the 37 categories, the ten most frequent experiences reported from most to least reported included: venting about a loved ones (LO) addiction, difficulty setting boundaries with LO, giving LO money, feeling frustrated in relation to LO's drug use, rationalizing why support of LO was necessary to continue, feeling anger in association with LO's drug use, feeling confused, helping a LO through a hangover, feeling anxiety and minimizing LO's substance-abusing behavior.

CONCLUSIONS

The present study had two major aims. The first aim was to examine whether individuals who attended a six-week community-based educational and support program for friends and family with a substance-abusing loved one would benefit from program attendance. Specifically, the focus of aim one was to examine whether program participants would report less behavioral enabling (i.e., behaviors that inadvertently increase the loved one's substance-abusing behavior) and more positive forms of coping as reported on standardized questionnaires from pretreatment to posttreatment and pretreatment to 30-day follow-up. The second study aim was to examine the concerns expressed by participants during the course of the six-week program.

Results of the Quantitative Analysis of Behavioral Enabling

The types of behaviors assessed by the BES were lying or making excuses for family members to hide their drug abuse, borrowing money to pay for the substance-abusing loved one's bills, and taking over their loved one's chores because they were drugging or drinking. As shown in Table 6, at pretreatment, the typical participant reported having engaged in at least minimal to medium levels of the types of enabling behaviors assessed.

As expected, on average, participants' reported fewer enabling behaviors, such that participation in the program had a meaningful positive impact on the reduction of enabling behaviors from pretreatment to post-treatment and from pretreatment to 30-day follow-up. Many group interventions, conducted with members of Al-Anon and Community Reinforcement Training, have reported similar decreases in enabling behaviors from pretreatment to posttreatment (Meyers, Miller, Smith & Tonigan, 2002;

Miller et al., 1999). A key element across studies that examine enabling in family members of substance abusers is the emphasis on teaching the family member how to recognize their unique enabling behaviors and providing support in applying this knowledge to their interactions with the substance-abusing loved one (Meyers et al., 2002; Rotunda, West, & O'Farrell, 2004; Yoshioka, Thomas & Ager, 1992). Other benefits that appear to correspond with reductions in enabling are positive changes in family member's psychological well-being and decreases in their loved one's substance use behavior (McFarlane, 2003; Miller et al., 1999).

Similar to other programs of this type, the Friends and Family Program teaches participants to recognize enabling behaviors and the ways in which enabling behaviors may interfere with recovery attempts and that enabling behaviors may inadvertently reinforce their loved one's use of alcohol or other drugs. Not only was the topic of enabling behavior addressed in the psychoeducational information that was presented during this six-week course, throughout the sessions, group members asked one another about enabling behaviors, advised one another on how to reduce enabling behaviors, and discussed the negative long-term outcomes that may result from continued enabling behaviors. It appeared that the combination of education and support from other participants created significant reductions in these types of behaviors. However, in contrast to other studies that have generally measured enabling behavior at pretreatment and posttreatment with partners of alcohol or drug users, results of the present study demonstrated that a community program that included predominantly parents of substance users also reduced enabling behaviors from the initial baseline assessment to posttreatment and from baseline to 30-day follow-up. It is especially important to note

that this gain was maintained from pretreatment over a short follow-up period (i.e., 30 days). This result suggests that community-based programs such as the Friends and Family Program that target behavioral enabling among loved ones of substance abusers may have meaningful short-term effects on participants' behaviors that appear to continue after the program ends.

Results of the Qualitative Analysis Information as Related to Behavioral Enabling

Results of the qualitative portion of the study reinforce that behavior enabling was a major concern of family members who attend a community-based program such as the Friends and Family Program. Specifically, behavioral enabling arose as a common topic discussed by group members (i.e. spouses/partners, parents, and siblings). However, one of the advantages of the present study over previous research is the ability to identify the most common forms of behavioral enabling among parents, siblings, and spouses with a substance-abusing loved one. Specifically, analysis of the content of the group sessions revealed that the most commonly reported types of enabling behaviors were difficulty with boundary setting and giving the substance-abusing loved one financial support. Because most of the participants were parents, it appears that financial support of an older adolescent or young adult child was common among parents of substance abusers.

Parents of Substance-Abusing Loved Ones

Although previous studies have focused on spouses of alcohol-abusing men, it is important to recognize the majority of participants in the present study were parents of substance abusing children. In this study, setting boundaries with their late adolescent or adult children appeared to be very difficult for parents. Consistent with previous qualitative studies with the family members of substance abusers (Orford et al, 2007),

parents who participated in this study reported difficulty setting boundaries with their children for fear that their substance-abusing child would not be able to function as well without their help. Related to this, these parents often reported that they did not want to confront the substance abuser after a drinking or drug-using binge because they wanted to avoid arguments with the substance abuser. The lack of willingness to confront a substance abuser about their problem has also been reported in the empirical literature (e.g., Copello, Templeton, & Velleman, 2006; Orford et al., 2007). Parents also reported difficulty setting boundaries with their children around finances. For instance, the father of a substance-abusing daughter said, "We kick her out, but then she shows up at our door and we end up doing the same thing [letting her move back in] all over again." Similarly, one mother reported, "I pay my son's rent because he can't get a job and get sober at the same time."

A number of other themes not previously identified in the literature emerged. For instance, many parents did not want to confront their adult or late adolescent children for fear that their child would become upset and use drugs as a way of coping. For example, one mother reported, "I am worried if I argue with him [son] that he will just go get loaded to get back at me." In addition, parents were concerned that confronting their adult children regarding their substance abuse had the potential to impact their relationship and their ability to see their grandchildren or negatively impact their grandchildren's welfare. For example, one parent of a cocaine-abusing daughter reported, "I could throw her out, but then how is she going to provide for my granddaughter?"

Parents also reported considerable difficulty watching the progression of their children's substance abuse. This painful experience also appeared to reinforce non-

confrontive behavior. Related to the last point, one parent pointed out how difficult it was to watch his son progress in his drug use and explained that he could live with alcohol use, but his son's descent into a methamphetamine addiction had "taken him over the edge." Although this parent reportedly paid his son's bills, it was interesting to note that the father decided to take over his son's financial affairs after his son began misusing drugs in additional to alcohol.

Siblings of Substance Abusing Loved Ones

Similar to parents, siblings of substance abusers also reported feelings of concern and worry. However, siblings appeared to have less difficulty setting consistent boundaries with the substance user. For instance, one brother shared, "my sister knows that she cannot come into my room because I don't trust her. She doesn't even try [to get in there]."

