

FAMILY FUNCTIONING IN FAMILIES WITH ALCOHOL AND OTHER DRUG ADDICTION

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Abstract

Alcohol and other drug addiction, a societal problem that is steadily growing, contributes to the destruction of families and communities. Research has identified a strong connection between disrupted family relationships and alcohol and other drug addiction. Individual in-depth interviews were undertaken with 12 participants who were residents and ex-residents in the Higher Ground Alcohol and Drug Rehabilitation Trust, Auckland, New Zealand. These interviews were analysed using a qualitative framework. The findings are discussed in the context of a broad range of academic research on addiction and its effects on families. The results show that the majority of participants had experienced painful and traumatic childhoods in their families of origin, which contributed to their subsequent addictive behaviour and which they felt had affected their current familial relationships. All participants and their families had suffered from various forms of family disruption, such as loss of custody of their children, loss of employment, marital breakdown, physical and psychological abuse, depression and ill health. Some participants had also committed drug-related crimes and experienced accidents as a result of their addictions, which also affected their relationships with their families.

INTRODUCTION

Alcohol and other drug misuse is an increasing social problem that contributes to the destruction of individuals, families and communities (see Rossow 2001, Vetere and Henley 2001). National statistics in the United States show that between 18,000 and 19,000 automobile fatalities each year can be traced to alcohol consumption (Brake 1994), and a disproportionate number of deaths from drowning, fires, violent crimes, and suicides are alcohol-related (Brake 1994, Rivers 1994). It is estimated that there are about 1 million heroin addicts and about 2.4 million crack and cocaine addicts in the United States (Holloway 1991).

Substance abuse results in enormous costs to the abuser, his or her family and the community. With respect to the New Zealand situation, the social costs of alcohol misuse have been estimated as being between \$1.5 billion and \$2.4 billion annually. This estimate includes direct costs such as hospital expenses, accident compensation payments and justice system costs. Indirect costs include lost production resulting from premature death and illness, lost working efficiency and excess unemployment (ALAC and Ministry of Health 2001). Jones and his colleagues (1995) estimated that alcohol-related lost productivity among the working population of New Zealand amounted to \$57 million per year. Each year between 7,000 and 22,000 alcohol-affected patients are treated at each of the country's three

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busiest emergency units – Auckland City, Middlemore and Christchurch hospitals. Hospital emergency departments estimate that 10 to 30% of their work is alcohol related.²

According to Rutter (2002), the pathway to drug misuse is complex and determined by multiple biological, psychological, cultural and environmental protective and risk factors that interact with each other and change over time, from conception to adulthood. One of the most popular theories of alcoholism, and addiction in general, has been termed the disease model.³ This conceives of alcoholism and other drug addiction as a progressive and predictable disease (Chan 2003). However, according to Chan, over time a fundamental transformation has taken place whereby the focus on the individual as the identified person with the addiction continued, but the family began to be seen as either being the cause of alcoholism or as partly responsible for its maintenance. A large body of research suggests that family members often play an important role in the lives of those who abuse alcohol and other drugs (see Berry and Sellman 2001, Blum 1972, Coyer 2001, Kaufman 1985, O'Farrell and Fals-Stewart 1999, Rossow 2001, Stanton 1985, Velleman 1992, Velleman et al. 2005, Vimpani 2005).

Researchers focusing on the role of family relationships in the creation and maintenance of alcohol and other drug-related problems have identified a strong connection between disrupted family relationships and alcohol and other drug addiction (Stanton et al. 1984, Stanton and Shadish 1997, Velleman 1992). Some research highlights the potential relations between alcohol-related coping behaviours and both psychological and relationship distress (Kahler et al. 2003). Issues related to alcohol and drug abuse colour all behaviour within a family system (Lederer 1991). Lederer suggests some markers that distinguish alcoholic families from other families, including reciprocal extremes of behaviour between family members, lack of a model of normalcy, and power imbalances in family organisation. According to Nace and his colleagues (1982), some psychological factors that affect the alcoholic and their family include the stigma associated with alcoholism, emotional withdrawal, guilt and craving. Velleman (1992) also writes about the impact of drinking on family roles, communication, social life and finances; for example, finances that are limited through expenditure on alcohol, family gatherings that are spoiled because of drunken behaviours, and roles that have to be allocated because the addicted family member is unable to carry out daily tasks.

