Stresses and strains for family members living with drinking or drug problems in England and Mexico*

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Summary

This paper is a first qualitative approach to the study of stresses, emotions and health related to drug and alcohol use and the family. The comprehension of the core aspects of the experience relatives living with an alcohol or drug user, and the way family members respond to it, can contribute not only to the knowledge about coping strategies, but also about family roles in the changing process. In this sense, the work considers cross-cultural aspects to explore and discover the psychological variations in each culture that are not present in the other.

Data are drawn from interviews with 12 English and 12 matched Mexican family members, and the focus is confined to the participant's descriptions of stressors they experienced, their emotional reactions and signs of mental or physical strain. The aim of this paper is to provide a detailed description, with illustrations, of stresses and strains, and the possible links between them.

The main data gathering the method used in the present project has been quite a lengthy semistructured interview, and the main analysis strategy has been qualitative (Strauss, Corbin, 1990).

The hypotheses derived from this work are that certain core aspects of the experiences of relatives in these circumstances are nearly universal. This core experience consist of finding the user unpleasant to live with; being concerned about the user's health or performance; experiencing financial difficulties; being aware of harmful effects on the family/home as a whole; feeling anxious and worried, or helpless and despairing or low and depressed, and experiencing poor general health or specific physical symptoms which the relative attributes, at least in part, to the stress of living with the effects of a drinking or drug problem.

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There are a number of facets to the cultural contrast between Mexico City and those parts of Southern England from which the English participants were recruited. Although the culture in which the Mexican participants resided may be more collectivist, and the English culture more individualist, they differ also along urban-rural, religious-secular, and Catholic-Protestant dimensions.

Key words: Stress, family, drug problems, transcultural, grounded theory, England, Mexico.

Resumen

Este trabajo es la primera aproximación cualitativa al estudio de la salud, las emociones y los estresores relacionados con el uso de drogas en la familia. La comprensión de los aspectos centrales de las experiencias de los familiares que viven con un usuario de alcohol o drogas, y la manera como responden a ello, puede contribuir no sólo con el conocimiento acerca de las estrategias de enfrentamiento, sino también con el papel de la familia en los procesos de cambio. En este sentido, se consideran los aspectos transculturales al explorar y descubrir las variaciones psicológicas de cada cultura que no están presentes en otras.

La información proviene de 12 entrevistas inglesas y 12 mexicanas a familiares con características semejantes, y se enfoca en las descripciones de los estresores que han experimentado, sus reacciones emocionales y los signos de estrés físico o mental. El objetivo de este trabajo es proporcionar una descripción detallada, por medio de testimonios, de los estresores y tensiones así como de los posibles vínculos que hay entre ellos.

El método principal de recolección de la información que se utilizó en el proyecto fue una entrevista semiestructuada, y la principal estrategia de análisis es cualitativa (Strauss y Corbin, 1990).

Las hipótesis que surgieron de este trabajo se basan en el hecho de que ciertas experiencias de los familiares son universales en esas circunstancias. Estas experiencias consisten en las repercusiones negativas de vivir con el usuario; el interés por la salud y el desempeño del usuario; las dificultades económicas; los efectos dañinos del consumo en la familia y el hogar; los sentimientos de ansiedad,

preocupación, desesperanza, desesperación y depresión; la manera como afecta la salud mental y los síntomas específicos que el familiar atribuye, en parte, al estrés por vivir bajo los efectos de la problemática del consumo de alcohol o drogas.

Hay un gran contraste entre la ciudad de México y las áreas del sur de Inglaterra, de donde proceden los participantes ingleses. La cultura de los participantes mexicanos tiende a ser más colectivista, mientras que la cultura inglesa es más individualista. También hubo divergencias en las dimensiones urbano-rural, religioso-secular y católico-protestante.

Palabras clave: Stress, familia, problemas de drogadicción, transcultural, teoría fundamentada, Inglaterra, México.

Background

Drinking and drug-related problems are recognized to exist on a large scale and to represent one of the greatest challenges for the prevention and treatment of ill-health in both 'developed' and 'developing' countries. Close relatives are important on at least two counts. Firstly, they are known to be at high risk themselves (14) (28). Secondly, the close family constitutes, the most immediate, micro-level social system surrounding the individual drinker or drug-taker. Because of the clinical orientation of most of the work on excessive substance use, it is the individual drinker or drug-taker who has held centre stage, whilst the social systems perspective has been a minor theme in the literature. Hence close relatives have taken minor parts and their importance in their own right, as well as their potential for influencing processes of change, has been comparatively neglected (16).

The second motive for a detailed study of the experiences of this group of people is more general. It. derives from the fact that living in a family where one member has a drinking or drug problem is a very common predicament world wide (15). Arguably such circumstances constitute one of the most common sources of chronic family stress. There has been a very great deal of interest in recent years, both on the part of theoretical psychologists and in the health related disciplines, in how people cope with stress (8). Although there have been studies of how relatives of people with drinking and drug problems cope (1,20), these have not on the whole been closely linked to a wider work on coping with stress generally, and the wider literature has not been much informed by them. An understanding of such a common predicament as living with an excessive drinking or drug-taking person, and how people respond to it, should be of great help in building an understanding of how people cope with stress generally.

The work to be reported in the present paper has a number of features that require explanation. The first is its theoretical orientation. The perspective adopted sees relatives as 'stressed' as a result of the excessive substance use of one particular family member. From this perspective a number of parallels can be drawn with other stressed groups such as relatives of family members with Alzheimer's disease, to those living with family members with other kinds of chronic illness or handicapping condition (17). This perspective has a long tradition in studies of alcohol and the family (10) and has some support in the literature on drugs and the family (7), but it stands in marked contrast to some other viewpoints including those emphasizing the deviant characteristics of relatives, such as wives' psychopathology or mothers' or fathers' deviant parenting styles (11,27); the co-dependency model (2), and that variety of systems theory that supposes that excessive substance use is functional in maintaining family homeostasis (23). A second feature of the present work is the unusually wide sampling which deliberately includes partners, parents, and other relatives, and those facing excessive drinking as well as others facing the excessive use of other drugs. The work to be reported also has a cross-cultural aspect whereby we are attempting to assemble a more broadly based and more nearly universal understanding of the experiences of relatives facing alcohol and other drug problems in the family (3).

Unlike Britain, Mexico is a largely Catholic (or more accurately 'syncretistic'-Catholic) country with much greater emphasis upon traditional family and religious values, larger average family size and a lower level of personal wealth. They are also likely to differ considerably in terms of individualism versus collectivism which has been identified in cross-cultural research as a major dimension along which cultures differ (25). Although undergoing rapid social change, particularly in urban areas, Mexico almost certainly remains a more collectivist culture than Britain. Hence the expectation is that Mexicans would value loyalty and self-sacrifice in relation to in-groups including the family, whilst Britons, being members of a more individualistic culture, would evidence a stronger commitment to autonomy and independence. Studies of the Mexican personality' (usually in comparison with the United Statesian personality) have tended to confirm aspects of this stereotype (6).