In contrast to parents, the siblings in this study seemed to be less protective and more willing to confront their substance-abusing siblings' directly. They also appeared more willing to confront their parents during the group session about the impact the loved one's substance use had on individual family members and the family system in general. For instance, one daughter said to her mother during a Friend and Family Program session, "sometimes I feel like you forget about me."

Albeit the sample of siblings was small, in general, the siblings seemed 1) to experience frustration that their parents were emotionally/financially supporting their sibling, and 2) a sense of resentment that they were being ignored because of the intense focus placed on their substance-abusing siblings. These findings support previous research highlighting the feelings of anger and resentment that siblings experience in

connection with their family members' substance abuse (Jackson, Usher, & O'Brien, 2006; Orford, 2007).

Spouses and Romantic Partners of Substance-Abusing Loved Ones

Results of the present study are similar to previous studies that have examined behavioral enabling among spouses and partners of alcohol-abusing men (e.g., Dittrich & Trapold, 1984; Miller et. al, 1999; Myers et al., 1997; Rotunda et al., 2004; Yoshioka et al., 1992). More specifically, in their review of the literature on spouses with alcohol-abusing husbands, Rotunda and Doman (2001) reported that spouses often feared for their financial security. As a result, they often made excuses for their partner's behavior to an employer to increase the substance abuser's job security. Although wives of drug abusers in the present study reported this same fear, they also reported additional fears. For example, they feared being put in a position of having to lie to family members, friends, or law enforcement regarding their husbands' use of illicit drugs. In addition, they were concerned that their spouses kept illegal drugs in their home.

Although less frequently endorsed, enabling behaviors such as helping a loved one through a hangover, making excuses for a loved one's behavior, and making a loved one feel guilty for substance use also emerged. These themes were consistent with considerable previous literature that has examined family barriers to treatment recovery (Galanter, 2004, Meyers & Smith, 1995; O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998). However, the involvement of parents and siblings in the present study yielded a more thorough understanding of the concerns of family members. For example, the brother of an alcohol-abusing sister reported that he helped his sister clean up her hangover mess, not for the purpose of helping his sister, but to protect his parents from

seeing "how bad she has gotten". 'Cleaning up a substance abuser's mess has also been noted in previous studies of spouses (e.g., Love et al., 1993; Rychtarik et al., 1988).

In summary, family members may differ in their feelings and behaviors in connection to their substance abusing loved one's use. Although parents, siblings, and partners appear to collectively struggle with mixed feelings of concern and resentment, as compared to parents, siblings appeared more likely to experience anger and a desire to confront their substance-abusing siblings. This appears to be related to their feelings of concern for their parents' well being as well as their own misgivings about the limited attention they receive from their parents in comparison to their substance-abusing siblings. Furthermore, while parents, siblings, and partners all reported difficulty with boundary setting, parents and partners appeared to have the most difficulty setting boundaries for a variety of reasons (e.g., financial security, concern for grandchildren, fear of their child's/partner's relapse).

Quantitative Analysis of Coping Strategies

It was also hypothesized that coping strategies would change as a function of group attendance. Specifically, it was expected that active coping strategies (e.g., active coping, planning, behavioral disengagement, positive reframing, and seeking instrumental/emotional support) would increase over time. Emotion-focused strategies (e.g., denial, venting, substance use, and self blame) were expected to *decrease* over time.

Although the Brief COPE Inventory assessed 14 types of coping strategies, due to poor internal consistencies, the following subscales were omitted from analysis: Substance Abuse, Venting, Acceptance, Active Coping, and Self-Distraction. Therefore, only nine forms of coping assessed by the Brief COPE Inventory were examined (i.e.,

Positive Reframing, Religion, Humor, Instrumental Support, Behavioral Disengagement, Self Blame, Denial, Emotional Support, and Planning). Consistent with the study hypotheses, three types of coping assessed by the Brief COPE Inventory (i.e., Positive Reframing, Seeking Instrumental Support and Behavioral Disengagement) significantly increased over time.

Positive Reframing

Coping strategies characterized by positive reframing refer to the family member's attempts to look at their loved one's drug abuse from a positive perspective (e.g., "I've been trying to see it in a different light, to make it seem more positive"; "I've been looking for something good in what is happening"). Previous studies using the Brief COPE Inventory describe positive reframing as an adaptive, active, emotional coping strategy because it involves an active attempt to reduce the emotional distress associated with the stressor (Carver & Scheier, 1993; Schnider, Elhai, & Gray, 2007).

In the present study, positive reframing significantly increased from pretreatment to posttreatment, and from pretreatment to 30-day follow-up. Consistent with previous research with psychoeducational support group interventions (Bernhard et al., 2006), the education and social support provided by this community program appears to have helped members develop ways of positively reframing their loved one's substance abuse. More specifically, positive reframing, that is, the capacity to see how their loved one's illness had impacted their self-growth increased from pretreatment to postreatment and from pretreatment to 30-day follow-up. Because family members of substance abusers often perceive the stresses associated with addiction outside of their control (Easley & Epstein, 1991), being able to positively reframe a negative experience may give the participant the

ability to shift their focus away from the stresses associated with addiction and give participants another way of viewing the substance abusers' disease. In turn, this may help participants manage their distress. These findings extend the earlier work of Orford et al. (2007) who examined qualitative reports of coping among family members after their participation in a psychoeducational intervention with primary care providers. Orford et al. found that increased awareness of their family member's addiction and their ability to see positive alternatives to interact with their loved one's contributed to family members' improved feelings of well-being and optimism.

Although the present study examined substance abuse, the benefits of positive reframing have been well documented in illness and stress research (e.g., Carver, 1997; Carver et al., 1989; Dunket-Schetter et al., 1992; Folkman et.al, 1986). Particularly in situations in which the life event is seen as "uncontrollable," positive reframing is associated with decreased feelings of anxiety and guilt in association with their loved one's suffering. For example, in Conway's (1995) examination of the children of mothers with breast cancer, many of the children perceived the illness as uncontrollable and often assumed internal blame for the outcome of their mother's health. Positive reframing helped the children examined by Conway to manage their anxiety over the "threat of loss." Similarly, Fortune, Smith, and Garvey (2005) found that positive reframing as a coping mechanism helped family members (e.g., parents, siblings, spouses) cope with their relative's lifelong mental illness (e.g., schizophrenia). Specifically, positive reframing resulted in decreased symptoms of distress.

