The Development of a Social Support Measure for the Family Members of Problem Substance Users

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Abstract

Overview

The current thesis reports on the design and development of a social support measure which explores the perceived functional social support needs of family members who have a relative with a substance related problem. A mixed methodological approach was adopted to operationalise the concept of social support specific to concerned and affected family members, thus completing the nomological set of instruments required to quantitatively assess the Stress-Strain-Coping-Support (SSCS) theoretical model of addiction and the family.

Methods

The 75-item self-completion Alcohol, Drugs and the Family Social Support Scale (ADF SSS) was piloted with ten family members, and the resultant 58-item measure was then subjected to extensive psychometric testing with one hundred and thirty two family members, and qualitative feedback was gleaned from one hundred and ten family members. This resulted in the production of a refined 25-item questionnaire.

Findings

Preliminary findings on the refined 25-item questionnaire indicate satisfactory levels of reliability (internal and test-retest) and validity (content and construct) for the overall measure and each of the three constituent sub-scales: Frequency of positively perceived general (α=0.913) and ADF related (α=0.727) functional support, and Frequency of negatively perceived ADF specific (α=0.851) functional support.

Qualitative information from family members revealed that the questionnaire was experientially applicable to their situation in dealing with the excessive alcohol and/or drug use of a close relation.

Discussion

The significance of producing a concise, psychometrically sound social support measure for concerned and affected family members is discussed in the context of implications for research, theory, policy and practice in the field.

Foreword

Study Background

Empirical evidence, particularly over the last thirty five years, has consistently reported that family members (for instance, partners, parents and siblings) living with a relative who has a serious alcohol and/or drug problem, develop negative physical and psychological symtomatology (see for example, Velleman and Templeton, 2003). The Stress-Strain-Coping-Support (referred to hereafter as SSCS) model is a useful theoretical approach to account for the experiences of family members who have a close relative with a substance related problem.

This proposition is evidenced by the fact that all elements of the SSCS are founded upon extensive qualitative research from both national and international studies. Additionally, three aspects have a range of quantitative data to corroborate the qualitative findings. However, there is no accepted quantitative measure of the fourth element, namely social support. In addressing this methodological gap, the current thesis reports on the development of such a quantitative measure.

Thesis Outline

This thesis aimed to operationalise the concept of social support as applied to people living with a relative who takes alcohol and/or drugs excessively. Therefore, Chapter 1 (Social Support) contextualises the study by examining theoretical conceptualisations in the social support domain, guided by relevant social support constituents identified previously in Alcohol, Drugs and the Family (referred to hereafter as ADF) qualitative research.

Chapter 2 (Alcohol, Drugs and the Family: Social Support), explores the social support needs and experiences of a particular population, those who are the concerned and affected family members of problem alcohol and/or drug users. Chapter 3 (Methodology) outlines the philosophical underpinnings of the study and evidence-based mixed methodological approaches to designing and developing a quantitative measure of social support.

Chapter 4 (Pilot Study: Method and Findings) reports on the pilot work which was devised to design, develop and refine a self-completion ADF Social Support Scale (referred to hereafter as ADF SSS) in a form adequate for larger scale administration to family members. Chapter 5 (Main Study: Method) details the mixed methods utilised to examine the psychometric and applicability properties of the test version of the ADF SSS. Chapter 6 (Main Study: Findings: ADF SSS Test Version) and Chapter 7 (Main Study: Findings: ADF SSS Refined Version) report on the extent to which the ADF SSS achieved satisfactory levels of reliability, validity and applicability.

Chapter 8 (Discussion) extrapolates and interprets the significance of the findings and the contribution of the study (the development of an ADF specific social support measure) to research, theory, practice and policy in the area.

Chapter 1: Social Support

1.1 Chapter Introduction

Since the seminal papers of Caplan (1974), Cassel (1976) and Cobb (1976) in the 1970s, there has been a proliferation of research into social support and conceptually allied areas such as social networks, social capital and social isolation. There has been very little overlap between the extensive general social support literature and specific social support properties in the Alcohol, Drugs and the Family (ADF) field. This chapter briefly outlines the main conceptualisations in the social support domain, focusing particularly on the theoretical constructs which are salient to ADF social support, why social support is an important concept to operationalise (i.e. translating the concept or its constituent elements into techniques of measuring) and theoretical approaches utilised to account for the influence of social support.

1.2 Conceptualisation of Social Support

When social support was initially examined during the mid-1970s to early 1980s, the term was primarily used in a concrete sense to denote a person, relationship or transaction. In the 1980s, social support underwent a conceptual transformation from a concrete term to an abstract construct, referring to an inferred characteristic or function of social relationships or transactions, rather than to the observable relationships or transactions themselves. As a result of this increasing abstraction, the concept remains fuzzy and almost any type of social interaction has been considered social support (Veiel and Baumann, 1992).

The contemporary voluminous general social support literature is both diverse and complex. The variability in definitions of social support reveals that there is conceptual confusion (Decker, 2007). Concerns over conceptual clarity have centred on the definitions of social support which are either so vague, or so broad that the concept is in danger of losing its distinctiveness (Hupcey, 1998). Although the literature abounds with a multiplicity of imprecise conceptual definitions of social support, there is little consensus on how the concept should be defined (Mutran, Reed, and Sudha, 2001). Classically, social support has been described in terms of social bonds (Henderson, 1977), social networks (Mueller, 1980), meaningful social contact (Cassel, 1976), availability of confidants (Miller and Ingham, 1976) and human companionship (Murawski, Penman, and Schmitt, 1978). These definitions tend to be vague and simplistic and rarely specify types of relationships, interactions between the provider and the recipient or the actual needs of the recipient for support. However, the notion of a supportive quality, which can be abstracted from particular relationships and transactions, underpins all of those definitions cited (Hupcey, 1998).

Taylor (2003: p. 235) summarised past attempts at defining social support as, 'information from others that one is loved and cared for, esteemed and valued, and part of a network of communication and mutual obligations from parents, a spouse or lover, other relatives, friends, social and community contacts such as clubs or even a devoted pet.' Nonetheless, the declining emphasis on providing a precise definition, reflects the difficulty in formulating a universally accepted definition of social support that encompasses all or even most uses of the term, and one that is not circular (Ducharme, Stevens, and Rowat, 1994). Considering the various interests, agendas and backgrounds of social support researchers, the field has moved away from universal descriptions. Many theoreticians have argued that the conceptual definitions of social support are too restrictive and inadequate because the concept is broad and multifaceted (Haber, Cohen, Lucas, and Baltes, 2007).

1.2.1 Multifaceted Concept

In addition to the lack of consensus about the conceptualisation of social support, the multifaceted versus singular nature of the concept is a major issue in the literature. Vaux (1988: p. 28) suggested that, 'no single and simple definition of social support will prove adequate because social support is a metaconstruct: a higher order theoretical construct composed of several legitimate and distinguishable theoretical constructs'. Over the past 20 years since Vaux's proposition, empiricists have identified distinct constructs of social support. Discord and diversity have coalesced around three pertinent variables:

- The range of social ties that are relevant to support.
- The relative importance of objective features of social relationships and supportive behaviour versus the individual's perception or appraisal of these.
- The variety of forms that support might take (Chak, 1996).

Research contributing to this multifaceted conceptual framework includes that of Veiel and Baumann (1992: p. 2) who argue that only a multifaceted approach would be adequate for conceptual clarity. They stated that the term 'social support', as currently used in social and scientific parlance, commonly implies an abstract characteristic of persons, behaviours, relationships or social systems. The evident diversity of what is subsumed under it is usually accounted for by postulating different sources, kinds, or other facets, forms and expressions of the phenomenon 'support'.

Cohen (1992) agreed that an all-encompassing definition should not be used, suggesting instead three sub-constructs of social support, based on Vaux's typology. These categories are social networks, perceived support and supportive behaviours. Concordantly, Stewart (1993) suggested that there were three aspects which are common to all definitions of social support: structural aspects of the support network, functional types of assistance available or actually received and the nature of the support. Additionally, Chak (1996)

posited three broad categories: structural, perceptual and functional social support.

As outlined, there is general consensus that the global notion of social support includes several related constructs and is multifaceted. Conceptually and operationally, researchers recognise implicitly or explicitly that the social support domain consists of distinct constructs and specific dimensions within constructs (Haber *et al*., 2007). Building upon a thorough and recent review of both general and ADF specific social support literature (sources cited throughout Chapters 1 and 2), this thesis proposes the following three component social support taxonomy: 1) structural, 2) perceived and received, and 3) functional social support.

The reader will note that the proposed taxonomy is subtly different than the previous distinctions outlined. It is the case that the subsequent definitions cited in this section evolved from Vaux's initial proposal to provide conceptual clarity. The author felt that the overarching constructs proposed encapsulates current thinking about the salient facets within the domain of social support. As with the global concept of social support, there is confusion within the sub-constructs, with different vocabulary used for dimensions with similar philosophical meaning, although, with patience, a pattern can be discerned. The salient dimensions relevant to ADF social support for each of the three categories are outlined below.

1.2.2 Structural Social Support

In seminal work on the structural approach, Lin (1986) postulated that an individual's linkage to the social environment can be represented at three distinct levels: the community, the social network and intimate and confiding relationships. The intermediate level of social environmental ties - social networks - represents a flexible compromise between the integration and

intimacy approaches. Social network analysis within this literature has been limited almost exclusively to the examination of a focal individual's network (a system of relationships with other individuals), originally termed a 'personal network' (Cohen, Underwood, and Gottlieb, 2000).