Finally, the main data-gathering method used in the present project has been quite a lengthy semistructured interview, and the main analysis strategy has been qualitative. Although this is not without precedent in the field of alcohol, drugs and the family (7), it does represent a departure from the almost exclusively quantitative approaches used in the past. It is our view, however, that a qualitative approach is the most appropriate for developing detailed theory which is 'grounded' in the accounts of their experiences given first hand by those whose circumstances we wish to understand (24). Quantitative methods might be more appropriate for testing the pre-existing theory about which we are confident. Fortunately, useful guides for psychologists and others who have previously been unfamiliar with qualitative research are now becoming more readily available (5,24). These make it clear that there are a number of competing philosophies underlying qualitative work. Henwood and Pidgeon (9) have recently described three strands to qualitative research: the empiricist (placing a high value on data reliability, for example); the naive humanist or 'contextualist' (assuming that careful interviewing, for example, will reveal the 'truth' of the participants' experience); and the constructivist (which assumes that

there are many 'discourses' or accounts out of which the social world is constructed). The philosophy underpinning the present research probably corresponds to the second.

This is the first report of findings from the Mexico/UK Alcohol, Drugs and the Family Project. Preliminary studies, which form the basis for the present work, took place both in England (20) and in Mexico (21).

This work report draws upon a small proportion of the qualitative interview data. Data are drawn from interviews with 12 English and 12 matched Mexican family members, and the focus is confined to the participants' descriptions of stressors they experienced, their emotional reactions, and signs of mental or physical strain. The aim of this paper is to provide a detailed description, with illustrations of stresses and strains, and the possible links between them.

Other reports focus upon ways of coping and social support as possible moderators of the stress-strain relationship (18,19).

Methods

Participants

The criteria for inclusion of a family were as follows: 1) at least one family member volunteered to take part (referred to from hereon as 'F') who was not her/himself believed to use alcohol or any illicit substance in an excessive or problematic way[6], 2) F considered that the drinking or drug taking of another member of the family (referred to from hereon as 'U' for 'user') had been a major source of distress for F, 3) U had been drinking or consuming drugs at some time during the last six months, and 4) F and U had been living under the same roof at some point in the last six months[7].

In Mexico participants were recruited from three areas of Mexico City, the centre, north-west and south-west. Recruitment was via a number of different sources: community centres providing general family services including food and accommodation; general medical health centres; and specialist community agencies providing treatment services and prevention directed at alcohol or drug problems.

In England, as in earlier research by our group (20,26), the net was cast wide both geographically and in terms of sources of recruitment. Participants were sought from a variety of community treatment agencies and via public advertising, throughout much of the South Western and Wessex regions of the country. Although this area contains few localities with high levels of deprivation, it is otherwise very mixed in socio-economic terms.

When recruitment of the full sample of 207 families was approximately three-quarters completed the 24 participants (from 24 separate families) listed in Table 1 were selected from the records for detailed qualitative analysis. They were selected to provide a reasonable match between 12 English and 12 Mexican interviews in terms of substance used by U (mainly alcohol versus mainly other drugs) and F's sex and relationship to U. Otherwise records were chosen at random. The present sub-sample of 24 is reasonably representative of the whole sample finally recruited.[8]

The Interview

A semi-structured format was used which divided the interview into seven parts: details of the family which included constructing a family diagram; the history of U's alcohol or drug use up to the present time; the impact on F and the rest of the family; how F and others had coped and reacted; social support, both formal and informal, for F and other family members; effects on the health and well-being of F and that of other members of the family; expectations for the future. Within each of these sections interviewers were instructed to ask as many open questions as possible relevant to a particular section of the interview, to ask sufficient questions to clarify what was said, to obtain descriptions of specific incidents that illustrated points being made, and to follow leads provided by the participant in answer to open questioning.

Interviewers were psychologist instructed to probe for information on certain topics if these were not spontaneously mentioned.

Interviews were carried out in the participants' homes, the offices of agencies through whom contact with participants has been made, or at the University or Institute, according to the participants' preferences. The duration of the interviews varied greatly from a minimum of 1 1/2 hours to a maximum of 12 hours. Roughly half the interviews were conducted over two (or very occasionally three) sessions. There was a significant difference in duration between the two countries, the median in Mexico being 3 1/2 and that in England 4 1/2.

Analysis

All interview reports, which vary in length from approximately 2,000 to 12,000 words, are being analyzed using a set of 25 preliminary categories based upon the named sections of the interview and upon preliminary work (20,21). A detailed coding instruction manual provides a guide to coders. The initial categories represent a first, and comparatively crude attempt at sorting the text that should be helpful for subsequent,

[6] This criterion was relaxed slightly during the course of the project to include the occasional family member who her/himself had a drinking or drug problem, but only where F's problem was judged to be significantly less serious than U's. This did not apply to any of the 24 participants referred to in the present paper.

[7] This criterion was also relaxed slightly during the course of the project to include the occasional family member who, whilst not living under the same roof with U at any time in the previous six months, lived very close by and interacted with U on a daily or very regular basis. This did not apply to any of the 24 participants featuring in the present report.

[8] In the full sample the proportions for drug type were: Mexico, 47 % alcohol, 53 % other drugs; England 60 % alcohol, 40 % other drugs. In terms of sex of interviewee: Mexico 77 % female, 23 % male; England 69 % female 31 % male. In terms of relationship of F to U: Mexico 43 % parents, 33 % partners, 24 % other; England 36 % parents, 52 % partners, 12% other.

TABLE 1
The sample
12 English and 12 Mexican relatives of people with alcohol or drug problems

	England			*Mexico*		
	Sex of U[1]	*Relationship of F to U*	*U's main drug(s)*[2]	*Sex of U*	*Relationship of F to U*	*U's main drug(s)*
1	Fem	Mother	Cannabis, ecstasy	Fem	Mother	Various incl. solvents, cannabis
2	Fem	Mother	Various incl. ecstasy	Male	Mother[3]	Various incl. alcohol
3	Male	Mother	Various incl. cannabis, ecstasy, LSD	Male	Mother	Solvents
4	Male	Mother	Amphetamines, etc.	Male	Mother	Solvents, cannabis
5	Male	Mother	Heroin, etc.	Male	Mother	Solvents, cannabis
6	Male	Wife	Alcohol	Male	Wife	Alcohol
7	Male	Wife	Alcohol	Male	Wife	Alcohol, cocaine
8	Male	Wife	Amphetamines	Male	Wife	Cannabis
9	Male	Sister	Alcohol	Male	Sister	Alcohol
10	Male	Father	Various incl. amphetamines, ecstasy, cannabis	Male	Father	Solvents
11	Fem	Husband	Alcohol	Fem	Husband	Injectable drugs[4]
12	Male	Son	Alcohol	Male	Son	Alcohol

1. U-Alcohol or Drug User. F-Relative interviewed
2. The full extent of U's drug use was often unknown to F
3. Aunt who had taken the role of U's mother
4. Type unknown

more detailed analysis. The initial categories are tools in the analysis rather than ends in themselves.

Interview reports were transferred into computer program TEXT BASE ALPHA files.