The present results suggest that the Friends and Family Program may help family members' develop an understanding that includes the benefits as well as the negatives

associated with a family member's addiction. Given the benefits that have been associated with positive reframing in the larger illness literature, additional research should examine positive reframing among family members of substance abusers.

Instrumental Support

In the larger literature, coping strategies that involve seeking practical support from others are characterized as problem focused strategies. Seeking help from others (i.e., Instrumental Support) emerged as a common form of coping among the participants in this study. In addition, participants were more likely to endorse getting advice or help from others and similar types of behavior from pretreatment to 30-day follow-up. The finding that instrumental support did not increase from pretreatment to posttreatment, but did increase from posttreatment to 30-day follow-up suggests that the weekly support groups provided suggestions for how to reduce their problems; however, after the program ended, participants may have recognized the importance of instrumental support and utilized the information that they learned in the sessions to seek additional instrumental support. This is important because some research has shown that families with an active substance-abusing family member are often isolated from external sources of support (Easley & Epstein, 1991). It also is also possible that participants may have needed time to assimilate the newly learned psychoeducational information. Similar to other studies utilizing brief psychoeducational programs, some forms of treatment that involve weekly sessions may strengthen over time because the program participants begin to apply what they have learned after the program ends (Bultz, Speca, Brasher, Geggie, & Page, 2000; Dore, Nelson-Zlupko, & Kaufman, 1999; Zelvin, 2007). Results from previous studies with partners of substance abusers suggest that increases in social

support seeking are adaptive and expected over time in connection with greater psychoeducation about their loved one's substance abuse issue (Orford et al., 2001, 2007). Qualitative themes also revealed examples of seeking instrumental support. As one mother of a cocaine abusing woman stated, "I am starting to reach out more to my sister."

Behavioral Disengagement

Behavioral disengagement has been conceptualized as both an avoidant and an adaptive coping strategy depending on the study; however, in situations in which the individual does not have control over a stressful event (such as another person's substance use), distancing oneself is generally considered adaptive (e.g., Luszczynska, Gerstorf, Boehmer, Knoll, & Schwarzer, 2007).

As such, one of the aims of the Friends and Family program was to teach family members to limit their involvement with the substance user particularly as their involvement revolves around their loved one's substance use. For instance, many of the interventions facilitated by the instructor and participants encouraged families to let their substance-abusing loved one solve their problems independently. As expected, behavioral disengagement as a form of coping increased from pretreatment to posttreatment. The qualitative findings support those of the quantitative findings. For example, as one mother explained, "This group is helping me to let go of my guilt and need to help my son through everything. I love him, but I'm done with this." Related to the reduction of behavioral enabling, it appears that participants may have been able to use more effective problem solving and active emotional strategies to manage the psychological distress associated with their family member's addiction.

These results support those of Orford et al. (2007) who observed similar trends in

his qualitative examination of family members who had completed a psychoeducational intervention for loved ones of drug and alcohol abusers. More specifically, Orford et al. found that scores on Independence (i.e., focusing on own life/needs, distancing from the relative's problem drinking or drug taking) increased. The Independence dimension assessed by Orford et al. appears very similar to the behavioral disengagement items assessed in the present study. Specifically, both assess distancing emotionally from the loved one's substance abuse problem. It may be that distancing from the stressor can be maladaptive if the family is denying that their loved one has a drug abuse problem (Orford et al., 1998, 2007). However, if it serves as a form of self-care or independence from the stressor for the purpose of personal well-being, behavioral disengagement may be an adaptive response.

Non-Significant Results

Of the remaining Brief Cope Inventory factors that yielded acceptable internal consistency (i.e. Religion, Humor, Active Coping, Self Blame, Denial, Emotional Support, and Planning), no change was observed from pretreatment to posttreatment or from pretreatment to 30-day follow-up.

Religion. Over the course of the six-week group, the use of religion as a coping strategy did not significantly change over time. In contrast to many self-help groups such as Al-Anon in which appealing to a higher power is a key focus, the present psychoeducational group did not focus on religion or spirituality. In addition, Harley found that religious beliefs are established by middle age (Harley & Firebaugh, 1993). Given that the present group did not focus on this dimension, and that the majority of participants were parents of adult substance abusers and the participants most often

appeared to be middle aged, it is not surprising that participants did not report changes in the degree to which they used religion as a coping mechanism from over time.

Humor. The use of humor as a coping strategy did not significantly change over time. A limitation of the Humor subscale is that it was not possible to establish whether 'humor' was a coping mechanism regularly used by participants; rather, it was only possible to determine that increases in humor were not reported over the course of the program and from pretreatment to 30-day follow-up.

Active Coping. The use of active coping or taking action to make the situation better did not significantly change over time. Although active coping was often reported during the sessions, the use of active coping did not significantly increase from pretreatment to posttreatment or from pretreatment to 30-day-follow-up. This finding is contradictory to the increases in other problem focused coping strategies observed over time on the quantitative measures (i.e., seeking instrumental support) and qualitative observations (i.e., improvements in boundary setting). It is possible that because these participants actively and voluntarily sought treatment, they may represent a population that uses active coping to a larger extent than family members of substance abusers who chose not to attend a community-based educational and support program.

Self Blame. Self-blame did not significantly decrease over time. Although the group intervention specifically encouraged members to accept that "they didn't cause it and couldn't cure the problem," group members may have already internalized this belief prior to their participation in the group. Mean analysis suggests that they did not endorse high levels of self-blame at pretreatment. Perhaps the initial belief that that they were not to blame supported their decision to join the group.

Denial. Similarly, in general, the participants did not appear to be in denial of their loved one's substance abuse. Specifically, it appears that their voluntary participation in a group designed to address a loved one's substance abuse problem may be an indication that in general they know their family member has a substance abuse problem. Also, on the initial background questionnaire, 70% of the participants reported that they had experienced one or more years of living with the substance abuser's addiction, and scores on the items that assessed denial on the Brief Cope Inventory were low at pretreatment.

Emotional Support. Scores on emotional support (e.g., getting emotional support from others) did not significantly change over time. Although scores on the Brief Cope Inventory did not change over the course of the study, many participants expressed the need for emotional support during the sessions. Specially, several participants who were quiet in the initial sessions began to share their experiences of pain and frustration in later sessions. Several members also voiced that the group felt like a safe place where they could express their negative feelings about their loved one's substance use. This may reflect members' tendency to "vent" and "seek support" exclusively in the group setting. This finding is consistent with Easley and Epstein's (1991) finding that family members tend to isolate themselves from outside support and minimize the severity of their loved one's addictive behavior to other family members and friends.