In some epidemiological studies, social support is defined as the number of social contacts maintained by a person or extensivity of a social network (Bowling, 1997). Social network analysis is generally described as structural or relational support and focuses on an individual's connection with his or her personal network (Chronister, Johnson, and Berven, 2006). Structural support refers to any number of quantitative characteristics of personal social networks, including: size, the existence and quantity of social relationships, frequency of contacts, physical proximity to social network members, duration and stability of relationships, composition, density, homogeneity and multiplexity of social ties in the network. Additionally including: interconnections, the role relationship of each member to the target individual, direction or degree of reciprocity (exchange of resources), conflict or admonishment (see for example, Chak, 1996; Chronister *et al*., 2006; Eckenrode and Hamilton, 2000; Tracy and Biegel, 1994).

The various dimensions of the construct of structural support are designed as ways of capturing the specific features of social relationships that are thought to be crucial for interactions to be supportive in nature (Chronister *et al*., 2006). One problem with this approach is that contact may be due to factors uncorrelated with support such as required contact due to employment etc. (Sherbourne and Stewart, 1991). Of special interest to social support researchers have been individuals' 'personal support structures', the subset of others upon whom people rely for assistance when facing stressful circumstances (Cohen *et al*., 2000).

Most theorists and investigators agree that social networks and social support are conceptually distinct phenomena and should be treated as such (Chak, 1996). Social network approaches have been criticised because of the

assumption that all social interactions are supportive. Specifically, 'the presence or absence of network is taken as proxy measures of supportiveness' (Chak, 1996: p. 77). Furthermore, the existence of a significant other person or group within a social network does not, of course, guarantee that this source provides positive support (Orford *et al*., 1998). More distant social roles, such as neighbours, co-workers, acquaintances from clubs and leisure-time activities and health or social care professionals, do not seem to perform the critical role of regulating needs and providing satisfactory support. Consequently, a large network alone, without its close core, cannot guarantee satisfactory provision of support (Argyle, 1992). Thus, it is not surprising that empirical studies have found social networks to be a weak predictor of health and well-being (Snowden, 2001). Therefore, the enumerative network characteristics must be distinguished from the support network members transmit to one another (van Dam *et al*., 2005).

In a conceptual sense this is why, under structural support, researchers have concentrated on 'qualitative' information such as affiliation with social ties. Pinkerton and Dolan (2007) present compelling evidence that it is the range of sources, both natural (for example, intimate relations, family, relatives, friends) and more formal support (for example, community groups, health and social care professionals, self-help groups) and not the pure amount of network members which is the most important variable in epidemiological studies. Presumably, natural support networks are a more enduring source of support, while other forms of support may be more transient.

The cultural determination of the norms and expectations governing role relationships would seem to make the support value of specific supportive provisions by natural and formal sources rather culturally specific (see Section 4.2.1, for the different socio-cultural data examined in this current study). However, whether one or other is a superior source of support is not clear (Hogan, Linden, and Najarian, 2002). Pertinently, Eckenrode and Wethington (1990) state that receiving support from network members spontaneously or without explicitly requesting it, preserves self-esteem, and reinforces intimacy

and dependability in the relationship with the provider. Thus, under the construct of structural support the most important aspects for operationalisation appear to be the extent, availability and adequacy of different sources in an individuals' personal support structures.

1.2.3 Perceived and Received Social Support

While some empiricists have conceptualised social support as having a strong personality component, in that an individual's appraisal of their extent and quality of social support is determined by innate personality traits, and is therefore expected to be relatively stable over time. Others have viewed social support as a perception that is based on experience and is thus vulnerable to fluctuations over time and subject to recent experience (Asendorf and Wilpers, 2000). As there is more substantial and compelling evidence for the latter view, this review focuses on the perspective that social support is a perception based on recent experience (Yap and Devilly, 2004).

The perceived aspects of social support are not necessarily expressed in behavioural manifestations. Debate continues over the merits of objective and subjective indices of social support (Haber *et al*., 2007). There has been increased emphasis on the distinction between perceived support and received support. Perceived support refers to cognition and evaluation of support. Under a cognitive label, perceived support is best thought of as the general perception of availability of supporting persons and actions (how supported the individual feels about potentially available assistance). The evaluative aspect examines the adequacy of and the satisfaction with supporters and received support (Laireiter and Baumann, 1992). The term 'received support' refers to the enumeration of reports of actual transactions that typically do occur or have occurred between people who exchange support (Argyle, 1992). Sarason, Sarason, and Pierce (1994) use 'enacted support' to describe the side of the provider and 'received support' to describe that of the recipient.

However, one's perceptions of support are not independent of the supportive transactions that give rise to them, and emphasis on one piece of the support equation may direct attention away from other important elements involved in the social support processes (Veiel and Baumann, 1992). Perceptions of supportive behaviours may also be modified by the context in which they occur. Important contextual features may include characteristics of the support provider, characteristics of the provider-receiver 'dyad' relationship (Lakey and Drew, 1997) and features of the broader cultural environment (Badr, Acitelli, Duck, and Carl, 2001).

Meaningful expositions of social support must focus not only on the enacted properties (that is what is provided or the shape that support takes) but also on the perceived properties (that is, what the support 'feels' like to the recipient). When the perceived aspects of social support are ignored, for example, qualitative properties such as whether accepting the support carried with it negative implications, research runs the risk of obtaining only half of the picture in terms of how support relates to outcomes (Ghate and Hazel, 2002). Therefore, both constructs should be viewed as intrapsychic phenomena recognising the role of the individual in perceiving, receiving and interpreting social support (McColl, Lei, and Skinner, 1995).

A number of studies have demonstrated that support transmitted and support received may not necessarily correspond and that the support perceived may differ notably from the support offered or enacted (McColl *et al*., 1995). Also it has been frequently reported that perceptions of available support are more likely to be related to physical or psychological health, than are measures of network characteristics or particular classes of supporter behaviour (Sarason, Pierce, and Sarason, 1996). Therefore, how support feels may be as important as, if not more important than, what it actually consists of (Ghate and Hazel, 2002).

A number of authors have suggested that received support may improve outcomes only if it modifies perceived support. This contention is supported by anecdotal observations that received support predicts outcomes less consistently than perceived support (Sarason *et al*., 1994). Meta-analytic data have failed to confirm these impressions (DiMatteo, 2004). However, the inverse relationship between perceived social support and psychological distress is well documented (Chronister *et al*., 2006). Interestingly, at least one rigorous study has demonstrated that perceived support can be manipulated through altering support levels in the environment (Barrera, Glasgow, McKay, Boles, and Feil, 2002).

A distinction which is seen as vitally important by many researchers, whatever the particular needs being served, is that between the availability of social support and its adequacy as perceived by the recipient. The subjective interpretation by the supportee of objective events has considerable influence on the extent of efficacy of the support. The more positive or compatible with the supportee's needs the perception of the supportive behaviour, the greater the chances that the support outcomes will be positive, and vice versa (Taylor and Lynch, 2004). Researchers have found that perceived availability of supportive others, or in the case of Lindorff (2000) satisfaction with the availability of supportive others, buffers the effects of stressors on strains better than self-reports of actual receipt of support from a supportive other for a self-reported stressor. This indicates that perceived support might better influence one's cognitive appraisal of stressors than received support. Thus, perceived support has a mostly ameliorative effect on stress (Glazer, 2006).

A substantial body of research has shown that the perception of availability of support from significant others is a more reliable predictor of adjustment and health outcomes than are the measures of support actually received from others (Sarason *et al*., 1994). Additionally, self-discrepancy theory implies causal relations between perceived support and emotional distress. Specifically, if an individual's appraisal of social support is discrepant from ideal beliefs, then emotional distress is implicit (Pierce, Strauman, and Vandell, 1999). In sum, this

evidence suggests that perceived or salient support is the most important determinant of stress mediation and well-being.

1.2.4 Functional Social Support

Limitations associated with the structural construct of social support have led researchers to focus on the functional dimensions of social support (Chronister *et al*., 2006). Efforts to develop definitions of supportive behaviour have served to highlight the complexity of categorising the social support domain (Sarason *et al*., 1994). Considerable attention has been given to developing typologies that classify various behaviours into dimensions of support. In the social support literature, this approach to defining supportive behaviours has been referred to as the functional approach because it seeks to delineate behaviours on the basis of functions that they might serve (Cutrona, 2000).

A source of diversity and confusion in social support thought and research concerns the varied functions of social support. People assist one another in an astonishing variety of ways, and relationships serve many functions. Unfortunately, this richness has been mirrored in the literature by a proliferation of complex and extensive terminology, distinctions and a host of overlapping dimensions, few of which have achieved widespread currency. The dimensions are often couched in idiosyncratic labels which are difficult to compare or integrate. Nevertheless, with patience, a pattern can be discerned, bringing order to the disparate distinctions (Veiel and Baumann, 1992).

Functional support refers to the type, quantity and quality of aid and assistance available or actually provided by interpersonal relationships (Glazer, 2006). The most essential aspect of social support is the perceived availability of functional support (McColl *et al*., 1995). There is some consensus concerning the main potential functions subsumed under the concept of social support. The four most often delineated in published reviews are outlined below:

(1) **Emotional**, expressive, emotionally sustaining, appraisal, esteem, close, affirmation or affect support.