This study explores the effects of alcohol and other drug addiction on the family system for people with severe substance use disorders who were residents or ex-residents of Higher Ground in Auckland, New Zealand. Higher Ground was established in 1989 in Auckland and provides a 25-bed, four-month residential therapeutic community for people with severe substance dependency on drugs and alcohol. The disease model and the 12-step philosophy of Alcoholics Anonymous are used in individual as well as group therapy throughout the treatment.

METHODOLOGY

One of the purposes of this research was to find out what kinds of family dynamics operate in families with alcohol and other drug addiction. The University of Auckland Human Subjects

² *New Zealand Herald*, 3 June 2006.

³ In 1956 the American Medical Association recognised alcoholism as a bona fide disease, which was a precursor to the 1970 Comprehensive Alcohol and Alcoholism Prevention Rehabilitation Act (revised in 1976). Through this legislation, alcoholism was socially and legally designated as a disease in the United States.

Ethics Committee and the Auckland University of Technology Human Ethics Committee approved the study. All names and other identifiers have been changed to ensure confidentiality of participants and people referred to in the interviews.

The Participants

Three women and nine men who identified as New Zealanders of European descent participated in the study.⁴ The women and six of the men were current residents of Higher Ground; the remaining three men were ex-residents. All participants were part of the Multiple Family Group (MFG) treatment programme in Higher Ground, whereby residents and their families come together on a weekly basis for group family therapy sessions. During July to August 2001 the staff members facilitating the MFG alerted participants in the MFG to the research project. Higher Ground also arranged a poster at strategic places at the facility, inviting participants to contact the researcher. Apart from the ex-residents, who were approached and invited to participate in the research, all of the residents approached the clinical director and let him know that they wanted to take part in the study. The ages of the participants ranged from early 20s to early 50s.

Data Collection and Analysis

The research took the form of in-depth semi-structured interviews of approximately one hour. With the permission of the participants, the interviews were recorded on audiotape and transcribed. It was my aim to understand the connections between family interactions and experiences of addiction. The interview material discussed here does not claim to be representative of a wider population.

With respect to the qualitative analysis, once the interviews had been transcribed, the resulting data were processed via a descriptive thematic analysis technique with an emphasis on the qualitative evaluation of the data (see Glesne and Peshkin 1992). "Thematic analysis is a method for identifying, analyzing and reporting patterns (themes) within data" (Braun and Clarke 2006:79). This involved multiple readings of the data and identifying connections, patterns, and themes. Braun and Clarke discuss what constitutes the prevalence of a theme and emphasise that there is no right or wrong method for determining prevalence, but that authors need to let the reader know how they analysed their data. In this study prevalence was counted across the entire data set. Each theme consists of accounts of the majority of participants, but only a few representative extracts are presented. The findings, which are presented in the results section, are then discussed in the context of a broad range of academic theories and research about addiction and family functioning.

RESULTS

Four main themes were identified in the interview data. The most salient finding of the research was that all participants felt they had been unable to develop functional relationships with either their family of origin or their current family members. They identified a strong connection between these dysfunctional family relationships and their substance use.

⁴At the time of the research there were no Māori or Pacific clients resident at the Higher Ground. I had hoped to interview Māori and Pacific residents alongside Pākehā (New Zealand Europeans) clients because they often have different family structures and may also have differing experiences of substance abuse.

Theme 1. Traumatic Childhood and Adolescent Experiences

The majority of the resident participants had experienced physical and sexual abuse and personal neglect in their childhood and said they had tried to cope with these experiences by taking alcohol and other drugs. In some cases the parents had left home and abandoned them to others' care, and some had never met either their mother or father. The majority of participants said that their parents were addicted to alcohol and other drugs, and they had some belief that this caused them (the participants) to be addicted to alcohol and other drugs as well.

Female resident B: And I come from a long line of addicts, so I have a strong addictive trait. I sort of grew up with a lot of resentment from my siblings. I woke up when I was eight years old one morning and my mother had cleared out in the middle of the night. A couple of months down the track I'd see her and I'd chase after her and I'd catch up with her and instead of, "Oh, I've missed you, I love you", I'd get, "Oh, you found me" and "Fuck off" from her.

New interview

Interviewer: So what happened to your parents?

Female resident A: I only just found my dad two years ago and he lives in Whangarei, and he's got about seven kids, and I went to stay with him for a week, and his kids didn't really appreciate a newcomer coming along, and so I just distanced myself from him I think. And my mum she disowned me when I fell pregnant.

Interviewer: So you have no contact with her?

Female resident A: No.