For purposes of the present paper attention has focused upon those parts of 24 interviews coded using EFF (for 'effects' or stressors) and HEALTH codes.[9]

The detailed analysis of stressful impact, feelings and health to be reported in this paper is based upon an analysis carried out by the first author using the aforementioned coding scheme as a basis. This has consisted of further sub-dividing categories, collecting instances of references that fall into sub- or sub-sub-categories, and exploring the links that participants appear to be making between the impact of drinking or drug-taking upon their lives, how they have felt, and their states of health and well-being. This process corresponds roughly to what Strauss and Corbin (24) call 'axial coding' and Dey (5) calls 'splitting and splicing'. Some comparisons between results from England and Mexico are made and commonalties and some possible differences in the experiences of family members in the two countries are pointed out.

Results

The results section is divided into four parts: (1) A description of commonly reported stressors; (2) A summary of the forms of strain experienced by participants, including both uncomfortable feelings and ill-health; (3) An analysis of the links drawn by participants between the domains of stressors and strains; (4) A brief presentation of the accounts of two interviewees, one Mexican and one English.

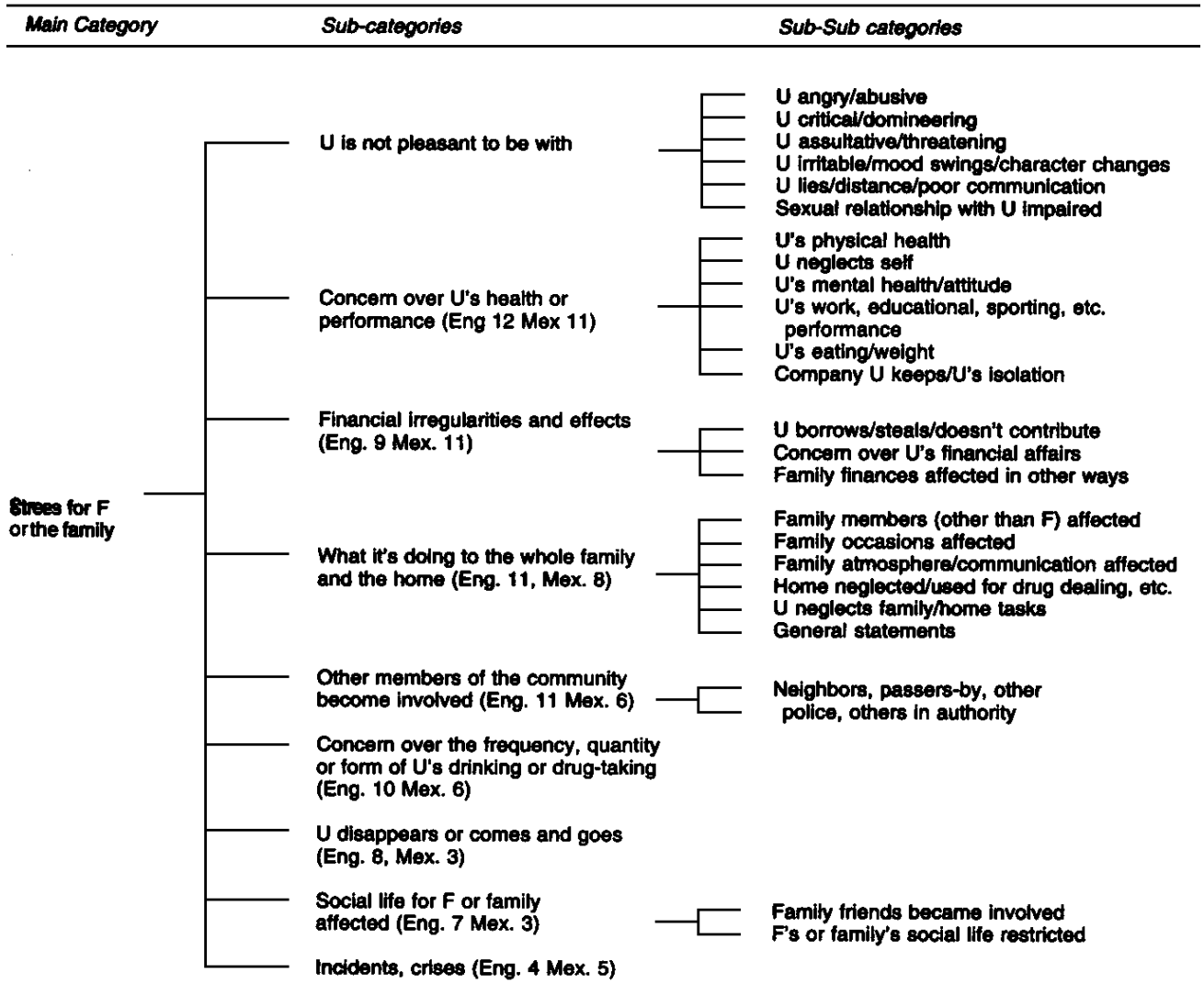
Stressors for family members

The main sub and sub-sub-categories used in the detailed coding of passages of the interview reports relating to stressors are shown in Table 2. The Table also indicates the number of English and Mexican interviews containing any passage(s) falling into a particular sub-category. The Table shows that some experiences, or 'stressors' as we term them here, are universal or near universal amongst these 24 participants whether Mexican or English. All reported in one way or another that 'the user' (U) had been difficult or unpleasant to live with, and almost all mentioned their concern over at least some aspect of U's physical or mental health, self-care, or ability to function in work, educational, social or leisure roles. Most described harm that was thought to have occurred for other members of the family or for the family as a whole, and most made specific mention of financial difficulties of some kind. These four sub-categories may, therefore, represent a common core of the stress experienced by close relatives irrespective of country and irrespective of the substance being used excessively by the users in their families.

It is not necessary to provide all the details of this core experience since much of it has already been well described in the literature, but some of the less well known or less immediately obvious sub-categories will be illustrated.

[9] The former embraced EFFFAM, EFFUSER and EFFPOS which were used to refer respectively to: negative impacts of U's alcohol or drug use on F or the family; negative impacts of U's alcohol or drug use upon U him/herself; and positive impact- upon U, F or the family. Similarly HEALTHFEEL, HEALTHPSYCH, HEALTHSE and HEALTHPHYS were used to refer respectively to: perceived consequences of problematic alcohol or drug use for F's feelings; F's psychological state; F's self concept or self-confidence; and F's physical health or symptoms.

TABLE 2
Stressors for family members
(N = 12 English plus 12 Mexican interviews)



One of the aspects of excessive users' behavior which is difficult for relatives to live with, for example, is behavior on U's part which is critical or domineering towards F. The following are, in brief, some of the items that were coded in that category:

U says, "My body is my own and I can do what I like"; threatened divorce, to take every penny, wants to leave and take their young children, to be free; has the power, satisfaction of being in control; dominant, critical of what F watched on TV, called F names, criticizes, provokes, demanding about meals; says relatives are too old and should die; abusive, paranoid, complains, said F was the mad one, hostile, sees F as worst enemy; doesn't let her attend church, criticizes F for her beliefs; pressure on F, blames others including F, should have you [F] sectioned when F is hovering goes behind her hovering it all over again.