Central to most conceptions of functional support is a dimension referred to as emotional, expressive or affect support. Emotional support comprises provisions of esteem and autonomy (facilitating self-regulation and choice) provided by empathic listening (helps one to reflectively consider possible solutions and make one's own choices) or appraisal (verbal feedback) and exemplifying compassion (Glazer, 2006). To illuminate, emotional succour involves verbal and nonverbal communication of caring (thoughtfulness, encouragement, personal warmth, nurturance; expressing commitment, security, unconditional regard, reassuring the individual that they are valued, admired and respected; affirmation, appreciation or endorsement of their perceptions, behaviour, expressed views or beliefs) and concern (love, affection, trust, 'being there' when needed, especially in times of stress) and is believed to reduce distress by restoring self-esteem (acceptance, self-evaluation, reinforcing sense of confidence and competence, meeting needs for recognition and bolstering sense of self-worth), enhancing relatedness (feelings connected to the supporter) and permitting the expression or ventilation of feelings (positive affect, comfort, exploring personal issues) (Birch, 1998; Cutrona, 2000; Hogan *et al*., 2002; Taylor, 2007).

(2) **Informational**, advice, cognitive support, guidance or feedback support.

The dimension of informational or cognitive support includes the transmission and provision of knowledge or letting another know how to obtain needed information, advice (making suggestions, clarifying issues), teaching a skill, feedback (meeting needs for esteem and identity) and guidance (motivational, problem solving). Also, informational support can provide emotional reassurance (enhance perceptions of control by reducing confusion in times of distress) as well as a guide to action (providing individuals with strategies to cope with their difficulties) (Birch, 1998; Cotterell, 1996; Cutrona, 2000; Hogan *et al*., 2002).

(3) **Social companionship** or positive social interaction or socialising support.

An important element of social companionship support is cooperating in shared tasks, interests (for example, spending time with others in leisure and recreational activities) and concerns (for instance, conversations). Research on helping behaviour illustrates that people often react negatively to being helped and that cooperation produces more positive reactions. The main focus of friendship is enjoying each other's company through exchanging positive verbal signals, taking an interest in each other by asking questions, seeking things they have in common, agreeing, complimenting, using self-disclosure, making jokes and talking about pleasant events. Socialising, positive social influence and intimate interaction reduces loneliness and isolation by strengthening social bonds and providing a sense of orientation in society and membership in a definite social group which enhances social reinforcement, attachment, acceptance, belonging and reliable alliance. It may also impact on stress by fulfilling a need for affiliation and contact with others, by helping to distract people from worry about problems, or by facilitating positive affective emotions and producing feelings of well-being (Argyle, 1992; Cohen *et al*., 2000; Cutrona, 2000).

(4) **Instrumental**, tangible, concrete, practical or material support.

The dimension of functional support which is most straightforward to define, and about which there is most agreement, is instrumental or tangible support. Instrumental functions involve the provision of aid in the form of resources and material help (for instance, goods and services, transportation, errands, chores, financial or physical assistance) to solve practical problems and to decrease feelings of loss of control. Instrumental support is particularly important when physical injury or illness occur (Birch, 1998; Cohen *et al*., 2000; Cutrona, 2000; Glazer, 2006; Hogan *et al*., 2002; Taylor, 2007).

These functions (i.e. all four of the types of functional support outlined above) may be performed on an ongoing basis (as with the daily exchange of affection between spouses). However, the usual connotation of social support is the provision of assistance in times of need. Importantly, functional support does not occur in a vacuum and, despite good intentions, supportive functions are not always beneficial; the achieved outcome will depend on the amount, timing and mode of assistance that occurs as well as characteristics associated with the context, the individual and the interactive nature (valency) of the transaction (Chronister *et al*., 2006). Moreover, hidden messages underlying the support process, such as perceived expectations of repayment, often undermine any positive effects (Cohen *et al*., 2000).

Although studies indicate that emotional support appears to have greater positive effects than instrumental and informational support, support functions typically co-occur, and thus researchers often have difficulty discriminating between the types of support that affect health outcomes (Chak, 1996). However, there is evidence that the effects of various support functions can be delineated when broken down by the provider and by the specific problem or source (Cutrona, 2000). Therefore, functional support can be thought of in terms of problem related social interactions with a broad range of people (i.e. spouse, family, relatives, friends, neighbours, work supervisors, co-workers, caregivers and professionals) involving four major kinds of assistance (i.e. emotional, informational, social companionship and instrumental) (Hogan *et al*., 2002).

Matching the type and source of functional support to the need or stressor, at the appropriate time and for the proper length of time, is a particularly salient determinant (Hupcey, 1998). Moreover, Cutrona (2000) drawing upon the work of Weiss (1974), Jacobson (1990) and Lin (1986), proposed a framework for matching types of stresses and supportive functions. Emotional support may be most appropriate in a crisis, informational during a period of transition (a period of change that involves a shift in a person's assumptive world) and instrumental for a deficit state (a situation of chronically excessive demands). This highlights the importance of the right kind of support being perceived as given and

received under the right circumstances and at the right time. For example, when adapting and recovering from physical illness, informational support may be more important shortly after a diagnosis has been made, whilst instrumental support may become more important later if symptoms persist and become chronic (Orford, 1992).

Additionally, different sources could provide the most helpful social support depending upon whether the task at hand was 'expressive' or 'instrumental'. For the former, support would be most helpful if provided by 'strong' ties (particularly those with partners) and ties that were 'homophilous' (i.e. ties with people who were similar in terms of characteristics such as age, gender, occupation, education and marital status). Conversely, for successful instrumental actions, use of numerous and widely diverse social resources is desirable. For example, family members may be most important during a crisis (for instance, immediately following a bereavement), but a wider circle of supportive others may be more important as time goes on (Orford, 1992).

It is apparent from elaborating the functional construct that there is overlap between the dimensions. As with the overall constructs (i.e. structural; perceived and received and functional) within the concept of social support, these functional dimensions are not mutually exclusive and influence each other in important ways (Glazer, 2006). In terms of summarising the functional construct, it refers to supportive actions, intangible (interpersonal) and tangible assistance provided (or potentially provided) by family members, friends, neighbours, colleagues, self-help groups and supportive others (Glazer, 2006). Additionally, Cutrona and Suhr (1994), in discussing the perceptions of what types of support are available, distinguish between nurturant and action-facilitating (i.e. perceived or actual expressive and/or instrumental provisions). Concordantly, Pierce and colleagues (1996) make the distinction between intangibles, such as the feeling of security that results from being loved and cared for by others, and tangible forms of support.

1.3 Impact of Social Support

Section 1.2 identified the main constructs comprising the concept of social support. Attention is now given briefly to illuminating why social support is an important concept to operationalise. The importance of social support derives from both its empirical relationship with individual and family functioning, impact on stress and coping responses, and the potential that it holds as a major form of intervention. Interest in social support grew out of intriguing findings indicating that the presence of social ties is negatively correlated with illness and positively correlated with ameliorating symptoms, speed of recovery and reduced risk of death from disease (Kaplan and Toshima, 1990).

The stress buffering (see Section 1.4.3) and health promoting influences of social support have been so well documented that it is now axiomatic to state that social support both enhances well-being and lessens the likelihood of physical and psychological problems (Dunst and Trivette, 1990). Support is seen as an interactive process in which particular actions or behaviours can have a positive effect on an individual's social, physical or psychological well-being. However it is argued, and evidence has been presented in Section 1.2.3, that received support affects health only insofar as it changes an individual's global perceptions of being supported (Laireiter and Baumann, 1992).

At the individual level, broad and compelling empirical evidence covering an extended time span points towards social support having an impact in terms of stress mediation and physical and psychological health. The availability of support is clearly linked to positive health outcomes in epidemiological studies. There are many conflicts in the literature about the benefits and consequences of supportive social relationships (for a review see Bowling, 1997; Cohen *et al*., 2000). In general, social support is thought to affect health through its influence on emotions, cognitions and behaviours (Cohen *et al*., 2000). Social support appears to enhance self-concept, with individuals who perceive more support also reporting higher self-esteem, higher perceived self-confidence, more

positive moods and greater feelings of belonging than those who report less support (Meehan, Durlak, and Bryant, 1993; Sinha, Nayyar, and Sinha, 2002). Additionally, receipt of social support may directly or indirectly enhance one's capacity to increase personal competence and enable one to access needed resources or services (Thoits, 1995).

Structural aspects of social support are thought generally to act as a main effect (see Section 1.4.2). Individuals with strong support networks have longer life expectancy, reported fewer stress related disorders and better coping mechanisms than persons who lack social support (Bowling, 1997). Social support is thought to play a role in the risk for, progression of and recovery from physical illness. In this case, the hypothesis is that social relationships influence behaviours, with implications for health such as diet, exercise, smoking, alcohol intake, sleep and adherence to medical regimens. Moreover, isolation and resultant failure to regulate emotional responses contributes to psychological problems and can trigger health relevant changes in the responses of the neuroendocrine, immune and cardiovascular systems (Cohen *et al*., 2000).

