Families, Systems, & Health
2018, Vol. 36, No. 2, 216–224

1091-7527/18/$12.00 http://dx.doi.org/10.1037/fsh0000339

Coping Strategies and Support Structures of Addiction Affected Families: A Qualitative Study from Goa, India

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Introduction: Despite the large burden of a relative's drinking on their family members, the latter's perspectives and experiences are largely neglected. The aims of this article are to assess the coping strategies used by affected family members (AFMs) in Goa, India, and to examine the nature of the support they have for dealing with their drinking relative. ***Method:*** In-depth interviews were conducted with adult AFMs selected through purposive and maximum variation sampling. Data was analyzed using thematic analyses. ***Results:*** The commonly used coping strategies included accommodating to the relative's behavior, financially adapting to their means, self-harm, attempting to reason with the drinking relative, covert intervening, and avoiding fights and arguments. There was a general reluctance to seek support, and the type and quality of support that was available was also limited. Support from neighbors or relatives was primarily through providing a "listening ear" or financial support. Religious and spiritual pursuits were commonly used to seek solace, and to manage negative thoughts and feelings. Formal support was sought for themselves or the relative through existing health services and Al-Anon, and occasionally from the police. ***Discussion:*** AFMs experience a considerable amount of strain in relation to their relative's drinking, and have to rely on different ways of coping and social support, as is available to them. Although there is a universality to the experiences of families affected by addictions, this must be interpreted with caution, as it is also accompanied by variations in cultural factors related to these experiences.

Keywords: alcohol, family, India, qualitative

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This study was supported by a grant from Grand Challenges Canada (S7 0653-01-10).

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Alcohol use disorders (AUDs) affect not only the person struggling with alcohol but also their family. This substance use disorder is similar to that of someone having a disability or a terminal illness (Copello, Templeton, & Powell, 2010).

Over 100 million family members are affected by the addictive behavior of a relative (Orford, Velleman, Natera, Templeton, & Copello, 2013), and this number will increase as the prevalence of addiction increases, as is happening across the world (World Health Organization, 2006). Uncertainty and stress characterize the family life of affected family members (AFMs; Hutchinson, Mattick, Braunstein, Maloney, & Wilson, 2014), who are affected by financial problems, persistent worry, and disagreeable behaviors that arise as part of the AUD (Orford, Velleman, Copello, Templeton, & Ibanga, 2010). Behaviors associated with AUDs create a stressful environment for AFMs to live in, impacting them psychologically and physically (Copello, Velleman, & Templeton, 2005). AFMs are more prone to medical and psychiatric conditions compared with family members of people without addictions (Ray, Mertens, & Weisner, 2009). AFMs are also commonly subject to domestic violence (D'Costa et al., 2007; World Health Organization, 2006). Children of parents with AUDs show difficult behavior, a decline in school performance, and are more likely to develop substance use problems themselves (Velleman & Templeton, 2016). Thus, the harmful effects on family members and family life can be considered as one of the most important aspects of alcohol's harm to others (Casswell, You, & Huckle, 2011; Room et al., 2010).

The rise in alcohol consumption and AUDs in India is a reflection of the political, social, and economic changes that have taken place in the country in recent times (Chaterjee, 2008; Jacob, 2009). A conservative estimate on the impact of AUDs on families is that for each person with an AUD, at least one close family member is affected (Orford et al., 2013). In India, because of the closeness of family bonds and the ways that families tend to continue living with each other (compared with the West), is it likely that the ratio of people affected is far greater. Considering the increasing prevalence of AUDs in India, one could conclude that this would be associated with a large number of AFMs, and this will be a largely hidden population, because AFMs are a "silent group," with their perspectives and experiences largely being neglected.

The alcohol user's behavior is often seen as a result of a dysfunction in the family (Copello, Templeton, Orford, & Velleman, 2010a), and in India, where particular emphasis is placed on family integrity, this dysfunction is perceived as shameful for the individual with an AUD and the family. Hence, AFMs in India have suffered in silence and little has been done to implement interventions to reduce their distress. Attitudes toward alcohol use are still evolving in India, and the impact of AUDs on family members has remained largely neglected by policymakers in India. Furthermore, in India, drinking is a predominantly male activity, and in a patriarchal society, this means that the voices of the predominantly female AFMs remain unheard. All these factors leave AFMs with little options in terms of a social safety net or support outside of their families.