Interviewer: Was she aware of your drug use?

Female resident A: Yeah. And she's an addict herself and she still is.

The majority of the residents were physically and sexually abused as children and adolescents. One female resident became pregnant because her stepfather sexually abused her, and her mother blamed her for the subsequent marriage break-up.

Interviewer: So can you talk a little bit more about your relationship with your mum?

Female resident B: When I was 15 she disowned me because she didn't want me to have a nigger baby, and I went over there a few years ago to make amends with her and mend some bridges. I just wanted her to admit that I was sexually abused from her husband and things like that and to get it all out in the open before 2000 and start fresh. She just totally denied it all and she blamed me for her marriage break-up. I just couldn't understand it because I was only a kid when I was sexually abused, so I just said to her I could never forgive her for saying that to me. She just said, well she didn't really give a fuck and I just said to her well remember what you said to me when I was 15 years old and I was carrying Anna [name was changed], how you disowned me. I said well it's my turn to do that to you and I've come up here to mend some bridges and you're not even prepared to meet me half way so it's my turn to do that to you.

New Interview

Male ex-resident H: Um, I've always had a very deep sense of loss that I hold about my family. I'm one of five children, my mother died when I was seven, I was moved around from several relatives throughout my childhood. I was physically abused. I was sexually abused, um, emotionally neglected. My father was an alcoholic. Um, he was not, when

my mother died, he had five children all under the age of 10. And um, you know it's only now in my recovery that I can see how devastating that sense of loss must have been for him. Um, at the time, all I really focused on was that I had been abandoned. My father was not emotionally available to us and even less so financially. We lived in a very poor, impoverished kind of a way; it was very, very difficult.

Another ex-resident experienced trauma within his family of origin, as a teenager, because they did not accept his homosexuality. His parents took him to an exorcist in the Church in order to "cure" him of his homosexuality, but the Church ended up expelling him, further straining his familial relationships. He felt that his parents never really accepted him because of his sexuality.

Interviewer: So your parents told you that you would go to Hell because you are gay?

Male ex-resident G: That's right, yeah. I mean, because they took me to an exorcist, you know? When I came out they bypassed the psychologist and the psychiatrist, which would have been bad enough, and took me straight to an exorcist [laughs], with the messages that reinforced about how bad I was. Not just about what I'd done, which is guilt, but the shame stuff, feeling bad about who I am, you know, that intrinsically I am bad, and it was so reinforced by having to go to an exorcist.

Theme 2. Family of Origin Relationships During Their Adulthood

As mentioned above, the majority of the participants had experienced abusive and difficult relationships with their parents throughout their childhoods. During adulthood most of those interviewed still experienced highly conflictual and difficult relationships with members of their family of origin. Two of the female participants mentioned that they had loyalty conflicts with their parents, particularly with emotionally unavailable mothers.

Female resident B: I always had loyalty problems towards my mum. She had such a bad life – I would have felt bad for her if I would have been really happy.

An ex-resident said that his family is "littered" with alcoholism and that one of his brothers had died as the result of a drug overdose. He described his mother as "a controlling woman" who "enabled him to use drugs" in his adulthood and felt that his father had been and still was "emotionally unavailable to him".

Male ex-resident I: I have two brothers. My parents, white middle class, brought up on the North Shore, not alcoholics. My family is littered with alcoholism and my two brothers were alcoholics. The dynamics: I guess we had the pretty standard common neuroses for dysfunction for sixties, seventies kids. My father is a workaholic. My mother is a very controlling, very controlling, angry woman. Was there for us, well, certainly, I was the youngest of the family and I was brought up different from my two elder brothers. My two elder brothers were beaten up, and I think I was like mollycoddled up. So I think that as far as my mother was concerned, she saw that beating them up didn't work. So she went to the other extreme with me. And so as a consequence of that I was enabled right through my life. I never had to take responsibility for anything because mum would fix it. Yeah, and Dad he was kind of there, but he wasn't there. Just like I kind of was like that with my kids: I was there, but I wasn't there.

Several participants had committed crimes such as drug-dealing, physical assault and stealing before they came into Higher Ground, having a further negative impact on their familial relationships.

Interviewer: So how did you come to that point of making that shift to become clean?

Resident B: Because nothing was working for me. I was just in a rut and I could see what I was doing to my parents, I could see the hurt on my mother and father, so I decided as much for them as for myself, because I was crazy. I was crazed.

Interviewer: What was the point of no return?