In the case of mental health, social support is thought to maintain regulation and synchronicity of these response systems and prevent extreme responses associated with dysfunction. This regulation occurs through communication of what is expected, of appropriate norms, of rewards and punishments and through the provision of coping assistance (Cohen *et al*., 2000). The extent and perceived adequacy of social support has been linked with positive mental health outcomes such as buffering the impact of life stressors, lower rates of depressive symptoms, milder temperament, decreased loneliness and more positive self-image (Pierce *et al*., 1996).

There is some controversy about which characteristics of social networks are essential to health. Social integration, whether defined as having a diverse range of relationships or involvement in a range of social activities, has most reported impact, while number of network members has proved less important (Cohen *et al*., 2000). It has also been pointed out that strong ties, as opposed to

more diffuse, extended networks may restrict access to new information and exert greater pressure for conformity (Orford, 1992). Interestingly, there is evidence of a positive link between having a variety of supporters and having better perceived well-being (Pinkerton and Dolan, 2007). The evidence suggests that social support can work by either main and/or buffering effects (Orford *et al*., 2005a). However, from the review in Section 1.2, it is apparent there is general consensus that the social support domain is multifaceted. Inherent therefore, is that the impact of supportive relationships on personal outcomes is complex and requires consideration of a broad range of pertinent variables (Chak, 1996). Furthermore, differing aspects of support have differential influences on individual and family functioning.

There is a growing body of evidence that social support directly and indirectly influences family functioning and adaptations to stressful life events and crises. Research has shown that adequacy of different types and forms of support, especially aid and assistance that match family identified needs, enhance family well-being (Dunst and Trivette, 1990). The mechanisms by which social support affects health may also vary according to group membership, for example, when family and friends with seemingly similar support functions are differently associated with health outcomes (Veiel and Baumann, 1992).

Also in terms of the functional view, different components of support have differential effects, depending on the stressor experienced. It also suggests that material and companionship support are probably most relevant to the direct effect, whilst emotional, esteem and informational support may be most important for the stress buffering effect. It is possible also, that social support has a direct effect on stress, for example by preventing exposure to certain stressors or by inducing a more benign appraisal of threat (Orford *et al*., 2005a).

Ryan and Solky (1996) suggest that the meaning and psychological effects of involvement and tangible supports vary in accordance with the degree of autonomy support that characterises a relationship. Autonomy support typically entails acknowledgement of perceptions, acceptance of the others' feelings, and

an absence of attempts to control experience and behaviour. Autonomy-supportive interactions are not simply beneficial as buffers during episodes of stress, but more generally tend to fulfil multiple psychological needs (Ryan and Solky, 1996).

Functional supports can be helpful in two distinct ways: they can straightforwardly assist one with a problem, and therefore represent tangible support, and they can demonstrate caring or love, and therefore represent a form of psychological support. Sometimes these two impacts co-occur, and sometimes they compete. That is, tangible supports can be offered either in a way that feels supportive and respectful of one's autonomy or in a way that threatens autonomy, sense of competence, or other needs so as to feel psychologically unsupportive, even if practically useful (Ryan and Solky, 1996). Although progress has been made in understanding the potential benefits of social support, research has yet to uncover the specific mechanisms and processes that underlie these benefits (Chronister *et al*., 2006). However, the next section details the current pre-eminent theoretical approach utilised to account for the influence and processes of social support.

1.4 Theoretical Approach

The philosophical roots of the concept of social support can be found in postulates about basic human requirements (Bowlby, 1969). Therefore, it is a largely atheoretical concept, as etiological models based on it do not need to refer to elaborate theories to explain empirical associations. This conceptual simplification, without doubt was mainly responsible for its basic appeal to policymakers and for its enthusiastic acceptance as a research paradigm in psychology, sociology and psychiatry (Veiel and Baumann, 1992). However, research in the area has subsequently been criticised for the lack of any unified theory to explain the processes by which social support influences stress and well-being, and thus we are left with interesting, but often inconclusive

correlational findings. Nonetheless, in order to provide sound, comprehensive theories and models of social support, the underlying knowledge base must be inclusive (Cohen *et al*., 2000).

Given the aetiology of social support, it is not surprising that there is little agreement amongst researchers about a theoretical model which accounts for the influence of social support (Cohen *et al*., 2000; Stewart, 1993). Prominent approaches include the social constructionist perspective and the relationship perspective (for details see Cohen *et al*., 2000). However, the perspective which has gained most attention, in terms of empirical evidence, and furthermore is most consistent with the epistemological position of this current thesis, is the stress and coping perspective.

1.4.1 The Stress and Coping Perspective

Lazarus and Folkman (1984), in their cognitive appraisal model of stress and coping methods, predicted that people's expectations of potentially stressful situations would mitigate their reactions to stress. A stress response is elicited when an individual appraises that they do not have sufficient resources to cope with a given situation. According to this transactional model, resources for dealing with a stressful situation may be internal and/or environmental.

Internal resources can be biological, such as having enough antibodies to fight off infection, or psychological, such as having a 'thick skin' in the face of insults. Environmental resources include situational factors that make it easier for a person to deal with stress, for example, having positive support sources. While stress theory in its original form regarded the individual as a passive organism reacting to adverse environmental conditions, the introduction of social support complements this view by postulating beneficial environmental (social) conditions that may modulate and even compensate for the effects of environmental stress (Cohen *et al*., 2000).

From a situation-specific perspective, coping can be defined as the behavioural and cognitive efforts to reduce, master or tolerate stressful situations and the emotions that accompany them. Thus, on the basis of these internal cognitive and physiological processes, individuals then engage specific coping strategies to deal with the situation as construed. The three classes of coping that have received the greatest theoretical and empirical attention are problem-focused coping, emotional-focused coping and seeking social support.

Problem-focused coping is usually defined as attempts to deal instrumentally with the perceived source of stress. Emotion-focused coping, alternatively, is most often defined as efforts aimed at reducing the emotional distress evoked by stressful situations. Research has consistently demonstrated that people use strategies from each class during nearly every stressful encounter and that coping strategies tend to be intercorrelated (Cohen *et al*., 2000; Orford, 1992).

According to Lazarus and Folkman (1984) how people interpret situations (i.e. appraisals) is very important in determining how stressful an event or situation is perceived. There are two types of appraisals: primary and secondary (Cohen *et al*., 2000). Primary appraisals involve judgements of whether the event or situation is a threat. These judgements involve questions such as 'Am I in trouble?' on dimensions such as harm, loss, threat or challenge. Secondary appraisals involve evaluations of personal and social supports available to cope with the event. Such evaluations involve questions such as 'What can I do about it?' Lazarus and Folkman (1984) defined personal and social resources as what an individual draws on in order to cope, and argued that such resources 'precede and influence coping' (p. 158). Perrewe and Zellars (1999) elaborate on the stress and coping perspective, conceptualising the perceived causal attributions and resulting emotions as mediating variables between the primary appraisal of felt stress and the secondary appraisal of coping choices (Goldsmith, 2007).

Based on this cognitive model for appraising stress and coping with it, one might expect that persons who perceive high levels of social support would be less likely to experience a crisis, when faced with an emotionally hazardous situation and, when they do experience a crisis, would be able to respond more effectively than a person who perceives few available sources of support. A review of the social support literature by Albrecht and colleagues (1994) suggests that improved physical and psychological health, work, educational and relational outcomes occur for individuals who have strong support resources.

Alternately, social support might protect persons against the adverse effects of stressors, by leading them to interpret stressful situations less negatively. It is argued that the perception of support availability reduces the effects of stress by contributing to less negative appraisals. As with received support, perceived support availability should be most effective in altering appraisals, if they counter the specific needs elicited by the stressful event (Cohen *et al*., 2000).

The stress and coping theory predicts that appraisals directly influence coping. If so, perceived support should influence coping. Specifically, the appraisal perspective predicts that beliefs about support will influence appraisals insofar as the perceived support matches the demands of the stressor. As this perspective emphasizes the role of appraisal in determining reactions to stressful events, stressor analyses should focus on appraisals. For example, events might be classified according to the extent to which they involve threats to self-esteem, or active appraisals that functional resources are needed (Cohen *et al*., 2000; Orford, 1992).

Perceived or actual functional support can bolster coping efforts by providing emotional support that promotes feelings of self-esteem and self-confidence. The sense of being supported can enable an individual to face a stressful situation that otherwise might seem overwhelming (Pierce *et al*., 1996). Moreover, functional resources can provide information and guidance that aid in assessing threat and planning coping strategies (Carpenter and Scott, 1992).

Information or advice provided by a confidante may increase the likelihood that a person will rely on logical analysis, information seeking or active problem solving under high stressors (Pierce *et al*., 1996).

The stress-support matching hypothesis (Cutrona, 2000) is perhaps the most explicit statement of how supportive actions should promote coping. The hypothesis is that social support will be effective in promoting coping and reducing the effects of a stressor, insofar as the form of assistance matches the demands of the stressor. According to this view, each stressful circumstance places specific demands on the affected individual.

The suggestion that social support exerts a beneficial effect by influencing the individual's appraisal of potential stressors and coping resources is known as the 'stress buffering' model of social support. This compares with the 'main effects' model, which purports that all social support is positive, regardless of the individual's perception of stress in the environment. As outlined in the foregoing section, these models also identify the conditions under which different kinds of social support influence health (Cohen *et al*., 2000).

