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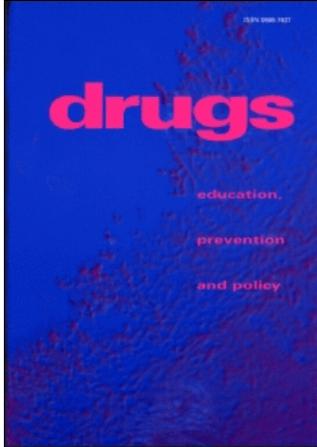
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The 5-Step family intervention in primary care: I. Strengths and limitations according to family members

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Abstract

Background: Family members affected by a close relative's substance misuse constitute a large but neglected, high-risk group. Interventions for that group are now being developed and tested in trials. More use should be made of qualitative methods to study process in such interventions.

Design: Semi-structured interviews with family members 12 weeks after assignment to a full or brief 5-Step intervention. Both involved a primary care professional giving a self-help manual, and the full version also involved up to five sessions of a psychosocial intervention.

Participants: 143 patients of GPs, health visitors and practice nurses in general practices in two areas of England. Patients were the family members of close relatives with drinking or other drug problems.

Analysis: Framework analysis and grounded theory analysis of post-interview reports.

Results: There was strong support for a form of intervention that involved face-to-face discussion with a primary care professional, and those who received the full intervention were appreciative of being able to talk to a professional who had time to listen and who appeared interested, understanding and caring. The self-help manual itself was reported to contain active ingredients for change, and a number of family members described transformations in their ways of coping with the problem whether they received the full or brief form of intervention. A common constellation of changes included increased consciousness of the nature and extent of the relative's drinking or drug use and its

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family effects, an acknowledgement of the family member's own needs and rights, a strengthening of resolve to assert plans and expectations, and a calming effect with reduction in stress symptoms. Many participants were unable to describe changes, however, and the following principal limitations of the intervention were described: prior familiarity with the material, perception that the intervention did not go far enough, belief that it was incapable of effecting change for the substance misusing relative, and a perception that sufficient professional expertise or sympathy was not always available in primary care.

Conclusions: Findings suggest that the 5-Step family intervention has positive potential in the primary care setting, but has limitations and may need strengthening for family members whose problems are of longer standing or who have already been exposed to relevant information.

Keywords: *Family intervention, substance misuse, primary care*

Introduction: Concerned and affected family members as a high-risk group

The impact of alcohol and other drug misuse on the family, in the form of marital and family disruption, domestic violence, financial difficulty, and risks to children, are generally acknowledged (Dorn, Ribbens, & South, 1987; Fals-Stewart, Birchler, & O'Farrell, 1999; O'Farrell & Murphy, 1995; Orford et al., 2005b; Strategy Unit, 2003; Wiseman, 1991). A conservative estimate of the number of adults in Britain who, in the course of a 12-month period, are significantly negatively affected by the serious problematic drinking or drug taking of a close adult relative is close to one million. The national survey reported by Singleton, Bumpstead, O'Brien, Lee and Meltzer (2001) estimated the 12-month adult prevalence of alcohol and drug dependence to be in the region of 7.4% and 3.7%, respectively. The estimate of nearly one million is based on a cautious estimate that one in five of such dependence problems are sufficiently severe to create significant stress for family members, and that each such problem affects one family member on average. Many would consider that calculation to be far too cautious. It also leaves out of account affected children and adolescents.

In view of the multiple and often chronic stressors to which family members of close relatives with alcohol and drug problems are often exposed (Orford et al., 1998a, 2005b), it is not surprising that they have been found to be at heightened risk for symptoms of mental and physical ill health and exacerbations of chronic illness conditions (Bailey, 1967; Copello, Templeton, Krishnan, Orford, & Velleman, 2000b; Moos, Finney, & Cronkite, 1990; Orford et al., 1998a; Velleman & Orford, 1999). A welcome development has been reports of a number of new family treatment approaches, including unilateral family therapy (Thomas & Ager, 1993), behavioural couples therapy (Fals-Stewart et al., 1999; O'Farrell & Murphy, 1995), community reinforcement-type family treatment (Miller, Meyers & Tonigan, 1999), network therapy (Galanter, 1999), social behaviour and network therapy (Copello, Orford, Hodgson, Tober, & Barrett, 2002) and the 'pressures to change' method (Barber & Crisp, 1995). While most

of those approaches focus on the treatment of relatives' substance problems or on the engagement of relatives in treatment, some have been specifically aimed at responding to the needs of affected family members in their own right. The latter include Al-Anon family groups (Humphreys, 2004) and a number of psycho-educational, counselling and stress-management approaches (Dittrich, 1993; Halford, Price, Kelly, Bouma, & Young, 2001; Howells & Orford, 2006; Zetterlind, Hansson, Aberg-Örbeck, & Berglund, 2001). Only the 5-Step approach developed by Copello et al. (Copello, Orford, Velleman, Templeton, & Krishnan, 2002a; Copello et al., 2002b) was designed specifically for use in the primary healthcare context.