Resident B: Well that day when I went to shoot a person and I'd go back to my parents house and my mother said to me she doesn't know who her son was and that really hurt me and I realised I was going to end up in jail forever. So I decided then and there ... oh and the police came and raided me again to see what I was doing, what I was up to, and I was so close to getting caught again for drug dealing and I realised enough is enough.

Most of the participants felt that they had no self-esteem when they were in “active addiction”, and two residents became suicidal as a result.

Male resident B: The thing my family was most shocked about was my suicide attempt. Everything else was second to that. Because once you're dead, like my dad said to me, 'Once you're dead, you're dead', and that's where my biggest shame was around. I mean, being a drug dealer I can live with that. That's something I did, I chose to do that, but trying to take my own life is something I still have trouble with. How did I get so low?

Other residents did not know how to talk to their family members about their addiction and had consciously created emotional and physical distance to avoid contact with them. Residents said that because of their past behaviours such as lying, drug dealing, stealing and in some cases physically abusing others, they felt too ashamed to get in touch with their families, although in some cases their families tried to help them. When they did spend time with them they often felt like they were “wearing masks” in order to maintain their secret addiction. Several participants felt that they were in denial about their own addiction so were unable to use their families as a resource to help them overcome it because of this.

Male resident B: Prior to coming into Higher Ground? I would have to lie, so I tried to rush. When I'd go to my mum and dad's house I'd put up my humour mask and I'd just be very funny, but always having to lie about what I was doing for a job. So I tended not to spend as much time as I normally would have.

Interviewer: So you were hiding from them?

Male resident B: Yeah I was always hiding, yeah – always hiding behind a mask.

New interview

Male resident E: In my mind as long as I wasn't close to them I couldn't hurt them. But realistically if I wasn't close to them the things I had done to others and myself did not hurt me as much. It wasn't so much in my face how my behaviour impacted on their lives. I lied, I stole, drunk far too much. For my living I lived far too much outside my means, and, yeah, having a champagne taste, with a generally very good income. But when that good income disappeared through my drinking and smoking I didn't stop. I could not stop and did not quite realise that then. I certainly did not know how to explain it to family and friends. And it's the lying, the denial of what I was doing.

New interview

Interviewer: How did you experience your relationships with your family prior to coming to Higher Ground? What were the dynamics?

Male ex-resident G: Um, I showed them the bits I thought that they wanted, so the good boy, successful businessperson, that sort of thing, and manipulated the bits that I could. So for years and years they didn't get to see my addiction or the effects of my addiction. It always looked like I had it together. So there's quite a bit of distance, really, in terms of intimacy.

Theme 3. Problematic Psychological Dynamics in Intimate Couple Relationships

Most of the residents felt they had brought their negative relationship patterns from their family of origin into their intimate couple relationships. They felt they had not learnt from their families how to resolve conflict constructively or how to communicate their feelings clearly and that this directly translated across to their relationships with their partners. Several female residents feared their partners' violence and control over them and said that their drug use was an attempt to escape the reality of these violent relationships. Other participants' intimate relationships failed because their partners got sick of their substance abuse and left them. In contrast, a number of residents reported that they were able to keep their intimate relationships together either because they kept their drug addiction a secret from their partners, or their partners "went into denial" around the drug use and "chose not to leave".

Most of those interviewed had lost their employment and experienced financial difficulties as a result of their substance use, which had a direct negative impact on their couple relationships and families.

Interviewer: What were the dynamics in your relationship at that time?

Male ex-resident I: Um, I guess as a consequence of the drug use there was no communication. There was no rapport between my wife and I, plus my focus was not on them or the kids. I mean, in hindsight I can see now I was completely obsessed about getting and using drugs, and anything that got in my way got swept aside . . .

Interviewer: So did your wife leave you because of your drug addiction or were there other issues?

Male ex-resident I: Well, I guess there were other issues but mainly my drug abuse, my drug addiction. I was there physically but the rest of me was completely gone. You know, I was there as a body really, but I mean, there were car accidents, fires. I was a danger to myself . . . my family and myself.

New interview

Female resident A: I just thought the more drugs I took, the sooner I'd die instead of living life. But I came to realise that there's more to life than drugs and living in fear. I was just basically living in fear and I was scared of his [her partner's] affiliation with gangs. If I went out, I'd get spotted and it'd get back to him and I just didn't want to get the hidings. I was just living in fear.

New interview

Interviewer: So did he [his partner] ever find out that you were taking drugs?