In sum, the stress buffering model assumes that stress leads to poor health outcomes and that social support buffers the impact of stress; in contrast, the main effects model assumes that social support influences health outcomes and stress is only one of several factors that impact on health. Whichever model is favoured, however, the coping perspective requires that a variable called 'social support' is operationalised (O'Donovan and Hughes, 2006).

1.4.2 Main Effects Model

The main effects model suggests that stress is not the only important variable influencing health outcomes. Instead, social support enhances health and well-being independently of stress. Specifically, the main effects model postulates that social support has a direct impact on health, independent of the amount of stress that an individual experiences, due to social networks providing people with regular positive experiences and stable, socially rewarding roles in the community (Joseph, 1999). The social environment influences health outcomes through a variety of processes including modelling, reinforcement, encouragement and peer influence (Cohen *et al*., 2000). According to this model, individuals with high levels of social support will have a stronger feeling of being liked and cared for and this has a permanent influence on the individual's overall physical and psychological health (Cohen *et al*., 2000).

The main effects model is a compelling explanation for the relationship between social support and health outcomes. However, there are several lines of evidence which challenge it. Firstly, not all studies on social support and health outcomes are consistent. Secondly, there is an assumed explanation that the correlation between social support and health is causal, in that high social support protects against health problems. However an alternative view is that individuals who have health problems shape their social support system. Finally, a third variable such as social class could cause both poor social support and poor health outcomes (Kaplan and Toshima, 1990). Considering these critiques, more complex models may be required to explain the relationship between social support and health. One such approach is the modified main effects model that considers the functional effects of social environment. The social environment may have either positive or negative effects upon health behaviour (Bowling, 1997). However, alternately, the stress buffering model provides an increased level of specificity. The precise mechanisms are described next (Cohen *et al*., 2000).

1.4.3 Stress Buffering Model

The most influential theoretical approach accounting for the influence of social support is the stress buffering model, which hypothesizes that support reduces the effects of stressful life events on health, through either the perception that support is available or the supportive actions of others. The stress buffering model proposes that support is related to well-being primarily for people under stress. According to the model, the essential components for stress to cause physical and psychological problems are high stress and low social support. When there is high stress and high social support, the impact of stress is buffered. Supportive actions are thought to enhance coping performance, while perceptions of available support lead to appraising potentially threatening situations as less stressful (Figure 1.1). This perspective is linked closely with research and theory on stress and coping (Lazarus and Folkman, 1984) and is discussed most prominently in major reviews and theoretical papers on social support (Cohen *et al*., 2000).

To illuminate, Figure 1.1 depicts the roles of social support in determining individual responses to potentially stressful events. In this case, support presumably operates by preventing responses to stressful events that are inimical to health. Support may play a role at several different points in the causal chain linking stressors to health outcomes. First, the belief that others will provide necessary resources may redefine the potential for harm posed by a situation and bolster one's perceived ability to cope with imposed demands, thereby preventing a particular situation from being appraised as highly stressful (Thoits, 1995).

Second, support beliefs may reduce or eliminate the affective reaction to a stressful event, dampen physiologic response to the event, or prevent or alter maladaptive behavioural responses. The availability of persons to talk to about problems has also been found to reduce the intrusive thoughts that act to maintain chronic maladaptive responses to stressful events. The actual receipt

of support could also play a role here. Support may alleviate the impact of stress appraisal by providing a solution to the problem, by reducing the perceived importance of the problem or by providing a distraction from the problem. It might also tranquilize the neuroendocrine system, so that people are less reactive to perceived stress or facilitate healthful behaviours such as exercise, personal hygiene, proper nutrition and rest (Cohen *et al*., 2000).

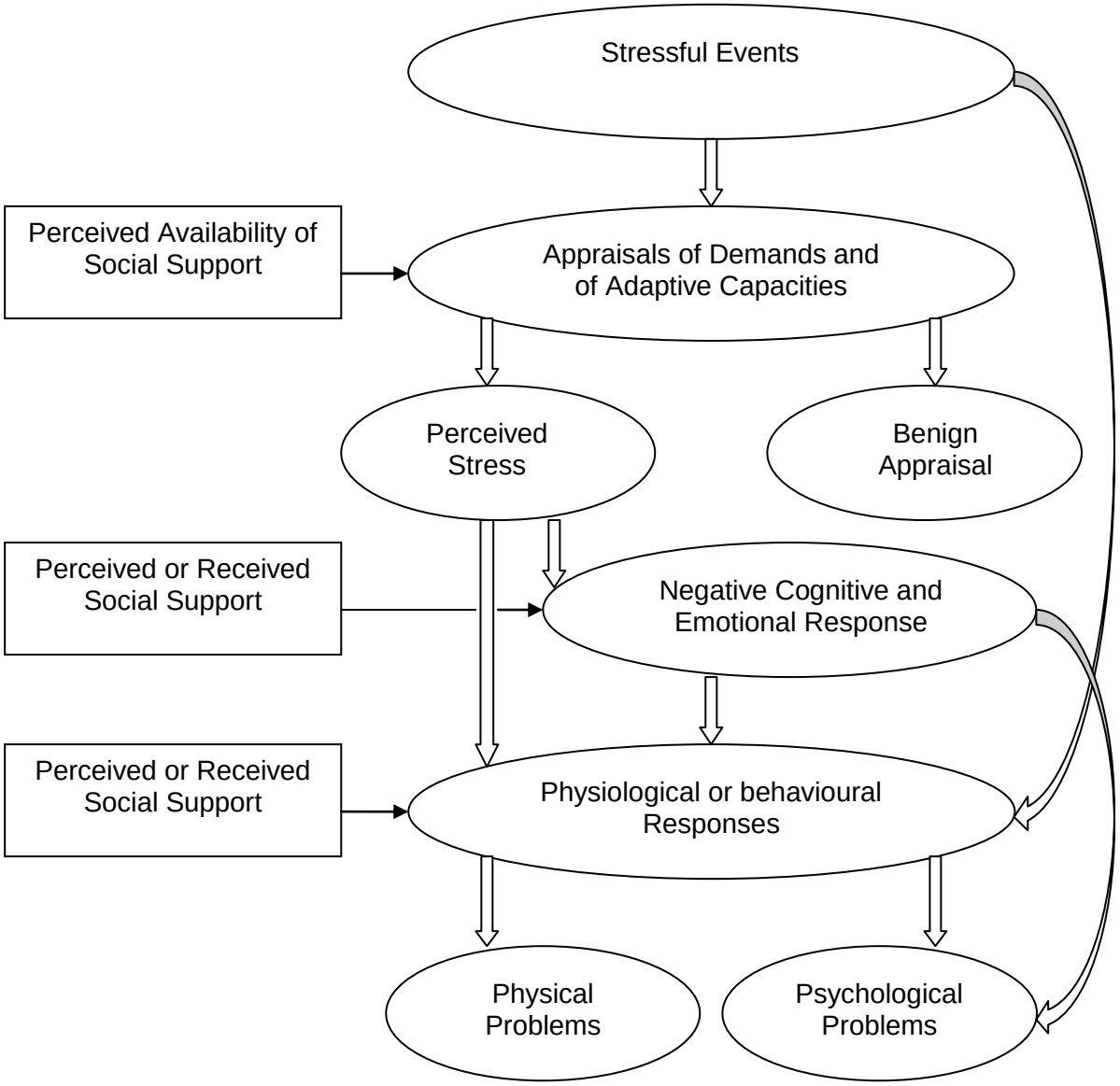

Figure 1.1: Pathways through which social support influences responses to stressful life events. Paths are all drawn in one direction for simplicity but feedback loops are possible (Cohen et al., 2000).

Furthermore, the stress-support matching hypothesis (Cutrona, 2000) suggests that received support is more likely to predict outcomes when the support is matched optimally to the demands of the stressor. Cutrona (2000) suggests that the controllability of a stressor is the primary dimension in terms of an appropriate match. Potentially controllable stressful events are presumed to elicit needs for problem focused coping (tangible support) to aid in preventing event occurrence or consequences. Uncontrollable events are presumed to elicit needs for emotion focused coping (emotional support) to help persons recover from the negative emotions elicited by an event.

Interestingly, Cohen and colleagues (2000) reported that consistent evidence for stress buffering was found among studies in which the social support measure assessed the perceived availability of social support that matched the needs elicited by the stressful event. There was also evidence that emotional and esteem support provided protection against a wide range of different stressful events. It appears an essential element of stress buffering on health and adjustment is one's perception about social support availability, rather than whether support is or was actually received (Cohen *et al*., 2000; Orford, 1992).

Although the literature generally concludes that existing evidence is consistent with matching notions, there are few studies designed to test specific hypothetical predictions. The lack of studies is to some degree attributable to the difficulty in providing an adequate test of the matching hypothesis. It requires the definition and measurement of distinct categories of stressors and of social support, relatively orthogonal measures of subtypes within each category, and a conceptual link between stress and support categorisations (Cohen *et al*., 2000; Cutrona, 2000). However, the current thesis reports on these complex operational dynamics in relation to a specific stressful situation. The study population are concerned and affected family members living with the problem alcohol and/or drug use of a close relative.

Chapter 2: Alcohol, Drugs and the Family: Social Support

2.1 Chapter Outline

What is included in this chapter is in no sense a comprehensive review. It is a partial review of the salient themes relating to problem substance use and the family. The ADF area is important to study because alcohol and drug problems are highly prevalent in society, and thus impact on a vast number of family members. There are believed to be in the region of eight million family members in the United Kingdom who are negatively affected by the problem alcohol and/or drug use of a relative (Velleman and Templeton, 2003).