Planning. The use of planning as a coping strategy (e.g., "I've been thinking hard about what steps to take") did not significantly change over time. This was surprising given the qualitative and quantitative reports of behavioral disengagement. However, it is possible that the nature of the program (i.e., six weeks) and the follow-up (30-days

posttreatment) were too brief to detect these types of changes. It is also possible that the program was not powerful enough to encourage the family member to make major changes (e.g., moving away from an alcoholic spouse, asking a substance-abusing child to move).

Summary of Qualitative Findings

Over the course of four six-week groups, experiences were recorded using qualitative methods in an effort to capture detailed narratives and "real life" examples of the types of concerns and experiences these family members endure in relation to their drug-abusing loved one. Several hypotheses were generated regarding the experiences of these family members and friends despite the relatively limited research available with these populations. Across the four community groups that participated in this study, many of the reported experiences were consistent with the hypothesis that family and friends of substance abusers display significant enabling behaviors, poor coping strategies, and feelings of distress in association with their loved one's substance use. Moreover, some of these behaviors and experiences were associated with participation in the Family and Friends educational group. It appears that this group offered members a safe place to discuss their frustration in caring for a loved one who struggles with substance abuse/dependence.

Across the 37 categories, the ten most frequent experiences reported from most to least endorsed included: 1) venting about a loved one's (LO) addiction, 2) difficulty setting boundaries with the LO, 3) giving the LO money, 4) feeling frustrated in relation to the LO's drug use, 5) rationalizing why continued support of the LO was necessary,6) feeling anger in association with the LO's drug use, 7) feeling confused, 8) helping the

LO through a hangover, 9) feeling anxiety, and 10) minimizing the LO's substance-abusing behavior.

The results of this study suggest that family members experience the most difficulty with implementing boundaries (e.g., setting limits to ensure personal well being), but also with other behaviors such as: helping a loved one through a relapse or hangover, lying or covering up the extent of a loved one's addiction to employers or other family members, and exaggerating personal distress to make the substance-abusing loved one feel guilty in an effort to make them stop using alcohol or drugs. Consistent with previous research (Barber & Crisp, 1995; Orford, 1994), many participants reported that they saw no other way to help their loved one stop their addiction and explained that these behaviors were intended to speed the loved one's recovery. Moreover, most of these behaviors were endorsed by the mothers of a substance-abusing son or daughter. Interestingly, when both parents of the substance-abusing loved one were present in the group, tensions often arose between the mother and father about the frequency of enabling behaviors and whether or not they were actually helping their child. These enabling behaviors are consistent with previous research (Orford 1994, 2007; Rotunda, 2001; Zelvin, 2007) and highlight the importance of addressing the multiple stressors that family members face as they struggle to make sense of how to best help their substance-abusing loved one.

Qualitative analyses revealed that the most common types of coping behaviors included rationalization of why support for the substance-abusing loved one was necessary and minimizing the severity of a loved one's drug abuse. Similar to the earlier finding regarding behavioral enabling and the difficulty of setting boundaries, mothers of

substance-abusers appeared especially likely to report rationalizing their child's substance use. Specifically, mothers often reported that their sons or daughters had developed an addiction because of a previous loss (e.g., death of other parent) or co-morbid mental health/learning disability. They often felt that in the context of their son or daughter's traumatic past, substance abuse had developed as a way of coping and expressed their wish that they had intervened earlier or differently to prevent the development of their child's addiction. Although many reported that the severity of their child's addiction had decreased over the course of the group or remitted completely, in later sessions, they shared that their child had relapsed or continued their substance use at previous levels despite their hopes for improvement. Related to this, many mothers acknowledged that they were somewhat socially isolated and fearful of sharing the details of their child's addiction with others. They explained that they coped by keeping it to themselves because of embarrassment and/or loyalty to their substance-abusing family member. Not surprisingly, many somatic complaints were reported in connection to these various coping strategies. The endorsement of somatic complaints appeared especially common among those whose family members were actively using. Several feelings were also mentioned during the sessions that had not been hypothesized. From most frequent to least frequent, these were anger, frustration, confusion, fears for a loved one's safety, anxiety, helplessness and sadness. Many of these feelings were reported as long standing in connection with their loved one's substance abuse. Other research has also reported a strong connection between emotional distress and caregiving (Orford, 2007; Yoshioka et al., 1992).

Similarly, several attitudes and opinions emerged during the sessions that were not previously hypothesized. Most often group members complained about their current life situation with respect to caring for their loved one. Many group members shared their experience of having a substance-abusing loved one. These complaints often included a description of their relationship to the substance-abusing loved one and the length of their loved one's addiction. Because many of the members endorsed the feeling that they did not have a safe place to talk to others about their loved one's use for fear that they would be disloyal or embarrassed, the group likely served as an outlet for them to share how difficult this experience was for them. Independent of the original hypotheses, group members also commonly engaged in advice giving to other group members and discussed the importance of attending this group with each other.

Design Limitations

Although this study illuminated many factors associated with behavioral enabling and coping strategies among the family and friends of substance abusers, the study has several notable limitations. Specifically, there was no random assignment and no comparison group. Therefore, participants may have reduced their levels of behavioral enabling and increased other forms of coping simply as a function of maturation rather than the education and support aspect of the program. Related to this, results may have been due to common factors associated with their participation in the group (i.e., attention from facilitator and expectation of benefit) rather than from the effectiveness of the intervention.

Moreover, the participants sought treatment voluntarily which suggests that they were motivated to make changes in their behaviors. Therefore, the participants may not

represent the larger population of family members of substance abusers. Rather the present participants may be more willing to acknowledge their loved one's alcohol or drug use and actively seek help. It is also important to note that the program participants represented parents, partners, and siblings of substance abusers. It is possible that a study of only one subgroup of individuals affected by their loved one's substance abuse may have revealed a more fine-tuned analysis of the problems specific to a particular subgroup.

In addition, participants may have been aware of answers that were consistent with decreased behavioral enabling by posttreatment and 30-day follow-up and responded accordingly (Folkman et al., 1986). Again, ideally future research that utilizes a control group may be able to address this question.