To illustrate this theme in greater detail, the following is taken directly from a single English interview report:

Sometimes U has been so abusive and "under the belt" particularly to F, that F began to feel very unsure of herself and to wonder if it was her who was to blame. Eg. U would say to F, "why did you have me... it was your fault, you said you couldn't have children, so why did you have me". U would bring up a very sensitive issue which F had talked to him about and use it against F, or U would ridicule F's or her husband's faith, something which is very special to them (An English mother).

And from a Mexican report:

There were two incidents that led to U taking the decision to give up drinking. The second incident was when F left him..... which produced a reaction in U. On that occasion F had been attending her mathematics classes in order to be able to help their children with their homework. U came up to her in the street and told her off for stopping taking care of him (U was under the effects of drugs at the time and hadn't been eating) and threatened her that he would set upon her physically when they got home (A Mexican wife).

Brief illustrations of the sub-category of concern over U's mental health or attitude are as follows:

U mentally rundown, preoccupied, apathetic; state of mind: desperation, helplessness, miserable; stress symptoms which U attributed to not wanting to 'do speed', but that he's got to be doing it, out in the evening and came back totally wasted, really funny and weird, lost all former 'get up and go', withdrawal into self, can't be bothered when not using; very preoccupied and withdrawn-, talk of suicide, hanging; suicide attempts; not turning up for sporting events U was previously very committed to, "extremely dramatic change in attitude"; U doesn't trust himself to have a relationship, he would like to but he won't; sometimes couldn't even talk, 'slanted' look in eyes; as if lost and speaking a lot of incoherence; drunk, woke saying a doll had spoken, that he had swallowed his tongue and couldn't control its movements, very anxious; black-outs, hallucinations. Brief indications of items falling in the **U borrows/steals/ doesn't contribute financially** sub-sub category are as follows:

Bought things for U which U sold; buys things for U, e.g. fares, cigarettes; U asks F for money for other things, F suspects for drugs; borrows without asking; pressure on F to give or lend money, on one occasion U asked another relative when a friend was present which made it difficult to refuse; stole from F; takes objects from the house; U broke into the meters in the house, took other things like F's leather jacket, a television, coffee maker, F's records which had sentimental as well as actual value; stealing not a problem but suspects U has taken small amounts from a pot in the bedroom; financial help from U is sporadic so the family economy is affected; F's mother works for U but he controls the finances and doesn't give her much money; two weeks before Christmas F had nothing and was freaking out, eventually F's friend bought food etc. for them instead of giving presents, each week after food and money went on U, they were much poorer than when she controlled the money.

From the report of an English interview:

F said U would take money, £2 here or there, but would deny it. She said he pinched her ring and took it to the pawn shop. She noticed it had-gone and U said he would get it back, but F insisted on getting it back herself. U gave her the ticket reluctantly.... U lost a gold chain F's sister bought him and a St. Christopher. F said they never turned up again. U said he lost them in a fight but F thinks he has pawned them. "I used to believe him, he made it sound so feasible, but not now" (An English mother).

And from a Mexican report:

Because U spends money on alcoholic drinks, F says that often she hasn't even the money to buy food for the children, and often has to go to her mother-in-law or ask for credit because she doesn't want her relatives to know about the situation (A Mexican wife).

An indication of some of the ways in which the **atmosphere and communication in the whole family** can be affected are given by the following:

U comes in making noise, etc., upsets everyone; U arrives in the early hours breaking things, picking fights; difficult as a family to sit down and talk about how to cope with U, a disaster all round; seldom sit down together as a family; the whole family finds it hard to talk about things; their daughter sometimes doesn't get much sleep and has to go to work the next day; the atmosphere is tense and strained, not happy; unfavorable consequences on the whole family because of others' rejection of U, criticism of F for treating U like a child, not abandoning him, etc., arguments between parents over U; strain on their marriage.

From an interview with one wife, the following:

F describes their home life as, "very difficult and sad", since U's problem stops her having a good relationship with U, and stops U having a good relationship with their children. There has been a constant atmosphere' of tension since they constantly feel terrified because of U's aggressive and violent attitude, particularly towards F (A Mexican wife).

A mother described how her son's drug problem had affected aspects of her interaction with her husband:

F said that when there's trouble or an emergency F deals with it and it is left to F -to deal with it. Her husband makes himself scarce. He is, "a very gentle, sensitive soul", but F has noticed that things are getting difficult for him... There have been occasions when F has had to stand between her husband and U because she was, "afraid they were going to kill each other, and that's unheard of for.... (her husband), he's very gentle" (An English mother).

Other stressor sub-categories appeared to represent less central aspects of the experience of family members since in one or another country or both, references to such experiences occurred in no more than half the interviews. Several of the sub-categories were coded more frequently in the English than in the Mexican interview reports. For example, there was a greater frequency of passages coded U **disappears or comes and goes** or **Social life for F or family affected** in the English interviews. Mention was made in a number of the English interviews, for example, of young adult 'users' staying away at the homes of friends or even in their own flats:

U is trying to get a flat. She goes off for days at a time without telling them, and will come back for three or four days, have a good meal and get some clean clothes. "She won't let us know where she is" (An English mother).

In Mexico, on the other hand, references to U 'coming and going' usually meant that U was out 'on the streets':

F has seen the change in U. He, "was always very neat and clean and tidy". Sometimes he spends the whole day in the street and arrives home dirty smelling of 'thinner, and 'cement' (organic solvents used as inhalants) (A Mexican mother).

References to F's or the family's social life being affected in the English interviews include a number of statements about invitations to private parties, inviting

friends home, and other references implying the existence of a non-kin friendship network and freedom to socialize which is being interfered with as a result of the drinking or drug problem. For example:

As far as her social life is concerned it has been affected "a lot". About a year ago when the whole thing came out in the open, an established friend told her, "I really can't be doing with all this, it is so tacky ". F has found that she has lost contact with a lot of people in the upper middle classes .... F will also go out less than she used. "I'm much more careful about who I see now" (An English mother).

There was a small number of passages about social life being restricted for the Mexican participants, but these made reference to neighbors and "fiestas" which are as likely to be public affairs in which the local community shares as they are to be private parties. No direct references were made to a non-kin or non-local friendship network:

F says that her social life has been restricted. "I no longer have any enthusiasm for going to "fiestas", I feel bitter and I don't feel like doing anything" (A Mexican wife).

Little by little F has taken responsibility for the family and has put his personal activities to one side. For example he didn't go to the fiesta because of fear that his father might arrive during the night and attack the family. On one occasion U (his father) asked F directly if he would look after his mother and sisters, and F thought, "I can't let my father down" (A Mexican son)

Signs of strain: relatives 'feelings' and health

The main sub-categories and sub-sub-categories into which statements of feelings fell are shown in Table 3.

Again there appears to be a common core of experience transcending country and relationship with U (parent, partner, other), consisting of feeling anxious or worried, helpless or despairing, and low or depressed. As will be discussed in greater detail below, these feelings were almost invariably attributed to U's drinking or drug-taking or circumstances or events connected with it.

General **emotional** upset; uneasy; not relaxed; wrung out; emotional; can't compose self.