In addition to prevalence, it is imperative to consider families affected by problem substance use for two main reasons: family members in these circumstances exhibit symptoms of stress which merit help in their own right and the involvement of family members in interventions with their problem substance using relatives can enhance positive outcomes (Orford, 1994).

2.2 Impact on the Family

It is recognised that certain problems, such as domestic violence, homelessness and crime are linked to alcohol and drug consumption (Barber and Crisp, 1995; Caetano, Nelson, and Cunradi, 2001; Maristela, 2001). What is not so clearly recognised, however, is that alcohol and drug problems occur in the context of the family, and do not just affect the substance users, but also those living in close proximity to them. For instance, around forty percent of first calls to

alcohol advice centres come not from the drinker, but from their family or friends (Stafford, 1997). Similar percentages also apply for problem drug use (Velleman and Templeton, 2002).

Furthermore, Velleman (2000) describes how family members often suffer many negative experiences, including violence, poverty and social isolation. As a direct result of these experiences, family members will often develop problems. Individual problems such as physical and psychological morbidity, symptoms such as anxiety, depression and psychosomatic complaints are common (Velleman and Orford, 1999), often leading to increased attendance at primary care services (Svenson, Forster, Woodhead, and Platt, 1995). Family problems include breakdowns in family structures and systems, including their impact on rituals, roles, routines, communication, social life and finances (Velleman, 2000).

Given the way that problematic substance use can affect the dynamics of the family via a transactional process, it is not surprising that research evidence is consistent in regard to the adverse impact on individual members of the family. In the United Kingdom, it is estimated that serious alcohol problems double the risk of divorce / separation, and that alcohol is a factor in forty percent of domestic violence incidents, and in twenty five percent of known child abuse cases (Eurocare, 1998).

2.3 Theoretical Approaches

Numerous theoretical models have been posited over the years in an effort to understand the experiences of families facing substance related problems. An historical review, in terms of alcohol problems, is detailed in Hurcom, Copello, and Orford (2000) and a description of six models including Co-dependency, Family Systems, Psychodynamic, Community, Feminist and SSCS, and the application of each model to real life cases, based on biographical data, can be found in Velleman, Copello, and Maslin (1998).

The key determinants that have influenced theories are the interpretation of symptoms of distress in family members, and whether these symptoms are seen as part of individual and/or family 'pathology', or as a result of exposure to severe and long lasting stress (Copello, 2003). Accordingly, Co-dependency, Family Systems and SSCS models utilised to explain problem substance use and family functioning are presented and critically appraised.

2.3.1 Co-dependency Model

The co-dependency model has been used to explain the dynamics within families where problem substance use exists. Hands and Dear (1994) depict the characteristics of co-dependency as an excessive reliance on others for approval and self-worth, excessive caretaking behaviour, rescuing of others and compulsive tendencies to enact these behaviours. In essence, co-dependency can be conceptualised as an addiction to caretaking and relationships (Gordon and Barrett, 1993), implicating the family member's own psychopathology in directly contributing to the substance using relative's problem (for a detailed account of the co-dependency model see Velleman *et al*., 1998).

The concept of co-dependency has been criticised both on theoretical and political grounds. Hands and Dear (1994), in a comprehensive review of the co-dependency literature, reported that descriptions of co-dependency have taken the place of definitions of the term, and that these descriptions have been elevated to diagnoses in the absence of empirical evidence. Anderson (1994) insightfully highlights that, within the co-dependency paradigm, families are viewed as homogeneous units and each is characterised by its deficits, and not its strengths. As a result, variations in excessive drinking and/or drug taking and its influence on non-problem substance using family members are ignored. Feminist writers have also attacked co-dependency, arguing that it pathologises 'feminine' characteristics such as caretaking, empathy and self-sacrifice which

have traditionally been socially sanctioned and seen as essential aspects of a women's gender role (Hurcom *et al*., 2000).

2.3.2 Family Systems Models

Family systems models postulate that problem substance use has a functional and meaningful role within the family. The systems view provides an explanation as to how a substance related problem becomes pervasive within the family unit. This view challenges the blaming of individual family members by stressing that everyone is caught in a system where alcohol and/or drug use has become somewhat functional, however, the concept of family responsibility is retained. In this model, even the most negative aspects of problem substance use are believed to allow the family some sought-after consistency and predictability (Copello, 2003).

Systems theorists have posited an intimate relationship between family functioning and problem substance use. Steinglass and colleagues (1987) suggested that using behaviour in the family system may serve two possible functions: 1) It may appear as a sign or signal of stress within the system and may be functional as a tension releaser or a way of recruiting help for the family or 2) Using behaviour may function as an integral part of the system, maintaining, in homeostatic fashion, rigidly established, repetitive patterns of behaviour involving closeness or distance, dominance or submission (Orford, 1990).

Orford (1990) states that the systems view can lose sight of the distress experienced by individual family members. Copello (2003) highlights that some of the concepts are not clearly defined, and thus not amenable to empirical study. Other methodological issues include: small sample sizes recruited from high socio-economic backgrounds within clinical settings, and a lack of control group or cross-cultural comparisons.

2.3.3 Stress-Strain-Coping-Support Model

The foregoing sections covered the theoretical backdrop (personality and dynamic interaction views) in which the development of a perspective known as the SSCS model occurred (Orford *et al*., 2005a, 2005b; Copello, 2003). This viewpoint has been developed by a group of practitioners and researchers in the United Kingdom called the ADF Research and Development Group (ADF R&DG).

2.3.3i Stress

The idea that family members experience stress as a result of living with a problem substance user first emerged in the 1950s. Jackson (1954) proposed that living with a problem drinker was stressful and might lead to a crisis reaction in the family. Grounded in verbatim recording of Al-anon meetings, Jackson (1954) documented stages of a stress reaction during which families progress through denial, recognition, disorganisation and escape before finally reaching a reorganisation of roles and responsibilities. The conclusion reached was that the symptomatology exhibited was a reaction to the continued stresses that spouses experience as they move through this process (Jackson, 1954). This work marked a new way of thinking; the current environment, for the first time, was thought to play a part in determining behaviour (Hurcom *et al*., 2000).

The acknowledgement that stress, and not individual pathology, contributed to the symptoms that the family members experienced was the cornerstone on which the ADF R&DG have based their research programme. Emerging from this work focusing on the stress faced by families, there appears to be a core set of experiences which are universal to family members who have a relative with a

persistent alcohol and/or drug problem. Across different socio-cultural groups and irrespective of the relationship to the relative, these common experiences include: finding the user difficult to live with, financial difficulties for the family, family members being concerned about the user's physical and mental health or performance and future safety and welfare, experiencing poor general health or symptoms which the family member attributes, at least in part, to the stress of living with the effects of a drinking and/or drug problem and harmful effects upon the family as a whole (Orford *et al*., 2005a).

2.3.3ii Strain

The stress which arises when a substance related problem develops in the family setting is often severe and long-lasting (Orford *et al*., 1998). Family members in these circumstances are at high risk of developing symptoms of stress which often manifests themselves in terms of physical (for example, digestive system and blood pressure problems) and psychological (for example, anxiety, psychosomatic complaints) health issues. As a result, family members also exhibit increased rates of healthcare service utilisation and diagnosis of trauma (Svenson *et al*., 1995). Additionally, Orford and colleagues (2005a) reported that cross-culturally family members were found to experience feelings of anxiety and worry, helplessness, despair and depression, as well as poor general health and non-specific physical symptoms (for example, loss of appetite, poor sleep). Concordantly, Andrade et al. (1989) reported the presence of psychological distress in the families of problem drug users. Family members exhibited higher levels of both psychological and physical symptoms of stress than the control group. This symptomatology is a direct measure of the strain family members are enduring.

2.3.3iii Coping

Coping theories have underlined the importance of cognitive appraisals as mediating factors between environmental events and behavioural and health outcomes (Lazarus and Folkman, 1984). The coping model emphasises the resources and coping skills which family members employ in response to stressful circumstances that arise when dealing with a problem substance using relative (for example, Barber and Crisp, 1995; Holmila, 1988; Orford, 1998).

Moos and colleagues (1990) found that contextual variables were more important as determinants of family member functioning (involving psychological and physical health) than personal characteristics. Furthermore, coping behaviours were associated with family member functioning, so that active coping strategies (behavioural and cognitive) were associated with less depression and physical symptoms, and the opposite was true for tolerant coping which appeared to be consistently associated with poorer outcomes for both family member and relative.

Exploring natural family coping mechanisms, Orford (1998) found that in response to stress, family members attempt to cope in a number of ways. These coping actions fall within three broad types, namely engaged, tolerant and withdrawal. Engaged coping includes attempts by the family members to modify or control the using behaviour; tolerant coping involves actions which are inactive, accepting of substance use; and withdrawal coping involves attempts to put distance between the family member and the relative. Both tolerant and engaged coping actions tend to be associated with higher levels of physical and psychological symptoms for family members. Additionally, Holmila (1988) proposed a three coping typologies model directly comparable to that of Orford and colleagues, thus, corroborating those findings. However, it must be noted that there is a dearth of longitudinal or prospective studies exploring family members' coping changes over time and the potential impact that this may have on both the problem substance user and the family (Copello, 2003).