The aim of this article is to assess the current coping strategies used by AFMs and to examine the nature of support they already have to deal with their drinking relative. This article reports part of the formative research of a larger project, Supporting Addiction Affected Families Effectively (SAFE). SAFE is a project based in Goa, India, examining the contextual applicability and adaptation of the 5-Step Method (a psychosocial intervention to support AFMs, developed in the United Kingdom; Copello, Templeton, Orford, & Velleman, 2010b) for Indian settings.

Method

Setting and Sample

Goa, in west India (population = 1.4 million people) has lower excise duties on alcohol and a "more liberal, wet culture" (Patel, Dourado, De Souza, & Dias Saxena, 2001) compared with other states in the country. Drinking patterns in men from Goa are characterized by low rates of abstinence and high prevalence of hazardous drinking among drinkers (D'Costa et al., 2007; Pillai et al., 2013; Silva, Gaunekar, Patel, Kukalekar, & Fernandes, 2003).

AFMs were recruited from primary care, a tertiary care de-addiction and rehabilitation center, private psychiatry clinics, local self help groups (e.g. Al-Anon), and the community.

AFMs were defined as any adult (≥18 years) living with a relative having drinking problems, as described by the referral source and corroborated by the AFM. Purposive and maximum variation sampling was used to ensure that data were obtained from participants demonstrating as wide variation as possible on dimensions of interest. The aim was to select 20 to 30 AFMs as participants, and the data collection was stopped once data saturation was reached.

Data Collection

Data were collected through in-depth interviews (IDIs), allowing for detailed in-depth probing of subject matter and providing information on context (Legard, Keegan, & Ward, 2003). Interview questions were designed to explore research objectives of the SAFE project and were also based on previous work with other AFMs (Orford et al., 2010). This article focuses on two crucial constructs related to the experiences of AFMs (Orford et al., 2013)—how the AFM copes with the relative's drinking and resulting behavior, and the support that the AFM receives.

Two trained research workers conducted the IDIs in the vernacular. All AFMs were interviewed face-to-face either at their homes, the project field office, or any other mutually convenient place. Written informed consent was taken individually from all participants. All audio-recorded interviews were first transcribed verbatim and then translated into English by trained research workers.

Quality of data was monitored on an ongoing basis through the following mechanisms. The supervisor examined in detail each individual transcript of the interview and checked it for richness and quality of data and interviewing style. Some transcripts were also examined in detail by RV and GV. Written feedback was then provided to the relevant research worker alongside their own self-assessment, with suggestions for improvement and questions to be emphasized in subsequent interviews.

Data Management and Analyses

Data were analyzed by Sydney Church and Urvita Bhatia under Abhijit Nadkarni's supervision. Data were analyzed using Thematic Analysis, which is a method for identifying, analyzing, and reporting patterns (themes) within data (Braun & Clarke, 2006). Themes were derived by retrieving pieces of data pertaining to identified codes and by examining their meaning in relation to the research questions. Themes are "general propositions that emerge from diverse and detail-rich experiences of participants and provide recurrent and unifying ideas regarding the subject of inquiry" (Bradley, Curry, & Devers, 2007, p. 1766). Patterns were derived by comparing similarities and differences between participants on these themes or by examining how the themes or codes were connected to or interacted with one another. The themes were supported by excerpts from transcripts to demonstrate that themes were as close to the data as possible and reflected the words used by the participants themselves.

Ethical Issues

The Institutional Review Board at Sangath (Goa, India) reviewed and approved the study. Any participant who indicated the need for help was referred to the existing, but limited, local services.

Results

The 30 participants in the study were predominantly females, in the 18-to-70-year age range, and wives of drinkers. The majority of the participants had completed primary or secondary schooling, and were employed (see Table 1).