Despite the greatly increased use of qualitative methods in order to reach a detailed understanding of people's health and illness experiences and the ways that they understand them (e.g. Charmaz, 1990; Crossley, 2003), there have been relatively few attempts to use qualitative methods systematically in order to study process in the context of randomized controlled trials (Oakley, Strange, Bonell, Allen, & Stephenson, 2006). No tradition has yet developed in the alcohol and drug problems treatment field of regularly using qualitative methods to study the experiences of clients or patients during the time in which they were taking part in treatment research. The present paper reports the analysis of qualitative data derived from interviews with clients at the end of an intervention for family members, in an attempt to understand the strengths and limitations of the intervention from the clients' perspective.

The intervention featured in the present paper was conducted in National Health Service primary healthcare practices in two areas in England. The participating primary care patients were family members who were affected by and concerned about the problem drinking or drug taking of close relatives. A trial was conducted that compared two levels of an intervention based upon a stress-strain-coping-support model (SSCS) of the experiences and health risks faced by such concerned and affected family members (Orford, 1992, 1998; Orford et al., 2005b). The more intensive, or full intervention consisted of a single session at which a 58-page self-help manual, based on the model and carefully prepared and piloted, was given and the intervention initiated, plus up to four additional sessions with a primary healthcare professional (PHCP), either a general medical practitioner, a health visitor, or a practice nurse. The briefer intervention consisted of a single session only with the PHCP, confined to giving the self-help manual. Both the intervention sessions, for which PHCPs received a single session of training supported by a professional manual plus back up from the research team, and the self-help manual, were based on a 5-Step approach derived from the SSCS model. The 5-Step approach for use with family members in primary care has been described by Copello et al. (2000a). The five steps are: listening non-judgementally; providing information (e.g. about drugs or dependence); counselling about ways of coping; discussing increasing social support; and considering further options for help and support. The self-help manual covered the same steps with exercises at each step and a number of 'case' examples.

Both the trial of full vs. brief forms of the intervention (Copello et al., submitted), and a non-controlled study of the full intervention that preceded the trial (Copello et al., 2000b), demonstrated before-to-after changes for family members in terms of reductions in two key outcome variables at 12 weeks after the start of intervention: tolerant and engaged coping (measured by the Coping Questionnaire, CQ; Orford et al., 2001; Orford, Templeton, Velleman, & Copello, 2005c); and symptoms (the Symptom Rating Test, SRT; Kellner & Sheffield, 1973). The trial involved 143 family members (51 received the full and 92 the brief intervention) and found no differences depending on whether family members were seen in the full or brief intervention practices (Copello et al., submitted).

Part of the 12-week, post-treatment assessment with family members who took part in the trial consisted of a semi-structured interview. The qualitative analysis of reports of those interviews forms the basis of the present paper (analysis of parallel PHCP data, providing the professionals' perspective, is reported in a companion paper: Orford, Templeton, Patel, Velleman, & Copello, in press).

Significant before-to-after changes, combined with an absence of between-group differences, suggest that this may be a promising intervention but not one that works exactly as anticipated. Furthermore, ratings made by family members at follow-up suggested that, while the majority were positive about the intervention, a sizeable minority were not. Sixty-one percent gave a rating of Better when asked overall how they would rate any changes that had occurred to their situations since the intervention started (15% Worse, 24% No Difference), with no difference between the two groups (64% Full, 60% Brief, *ns*). Family members in the full intervention group were asked to rate out of ten how helpful they had found the sessions with their PHCPs. Both groups were also asked to rate out of ten how helpful they had found the self-help manual. In each case between a third and a half gave ratings of five or lower. The aim of the present paper, therefore, is to use the qualitative data obtained from family members at follow-up to help us understand better how the intervention might be functioning to aid positive change, when it does, and, when it is not successful, why that might be.