2.3.3iv Social Support

In contextualising ADF specific social support the author will first explore the general domain of social support. The global concept of social support, the interrelationship between constructs and the dimensions within constructs must be made explicit. Questions arise as to whether one construct is more fundamental to the concept of social support than another, whether one construct provides a better predictor of well-being and whether one construct provides a better measure of stress-related social support (Chronister *et al*., 2006). The extent to which disaggregated constructs of social support are interrelated was the focus of investigation in three studies. The findings indicated that, although conceptually distinct, the different constructs of the support domain were, with few exceptions, significantly related to one or other as predicted (Dunst and Trivette, 1990).

However, despite the fact the constructs do not operate in isolation from each other and are interconnected aspects of a superordinate concept, they are sufficiently different to caution against regarding them as synonymous. Also, within each of the constructs, relevant characteristics may differ in their degree of stability over time (Veiel and Baumann, 1992). In terms of the overall scope and depth of empirical work, too little attention has been paid to the interconnections among constructs (and dimensions within constructs) and their impact on situation specific coping (McColl *et al*., 1995).

Orford and colleagues (1998) argue that, rather than striving to identify a single model that represents the influence of global social support, researchers should develop more sophisticated and precise models theorising about the linkages between specific support constructs and dimensions, life stress variables and indicators of distress. This would involve more focused research combining both quantitative and qualitative methods into the links between specific stressors

and types of useful support in coping with them. Specifically, this would involve examining matches between mode and source of support and particular coping tasks, support needs, timing and expectations.

Social support incidents are most easily identified in the tapestry of social life when a focal person has experienced an acute stressful event or displays distress (Vaux, 1990). Therefore, the vast majority of research on stress, social support and health has focused upon discrete life events. However, family members living with a long standing problem drinking and/or drug taking relative experience stress of an ongoing or chronic nature which may have greater consequences for health, although, given the impact of problem substance use on families, rates of negative life events are also likely to be higher than normal (Orford *et al*., 2005a). 'Caregiving' can be time-consuming, stressful and, when not reciprocated, can create indebtedness and become a burden (Schulz and Martire, 2004). Moreover, living with someone with a serious alcohol and/or drug problem often brings about stress in myriad of areas, including relationships, assets and social role (Orford *et al*., 2005a).

What people find most supportive is likely to depend upon their circumstances; including the nature of any stresses that they may be facing. Family members attempting to cope with drinking and/or drug problems constitute one specific group for whom the study of social support may be of particular importance both theoretically and practically. Not only are the circumstances faced by this group extremely common and often very stressful, but also they are difficult to neatly categorise. These very particular circumstances share features with many other forms of stressful and challenging situations but possess special features all of their own (Orford *et al*., 2005a).

One paradigm conceptualises social support (see Section 1.2) as the frequency of contact with others, the resources that persons perceive to be available or that are actually provided and the perceived adequacy of that support from both formal support groups and informal helping relationships (Cohen *et al*., 2000; Hooyman and Kiyak, 2002). Specifically, it includes a process involving the

provision or exchange of tangible or intangible resources in response to the perception that others are in need of such aid and assistance. These needs are often associated with acute or chronic stressful experiences such as living with problem drinking and/or drug taking (Cohen *et al*., 2000). The provision of social support resources is especially critical in stressful conditions ameliorating uncertainty and concerns (McIntosh, Silver, and Wortman, 1993).

There are two central questions that arise in relation to ADF specific social support (Orford *et al*., 1998) - what social support do family members ideally need in coping with their stressful circumstances and what social support do they actually receive? Hartney and colleagues (1998) and, more recently, Orford and colleagues (2005a) explored the social support experience for concerned and affected family members focusing on the support they described as helpful and effective. Consistent with general functional support categories, four main dimensions were identified: emotional, informational, social companionship and instrumental support (Hartney, Hewitt, and Foxcroft, 1998; Orford *et al*., 2005a). Pertinently, in addition to the general functional dimensions outlined, two further dimensions relating specifically to ADF social support were identified: support for coping (for example, awareness of alternatives, non-judgemental approach) and attitudes and actions towards the problem substance using relative.

These salient ADF social support dimensions highlight the particular attitudes and actions of other people that are found supportive by family members trying to search for effective ways of responding and standing up to problem drinking and/or drug taking. They have special significance when one understands the nature of the stressors family members are typically under, and the coping dilemmas which they typically face (Hartney *et al*., 1998; Orford *et al*., 2005a).

Specifically, the dimension of support for coping involves functional support or backup for the family member in the position that they are taking in the face of the excessive drinking and/or drug use. To clarify, this dimension does not include coping by support seeking or reluctance to seek support, this dynamic is

captured under the theoretical concept of coping in the SSCS model. Family members were found to be particularly appreciative of other people who supported their own coping efforts rather than criticising or opposing them. This included having supportive people who share the problem, understand what it is like for the family member, and largely concur on approaches to the relatives' substance use problem by, for instance, agreeing a common tactic, such as not bringing alcoholic drinks to a party (Hartney *et al*., 1998; Orford *et al*., 2005a).

The dimension of attitudes and actions comprises relations, friends, neighbours or professionals who interact sympathetically or positively towards the relative. Supportive other people were perceived by the family member to have a good relationship with the drinking and/or drug taking relative, including listening to, talking to, worrying about or advising them, expressing positive sentiments to them, calming an intoxicated relative down or remaining with or looking after them, protecting the relative in the face of difficulties or aggression, maintaining a view of the relative as someone who should be helped and who potentially could change, and direct intervention with the relative to modify drinking and/or drug taking or taking the relative to a treatment setting (Hartney *et al*., 1998; Orford *et al*., 2005a).

The ADF specific dimensions outlined highlight that, in order to understand the adequacy of social support provided by other people, it is necessary to know not only something about the relationship between the family member and potentially supportive other people, but also something about the relationship between other people and the relative. Implicitly, the supportive relationship between other individuals and the family member are most likely to be beneficial if the family member perceives the relationship between other people and the relative also to be positive. Support for both the family member and the relative potentially emanates from a myriad of sources such as family and friends, as well as outside agencies (for example, primary care, counselling and self-help), and other types of service (for example, social services, police and solicitors) (Orford *et al*., 2005a).

It is extremely important to emphasise this interaction may not be perceived as supportive by family members. Family members have reported experiencing very mixed support from others, with many people falling short of their ideal support needs. That is particularly true of the relative's friends and associates who are often seen as unsupportive because of the bad influence they exert upon the relative. This is principally because of their own excessive use or dealings in drink and/or drugs. From the family member's perspective, other people supportive of the relative's continued problem use or undermining change towards reduced use are even worse than those who are openly critical and hostile towards the relative (Hartney *et al*., 1998; Orford *et al*., 2005a).

Family members expressed uncertainty over whether insults, rejection, or physical violence were good or bad for relatives. However, family members generally perceived actions from other people that were negative or unsympathetic (for example, uninvolved, uninformed, condemning) towards the relative as unsupportive. This could include stating that the relative is not liked, making it clear that they do not want to know the relative or have anything more to do with them, beating the relative up or spreading unpleasant rumours about the relative. Actions which could create heightened tension, but were generally perceived as more useful were other people defending the family member in the face of the relative's aggression or helping the family member to control the relative's behaviour by speaking severely to the relative, giving the relative ultimatums, making threats or suggesting punishments (Hartney et al., 1998; Orford *et al*., 2005a).

The extent and quality of social support available for family members can have a significant impact on their ability to cope and their experienced stress. Research has shown that commonly, family members feel undermined in their coping efforts to stand up to their relatives' excessive drinking and/or drug taking (Orford *et al*., 2005a). The failure of family members to obtain concerted support for their attempts to respond to the problem drinking and/or drug taking took a number of forms, but often included disapproval, disagreement or

criticism by other people of the family member's approach in the face of the problem, lack of sympathy or consistency for the family member's position and restraining rather than supporting the family member's struggle for some distance or independence (Hartney *et al*., 1998; Orford *et al*., 2005a).

In illuminating the positive and negative characteristics of the two ADF specific dimensions, it is important to have an appreciation of what constitutes good and poor social support for family members in general (Orford *et al*., 2005a). Table 2.1 outlines salient examples reflected in qualitative data (Hartney *et al*., 1998; Toner, 2002) for each of the four main functional dimensions.

Positive instances	***Negative instances***
1) Emotional Support	
Talking to family member about the problem	Uninvolved or distant
Listening in an accepting way	Lack of understanding or sympathy
Helping the family member realise that there are others in a similar situation	Negative reaction by being judgmental, taking sides or condemning
2) Informational Support	
Informed advice	Conflicting or unhelpful advice
Provision of accurate information	Unwillingness to talk through strategies or give direction
3) Social Companionship	
Distraction from the problem	Lack of availability
Cheering the family member up	Pressure to attend activities or events
4) Instrumental Support	
Offering the family member or relative respite or temporary accommodation	Refusal or help not being forthcoming
Taking care of relative when family member is away	Loss of independence or autonomy
Giving or lending the family member money	Indebtedness, reliance or burden

Table 2.1: Instances of positive and negative support for family members.