Coping

Accommodating to the relative's behavior. Often, family members reported trying to keep the peace in the house by accommodating to the behavior of their relative. They would do this by extending their familial (often nurturing) role to include managing the impact of the drinking on the relative—for example, taking them to the hospital when they were ill or bringing them home when they passed out on the road—and ensuring that they were fed:

> After doing so much we will not leave him (drinking relative) alone to die. I try different remedies hoping that someday he will improve. God has given me this life; so one day he will improve. When he falls down on the road I curse him but I do not leave him there. (Mother, 40 years)

Table 1
Sample Description

Variable	Number (n = 30)	Percentage (%)
Gender		
Female	28	93
Age		
18–30 years	3	10
31–44 years	13	43
45–59 years	12	40
>60 years	2	7
Mean age (*SD*)	43 years (11.76)	
Religion		
Hindu	17	57
Christian	12	40
Muslim	1	3
Education		
No education	4	13
Primary and secondary school (1–10 years)	18	60
Higher secondary and above	8	27
Employment		
Employed	18	60
Unemployed	11	37
Student	1	3
Relationship		
Mother	3	10
Wife	19	63
Sister	2	6.7
Brother	1	3.3
Daughter	1	3.3
Son	1	3.3
Sister-in-law	2	6.7
Brother-in-law	1	3.3
Mean age of marriage in spouses of drinking relative (*SD*)	22 years (6.8)	
Awareness of spouse's (of drinking relative) drinking at the time of marriage	9	47

> Every time my brother (drinking relative) passed out somewhere I took him to hospital all by myself as my other family members were occupied in their work. When he was at home in a comatose state for around 6 months, I started visiting a nearby temple very often to divert my mind. I have even borrowed money from total strangers to help him, but he doesn't appreciate what I am doing for him. (Sister, 34 years)

Financially adapting to their means. For many families, the drinking relative was the sole (and certainly the main) financial provider, and so when finances were short, they were forced to adapt by whatever means they could. They did this through selling household goods, begging for food or money, and making do with what they already had:

> I had bought gold worth Rs. 7 to 8 lakhs (approx. USD 10,301 to 11,773) from abroad, but I sold it all. Due to insufficient money I sold my ring, pair of earrings, leg gold ornaments, bangles, and mangalsutra (ornament worn by married women in India). (Wife, 59 years)

Self-harm. Across the interviews, there was a common theme of family members becoming exasperated with their relative and striking back through either yelling or, in a few cases, retaliating physically. Sometimes frustration with the relative not changing his behavior culminated in family members trying to shock their relative through consuming alcohol themselves or self-harming, out of despair:

> I became upset and consumed sedatives . . . I do not know how my brother (drinking relative) managed those three days . . . I had taken the tablets to try and scare him. (Sister, 34 years)

> I drank alcohol to see if he improves himself but he does not. Two times in anger I drank alcohol, I am

> telling you the truth, why should I lie . . . But still he did not improve. (Wife, 51 years)

Attempts to reason with the drinking relative. Family members reported having attempted to communicate to their drinking relatives about their pattern of drinking, behavior, and impact of drinking. This was done in an attempt to influence positive change and to convince, and, in many cases help, the drinker to stop drinking:

> Now I have realized that if I had to keep quiet and not said anything then he wouldn't have done anything (about his drinking). After I told him off he would feel guilty about himself and would lie quietly in one place. I had a fixed time; when he woke up in the morning I would tell him everything. Yesterday you did this, you did that. (Wife, 47 years)

Covert intervening. A major complaint of AFMs was that the relative would not listen to their entreaties to stop drinking, and so efforts were made to intervene covertly by attempting to curb the relative's drinking habits in a discrete manner:

> Yes, he consumes one bottle for the entire day. I sometimes empty half the bottle and add water to it. (Wife, 60 years)

> Earlier I used to hide his alcohol . . . I would hide his money, if he had more money. Because when he has money he does not understand anything . . . as to how much he is drinking. (Wife, 51 years)

Avoiding fights and arguments. Family members often reported that avoiding arguments when their relative was drunk and keeping quiet were the best coping strategies, as that resulted in the least retaliation from the relative. AFMs also reported physically exiting the situation and finding a place elsewhere to sleep in order to temporarily avoid their relative:

> I would not let him start a fight and let the situation deteriorate. I would not argue with him because if I did that, the quarrel would worsen. One has to manage the situation as one has to maintain peace in the house. (Wife, 37 years)

Support

Perceived impossibility of seeking and getting support. Although there were preferred sources of support that were highlighted a common narrative among the interviews were those of barriers in seeking support. AFMs highlighted a general reluctance to seek support, and the limitations of the type and quality of support that was available:

> I never tell my matters to anyone outside the house . . . I have always been like that. From my childhood there was this culture in our house that you are not supposed to tell anything happening in the house with people outside the family. So I followed that and that affected my sanity. (Wife, 47 years)

> My sisters did not help very much in this situation. My brothers in law did not help by speaking to or guiding my brother either. I went through all the trouble by myself. It was this lack of support that forced me to attempt suicide by consuming sedatives. (Sister, 34 years)

Informal support. Despite societal stigma, in many cases, AFMs reported receiving support from neighbors or relatives, primarily by providing a "listening ear" or financial support. Despite family members lamenting that nothing helped the behavior of their relative, which they were most aggrieved by, on the whole, those who reported having someone to talk to about their problems experienced a sense of relief:

> I have a sister younger to me with whom I would share (problems) some times. And there is my sister-in-law's daughter staying here in Goa, I would tell her sometimes. (Wife, 47 years)

Religion

A majority of those interviewed turned to religion and spirituality to seek solace, and to manage negative thoughts and feelings. On the whole, religious beliefs appeared to offer a sense of control over the situation by displacing control to God and asking God for help:

> After listening to the Om Shanti [spiritual discourse] Sessions I felt better. It controls all the senses of the human. And you understand it and you get a type of energy. Then just for passing Time I would go and listen to those sessions . . . I felt good in the same manner. (Wife, 56 years)

Formal Support

Formal support was sought for themselves or the relative through rehabilitation centers, doctors, or hospitals. AFMs themselves also relied on help from Al-Anon, a self-help group specifically for family members affected by AUD. Occasionally, when they felt that the situation was getting out of hand (e.g., domestic violence), AFMs called the police to try and control their relative's drinking behavior:

> I faced lot of criticism from people (for husband's drinking). I was blamed by them but in Al Anon we all are same. All have some or the other problem, no one criticizes anyone there but everyone tries to empathize with each other. (Wife, 49 years)

> I choose not to make an issue (about her son's drinking) because I do not want my family issues aired in the open. However, once I couldn't bear it anymore and went to the police. (Mother, 50 years)

Discussion

Coping

We found individual differences in the AFMs way of coping, with the underlying common thread being action-oriented responses.

A frequently occurring theme was AFMs attempting to maintain the equilibrium in stressful situations or to adapt to the situation. This included accommodating to the relative's behavior, and particularly accommodating to experiences in the family environment, including abuse and blame from the drinker and others. However, the underlying reasons for such responses varied—for instance, the relative's need for the AFMs support, to maintain family cohesion, the AFM's belief that leaving was not a choice (particularly because of their own lack of financial independence). and so forth. This behavior was seen even in extreme situations of abuse, which is put up with to maintain family harmony. This reflects a patriarchal society in which women are generally disadvantaged in achieving equal political, social, and economic rewards. Although there is increasing economic independence and autonomy of women in Goa, the typical Indian family is still patriarchal, and that shapes the accommodating behavior which female AFMs display in response to the drinking relative.

Some AFMs preferred to exit the situation, which may be perceived as falling in between the cusp of "trying to stand up" and "withdrawing." This involves a sense of gaining independence, implies an attempt to focus on one's own needs, and improves quality of life. Compared with other responses, exiting the situation also implies physical and/or emotional distance created between the AFM and the drinking relative as well as a realization of the futility of their own attempts to change the drinking relative's behavior. Taking action in relation to the drinking behavior was found to be common among AFMs. Taking action implies that the family member attempts to gain control over the family environment by affecting change, for example, by talking to the relative about the consequences of their behavior (Orford et al., 2010). However, the instances of self-harm, and covert intervening particularly, suggest that AFMs may actually be feeling powerless or considerably restrained by their circumstances, because of which they have to resort to "less assertive" forms of taking action, for example, concealing the fact that they have slipped medications into the meal.

We found that our findings fit well with the three ways of coping that AFMs broadly adopt when dealing with a substance-misusing relative: putting up (e.g., sacrificing one's needs), standing up (e.g., intervening), and withdrawing (e.g., focusing more on one's own life or needs; Orford et al., 2001). Although any one way of coping cannot be ascribed a value of good or bad, the helpfulness or unhelpfulness of the way is largely dependent on the situational context in the family.