Male resident G: Yes he did. I mean, the thing is he was in denial about it. I remember that I'd started vanishing from home for days at a time, and he'd want to know where I'd gone and all that sort of thing and I'd make up stories, you know, like really impossible stories [laughs]. But he stuck around, you know? It wasn't very healthy, really. I mean, if he'd been really emotionally healthy himself he would have left. And if I'd been emotionally healthy while I was using I would have finished the relationship earlier than

that. Um, but I mean, he'd find syringes and bags of powder and I'd tell him it was my brother or someone who was visiting must have left it, you know, just that sort of stuff. And, he bought it for a while, but then he started opening up my bank statements and doing, like, covert investigations and I was, like, really angry when I found out, you know? That he was doing that stuff to try and find out what was going on.

Theme 4. Destructive Parenting Styles

Some residents said they had neglected and abused their own children as a result of “unresolved issues from their family of origin”. They also expressed fear that their children might follow in their footsteps: having witnessed their addictive behaviours for years they were concerned that the children might come to “model” the very same behaviours in the future. They also expressed shame and guilt about their “abusive parenting” while they were in “active addiction”. One male participant’s wife left him, so he temporarily lost access to his children, and two female participants lost custody of their children because of their substance abuse, and they felt very guilty and ashamed of this. Both of these women had male partners who had physically and emotionally abused them and their children.

Interviewer: So you sort of said before that you love your children but you don't act like that? Can you talk about that?

Female resident B: I don't know how to love them properly. I don't know how to tell them about their good things. All I know how to do is to break them, run them down. I would scream at them and I would emotionally abuse them, mentally as well. “Don't cry”, I'd say to them, you know? “What are you fucking crying for? Don't cry. Don't you fucking cry!”

Interviewer: So when you said these things to your children, or you're hiding in the bathroom with your syringes, what was the feeling you had about yourself?

Female resident B: That I was just a bitch. My main thing was I just didn't want to lose my kids. I didn't want my kids to come in the bathroom and see me overdose, or I didn't want to walk into my kids' room and find them playing with my syringes and things like that, but they nearly had. I'd never, ever let them get a hold of them but there might be a day when I lapse and they do get a hold of them. They deserve a mother that's there and will come outside and roll down the hill with them, or run around and chase a ball, instead of a mother who's like, “No, fuck off, go away”.

New interview

Interviewer: So in terms of your role as a mother, how did you see your role before you came here?

Female resident A: Pretty slack mum. I wouldn't get out of bed and I just wouldn't go out with her [her daughter] and do things with her like I should do. I did it when my ex was in jail. She had her friends staying and all that, but once he got out of jail and the violence started again it just all stopped, and I just basically said to her that her friends couldn't come over anymore. Later on I didn't like her boyfriend that she was with and we just drifted apart really.

New interview

Male ex-resident I: ... so I mean I was verbally abusive, and emotionally abusive, to the kids as well, I mean I wasn't emotionally there for the kids.

DISCUSSION

The most salient finding of the research was that all participants felt they had been unable to develop functional relationships with either family-of-origin or current family members. They identified a strong connection between these dysfunctional family relationships and their subsequent substance abuse. Alcohol and other drug addiction affected all areas of the lives of those interviewed, including their health, employment, finances, family-of-origin relationships, and intimate and current family relationships. The findings of this study resonate with the existing literature about the effects of substance abuse on the family and in general.

Research shows that those who suffer from substance abuse usually experience family disruption (Kaufman and Kaufman 1979, Velleman 1992), family violence (Bushman and Cooper 1990, Coleman and Strauss 1983, Kaufman et al. 1989), loss of employment and financial instability (Liddle et al. 1995, Velleman 1992), marital breakdown (Kosten et al. 1983), and physical and psychological abuse (Bushman and Cooper 1990, Kaufman et al. 1989, Rossow 2001). Participants in this study experienced all of the above.

Kaufman and Pattison (1981) suggest that alcoholism can adversely affect the family system and that dysfunctional family systems can promote, and maintain, alcoholism. According to Bennett and Wolin (1990:197), “alcoholism is very much a family illness. ... When alcoholism is diagnosed for one family member, the chances are very good that it has previously appeared in prior generations and that it will surface again in the next generation.” Family studies show that first-degree relatives of alcoholics are three to five times more likely to develop alcoholism than the general population (Schukit 1999). Children of parents who are alcoholics face a higher risk of alcoholism, even when adopted into a non-alcoholic family, suggesting a genetic component to alcoholism as well (Hesselbrock 1995, Cadoret et al. 1985). Seilhamer (1991:181) states that “there is a general consensus that children of alcoholics are more likely to experience a host of psychosocial difficulties, as well as an increased risk for adult mental health problems, such as depression, substance abuse, and antisocial behaviour.”