Method

Typical 12-week family member interviews lasted for 1 hour 15 minutes (range 45 minutes to 2 hours 20 minutes). Besides structured questioning and standard questionnaire completion, which took about 20 minutes, the remainder of the time was devoted to the semi-structured interview. Interviewers, of whom there were four including two of the present authors (LT, AP), were instructed to explore the family member's circumstances and concerns about the relative's drinking or drug taking at the time of beginning the intervention, perceptions of the intervention, changes that might have occurred since then, and, if there had been changes, to what they might be attributed. Interviewers were trained to use

open-ended questioning, to probe and clarify, and to obtain concrete examples where possible. They were given feedback on early interview reports in order to further develop those techniques.

In order to generate textual data for analysis, a method, developed within our research group, of note taking and report writing was used, which does not involve tape-recording and transcribing interviews. The interviewer is required to take detailed notes of all points that are made by the interviewee, including words and phrases verbatim when they are judged to be particularly significant or illustrative. As soon after the interview as possible, preferably within 24 hours and certainly before the next interview is conducted, the interviewer uses the notes to construct a detailed report, clearly showing verbatim quotations within double speech marks. We think of such a report as the interviewer's field notes. There are pragmatic and theoretical reasons for preferring the method. In our experience, tape-recording can be awkward, sometimes disliked, and prone to technical faults. However, the most important pragmatic reason for not relying on tape-recording is the time, cost and difficulty of making transcripts, or even of listening to recordings of long interviews. Teams rarely have such resources and it is not uncommon for recordings to be stock-piled and never properly analysed. The second justification for the note-taking/report-writing method is more fundamental and concerns the intended purpose to which the results will be put. If the intention is to carry out some kind of discourse or conversational analysis (Willig, 2001) then *how* things are said is of the utmost importance and a full recording is probably necessary. If, on the other hand, what is of interest are the themes addressed by *what* is said, then the full recording is not necessary provided the interviewer-reporter can capture the main bulk of an interviewee's meaning (and some exact quotations from the interviewee are usually helpful in doing that) in the report. Indeed a full transcription, with all the *ums* and *ahs*, repetitions and irrelevant asides, is often frustrating and unhelpful. In any case a transcription is already a condensed version of what took place: for example, most of the non-verbal aspects of the exchange, which can be referred to in field notes, are omitted in a transcript.

The analysis of post-interview reports used a combination of a relatively structured method of qualitative analysis developed by Ritchie and Spencer (1994) and referred to by them as 'framework analysis' and the less structured grounded theory approach (Strauss & Corbin, 1998), which aims at model building grounded in people's accounts of their experiences. The analysis proceeded in stages. At the first stage separate sets of six or eight post-interview reports each, selected at random, were read by four of the present authors and agreement reached about a coding framework that covered the main topics. That resulted in over 40 codes, which at later stages were used as the framework for attempts to answer specific questions. For example, material included under the code 'coping-related' contained much that was of relevance to answering the question, 'What kinds of positive changes occurred that were attributed to the intervention?' Material included under 'time issues' was amongst material that was helpful in attempting to understand why the intervention sometimes

appeared to be ineffective. By the end of the process all interviews had been included in the analysis. The authors met regularly as a team throughout the period of analysis and paper drafting in order to discuss, challenge and refine the results and conclusions, and all authors have commented on several drafts of the present paper.

Results

Interview content, according to the analysis of post-interview reports, fell into three broad areas: (1) positive transformations in their family lives that occurred for some family members and which they attributed to the intervention; (2) the value of talking to a primary care professional or studying a self-help manual; and (3) reasons why the intervention was sometimes not helpful. Each of those three broad themes will be presented. They will be illustrated with case examples taken from the post-interview reports. Where illustrations include a verbatim quote from a family member, the quote will be indicated by placing it within inverted commas.

Positive transformations

In slightly less than half of the reports that were studied in detail, there was some evidence that transformations in family life had occurred that were consistent with the aim of the 5-Step intervention, and which family members attributed to the intervention. In about half of those instances the reports provided clear and ample evidence of such changes; in the other half there was some, but less clear, evidence. The following four types of transformation were described.

1. Focus on own life and needs. The most frequently mentioned type of change referred to was an increase in independence or distance from the relative's problem drinking or drug taking. This was most commonly referred to in terms of an increased focus on oneself and one's own needs.