Quantitative Limitations of Present Research Design

Related to study limitations related to the quantitative portion of the study specifically, the sample was small which limited the power necessary to detect statistically significant differences over time. This may have been a particular concern on the Brief COPE Inventory subscales because each subscale is comprised of only two items. An additional limitation is the low internal consistency observed for several of the Brief COPE Inventory subscales. Other concerns associated with the Brief COPE Inventory are that because each subscale only had two items per factor, it is possible that there were not enough items to accurately reflect participants' true experience of each form of coping. Another statistical concern of the present study is the possibility of inflated Type I error rate. Related to this issue, while the correlations are presented between each of the subscales of the Brief COPE Inventory and the Behavioral Enabling

Scale, these correlations should be interpreted with caution given the poor internal consistency of some of the Brief COPE Inventory subscales and the number of correlations reported. It is also important to recognize that participants were not given much time to complete the questionnaires. The reason for this is that each session of the Friends and Family Program was designed for the entire two-hour period. Thus, the surveys were given quickly before the first session (i.e., Pretreatment) and shortly after the last session (i.e., Posttreatment). Also, to date, the Brief COPE Inventory has not been used with loved ones of substance abusers. Rather, the Brief COPE has been used to assess coping among chronically ill populations and their loved ones. It is important that future studies attempt to replicate these findings.

Study Strengths

Despite the study limitations, the present study extended previous research by employing standardized quantitative measures, a qualitative analysis, and a longitudinal design. Many of the correlational analyses yielded relationships in the expected direction and added to our understanding of behavioral enabling and various forms of coping. Moreover, the qualitative component offered new insights to the specific ways in which family members cope and react to their substance-abusing loved ones. One of the strengths of this grounded theory approach was the ability to highlight critical issues faced by family members (mostly parents) who care for a substance-abusing loved one. This approach arguably provided greater insight into the experience of family members dealing with a substance-abusing loved one as well as the greater effects on the family system. Moreover, two independent coders were used to further minimize the potential of investigator bias. Finally, by using a longitudinal design with both qualitative and

quantitative analysis, it was possible to compare progress in coping and enabling over time and highlight other variables unanticipated by previous studies (i.e., group themes, unique feelings generated by participation in group) as well as contradictions between the two forms of analysis.

The examination of four six-week groups may have also increased the generalizability of the study because the primary researcher was able to examine groups across four distinct time periods amidst seasonal changes and client turn over within the community organization. Furthermore, relatively few studies have examined free community programs. Therefore, examination of this intervention may add greatly to our understanding of the issues facing individuals with little resources for fee-based service.

Finally, the present study supports previous research that has demonstrated the benefits of counseling for reducing behavioral enabling. It also extends the qualitative work of Orford et al. (2007) who examined family members' distress in connection with support from their primary health care provider. However, the present study was the first to date to assess how a weekly psychoeducational support group of this kind for loved one's other than spouses may have significant benefits on behavioral enabling.

Directions for Future Research

Research on the concerned significant others of substance abusers continues to be relatively limited in comparison to what we know of the substance abusers themselves. Foremost, increasing the sample size would give us a better sense of coping and enabling across a wider range of significant others. Secondly, a larger sample would increase power and sensitivity to statistically significant variables. Additional studies with a more diverse range of participants (e.g., including the minor children and friends of substance

abusers) may also benefit our understanding of these issues. Ideally, the effects of this type of program should be compared to a wait list control. Another possibility is to examine whether a group format is more beneficial than individual treatment for enabling and coping behavior. The present study should also be replicated with a larger number of groups or groups that attend different types of community-based programs. Other behaviors not examined in the present study may also influence the degree to which participants benefit from this type of program. Therefore future researchers should address whether anxiety, depression, stress, and so forth impact the degree to which participants' benefit from this type of program. Because much of the research has found negative associations between enabling and psychological functioning among caregivers of substance abusers (Moos et al., 1990; Orford, 1990), variables such as family cohesiveness, the participant's use of alcohol or drugs, and readiness for change may serve to moderate or mediate the outcomes of treatment. In addition, six participants noted that they were currently attending some other form of treatment (i.e., Al-Anon, Faith-Based treatment). Therefore, it is difficult to know whether participation in other types of treatment may have impacted the study results and should be controlled for in future studies of this type. Because the participants' education level may affect the degree to which they are able to understand and incorporate a considerable amount of manualized material in a short period of time, participants' education level should be considered in future research.

Study Summary and Conclusions

The results of the present study suggest that a brief community-based psychoeducational and support group is associated with reductions in enabling behaviors

and improvement in positive reframing, seeking instrumental support, and behavioral disengagement. The categories of enabling and coping responses identified in this study correspond closely with research from previous studies and indicate that difficulty with boundary setting (e.g. paying a substance abusing loved ones bills), poor coping strategies (e.g. withdrawing from instrumental support, denying the severity of a loved one's addiction), and negative feelings (e.g. anger and resentment) are common among family members of substance-abusing loved ones.

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APPENDIX A

INFORMED CONSENT DOCUMENT
(Qualitative and Quantitative Phases)
OLD DOMINION UNIVERSITY

PROJECT TITLE: Effects of an Educational and Support Program for Family and Friends of a Substance Abuser

INTRODUCTION
The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES. This study is titled: Effects of an Educational and Support Program for Family and Friends of a Substance Abuser. If you say YES, we would like you to complete four brief measures in the beginning of the Friends and Family program (first or second session) and at the end (last session) of the Friends and Family program. You will be asked to complete these measures during your regularly scheduled meeting time. Thirty days after you complete the Friends and Family Program, we will mail you the questionnaires and ask that you complete them at your home and return the completed questionnaires in the prestamped, preaddressed envelope that will be provided to you. If you would prefer, we will call you 30 days after the program has ended and will ask you the follow-up questions over the phone.

RESEARCHERS
Responsible Project Investigator: Michelle L. Kelley, Ph.D., Professor of Psychology, Department of Psychology, College of Science, Old Dominion University.

Study Investigator: Amanda Jeffrey-Platter, M.A., Doctoral student in the Virginia Consortium Program in Clinical Psychology (Psy.D. program), Old Dominion University, William & Mary University, Norfolk State University, & Eastern Virginia Medical School.

DESCRIPTION OF RESEARCH STUDY
Little information is available on whether individuals who attend voluntary support groups such as the Friends and Family Program benefit from their participation in this type of setting. If you say YES, then you will join a study involving research on the possible benefits of attending a program for friends and family members of an individual who misuses alcohol or other drugs. If you choose to participate, you will be asked to fill out some questions that assess your previous counseling experience as well as how much you know about alcohol and drugs; however, you will not put any identifying information (such as your full name) on the actual survey forms at any time. These surveys are typically completed by everyone who attends the Friend and Family Program regardless of whether or not they participate in the study. By saying "Yes" to participation in the study, you are saying that you will allow the researchers to have your answers on these surveys too.