It is probably impossible to determine how much a genetic predisposition is a contributing factor to familial transmission of alcoholism and drug addiction and how much is caused by particularly unhealthy family dynamics and other socio-cultural factors such as poverty. However, social factors that affect early development within the family – such as a lack of mutual attachment, ineffective parenting and a chaotic home environment – have been shown to be crucially important indicators of risk (Coyer 2001, NIDA 1997). The strongest social predictor of alcohol and other drug abuse has been shown to be misuse by parents and friends (Challier et al. 2000). Glick et al. (2000:535) argue that “child abuse is most likely to occur in a context of alcohol and high stress.”

The majority of the participants experienced abusive childhoods and explained that alcohol and other drugs were a direct cause of abusive behaviour from their parents, who were stressed because of their own addiction, poverty and abusive relationships. Some of the participants also believed – possibly through being exposed to the disease model in Higher Ground – that they had inherited their alcohol and/or drug addiction from their parents. On the other hand, some of those interviewed had family members addicted to alcohol and other drugs who they felt had modelled addictive behaviour to them. Hence residents utilised socio-biological genetic explanations as well as social and contextual explanations in order to

understand and explain their own alcohol and other drug addiction. The results of this study suggest that inter-generational transmission of substance abuse is an important factor in the lives of both female and male participants.

It appears that optimal family influences are important factors in protecting against the development of adolescent alcohol abuse (Foxcroft and Lowe 1992), and that destructive family influences can create the opposite effect (Catalano et al. 1999, Rossow and Lauritzen 2001). According to Jesse (1989), children from alcoholic/addictive families are often victims of physical and sexual abuse, neglect, and ongoing family problems. They are more vulnerable to substance abuse (see Kumpfer 1987). Berry and Sellman (2001) found in their study with 80 alcohol- and/or drug-dependent women that a sizeable percentage of the women came from backgrounds characterised by parental conflict and alcohol and drug problems. Within their first 15 years 51% were subjected to sexual abuse and 39% were exposed regularly to physical abuse perpetrated by their parents or a parental figure. Two female participants of this study had been sexually abused, one by her stepfather. Her mother never believed that he abused her and blamed her for her marriage break-up. Both participants felt they had to “do drugs” in order to cope with the trauma and stress of their lives.

Berry and Sellman (2001) also found that half of the women in their study reported that they rated emotional abuse as being “very distressing”. This was also the case for two of the female participants in this study. However, some of the male residents also experienced sexual and physical abuse and emotional neglect and were deeply affected by these experiences as adults. For example, a gay ex-resident had difficulties with his parents because they wanted to “cure” him of his homosexual orientation and resorted to a Christian exorcist. Not surprisingly, this procedure did not work and he was expelled from the Church. Consequently he lost both his family and his social networks, which were very important to him, and started to misuse drugs. In his and probably many other cases, societal factors such as homophobia can also be a factor for the misuse of drugs.

Minuchin (1979) contends that communication strategies can become fixed in stereotyped patterns of interaction, which can reduce the degree of openness in a family system. He argues that these families could become closed systems where coping mechanisms no longer function. This seems to be the case in the familial relationships of those interviewed. All of the participants stressed that communication with their families was either difficult or impossible. A study by Prest and Storm (1988) examining the relationships between 10 adult compulsive drinkers and their spouses (and comparing these with compulsive eaters’ relationships with their spouses) showed that these couples were frequently unable to process feelings and resolve conflicts. In order to cope with the resulting feelings and distance created, they engaged in compulsive behaviours, according to the authors. Velleman and his colleagues (2005) also point out that high levels of family conflict can increase the risk of substance misuse. The residents interviewed in this study felt that the dynamics in their families were so dysfunctional that they had resulted in permanently unresolved conflicts, denial, break-down of open communication and mutual caring, which then became a further trigger for substance abuse.

A gender-specific theory of addiction, according to O’Connor et al. (2002), is that women who grow up in drug-addicted families may develop the belief that to be loyal to their addicted family members they too must use drugs, which can make them vulnerable to

psychopathology, including addiction and depression.⁵ Two of the female participants experienced loyalty conflicts with their family members. One woman felt that she had no right to be happy because her mother had such a difficult life. This delayed her process of recovery for many years.