A good illustration is provided by the mother of a problem drug-using son. The aspect of the sessions that she had found most useful was talking about things that she would not normally discuss with anyone else and which had led her to have a better insight into her greatest anxieties. The session in which she had discussed her anxieties about her son being unable to cope without her had been a particularly helpful session, she said, as her GP had helped her to realize that no amount of worrying would change anything and that she should try to focus on other things. She said the sessions had given her the initial, '...kick up the backside... to get on with my life... not to feel guilty about it'. She said her GP would steer her back to focusing on herself whenever she began to discuss her son (unlike previous contacts with her GP where the focus had remained on her son's treatment). When she was recruited into the project and her son had enquired about it, she had explained to him that the project was about her and told him that, '...it was nothing to do with you. The world don't revolve

around you . . . I told him that . . . [GP] had told me to go off on holiday and enjoy myself. She explained that she had never dreamt of saying anything like that to her son before as she would have been too concerned about him going off to use drugs.

Another mother of a drug-using son said she was thinking more about herself since the intervention and was starting to get support for herself. She said she was now more likely to talk about the problem: she had never been open with people before, had locked it in, was now getting things out more and was feeling better in herself. She was now taking steps not to let her son take her for granted, for example by assuming that she would look after his young child while he went back to bed.

Those two examples also illustrate a number of sub-themes. Talking more openly about the family problem to a primary care professional or to others, and gaining support for her/himself in his or her own right was often at the core of this category. Other important sub-themes were: doing things for oneself; not allowing oneself to be taken advantage of; feeling less guilty; and worrying less about the relative's alcohol or drug problem.

2. *Being assertive.* Family members spoke of being more assertive with their relatives, by communicating more directly with the relative than previously, by being more directive in arranging alternative activities, or by being firmer in maintaining a course of action. This was well illustrated by three wives of men with drinking problems. One described how the family situation was now dramatically improved because in the second session with her health visitor they had calculated how much her partner was drinking, concluding that he was drinking at about ten times the recommended level. She had fed this information back to her partner who had not realized the full extent of his drinking. She reported that he was now drinking far less, was more involved with the children, that their relationship was better, and that she felt she herself was coping better.

Another wife described how she was now refusing to go to the pub with her husband, but instead was organizing alternative activities for them both, for example going out for a meal.

Another described how the sessions had made her feel more confident and positive. Although her GP had not told her what to do, two of the sessions had been particularly helpful because her GP had made her realize that she had to stick to her guns about putting the house up for sale and being determined to leave her husband if he didn't stop drinking. That seemed to have triggered a change in him, particularly dramatic around Christmas time, and he was now limiting his drinking and being much more pleasant to live with.

3. *Calming down.* Family members explained how the sessions had helped them become less emotional in their interactions with their relatives. For example one partner of a violent drinking man described changes that she had been able to make by talking to her health visitor. She had realized that her partner

was controlling her and the whole mood in the house, and that things needed to change. He used to wind her up but that no longer happened. She used to give herself a headache but realized that, 'it was a waste of time'. She analysed their rows, how they started and what happened, and realized that her relative started them and decided, 'I'm not going to keep giving myself headaches all the time'. So now if he tried to wind her up, 'it's diffused there and then'.

A partner of a drug-using man spoke very positively of her sessions with a practice nurse. Most useful had been a session that had focused on how to divert the anger she had felt about the cost of his heroin habit and his failure to contribute to the household financially. She had been finding it very difficult to contain that anger, but had now learned to talk to her partner rather than shout at him, as a result of which they were talking more, he had cut his habit down by half and was now contributing financially for the first time. She said she felt she could relieve her own pressure and was now coping better.

Another wife was very positive about her sessions with her GP. They had looked at her role in maintaining her husband's behaviour, realizing that she might be reinforcing his negative self-esteem by criticizing him as a father. She was now taking things less personally and trying to deal with the underlying issue rather than the emotion. She felt a lot stronger, more assertive, and her panic attacks had stopped.

4. Seeing the links. Family members spoke of gaining an understanding about their relatives' drinking or drug taking, or a realization of the links between the drinking or drug problem and their own physical or mental health. Sometimes this took the form of gaining a useful piece of information, for example a mother discovering the significance of tin foil in her son's drug use. An example of making links with the family member's own health was given by a wife who had spent much time having medical tests carried out, and as a result of the sessions was beginning to realize that the pain she had been getting and her depression might be linked to her husband's drinking. She had told her husband so. A young adult daughter of a father with a drinking problem explained how her GP had got her thinking, had helped her realize that she was angry with her father for making her sister leave home, and had made her realize why she was depressed. Her father's drinking remained unchanged but she was no longer letting it worry her, and was feeling less anxious.