Social Support

AFMs are "neglected," their voice "unheard" (Orford et al., 2010), which implies that appropriate basic support is almost nonexistent or denied to them. In India, uptake of mental health care is further complicated by stigma and inaccessibility, and this lack of support was highlighted in the interviews as well (Shidhaye & Kermode, 2013). Emotional, material, and informational support are the most commonly found categorizations of support that have been described in previous research (Orford et al., 2010). In our study, although religion and formal sources of help provided emotional and/or informational support, informal sources provided emotional, informational, as well as material support.

Religion played a key role in providing a space for emotional release, relinquishing of responsibility/control, and eventually helping in attaining emotional relief. This was a crucial source of support to many AFMs, as it transformed experiences of anxiety and helplessness into feelings of calmness and provided reassurance, even if only in the short term. Al-Anon, a "fellowship"-centered group for family members living with a drinking relative, was also

found to be particularly helpful. AFMs accepted it as a space where perceived shameful and stigmatized experiences could be shared and also where they could achieve empowerment and acceptance.

AFMs tended to rely on their wider social networks, such as neighbors, for informal support, advice, and monetary help, and formal support was accessed as the last resort. Such reluctance is also seen in other cultures; for instance, in spouses of men with an addiction in Iran, formal help seeking was not viewed positively, and was delayed to preserve the family's status and to avoid shame associated with help seeking (Fereidouni et al., 2015).

Limitations and Strengths

Limitations of our study include the generalizability of our findings related to the nature of sampling (i.e., purposive sampling, and some recruitment through a support group for family members) and overrepresentation of women (however, previous studies have seen similar participation rates of women; Orford et al., 2010). Also, the applicability of our findings to other settings must be considered with caution, given cultural differences in the ways in which the family and addictions are constructed in societies.

One of our study's essential strengths is its scope and aims. There is extremely limited research emerging from India in the field of addictions and the family, and our study adds to the evidence base on experiences of AFMs in India. Other strengths of our study include its reliance on maximum variability in sample selection, which allowed us to explore the richness and breadth of individual experiences of AFMs, and the use of a systematic methodology to conduct data collection and analysis.

Conclusion

In conclusion, our study shows that AFMs experience a considerable amount of stress and strain in relation to their relative's drinking, and have to rely on different ways of coping and social support, as is available to them. Overall, because many of the findings from our study are consistent with those from other settings, one may deduce that there is a universality of the experiences of families affected by addictions. This universality must be interpreted with caution, as it is also accompanied by variations of factors around these experiences. These factors are primarily external to the lives of AFMs (e.g., societal expectations of how family members should address their problems, social support that is available for them) and could influence the internal lives of AFMs (e.g., guilt and blame). Orford (2017) explains this phenomenon well, in utilizing the term "variform universal" to describe the experiences of AFMs in sociocultural groups in Mexico compared with the rest of the world. There are two important points to note: that cultural differences may exist in terms of structures and processes that influence the experiences, and that specific experiences are given greater importance in certain cultures. Finally, future directions required to focus on the needs of AFMs include research on contextual and effective interventions, and its subsequent integration into routine clinical practice; and at a broader level, the inclusion of the needs of family members in the policy landscape. Some relevant themes that shed light on the role of formal care, which is consistent with existing literature, include the reluctance to seek help and inaccessibility of external agencies for support for AFMs. This situation makes it even more imperative for researchers and practitioners to fill gaps that will help broaden the scope of current treatments for addictions in India and elsewhere. Some ways include routine mental health screening in primary and tertiary care settings (AFMs are likely to present with common mental disorders) and referrals, and provision of basic emotional support (in addition to psycho education) that can be offered to families in treatment engaging substance misusers. In addition, there is a need to systematically examine the needs of AFMs and tailoring interventions (preventative as well as treatment oriented) for them, and capacity building of medical as well as nonmedical professionals to deliver basic psychosocial care, which has an increasing evidence base. From a policy perspective, India has not yet formulated a national policy on alcohol, and its Indian National Mental Health Policy focuses on treatment for family members from a caregiving lens. There is a need for a comprehensive policy and operational strategies that reconsider the needs of people with substance misuse problems and their family members, both in their own right.

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Received May 31, 2017
Revision received November 7, 2017
Accepted January 4, 2018 ■