Worry, preoccupation: worried; preoccupied; can't enjoy a meal waiting for U to arrive; can't concentrate; can't get it off my mind; you think, where are they, what are they doing?; forget things because thinking about U; plays on your mind.

Tense, nervous: tense; anxious; nerves in pieces; nervous; suffer from nerves; panicky; trembling; on edge; on tender hooks.

Irritable, quick-tempered: react to criticism; fly off the handle; ratty at work; quick-tempered with everyone; sensitive and irritable; annoyed over the smallest thing; always in a bad mood.

The helpless/despairing sub-sub-categories:

Helpless, can't cope: hopeless, helpless, can't control the problem; frustrated, don't know what to do; impotent; can't cope; can't put up with it; can't stand it; desperate; hanging on by a thread; too much to handle.

Resigned, despairing/disillusioned: don't care any more; no future; no hope; despair; apathy; resigned; putting no effort into things; don't expect things; don't make plans; stopped fighting; disillusioned.

Lost faith, trust/hope in U: expecting to be let down, thinking the worst; fearful that U will use again; don't know whether what U says is genuine; lost faith in U; lost trust, frightened for U and U's future.

And feelings of being low/depressed:

Depressed/miserable/unhappy: depressed; miserable; dragged down; low, down; sad, unhappy.

Low energy, enthusiasm: not light hearted; don't do pleasurable things; low enthusiasm, spirit, energy level and stamina low; not in the mood for going out socially.

Suicidal thoughts: wanted to kill self, meant to commit suicide; preoccupied with death; wished to die.

Although these three sub-categories of anxiety, despair and depression are distinguishable in terms of the words used, it was most often the case that these three themes ran together in participants' accounts and some referred explicitly to experiencing 'all' or 'the whole gamut' of emotions. The following are some typical examples:

F and U get on OK but, "I couldn't have stood her here any longer". It has got to the point where F doesn't want to talk to U. "I push it on to (husband). I feel I can't cope with her here. We've all had enough physically and mentally... I can't take the noise and the aggro.... I can't be bothered going into reels of conversation". F says to U, "I don't want to hear all about your drugs and raves". F's husband and U both yell at each other, but they seem to like it. It depresses F and she has to go away (An English mother).

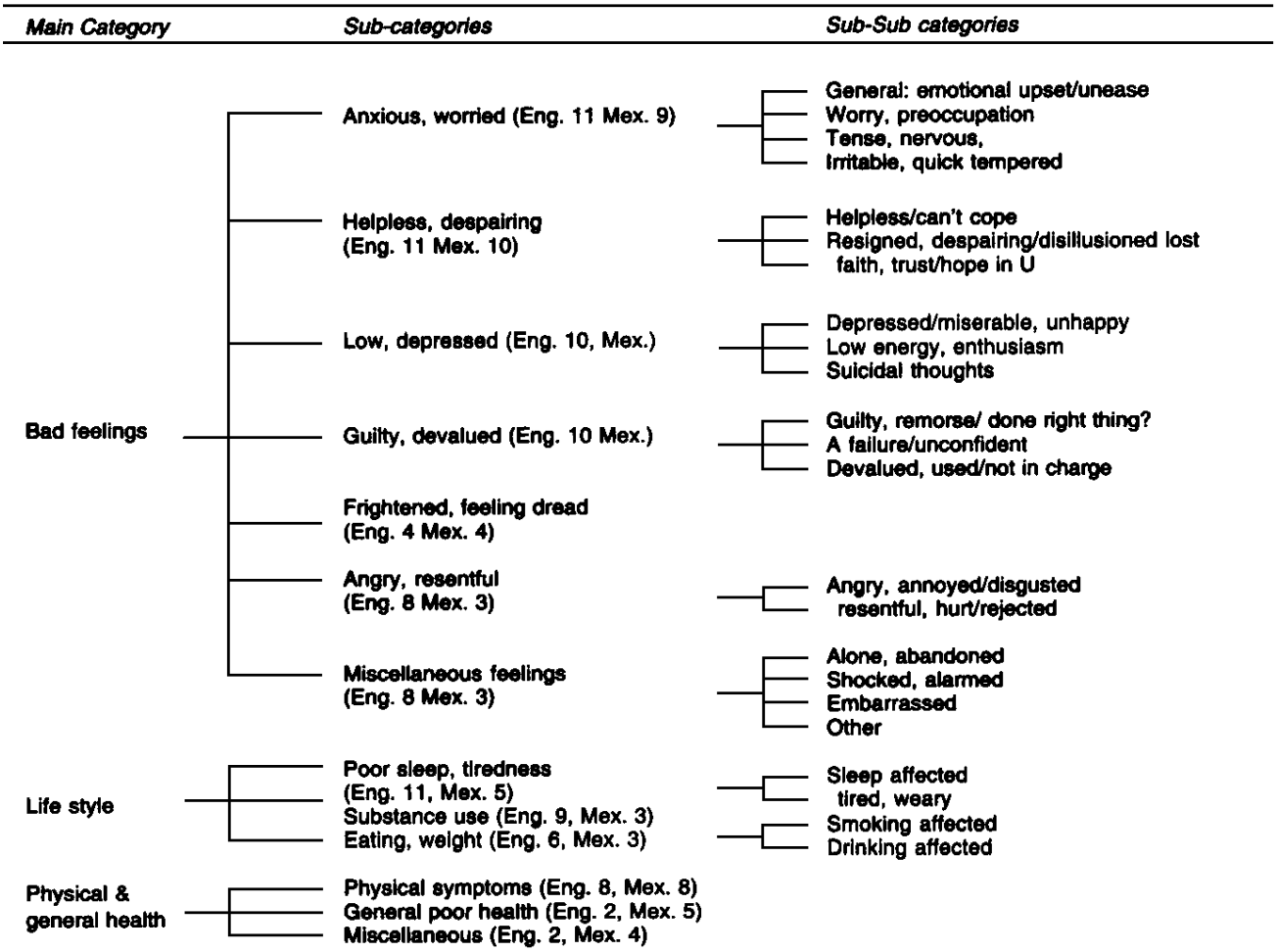
It has affected the lives of all members of the family.... F has become "very sensitive, and irritable... She has felt anxious and depressed because of the situation since they live in constant worry because of all that U provokes. "I can't put up with the situation any longer, I tell my mother that we can't go on like this, that this is no life". Two years ago F attended Neurotics Anonymous since she meant to commit suicide because she felt very depressed because of the problem she had with the family (A Mexican sister).

The majority of passages coded in the guilty/devalued sub-category were found in the reports of English interviews, but examples existed in both countries.

F feels badly, thinking that she gave in to U too much, that she defended and supported him too much. I always defended him against others hitting him. I gave in to him a lot. I didn't let him solve his own emotional problems. While I was there no-one was allowed to hit him or tell him off. I feel to blame for having given into him. I was keen that he shouldn't experience the lack and humiliations that I had because I was an orphan, but I can see that I went too far" (A Mexican foster mother).