In summary, transformations in ways of responding to a close relative's excessive drinking or drug use were described by a proportion of those who received the intervention. They appear to involve a constellation of changes that includes an increased consciousness of the nature and extent of the relative's drinking or drug use, and its effects on the family member's health and wellbeing, an acknowledgement of one's own needs and rights, a strengthening of resolve to assert reasonable plans and expectations, and a calming effect with associated reduction in stress symptoms. Although in some of the examples cited there had been accompanying changes in the relative's behaviour, in most cases the transformations described constituted what family members believed to be better

ways of coping with an ongoing set of stressful circumstances. It should also be noted that in nearly all the examples given so far family members had received the full version of the intervention that involved up to five consultation sessions with their primary care professional. In the next section we address the question of whether the simple provision of a self-help manual can achieve the same results.

The value of talking to a primary care professional or studying a self-help manual

As part of the debriefing at the 12-weeks follow-up point family members were asked how they thought they would have felt if their general practices had been in the alternative group. Those in the full intervention group were asked how they would have felt if their PHCPs had simply given them the self-help manual. Those in the brief intervention group were asked how they would have felt if their PHCPs had been able to see them for further sessions in addition to giving them the self-help manual. The majority of both groups expressed a preference for professional contact. Of those in the full intervention group, 71% thought they would have felt Worse without further PHCP contact (24% About the Same, 5% Better), and of those in the brief intervention group 71% thought they would have felt Better with more PHCP contact (29% About the Same, and none Worse).

Those who received the full intervention were mostly very positive about the contact they had had with their doctor, health visitor or nurse. A number of themes were apparent in the ways family members talked about those contacts. Some family members referred to appreciating *Simply Talking*. A more specific element was *Relief of Getting Things Off My Chest*. For example, 'get a lot off my chest, otherwise things go round in my head', 'share the issues, share the load, it's dreadful when you can't talk about your fears and worries', 'talked about how my husband's been affecting me', 'I would write things down on a bit of paper to show to the health visitor', 'it's better if you are able to see the practice nurse for a few sessions as having someone to talk to is helpful'.

A central theme was *Talking to Someone Who Cares*. It combined being enabled to talk, with the special condition provided by a PHCP who showed interest and who listened in a way that made the family member *Feel Worth Something, Not Alone, Not a Failure*. For example, 'somebody cared, was interested, was willing to give up time', 'made me feel special, as if worth something', 'not critical, not [made to feel] failed as a parent, never felt belittled or uncomfortable', 'because there isn't anybody you can talk to... without any judgements... you need to unload in that situation'. Family members who had received the full intervention were overwhelmingly positive in the things they said about their PHCPs personally. Four related characteristics predominated: *Interested, Concerned, Approachable* (e.g. 'concerned, bothered to sort out the information I wanted', 'took an interest', 'wonderful listener'), *Has Time For You* (e.g. 'time to see you rather than push you away', 'not hurried, someone giving time to you'), *Understands* (e.g. 'impressed with GP's knowledge of drug issues', 'a god-send, unlike a friend who is supportive but cannot understand') and *Enables Me To Talk More* (e.g. 'I used to lock things inside, now I get things out and open more').

Explaining why they would have felt worse without the extended professional contact, those who had received the full intervention argued that it was necessary to talk to someone, and that if that had not been available they would have felt they had received second best. For example, 'a book alone is not as good as being able to talk to someone who would listen', 'it would have suggested that the GP wasn't really bothered', 'I would have felt fobbed off'.

On the other hand family members had much to say that supported the view that the self-help manual—carefully prepared to cover the same ground as the full intervention—itself had a positive impact. Although there were family members in the full intervention group who had not liked the self-help manual that accompanied the intervention, many were clear that the manual itself had been a positive component. As one family member who received the full intervention put it, 'it's a therapy really in some ways'. Another family member who now avoided getting into rows with her partner specifically mentioned being helped by reading the part of the manual that dealt with the causes of rows. Perhaps the most explicit reference to the manual in the full intervention group was by a mother for whom her GP made an arrangement that she would leave the manual at the surgery and have the use of a private room for an hour before each appointment during which she could work through a step of the manual and do the relevant exercises contained in that section. She would read out her responses to the exercises with her GP, which had enabled her to discuss things with her GP that she would not normally have been able to discuss. One of the minority who stated a preference for the manual alone said, '[it would have been] much better, I like to do things in my time, without pressure. I'm very much a self-contained person'.