Intimate couple relationships were also highly conflictual for many of those interviewed, with two female participants saying they became suicidal as a result of ongoing physical and emotional abuse from their male partners. The bulk of research indicates that domestic violence and alcohol or other substance abuse are strongly associated (see Flanzer 1993, Kyriacou et al. 1999 cited in Glick et al. 2000:533). O'Connor et al. (2002:79), in their study of the role of socio-cultural factors in women's addiction patterns, argue that "a lack of voice or power in society can lead disenfranchised women to seek out men with social power in the neighbourhood, often drug dealers and pimps." They also found that some women turn to illegal activities to support themselves, including drug dealing and prostitution, which is what two of the female participants in this study had done. Both participants said they had limited economic and social conditions when they grew up, and reported being physically and emotionally abused by their parents before taking up with abusive partners themselves. They felt that their mothers, who had also been abused by their spouses, did not support them in any way, and noted that they had little education and unsatisfying careers, making them relatively powerless in society at large. Both of these women also felt powerless in their lives and suggested that they had attracted partners to them who reinforced what they had experienced in their childhood and adolescence (one of their partners was a drug dealer; the other was a gang member). According to these women, their addiction was a desperate attempt to cope with hopeless and painful situations in their lives.

However, the participants with children did not just experience themselves as the victims of alcoholic or drug-addicted families. All of the parents among the participants explained that they also abused their own children to a degree that two of the female residents lost custody of them and one resident did not see his children for an extended period of time. Research shows that drug-addicted mothers often lose custody of children who have been neglected and abused (Hughes et al. 1995) and that they experience low self-esteem, difficulty developing a maternal identity, isolation from friends and family, and chronic life stress (Coyer 2001). All participants with children feared the long-term effects their actions might have on them. They also experienced a lot of shame and guilt as a result of their parenting, which, according to Isaacson (1991), is a typical dynamic in families with alcohol and drug addiction. As already outlined above, most of the participants experienced conflictual and difficult relationships with their family of origin as adults. Some participants felt "enmeshed" with their family members. There is a body of literature that focuses on "codependence" as one of the major patterns in families with alcohol and drug addiction (see Koffinke 1991). Koffinke (1991:201) argues that a codependent "feels compelled to fix the problems that result from the chemical dependence and to protect the addict from its consequences." Some participants mentioned that their parents, siblings and intimate partners did try to fix the problems for them for quite a long time before they realised that they could not help them any longer. This caused distance in the family system because some family members cut themselves off from the person with the addiction out of disappointment and hurt. In some cases the residents distanced themselves because they were too ashamed to face their families.

⁵ For a more in-depth discussion on gender differences in drinking, see Holmila and Raitasalo 2005.

Individuals with serious substance abuse disorders often commit drug-related crimes and experience accidents (Brake 1994, Coleman and Strauss 1983, Greenberg 1981, Lipsitt and Vandeboss 1992) that further impact negatively on their family relationships. There is also a co-occurrence of drug problems with clinical disorders such as antisocial personality disorders, conduct disorders in adolescents, and depression (see Liddle et al. 1995, Kumpfer 1987), all of which have effects on family relationships as well. Most of those interviewed reported that they stole from family and friends because of the high prices of illicit drugs and felt a lot of shame about their behaviour. Some of the participants were drug dealers and came into Higher Ground because the police caught them. Several participants became violent through their drug misuse and lost their intimate relationships as a result of their behaviour. Participants also caused car accidents and fires, which had a negative effect on their familial relationships.

A number of participants reported that they were suicidal because their situation seemed so hopeless. This is also something that has been identified in research. For example, Rossow and Lauritzen (2001) found that self-reported suicidal behaviour and ideation among drug addicts are highly prevalent. In their study 38% of the participants reported having attempted suicide once or several times. The proportion was higher among those who had had various traumatic experiences during childhood (sexual or violent assaults, bullying, parents' alcohol abuse, parents' psychiatric problems, school adjustment problems and own psychiatric problems), and increased with the number of such negative childhood experiences. The participants in this study who were suicidal experienced a number of the adverse factors mentioned above, such as parents' alcohol abuse, and felt they could not cope without drugs. It was also difficult for them to ask for help and they felt isolated.