When U was at his worst F described the relationship as "non-existent, you feel you're just there to do the cooking and cleaning. You get to the point where you don't care anymore, you have been dragged down for months, you lose confidence in yourself. You think, is it

TABLE 3
Strain for family members
(N = 12 English plus 12 Mexican interviews)



my fault?.. I don't know why it is happening, when it's going to stop, why it started, and then is it my fault? (An English wife).

F has felt very depressed and hopeless, and even came to believe everything that her husband said of her: "That I'm no use, that I'm the worst of women and that there are many better than me, that with other women he feels better sexually, and with me no, that I'm rubbish, etc."... F felt very depressed and devalued (A Mexican wife).

"You feel terribly responsible for bringing them into the world, you think what have I done?... You see them making mistakes and think what can I do about it, you feel you must have made awful mistakes not getting through to them about the dangers". F said that she didn't feel like this all the time, just when things were at their worst. If she knew then what she knows now she wouldn't have had any children. "I thought having kids was simple but it is not. I feel U is out there so vulnerable but your hands are tied" (An English mother).

Angry/resentful is the sub-category covering bad feelings with the clearest direct reference to U and U's behavior. It covers feelings of being angry, annoyed, mad or disgusted *with U*, resentful, offended, hurt, cheated, let down or disappointed *at the way U has behaved*, as well as feelings of hate (often expressed as mixed or alternating love and hate) *towards U*, feelings of rejection *towards U*, and feeling like shouting out, hitting, locking away, or suffocating U. Again these feelings were more commonly expressed in the English than in the Mexican interviews, but these are examples from both.

F said she still gets angry and annoyed. "At times you feel sorry for them for what they are going through, then you get annoyed, then you feel guilty, then you end up hating them but they can't see what they're doing. You go through it all" (An English mother)

When she realized (that U was taking drugs) she felt very let down... She still feels very angry towards U... The fact that U went out in the evening to drink leaving her and the children alone at home made her angry... At times she had some feelings of rejection towards U. She felt a certain uncomfortableness when he made any demonstration of physical affection towards her, although she couldn't explain why this happened (A Mexican wife).

"Not a lot gets done. I'm damned if I'm going to do anything if she's not". Housework, the decorating and the garden just get left (An English husband).

Table 3 also shows the sub and sub-sub-categories into which statements about ill-health were placed. In the majority of interviews from both countries mention was made of symptoms of physical ill-health. These included: sickness, anemia, headaches, neuralgia, back pain, 'pains', hypertension, asthma, hair loss, change in pattern of bowel movements, gall bladder trouble, shortness of breath, palpitations, diarrhea, migraines, 'minor ailments', itching. In a number of interviews, slightly more from Mexico than England, poor health was referred to in general terms, such as: health poor, weak, in decline, felt ill, health 'went', put years on me, in bad health, felt fragile, neglected self. A miscellaneous health category included such references as: sexual diseases transmitted by husband (U), danger of the reoccurrence of epilepsy, miscarriage.

Possible signs of strain in areas referred to collectively here as 'life-style' were mentioned more frequently in the English than in the Mexican interviews. These included poor sleep/tiredness, e.g. sleep affected, up at night, sleep more; insomnia; spend more time in bed as an escape, lay awake the whole night; wake early; up at night talking with U; sometimes sleep for two days; tired; fatigued; weary with it all. Some reference of this kind occurred in all but one of the English interviews. References to F's smoking, drinking or drug-taking, going up, fluctuating more, or in two instances going down, also occurred in three-quarters of the English interviews but in only one of the Mexican interviews. Similarly, references to eating changes were more common in the English interviews, e.g. eat a lot when nervous; neglect eating; loss of appetite; weight change; have over-eaten under stress; some days eat a lot others not at all; eat less because U doesn't eat; weight reduction.

The links between stressors, emotions and health

First to be considered are links between stressors and bad feelings.

Many links between stressors and bad feelings are drawn immediately and directly and the link is made within the structure of a single sentence. One relative is preoccupied with thinking *about U's drug use.* Another is despairing about U's continued drinking. A third one is angry *about what U is doing to the family.* Other links between stressors and feelings are slightly more elaborate and made at greater length, but nevertheless the links were almost always drawn clearly and unambiguously. The 24 interviews contained numerous instances of these connections of which the following are examples:

F said, "You go through all the feelings". She said she had felt worried, angry, hate sometimes and resentment. She is always worried. She said she worried while waiting for U to come in and waited for the door "At least when he is in I can relax, he's there, I think at least I know he's there and he is not into any mischief" (An English mother)

For F it has been the most difficult stage of her life and she has been badly affected by U's drinking... when U drinks he attacks her physically. On one occasion their eldest boy intervened to stop him hitting F, and U struck him such a blow that F had to take him to see a doctor... Comments that people make about U's drinking also annoy F and even more so when they do this in front of the children. Neighbors say that U is going out with another woman or that they've seen him lying drunk in the gutter. This makes F feel very bad and she worries about what the children will think of their father... Her relationship with U has been affected because she feels so badly about things and is worried that the children will grow up seeing U's consumption as something normal (Mexican wife).

A number of participants articulated a causal sequence in which their own feelings about U's behavior or about their own reactions to U's behavior, played a mediating role in causing still further bad feelings. For example one English father described how he had thrown his son out of the house some months previously as a result of his son's drug use and what the drug use had done to change his son's character, and how badly he (the father) had felt since then:

F has found it difficult to work and to concentrate. He will pick up something to do and put it down again and walk around the house. He can't get it of his mind. He found himself caught between, "trying to take a positive action", and wondering, "but have I abandoned him when he needs me". F said there was, "a feeling of not being able to affect the situation, of being a parent and then not being in control". F felt in a position, "beyond my experience and not knowing what action to take... (F) never realized how a situation would totally be able to dominant my life, not just day to day but minute to minute. Initially I could not get it out of my mind. 'Where was he? What was he doing?"... Each time they (F and his wife) have taken an action they are left wondering, "have we done the right thing?". That uncertainty itself is debilitating... F feels the changes in their ways of reacting have come about because of, "a wearing down process of attrition, a cumulative process of two years of hurt and being disappointed and upset... There's a sadness and the quality of family life is diminished and I don't know if it will ever be regained".

We turn now to the links between stressors and symptoms of physical ill-health. These are generally more tentatively drawn than the links between stressors and bad feelings described above.

Others are aware of concurrent stressors which may have combined with the family drinking or drug problem to produce ill-health. For example:

It is F who is ill because of U's consumption and because of the death of F's mother. He's been suffering from a bad headache in the upper left part of his head and the doctors still don't know what he has got. They prescribed an injection when the headache was very bad. F says he always used to be a very healthy man (A Mexican husband).

Other participants made a link more confidently:

It's just a constant worry. I lost hair when he was in prison. It's just as much a sentence for me as perhaps for him. You're hooked onto the addict, you also become an addict", always thinking about the problem. She will,

"constantly feel upset, tired, sometimes sleep and sleep for a couple of days... Sometimes I get headaches", normally in relation to specific stressful events such as, "something to do with the courts" (An English mother).