A summary of replies to some of the standard questions about the manual included in the interview may be noted here. For example, all family members were asked how many times they had looked at the manual. The median reply was 5 times, with 27% 10 or more times and 20% once or twice only. When asked how long had been spent looking at the manual, the median reply was 3 hours, with 30% reporting more than 5 hours and 20% one hour or less. There were no significant differences between the full and brief groups. Interviews with family members who had received the brief intervention (the manual given to the family member at a single session with a PHCP who had not received training in personally carrying out the 5-step intervention) included a number of accounts of family members appearing to have made significant transformations on the basis of reading and studying the manual alone. For example, a wife explained that the manual had been, '...telling me I've got a right to think about me', that she should not blame herself, should consider her own needs, and that there were other people in the same boat. From reading about the cases described in the manual she had realized that, 'people worked round it and sought help'.

Another partner who described how the manual had helped her to focus on herself more (she estimated that she had studied the manual for 5–6 hours), realized as a result that, 'people feel the same as me...it went straight to

the point . . . made me see that I wasn't the problem'. It had brought home to her that, 'I was getting help for myself'.

Others were of the opinion that the manual had helped them respond more calmly. A sister, for example, who estimated that she had studied the manual for perhaps 30 hours in all, reported that she now tried to reason with her brother rather than to shout and scream at him because in the manual it had said there was then more chance of relatives listening. The case studies had made her realize that it was a good idea to be easier on relatives. As a result her brother had responded well and she felt better.

A mother also described being more understanding with her drug-using son, no longer screaming and shouting at him, because reading the manual had made her realize that she was not the only one facing such family problems. As a result of reading the manual she had also discussed the problems with friends, which she had never done before, finding more than one who had been through similar experiences themselves. Her husband, her son's step-father, had also become less critical because she was able to talk about it more. Her relationship with her son was improved and everyone was calmer.

The case examples provoked more comment than any other aspect of the material provided in the manual. Some stated that they were unable to identify with any of the cases, but a larger number had identified with them. For example: 'an accurate reflection of what a family had been through . . . to the point', 'could have written a lot of it . . . obviously well researched', 'got to the nitty gritty', 'it's exactly how things are near enough, true, realistic'.

The most positive theme in family members' replies to interview questions about the manual was one that might be called *Realizing you are Not Alone*. Examples were: 'realize a lot of things I used to worry about are normal with a heavy drinker . . . it made me feel not alone', 'a lot of parents had a lot of problems in there . . . made you feel not on your own', 'seeing others in the same situation, you don't feel you're the only one dealing with it', 'nice to know that others have the same impression, it affects them in the same way'.

Why the intervention was sometimes not helpful?

Reports of the semi-structured sections of the interviews provided clues about why some family members might have found the intervention relatively unhelpful. There were five dominant themes, as follows.

1. *There was nothing I didn't know already.* The most commonly expressed sentiment was that there was little or nothing that the family member didn't already know. That kind of remark was often made in relation to the manual, despite overwhelmingly positive comments about its design and presentation. A related view was that the intervention had come too late for the family member and would have been appreciated years earlier when the family member had first realized the existence of the drinking or drug problem or had lacked any information about it or had not yet learned a way of coping.

Examples are: 'the exercises were geared to cutting oneself off from the situation, I learned to do that and don't need a book to tell me', 'I knew most of it, I was told most at my husband's rehabilitation two or three years ago, I know most of the agencies, I learned it over the last ten years', 'the experience of living it is much more help, there is nothing new that it could tell me, I could rattle off a dozen case studies I'd known, it's a bit condescending to someone in my situation'.

2. *It wasn't directive enough.* A number of family members commented about the self-help manual that it didn't go far enough because it was not sufficiently directive about what a family member should do. For example: 'a good introduction to something deeper, frustrating because there was not advice on how to be assertive, I wanted answers, I wanted to know what I could do at home, it was missing a chapter on "what to do now"', 'not much impact, just words, wanted action', 'would have preferred more direct guidance on how to stop the drinking, although I know there are no magic answers, there is nothing telling you what to do to stop the drinking', 'advice was missing, I thought it was going to be more directive and was disappointed when I realized it wasn't, its not a cure-all, I was hoping to be given a solution'.

3. *What can they do for my husband (or wife, son, daughter etc)?* A number of family members simply stated that the intervention was unable to be helpful because it did not affect their relatives' drinking or drug taking. For example the mother of a problem drinking daughter said that the sessions, '...were very helpful in that they made me think about it, but at the end of the day if... [her daughter] is unconscious I can't tell her what to do', and she felt strongly that the only thing that mattered was her daughter not drinking. Another example was a sister-in-law who saw the problem as her brother-in-law's drinking, which was not changing. Another family member said, 'what can they do for her? They can give her tablets but she doesn't want them'.