In addition, if you say YES, then you agree to let the Study Investigator sit in on the six sessions of the Friends and Family program and take handwritten notes on what is said during the sessions. In addition, you will be asked to fill out brief measures that assess how you manage your stress and your behavior with the alcohol or drug abuser. If you say YES, then you will be asked to complete these measures three times: at the first session (during the regular group meeting time), at the last session (during the regular group meeting time) and about 30 days after the program has ended you will be mailed the measures again. You will be asked to complete the

two short measures and return the completed measures in a pre-addressed, prestamped envelope. If you prefer, we can call you and ask you the questions over the phone. Between 15 and 30 individuals are expected to participate in this study.

EXCLUSIONARY CRITERIA

If you participate in the Friends and Family Program you are eligible to participate.

RISKS AND BENEFITS

You may be uncomfortable having someone write down what you say in the Friends and Family sessions. If you feel uncomfortable, please let the Study Investigator know and she will stop writing down what you say. Please know that anything that is written down will not have your full name on it. Also, the notes that the Study Investigator takes down will not be released to anyone other than the Study Investigators.

If you decide to participate in this study, then you may face a risk of mild uneasiness in filling out the questions about whether you have been in counseling, what you know about alcohol and drugs, how you manage your stress, and how you interact with your substance-abusing family member or friend. You may skip any items or questionnaires that you find stressful. If you experience stress from completing these questionnaires, please contact the Friends and Family Program facilitator, Nora Hamel M.S., who can talk with you or suggest someone for you to talk with. In addition, there is also the risk that someone will learn that you have participated in the Family and Friends Program when the surveys are mailed to your home or you are called 30 days after the program has ended. At the last group session, we will ask if it is okay to mail the questionnaires to you or phone you. Also, because we need your name in order to mail you the follow up surveys, there is the possibility that someone you know will learn that you have participated in the Friends and Family Program. We will take every precaution to contact you in a way that is most comfortable for you. As with any research, however, there is some possibility that you may be subject to risks that have not yet been identified.In addition, there is the possibility that someone other than the research team might see your survey answers and things you mention in the Friends and Family meetings. However, we will carefully guard your information by keeping everything locked and it will only be viewed by the study team members. There is also the rare possibility that the master list could get lost. While this situation is unlikely, it is a possible risk as with any research and should also be noted.

BENEFITS: There is no direct benefit to participating. The main benefit to you for participating in this study is that you may better understand more about alcohol and drug use, and how you manage the stress of having a friend or family member who abuses alcohol or other drugs. Additionally, you main gain more understanding as to how you behave with your substance-abusing friend or family member.

COSTS AND PAYMENTS

The researchers want your participation in this study to be absolutely voluntary. If you complete the four brief questionnaires described in this form at all three points—at the beginning of the Friends and Family program, at the end of the Friends and Family Program, and at the 30-day follow-up, we will mail you a $10.00 gift card to Wal-mart. You must complete the surveys at all three study points to receive the gift card.

NEW INFORMATION

If the researchers find new information during this study that would reasonably change your decision about participating, then they will give it to you.

CONFIDENTIALITY

Although there is the risk that someone will learn of your involvement in the Family & Friends program as noted above, all information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations and publications, but you will not be identified. We will not ask for your full names on any questionnaires.

WITHDRAWAL PRIVILEGE

It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study -- at any time. Your decision will not affect your relationship or participation in the Friends and Family Program, or otherwise cause a loss of benefits to which you might otherwise be entitled.

COMPENSATION FOR ILLNESS AND INJURY

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of harm arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in this research project, you may contact Dr. Michelle Kelley at 757-683-4459 or Dr. David Swain the current IRB chair at 757-683-6028 at Old Dominion University, who will be glad to review the matter with you.

VOLUNTARY CONSENT

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them: Dr. Michelle Kelley: mkelley@odu.edu, 737-683-4459 and Amanda Jeffrey-Platter: ajeff008@odu.edu. If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should call Dr. David Swain, the current IRB chair, at 757-683-6028, or the Old Dominion University Office of Research, at 757-683-3460. And importantly, by signing below, you are telling the researcher YES, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

Subject's Printed Name & Signature	**Date**

INVESTIGATOR'S STATEMENT

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Note: You can elect to participate in either of the qualitative or quantitative surveys without having to participate in both.

APPENDIX B

INFORMED CONSENT DOCUMENT
(Qualitative Portion only)
OLD DOMINION UNIVERSITY

PROJECT TITLE: Effects of an Educational and Support Program for Family and Friends of a Substance Abuser

INTRODUCTION
The purposes of this form are to give you information that may affect your decision whether to say YES or NO to taking part in this research, and to record the consent of those who say YES. This study is titled: Effects of an Educational and Support Program for Family and Friends of a Substance Abuser and all study measures will be conducted within your group sessions.

RESEARCHERS
Responsible Project Investigator: Michelle L. Kelley, Ph.D., Professor of Psychology, Department of Psychology, College of Sciences, Old Dominion University.

Study Investigator: Amanda Jeffrey-Platter, M.A., Doctoral student in the Virginia Consortium Program in Clinical Psychology (Psy.D. program), Old Dominion University, William & Mary University, Norfolk State University, & Eastern Virginia Medical School.

DESCRIPTION OF RESEARCH STUDY
Little information is available on whether individuals who attend voluntary support groups such as the Friends and Family Program benefit from their participation in this type of setting. If you decide to participate, then you will join a study involving the possible benefits of attending a program friends and family members of an individual who misuses alcohol or other drugs. If you choose to participate, then you agree to let the Study Investigator sit in on the six sessions of the Friends and Family program and take handwritten notes on what is said during the sessions. However, she will not record your full name. Also, as part of the Friends and Family program, you are asked to fill out a few questions that ask you whether you have ever been in counseling, what you hope to get from attending the program, and how much you know about alcohol and drugs. These questions are a regular part of the Friends and Family program, but if you choose to participate in this study, the Study Investigators will have the answers to the questions too. Approximately 8-15 individuals are expected to participate in this study.

EXCLUSIONARY CRITERIA
If you participate in the Friends and Family Program you are eligible to participate.