When F knew of U's consumption she felt ill. "My body was paralyzed and I had a bad feeling in my chest". Sometimes when she has been desperate she has wished to die, "because U does not get better". About her general health F has noticed lately that she forgets things because she is thinking about U, and sometimes she can't sleep (A Mexican mother).

Participants sometimes attributed ill-health in other family members to U's drinking or drug problem:

F thinks his older sister is now anorexic. This he thinks is a result of the situation in the family over the years. She doesn't acknowledge that she is anorexic, however, and is not receiving any medication or specialized help. F thinks stressful situations in the home life may have been detrimental to his sister's health and well being... which in turn has lead to the physical consequence of anorexia (An English son).

Whilst all interviewees made clear connections between the stress of living with someone with a drinking or drug problem and their own negative emotions, and many made connections, some tentatively, with their own or others' symptoms, the following passage is unusual in the clarity with which a connection is made with a change in F's social personality:

U's behavior has been upsetting F who certainly feels that he has lost a lot of confidence because of U's problem. "I don't find it easy to talk to people anymore". He said that he has noticed a timidity in himself in asking for things, for example at work when he has to meet other people and get information. He said he finds that aspect difficult. "I find it a lot easier to get it out of a machine than a human being". F said he did think it was related to U's drinking. He said that five years ago he didn't have difficulty in gathering information from humans. Sometimes when U has been drinking she will lay into him, and she will tell him how useless he is. For example, she has commented on the way he speaks and his accent and about dropping his h's. She has told him that you don't get high up people with his accent, and has said no wonder he hasn't got promotion because of the way he speaks (An English husband).

Two Illustrative accounts

In the foregoing, general themes have been illustrated with passages extracted from individual interviews. In Figures 1 and 2 the main themes, regarding stressors, feelings and health strains, taken from two interviews, have been brought together in diagrammatic form to illustrate the connections being made by these two informants. Although the distinctions are not entirely clear cut, the stressors are mostly shown on the left, feelings in the middle, and strains in terms of psychological or physical ill-health or lack of well-being on the right. Filled arrows indicate causal connections that were clearly made by the informant, whilst open arrows represent connections that were less clearly made. The filled connections, without arrows, in the centre and top right of Figure 1 and top centre of Figure 2 join different facets of a single, multifaceted theme.

The Mexican mother, a part of whose account is depicted in Figure 1, described her 24 year old son's solvent abuse as the most important problem for their family. At the time of interview he had been attending another centre as an outpatient, and had been abstinent from solvents for two months. F herself, separated from her husband for many years, worked outside the home in a children's clothes factory.

Figure 1 shows her concern for the stress on her mother and daughter, her realization about the strain experienced by the whole family, and the effects on her own psychological health. Also shown at the bottom of the diagram is the way in which F would castigate herself for feeling hopeless and for wanting to see quicker results from treatment. Not shown in the diagram is her concern for her daughter's children who had been frightened by U's loud and aggressive behavior in the home, and who had shown some signs of being disturbed. F described how the situation at home had improved recently, how arguments had lessened, and how she herself felt more controlled and calmer and would go off to work feeling less troubled than previously.

Figure 2 shows some of the major themes that emerged from the interview with the English wife of a

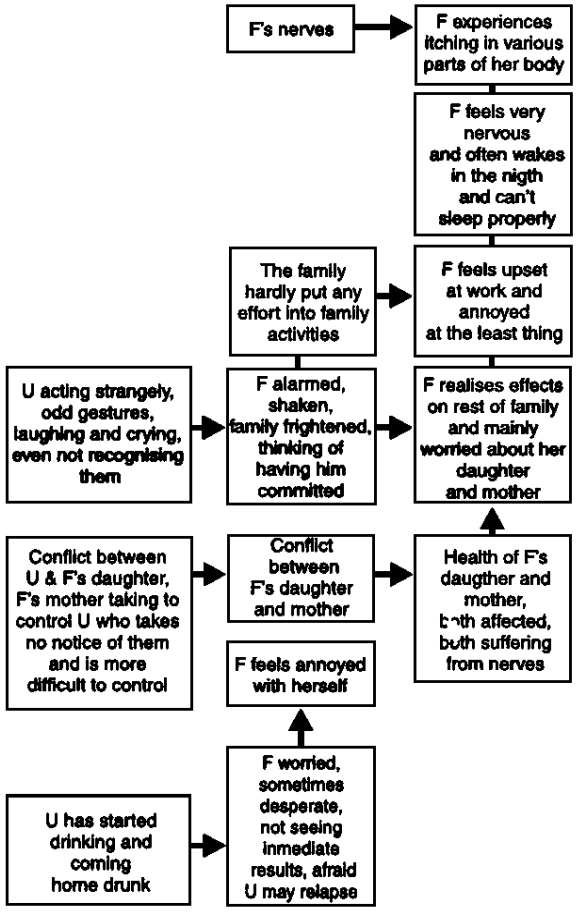


Figure 1. The links between stressors, emotion and strain described by a Mexican mother of a drug user.

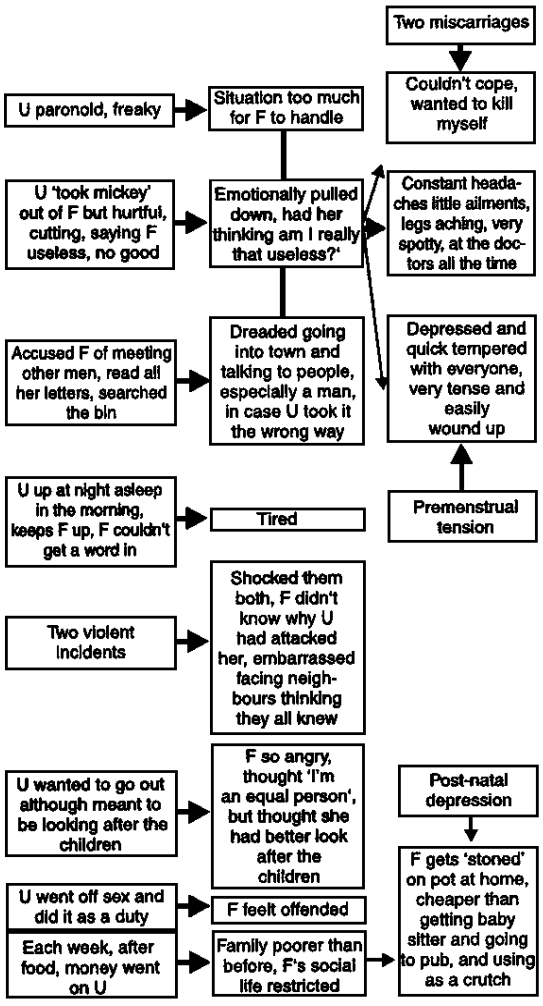


Figure 2. The links between stressors, emotion and strain described by an English wife of a drug user.

man who had used amphetamines, including injecting, and was now prescribed amphetamines (and tranquilizers) in tablet form, and was shortly due to enter a residential rehabilitation centre. F and U, both in their mid twenties, had a baby and an older child of F's. She and U had both taken cannabis and speed, "as part of the social scene", for many years and F saw nothing wrong with this. U's consumption, however, had escalated to the point at which he needed it and was irritable without it, and this, plus U's injecting, F did not understand or approve of.