According to Allen and Britt (1986:149), there is a strong correlation between class and the prevalence of symptoms of psychological disorders. Several of the participants experienced poverty in their childhoods. Together with other contributing factors such as parental drug addiction and physical abuse and neglect, this caused them to become depressed, suicidal and addicted to drugs in their adult life. Several found that both taking drugs and dealing drugs – which, they noted, were ways of socialising with their peers – were appealing ways of escaping the painful reality of their everyday lives. According to O'Connor et al. (2002), most drugs function at the beginning to reduce shame and guilt and other negative effects. However, over time, drugs that serve to alleviate these symptoms stop working and instead cause the symptoms to escalate, which is what all of the participants experienced.

Socio-cultural factors such as poverty, racism, sexism, homophobia and the generational transmission of negative family patterns can have significant impacts on an individual's likelihood of becoming addicted to alcohol and other drugs (see Vimpani 2005). The developers of both social policy and therapeutic treatment programmes need to take these socio-cultural factors into account so that individuals who experience alcohol and other drug addiction do not become individually pathologised and stigmatised by a society that creates conditions that greatly contribute to substance abuse in the first place. In New Zealand there are already a number of effective strategies for addressing alcohol and other drug abuse. With respect to policy development, the change in the New Zealand Sale of Liquor Act in 1999 was a step in the right direction. This Act reduced the minimum purchase age for alcohol but provided better access prevention for those below the legal minimum purchase age by simplifying the legislation and specifying proof-of-age documents.

In 1976 a Royal Commission into the Sale of Liquor resulted in the formation of the Alcoholic Liquor Advisory Council (ALAC) in 1977. Their statutory mandate is to promote moderation and facilitate treatment, prevention and research into alcohol problems. ALAC has established a Māori problem prevention and treatment programme, which supports strategies to promote moderation and introduce responsibility guidelines to reinforce traditional practices for looking after visitors on marae (meeting houses). This initiative, and others such as Whānau Ora (which will be discussed later), are very important because research demonstrates that considering cultural factors in the treatment of Māori is essential. One study shows that Māori believe that a sense of belonging to iwi (tribes), identifying as a Māori and having pride in being Māori are very important for the recovery process (Huriwai et al. 2000).

The Ministry of Education and ALAC funded a Community Action on Youth and Drugs (CAYAD) project, which was implemented in five localities. The workers in this project developed specific strategies to reduce school suspension for cannabis use. There are also a number of different community initiatives such as Whānau Ora, which is a health promotion and disease prevention programme that, among other issues, addresses alcohol and other drug abuse. This programme strives to improve and enhance whānau (extended family) wellbeing by taking a holistic approach. Another community action project, a collaboration with two Māori trusts, tried to develop and implement strategies to reduce drunkenness in environments in which Māori drink. One of their objectives was to develop and implement a marae-focused programme aimed at increasing support among Māori for culturally appropriate strategies to prevent alcohol-related traffic crashes (Casswell 2001). An evaluation of this programme found evidence of enhanced social cohesion in the local communities, especially in terms of the perception by Māori communities of the police, who had become active partners in this initiative, and of Māori by the police (Moewaka Barnes 2000).⁶ Residential treatment centres for people suffering from substance abuse disorders, such as Higher Ground and Odyssey House, have included the family in their treatment of clients who suffer from addiction to alcohol and other drugs. I was part of developing the Multiple Family Groups in Higher Ground, and these have operated successfully since 1997.⁷

CONCLUSION

This study was based on interviews with 12 residents and ex-residents of Higher Ground in Auckland, New Zealand. The small sample size presents some limitations with regard to the applicability of the findings to the population in general, and there is a need for more quantitative and qualitative studies on this complex topic in order to test their applicability. Further investigation into this topic within the New Zealand context should also include the participation of Māori and Pacific people who experience problems with substance abuse, in order to explore whether their sometimes-differing family structures compared to New Zealanders of European descent have any effect on their experience of the relationship between addiction and family dynamics.

Despite these limitations, this study has provided a glimpse into how residents and ex-residents at Higher Ground experience their relationships with their family of origin, with their intimate partners, and with their children. There is also a need to recognise the great

⁶ For a more in-depth discussion on approaches to preventing alcohol-related problems, see Casswell 2001, Stewart 1997 and Vimpani 2005.

⁷ For a review of the literature on family-involved treatment for alcohol misuse, see O'Farrell and Fals-Stewart 2001 and Vetere and Henley 2001.

diversity and complexity of psychological dynamics within addicted families, and how these are often a reflection of increasingly pluralistic societies which create the social conditions that provide fertile breeding grounds for addictions to take hold.

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