4. *The intervention is not powerful enough to change the way I cope.* There were other statements, which equally expressed the view that the problem was beyond the influence of the intervention because it was so difficult for the family member to cope differently or to make a break. For example, the female partner of a problem drinker stated that she had not changed her way of coping, preferring to stick to what worked and what her partner expected. Another example was that of a depressed, socially isolated mother of a drug-using son who said, 'it's a really bad life that I've got... [he] can walk all over me... I can't be strong enough against him'. Another depressed mother of a problem drinking son, whose coping was unchanged, admitted she lived 'around him', and couldn't practice tough love as recommended for example by Al-Anon. A wife of a problem drinking husband, describing herself as very unhappy and wanting more than anything else to leave her husband, but finding that difficult without funds of her own, said,

'I want to get away from him but this [the intervention] won't help in that respect'.

5. *PHCPs lack the necessary expertise or are unsympathetic.* Finally, despite a large majority being of the view that the surgery was the right place and the PHCP the right person to deliver this kind of intervention (on grounds of convenience, comfort, being known there, and not being specialist), there were some family members, more often amongst those who had received the brief intervention, who felt that the surgery was not the right place for this kind of intervention, or that the GP, health visitor or practice nurse was not the right person for it, either because PHCPs lacked the specialist expertise that was required, or simply because they were unsympathetic to family members' predicaments. For example: 'GPs, health visitors and practice nurses are not the best people because drugs are specialist', 'a more specialized service with a better understanding of alcoholism would be appropriate where... [the relative] can continue to receive support once he'd dried out', 'the GP doesn't want to know any more, ... [PHCPs] are not the right people to do work with family members, they don't have the time', 'they're just so indifferent, I don't think they're very concerned, I think they think it's self-inflicted', 'it's not sympathetic enough towards the drug abuse, it would have to be somebody who dealt with drugs, knows what they're talking about, the surgery is too medical'.

Discussion

We believe that the analysis of qualitative interview data from family members who took part has advanced our understanding of the strengths and weaknesses of this type of intervention. The central points that have emerged are three-fold. First, there is a strong preference for professional contact, not just provision of a manual. Second, some family members described the very kinds of transformations in their ways of coping that our model predicted, and the manual is itself viewed as containing material sufficient to bring about such transformations. Third, there are a number of factors that operate to limit the effectiveness of the intervention whether it be in its full or brief form. Each of those points will now be discussed in more detail.

Preference for professional contact

There was very strong support from family members for the value of being able to talk to a primary healthcare professional who gave the impression of being concerned, approachable and understanding, who had time for the patients, enabled them to talk about their concerns and the stress they were under, and who made them feel that they were worthwhile rather than being made to feel failures. Evidence for that basic model of a good patient–professional relationship came both from what family members who had the full intervention said about their contacts with their GPs, health visitors or practice nurses, and also from the

very clear preferences that both groups stated for having professional contact. The majority of those who had such contact thought they would have been worse off without it, and the majority of those who had not had that opportunity would have liked it. Those who had received only the brief intervention, although they were just as likely to rate their circumstances as changed, and had used the manual as much, were more likely at the end of the intervention to be negative about it and to state an opinion that the surgery was not the right place for it or that the primary care professionals they had met were not the right people to deliver it.

The appreciation that family members expressed about being able to talk to a primary care professional who appeared to care and show understanding may be common to most general practice patients with psychological problems. In the present case, however, it is likely to reflect, additionally, the appreciation felt by a group that has in the past been unrecognized, unprovided for and often blatantly misunderstood and stigmatized by professionals (Orford et al., 2005b). It came as a pleasant surprise to many of the family members who took part in the present study to find professionals who took a special interest in their problems. Those professionals who delivered the full intervention had received brief induction and training in the stress–strain–coping–support model, which explicitly takes a view opposed to family pathology, codependency and systemic models. The latter models take a less clear view of the stressors and threats posed to family members by a close relative's drinking or drug problem and are therefore at risk of 'blaming the victim' (Ryan, 1971).

Transformations in ways of coping

Many family members described changes in ways of coping predicted by the stress–strain–coping–support model. In particular they described an increasing focus on the self as a person in her or his own right, increasing assertiveness in relation to the relative's drinking or drug taking, and the taking of a more open but calmer approach towards the relative. Those three types of change correspond, respectively, to what we have identified in previous research as increased independent coping, increased engaged coping of an assertive kind, and decreased engaged coping of an emotional kind (Orford et al., 1998b, 2001). Also described were cognitive changes in the form of increased consciousness of the relative's problem and its effects on the family member and relative. The latter, cognitive, changes are not highlighted in the SSCS model but are consistent with models such as that of Asher (1992), which place greater emphasis on transformation of attitudes, for example becoming clearer that the problem is not a reflection of one's own deficiencies.