Figure 2 shows a whole series of connections between events and difficulties associated with U's drug use and F's feelings. These ranged from feeling tired because U kept her up at night talking, to feeling offended that their previously good sex life had deteriorated to a point at which U was doing it merely out of duty, to feeling that U was, "emotionally pulling me down", and that the situation was, "too much for me to handle". A further important feature of the causal connections drain by F in her account is the relative contributions to F's physical and mental ill-health, made by U's drug use on the one hand and F's pre-menstrual tension, miscarriages and post-natal depression on the other hand. F was clear that her miscarriages had contributed to her suicidal feelings, and that feeling depressed after child birth had combined with social and financial factors consequent upon U's drug use, in making her more socially isolated than she would otherwise have been and contributing to her using cannabis as a crutch. She had changed her mind, however, about the relative roles of PMT and U's behavior towards her in the origins of her headaches and other physical symptoms and her feelings of depression and her quick-temperedness:

Now she feels it was stress-related although she didn't feel this at that time. "I thought I'd been coping really well, but now I find I was just coping"... She was very tense all the time and easily wound up. F felt this was quite a bit to do with U's drug use. F feels U's drug use was the main reason for her stress. F has always put her stress symptoms down to PMT which she does suffer from, but now thinks a lot that it had to do with the situation.

Discussion

The experience of relatives: Is it universal?

The present results serve to help us formulate hypotheses for testing using further data from the same and other projects. The first hypothesis to be derived is that certain core aspects of the experience of relatives in these circumstances are near-universal, transcending culture, socio-economic circumstances, gender of relative, and relationship of relative to the alcohol or drug user. This core experience consists of findings the user considers unpleasant to live with; being concerned about the users health or performance; experiencing financial difficulties; being aware of harmful effects on the family/home as a whole; feeling anxious and worried or helpless and despairing or low and depressed, and experiencing poor general health or specific physical symptoms which the relative attributes, at least in part, to the stress of living with the effects of a drinking or drug problem.

The number of participants whose data are included in the present report is too small to test the different components of this universal core experience hypothesis. There were, for example, too few male relatives to test the interesting hypothesis that this core experience applies equally to male relatives as to female. Most of the illustrations provided were from interviews with women, including both the longer illustrative accounts, and, notably, all the illustrations of the guilty/devalued sub-category. Examination of a larger data set will be necessary to explore what aspects of the experience are common to the two sexes and which are sex-related. The same goes for parents compared to partners, and alcohol versus other drugs. Furthermore, if there is a common core of experience, it might reasonably be asked who does not share this experience. Including in the sample only those relatives who had found the alcohol or drug use to be a source of distress, and recruiting many participants via specialist agencies, may have excluded relatives who share less of this experience.

Are there cultural differences in the experiences of relatives?

It is a common experience in cross-cultural research that a number of additional factors are confounded with the cultural or country contrast (3). The present research was no exception. For one thing, the general level of poverty was greater amongst the Mexican participants. Although the socio-economic status of the English families varied considerably, even those whose socio-economic position was least advantageous enjoyed better material conditions than many of the Mexican families. The numbers of family members living together in the household was markedly higher in Mexico. Furthermore, as Table 1 shows, the main drug groups used by the problem drug users were not the same in the two countries. In particular the problems of inhalants in the Mexican families is a fair reflection of the importance of this group of substances in Mexico as in other Latin American countries (12). This itself is probably a further reflection of socio-economic differences since inhalants are affordable by poor people while most illicit drugs are less affordable. Quite apart from these confounding differences, there are a number of facets to the cultural contrast between Mexico City and those parts of Southern England from which the English participants were recruited. Although the culture in which the Mexican participants resided may be more collectivist, and the English culture more individualist, they differed also along dimensions such as urban-rural, religious-secular, and Catholic-Protestant. Without data from a variety of other socio-cultural groups, differences in the results from the two countries should only be attributed to any particular dimension with great caution.

The most striking aspect of the present comparison between data from the two countries, however, is the large area of common experience. Despite the many differences in their cultures, we believe a mother in Mexico City concerned about the effects of her son's dependence on inhalants and an English wife living in a small country town in Southern England and concerned about her husband's excessive use of amphetamines, would find that they had many areas of shared experience.

There are, nevertheless, some intriguing differences between the reports from the two countries, and here we can formulate only very tentative hypotheses. Since no hypotheses concerning stressor categories were stated in advance, and the number of interviewees featured here is small, these differences might be attributable to the different average length of the interviews in the two countries or might otherwise be of no significance. They may, on the other hand, be indicative of real socio-cultural differences which could be explored in the analysis of larger numbers of interviews from the two countries. These differences may be, for example, reflected differences in the social networks and social opportunities of participants in the two countries. We can speculate that the greater frequency with which the English relatives reported concern about the user disappearing from the home or 'coming and going', and the greater frequency with which they reported their own social life and/or that of the family having been affected, might be real effects due to the greater restrictions upon independence in Mexico. The absence of a universal system of welfare guaranteeing at least a modest standard of living, and a generally higher level of poverty may contribute to more kin-dominated social networks, less reliance on non-kin friends for social support, less access to telephones, private transport and other aids to mobility and independence, and fewer sources of alternative accommodation. A greater adherence to collectivist and family centred values would also be expected to be associated with a lower premium being placed upon independence (25). In particular much has been written about the social restrictions upon women family members in Mexico, and the culture of male family authority and 'machismo' in general (6,13).

It is less easy to construct an hypothesis to explain the more frequent mentions of feeling guilty and devalued, and angry and resentful, amongst the English interviewees. It seemed less easy to elicit these feelings in the Mexican interviews which were more likely to remain confined to the expression of the worried/helpless/depressed triad along with reports of possibly stress-related physical symptoms and general ill-health'. One possible partial explanation rests upon the observation that in more collectivist cultures the feeling of guilt (linked to individual behavior) is less common than that of shame (linked to loss of face socially), and the emotion of anger (focused on needs of self) less common than that of empathy (focused on the other) (25). An alternative explanation is that interviewees felt more constrained in expressing certain feelings in Mexico due to the more constraining circumstances of the interviews that sometimes pertained there, and by the often greater social distance that existed between interviewer and participant.

Finally the question must be asked to what extent the present findings have been constrained and determined by the assumptions that we declared in the introduction. It will be clear, for example, that the overall stress-strain framework within which this paper has been written was not 'discovered' in the course of the research but was imposed at the outset. Some will no doubt wish to argue that the language of harmful impacts of alcohol and drug use on the family, of negative feelings and symptoms of ill-health, and the attributions of the latter to the former, represents just one of a number of possible 'discourses' on the subject (4,22), and that the way we selected and interviewed participants made it inevitable that this particular way of construing events would be the dominant one elicited. Although we acknowledge a certain degree of truth in that argument, we believe that by careful, sensitive and detailed interviewing, we have helped to expose part of the 'reality' of the experience of people who are close relatives of family members who are using alcohol or other drugs excessively. Furthermore we suggest that this is a reality shared by millions of people around the world.

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