RISKS AND BENEFITS
RISKS: If you decide to participate in this study, then you may face a risk of mild uneasiness in filling out the questions about whether you have been in counseling and what you know about alcohol and drugs. You can skip any items that you find stressful. You may also be uncomfortable having someone write down what you say in the Friends and Family sessions. If you feel uncomfortable, please let the Study Investigator know and she will stop writing down what you say. Please know that anything that is written down will not have your full name on it. Also, the notes that the Study Investigator takes down will not be released to anyone other than

the Study Investigators. As with any research, there is some possibility that you may be subject to risks that have not yet been identified.

In addition, there is the possibility that someone other than the research team might see your survey answers and things you mention in the meeting. However, we will carefully guard your information by keeping everything locked and it will only be viewed by the study team members. There is also the rare possibility that the master list could get lost. While this situation is unlikely, it is a possible risk as with any research and should also be noted.

BENEFITS: There is no direct benefit to participating. The main benefit to you for participating in this study is that you may better understand more about alcohol and drug use, your level of stress, and how you manage the stress of having a friend or family member who abuses alcohol or other drugs. Additionally, you main gain more understanding as to how you behave with your substance-abusing friend or family member.

COSTS AND PAYMENTS

The researchers want your decision about participating in this study to be absolutely voluntary. Yet they recognize that your participation may pose slight discomfort in filling out the questions that measure your knowledge of alcohol and drugs. However, the researchers are unable to give you monetary payment for participating in this study.

NEW INFORMATION

If the researchers find new information during this study that would reasonably change your decision about participating, then they will give it to you.

CONFIDENTIALITY

All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations and publications, but the researcher will not identify you. The study investigator will not record full names on the questions the measure or the handwritten notes. In addition, any handwritten notes that we take during the meeting will be carried back and forth in and out of group room only by means of a locked briefcase.

WITHDRAWAL PRIVILEGE

It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study – at any time. Your decision will not affect your relationship or participation in the Friends and Family Program, or otherwise cause a loss of benefits to which you might otherwise be entitled.

COMPENSATION FOR ILLNESS AND INJURY

If you say YES, then your consent (saying yes to being part of the study) in this form does not waive any of your legal rights. However, in the event of harm arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in this research project, you may contact Dr. Michelle Kelley at 757-683-4459 or mkelley@odu.edu, Amanda Jeffrey Platter at ajeff008@odu.edu or Dr. David Swain the current IRB chair at 757-683-6028 at Old Dominion University, who will be glad to review the matter with you.

VOLUNTARY CONSENT

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them:

Dr. Michelle Kelley: mkelley@odu.edu, 757-683-4459
Amanda Jeffrey-Platter: ajeff008@odu.edu, 928-230-3855

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should call Dr. David Swain, the current IRB chair, at 757-683-6028, or the Old Dominion University Office of Research, at 757-683-3460.

And importantly, by signing below, you are telling the researcher YES, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

Subject's Printed Name & Signature	**Date**

INVESTIGATOR'S STATEMENT

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Investigator's Printed Name & Signature	**Date**

APPENDIX C

Permission to Attend

My name is Amanda Jeffrey and I am a doctoral student from the Virginia Consortium Program. I would like to attend your Family and Friends group in order to better understand what challenges you face in knowing someone with a substance abuse issue. My goal is to sit and listen to your experiences. At no time, will any confidential information be revealed about any group members that attend the program. If you are comfortable with my presence in the group, please sign below.

Member's Signature / Date _____

Group Leader, Nora Hamel, Signature / Date _____

Attending VCCP PsyD Student: _____

APPENDIX D

Survey

Answers to the following questions will help us know what you need or would like to learn about substance use/addiction and your particular situation. Please do not provide any anything that would identify you, your full name in your responses.

1. How long has your friend or family member's alcohol and/or drug use been a problem for you?

2. What would you like to learn from the Friend and Family member class?

3. Does your friend or family member who abuses alcohol and/or drugs have any other mental health disorder (e.g., (i.e. ADD/ADHD, schizophrenia, depression, bi-polar disorder or other)? If so, please **list all other diagnoses/disorders**.

4. Do you **currently** attend:

   a. Al-Anon
   b. Nar-Anon
   c. Faith-based counseling
   d. Other mental health counseling (psychologist, social worker, etc.)

5. Have you attended any of the following in the **past (not currently)?**
   a.Al-Anon
   b. Nar-Anon
   c. Faith-based counseling
   d. Other mental health counseling (psychologist, social worker, etc.)

6. Is there anything else about you or your particular situation that you think we need to know so that we may provide you with a valuable educational experience?

APPENDIX E

Friends & Family Education

Please circle the letter that indicates the correct answer:

1. People use alcohol or other drugs because they lack the _____ required to deal with day-to-day functions.

A. survival skills
B life skills
C willpower

2. Mixing different types of drugs confuses the central nervous system.

A agree
B disagree
C don't know

3. Which of the following is an ego defense mechanism that could lead to death?

A devaluation
B affiliation
C denial

4. _____ growth is arrested by a persons drug or alcohol use.

A intellectual
B emotional
C physical

5.When a person stops drinking or using drugs on their own,

A life gets better
B nothing changes but their lack of alcohol or drug use
C life gets worse

6. Each role in a family is determined by

A the person dependent on drugs or alcohol
B the family
C the family's chief enabler

7. Is it possible for a person who is using drugs or alcohol to develop and maintain a healthy emotional relationship?

A yes, always
B no, never
C yes, sometimes

8. The difference between anger and resentment:

A. there is no difference

APPENDIX E – CONTINUED

Friends & Family Education

B. resentment is always justified
C. resentment is anger held over from the past

9. After a dependent person stops using drugs or alcohol, families will need to

A. keep their defenses up at all times
B. continue to bring up past behaviors
C. learn to emotionally detach
D. go nuts

10. The building of healthy family relationships requires healthy family members to

A. talk
B. ask questions
C. have no secrets
D. all of the above

11. The central nervous system is confused when a person uses

A. alcohol
B. cocaine
C. marijuana
D. a mix of all of the above

12. You should always reconcile with the person you forgive.

A. agree
B. disagree
C. don't know

APPENDIX F

BRIEF COPE INVENTORY

These items deal with the ways you've been coping with the stress in your life since you found out that your loved one is using drugs and or alcohol. There are many ways to try to deal with your problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but we are interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not--just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