The manual, which was very carefully developed and pre-tested, was complimented for its design and presentation, and was reported to have been studied by family members for a median three hours. The case examples included in the manual were appreciated by many and it was often said that it helped the family members realize that they were not alone in their troubles. Those who

described transformations in their ways of coping sometimes referred specifically to things that were said in the manual. We can only conclude that the manual was itself one of the most effective components of the intervention.

We had expected that many family members would wish to keep their participation in the project secret from their relatives, and that it might create a problem for family members if the self-help manual was seen by relatives. The interview included questions about this. Over half said they had discussed the manual with someone other than their PHCP, most with another member of the family, others with a friend or a work colleague. In practice only a minority (22%) had deliberately kept it hidden from the relative whose problem they were concerned about. For example one said, 'I thought he might feel that I'm trying to cause aggro, which I'm not'. Another said she felt the relative would be upset to know that she was getting help, because he was very sensitive, and she had hidden the manual in a bag. Another was worried that the relative would feel, '...horrified that I think he's a drunk', although she had told her relative about her participation in the project. A number of others expressed caution about displaying the manual openly (e.g. they kept it in own room or read it when the relative was asleep), but the majority stated that it had been no problem the relative knowing of its existence and of the family member's involvement in the project. Of the majority whose relatives were aware of the project, a small number described positive reactions on the part of their relatives, e.g. 'she thinks it's great, she's quite happy that I'm trying to seek help', but the majority of relatives were described as responding with indifference, or with only temporary effect.

Factors that limit the intervention's effectiveness

The final point is that this intervention in the primary care context was limited by a number of factors to which family members drew our attention. Some family members said that the intervention offered nothing that was not already very familiar to them, as a result as having coped with the problem for a number of years and often having had contact with one or more treatment agency. It was the case that the present intervention was innovative in primary care and that even those practices that volunteered to take part (only a minority of those approached) found it difficult to identify suitable patients. Most primary care professionals who took part recruited only one or two family members within the study period of 16 months, and some were unable to recruit any. It was inevitably the case, therefore, that many of the family members recruited had been coping with their relatives' drinking or drug problems for a considerable time. Quite a number commented that the intervention would have been more useful to them some years earlier. Others were of the opinion that such an intervention for family members was not directive enough or was impotent in the face of continued excessive drinking or drug taking.

Limitations of the present research

It should be borne in mind that interviews were carried out with family members only 12 weeks after entry to the study and at a time when the intervention might only very recently have been completed or, in some cases, while it was still ongoing. A longer follow-up would be preferable. Also ideal would be checking with family member participants that post-interview reports written by interviewers were considered an accurate account, and, in addition, checking with participants that our conclusions were valid from their perspective—what Stiles (1993) called testimonial validity. Neither of those procedures was undertaken, but the care with which interviewers were trained and their work monitored, the careful and detailed nature of their reports, and the results of auditing similar reports against tape-recordings in another study (Orford et al., on behalf of the UKATT Research Team, 2005a), gives us confidence in the present findings. It should be noted that the large majority (86%) of participating family members were women, mostly partners or mothers, and extra caution is therefore necessary in drawing conclusions about the strengths and weaknesses of the intervention for affected male family members.

Conclusions

The views of participating family members, reported in this paper, contribute to an overall evaluation of this attempt to respond to the needs of family members in the primary healthcare setting. This patient group is one that has hitherto been neglected but is one at high risk for ill-health of various kinds on account of the multiple, often chronic, stressors to which they are exposed. There are many difficulties in the way of delivery such an intervention. They include obtaining the commitment of primary healthcare workers, identifying affected family members, and meeting the latter's needs. Despite the difficulties, most family members found the present intervention, including the self-help manual, to be appropriate and beneficial and believed the primary healthcare setting and their primary healthcare professional to be appropriate places and personnel for the delivery of such an intervention. At the same time the present analysis has drawn our attention to limitations of the present intervention. In its present form it may be most suitable for those who are at a comparatively early stage of becoming more aware of their relatives' alcohol or drug problems and/or who have previously received little help or information. Further thought needs to be given to training and supporting primary healthcare staff in the earlier identification of patient who are affected family members, including conveying to such patients that they have a right to such an intervention. For those at a later stage a different emphasis may be required. The self-help manual, though generally well received, may need modifying to make it relevant to family members at different stages.

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