1 = I haven't been doing this at all

2 = I've been doing this a little bit

3 = I've been doing this a medium amount

4 = I've been doing this a lot

1. I've been turning to work or other activities to take my mind off things.

   1 2 3 4

2. I've been concentrating my efforts on doing something about the situation I am in.

   1 2 3 4

3. I've been saying to myself "this isn't real"

   1 2 3 4

4. I've been using alcohol or other drugs to make myself feel better.

   1 2 3 4

5. I've been getting emotional support from others.

   1 2 3 4

6. I've been giving up trying to deal with it.

   1 2 3 4

APPENDIX F – CONTINUED

7. I've been taking action to try to make the situation better.

1 2 3 4

8. I've been refusing to believe that it has happened.

1 2 3 4

9. I've been saying things to let my unpleasant feelings escape.

1 2 3 4

10. I've been getting help and advice from other people.

1 2 3 4

11. I've been using alcohol or other drugs to help me get through it.

1 2 3 4

12. I've been trying to see it in a different light, to make it seems more positive.

1 2 3 4

13. I've been criticizing myself.

1 2 3 4

14. I've been trying to come up with a strategy about what to do.

1 2 3 4

15. I've been getting comfort and understanding from someone.

1 2 3 4

16. I've been giving up the attempt to cope.

1 2 3 4

17. I've been looking for something good in what is happening.

1 2 3 4

18. I've been making jokes about it.

1 2 3 4

19. I've been doing something to think about it less, such as going to movies,

1 2 3 4

APPENDIX F – CONTINUED

watching TV, reading, daydreaming, sleeping, or shopping.

20. I've been accepting the reality of the fact that it has happened.

1 2 3 4

21. I've been expressing my negative feelings.

1 2 3 4

22. I've been trying to find comfort in my religion or spiritual beliefs.

1 2 3 4

23. I've been trying to get advice or help from other people about what to do.

1 2 3 4

24. I've been learning to live with it.

1 2 3 4

25. I've been thinking hard about what steps to take.

1 2 3 4

26. I've been blaming myself for things that happened.

1 2 3 4

27. I've been praying or meditating.

1 2 3 4

28. I've been making fun of the situation.

1 2 3 4

APPENDIX G

The Behavioral Enabling Scale - Revised (Rotunda, 2004)

Please mark X next to best descriptor of your behavior:

	Not at all	Rarely	Sometimes	Often	Very often	NOT APPLICABLE
1.I gave my Friend or Family member money to buy alcohol or drugs.	____	____	____	____	____	____
2. I purchased alcohol or drugs for my Friend or Family member.	____	____	____	____	____	____
3. I took over my Friend or Family member's chores because he/she was drugging or drinking.	____	____	____	____	____	____
4. I lied or made excuses to family/friends to hide my Friend or Family member's drinking/drugging.	____	____	____	____	____	____
5. I drank/used drugs with my Friend or Family member.	____	____	____	____	____	____
6. I told my Friend or Family member it was okay to drink or use drugs on certain days for special family or social gatherings.	____	____	____	____	____	____
7. I borrowed money to pay bills caused by my Friend or Family member's drinking/drug use.	____	____	____	____	____	____
8. I changed or cancelled family plans or social activities because my Friend or Family member was drinking, using drugs or hung over.	____	____	____	____	____	____
9. I had sex with my Friend or Family member when I really didn't want to because he/she had been drinking or drugging.	____	____	____	____	____	____
10. I asked for help from police, a judge lawyer or other professional to get my Friend or Family out of trouble related to drinking or drug use.	____	____	____	____	____	____

APPENDIX G- CONTINUED

The Behavioral Enabling Scale - Revised (Rotunda et. al, 2001)

	Not at all	Rarely	Sometimes	Often	Very often	NOT APPLICABLE
11. I threatened my Friend or Family member that I would have no contact with them because of the drinking/drugging, but did not follow through with it.	____	____	____	____	____	____
12. I paid my Friend or Family member's lawyer or court fees, or bailed them out of jail due to drinking or drug-related offense.	____	____	____	____	____	____
13. I helped Friend or Family member through a hangover.	____	____	____	____	____	____
14. I cleaned up (vomit, urine etc.) after my Friend or Family member got sick.	____	____	____	____	____	____
15. I encouraged other family members to ignore or be silent about Friend or Family members drinking/drug use.	____	____	____	____	____	____
16. I helped conceal Friend or Family member's drinking or drug use from employers or coworkers.	____	____	____	____	____	____
17. I coaxed Friend or Family member in the morning to go to work when he/she was hung over.	____	____	____	____	____	____
18. I made excuses to others for my Friend or Family members impaired behavior when he/she was drunk or high.	____	____	____	____	____	____
19. I reassured Friend or Family member that his/her drinking or drug use was not that bad.	____	____	____	____	____	____
20. I lied or told a half-truth to a physician, counselor, probation officer, judge, police officer about a Friend or Family member's alcohol or drug use, or participation in treatment programs.	____	____	____	____	____	____

APPENDIX H

FOLLOW-UP CONTACT

Please indicate in writing how you would like to be contacted at 30-day follow up. Also, if you are comfortable listing alternative phone or address information in case of change in residence, please do so at this time:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Member's Name / Date

(Print)_____/(Sign)_____

VITA

AMANDA JEFFREY PLATTER
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EDUCATION

Psy.D. *Expected 2010*	**Virginia Consortium Program in Clinical Psychology**, Norfolk, Virginia A University Based, APA accredited program, jointly sponsored by: The College of William & Mary, Eastern Virginia Medical School, Old Dominion University, and Norfolk State University
Dissertation Title:	*Effects of an Educational Support Program for Family and Friends of Substance Abusers.* Proposed: September 2007
M.A. 2003	**California State University Long Beach**, Long Beach, California Degree: Psychology (research concentration) Thesis Title: *The Relationship between Attachment, Psychopathy and Personality Traits Among Adolescents.*
B.A. 1999	**California Polytechnic State University**, San Luis Obispo, California

ADVANCED PRACTICUM TRAINING

AUG 08 – May 09 — ***College of William & Mary Counseling Center**, Williamsburg, Virginia*

Population: Outpatient college students
Diagnoses: Affective disorders, eating disorders, anxiety disorders, personality disorders, history of child abuse and phase of life concerns.
Responsibilities: Brief and long-term psychotherapy, co-facilitation of interpersonal processing group, outreach planning, intake interviews, crisis intervention, personality assessment, and treatment planning from psychodynamic, interpersonal, and cognitive behavioral theoretical orientations.
Hours: 22 hours on site/weekly
Supervision: Carina Sudarsky-Gleiser, Ph.D., Licensed Clinical Psychologist & Becca Marcus, Licensed MSW; 2.5 hrs/week via videotape and live supervision.