To elaborate, the problematic nature of support for the family members of relatives who drink and/or take drugs excessively was so evident that the failure of support was not surprising, but rather the fact that support was ever

satisfactorily received. Being listened to is of importance because family members in these circumstances are often not listened to, and being given information is valued because family members are often cut off from accurate information about what is going on. Supporters who have experience with dealing with alcohol and/or drug problems in the family are significant because they can give adequate validation of feelings, good comprehension and insight into the stressful situation, and not further threaten the self-esteem of the family member (Orford *et al*., 2005a). Additionally, they can restore motivation and a positive view of the future (Veiel and Baumann, 1992). Family members also appreciated the offer of an occasional place to escape to, as their circumstances are occasionally intolerably stressful or dangerous. However, family members reported that they had often found, in practice, that these kinds of support were a rare and precious commodity (Hartney *et al*., 1998; Orford *et al*., 2005a).

In summary, an integration of available evidence relating to the general and ADF specific social support domain suggests that it comprises the following constructs and dimensions depicted graphically in Figure 2.1.

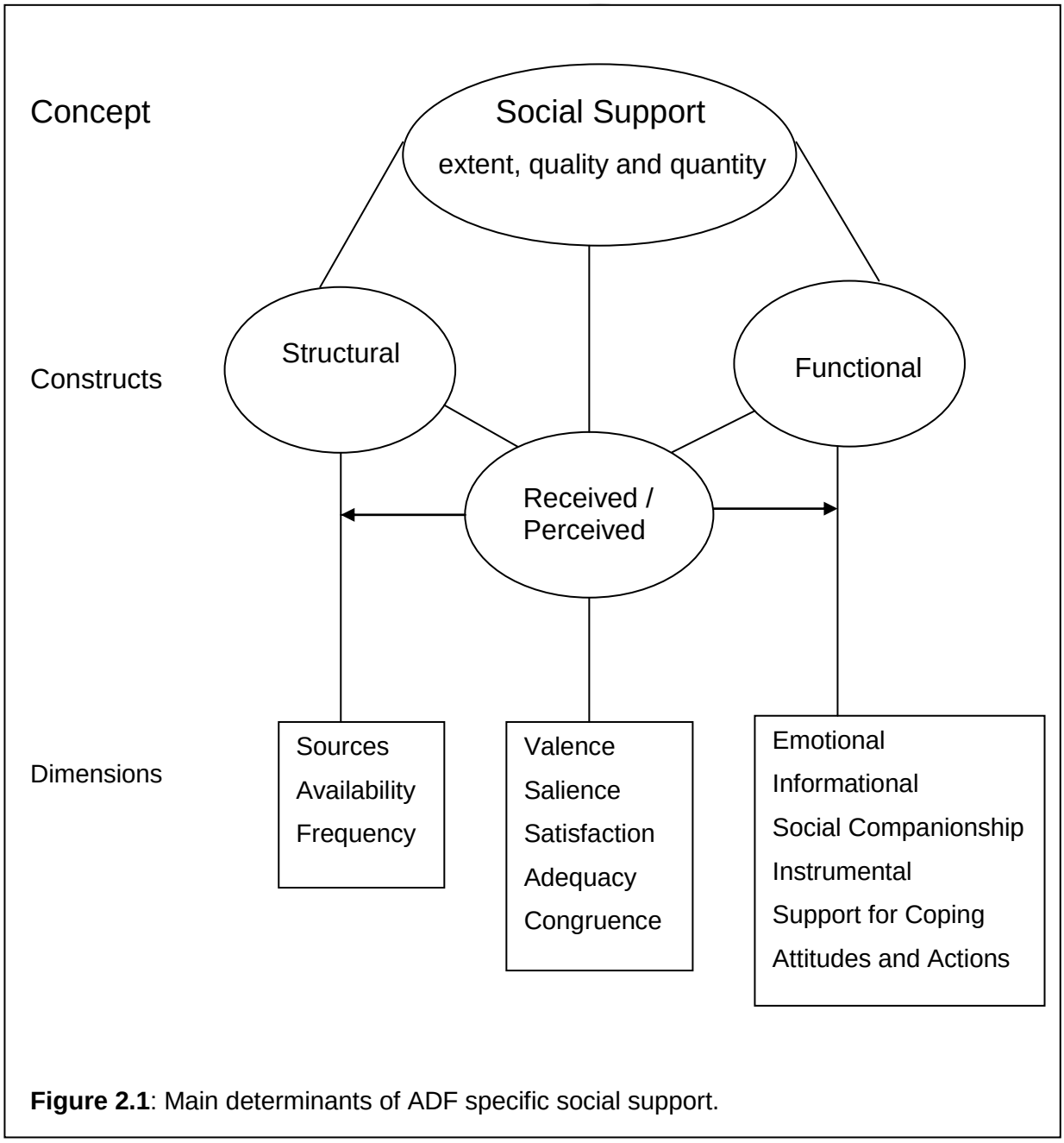

Figure 2.1: Main determinants of ADF specific social support.

Although it is possible to distinguish operationally between the three different support components, they are, as one might suspect, conceptually, logically and empirically interrelated. Additionally, the ADF specific functional dimensions overlap with the general expressive and instrumental forms of social support.

The facets outlined were utilised to operationalise the concept of social support for family members. However, before an exposition of this process, this thesis will provide a brief overview of the integrated SSCS model.

2.3.3v Stress-Strain-Coping-Support

As described by Orford and colleagues (2005a), the SSCS model contrasts with alternative conceptual models in a number of ways. In contrast to personality models, the SSCS perspective assumes that family members facing alcohol and drug problems are no different from families facing other stressful circumstances related to the problems experienced by one family member, such as schizophrenia (Birchwood and Smith, 1987), Alzheimer's disease (Matson, 1995) and compulsive gambling (Krishnan and Orford, 2001).

Additionally, the SSCS perspective does not assume that excessive drinking and/or drug use is likely to be a 'symptom' of a more fundamental problem elsewhere in the family system, or that it is serving some sort of function for either the family member or the family system as a whole. In this sense the SSCS perspective contrasts with both personality and systemic models. Finally, within the SSCS perspective, families are not seen as causal in relation to the substance related problem. Causes that contribute to the development of alcohol and/or drug problems are multiple and varied, involving both environmental and individual factors (see for example, Orford, 2001; Rachlin, 1997). The SSCS model is based on the interactions between the family member and the relative, and the view that family members do have some potential for influencing their relatives (Orford *et al*., 2005a).

In summary, there are four central tenets which form the basis of the SSCS interactional model. The first assumption behind the SSCS viewpoint is that excessive drinking and/or drug taking constitutes a problem for the relative and for anyone who is a family member. This is because serious drinking or drug problems are, by their very nature, associated with a number of characteristics which are very damaging to intimate relationships and can be extremely unpleasant to live with. Such problems frequently continue unabated, often

intensifying, over a period of years and are appropriately construed as long-standing stressful conditions for family members. The second assumption views family members as being at risk of strain, in the form of symptoms of physical and/or mental ill health, as a direct consequence of the chronic stress occasioned by living with a relative with a drinking and/or drug problem (Orford *et al*., 2005a).

The third assumption of the model is that family members are faced with the large and difficult life task of how to understand what is going wrong in the family and what to do about it, which includes mental struggle and many dilemmas. In particular, this task involves the core dilemma of how to respond to the relative whose drinking and/or drug taking behaviour is seen as a problem. The ways of understanding reached by the family member at a particular point in time, and ways of responding are what are referred to collectively as 'coping' ('responding', 'reacting' and 'managing' are synonyms). The word is certainly not limited to well-thought-out and articulated strategies. It includes ways of understanding or responding that the family member believes to be effective as well as those judged to be ineffective. It includes feelings (for example, anger or hope), tactics tried once or twice and quickly abandoned (such as trying to shame the relative by getting drunk oneself), philosophical positions reached (for instance, 'I've got to stand by him because nobody else will') and 'stands' taken (for instance, 'I'm not coming back until…') (Orford *et al*., 2005a).

A further belief about coping with a relative's excessive drinking and/or drug taking is that some ways of coping are found by family members to be more effective than others. The word 'effective' is being used in two senses here. First, family members may find some ways of responding to be more productive than others in buffering the effects of stress and hence preventing or reducing the strain they themselves experience (or which other members of the family, children for example, experience). Second, family members may find some ways of managing the problem to be relatively effective and others relatively counter-productive in having a desired effect upon the relative's drinking and/or drug taking (Orford *et al*., 2005a).

Lastly, the model rests on the assumption that social support is a powerful factor with potential to mitigate the effects of stress on health. By the same token, unsupportive behaviour can further exacerbate the stresses and strains that the family member experiences. Support, it is assumed, can come from many directions and certainly includes both kin and non-kin informal sources as well as more formal sources offering professional services or self-help. What is important about the support which these sources can provide is the support they give the family member in arriving at and maintaining ways of coping (Orford *et al*., 2005a).

Like all human social support, the support received from these others may take a variety of forms, including social companionship, emotional, informational or instrumental support. But, from the SSCS perspective, the important ingredients are thought to be such things as whether the supporting person understands the stressors and dilemmas faced by the family member, appreciates the ambivalence that the family member feels towards the relative and does not inappropriately 'take sides', understands the difficulty of finding a way of coping and reinforces the family member in her or his chosen ways (Orford *et al*., 2005a).

The main components of the SSCS model, when applied to families where a member of the family has a serious drinking or drug problem, are illustrated in Figure 2.2.

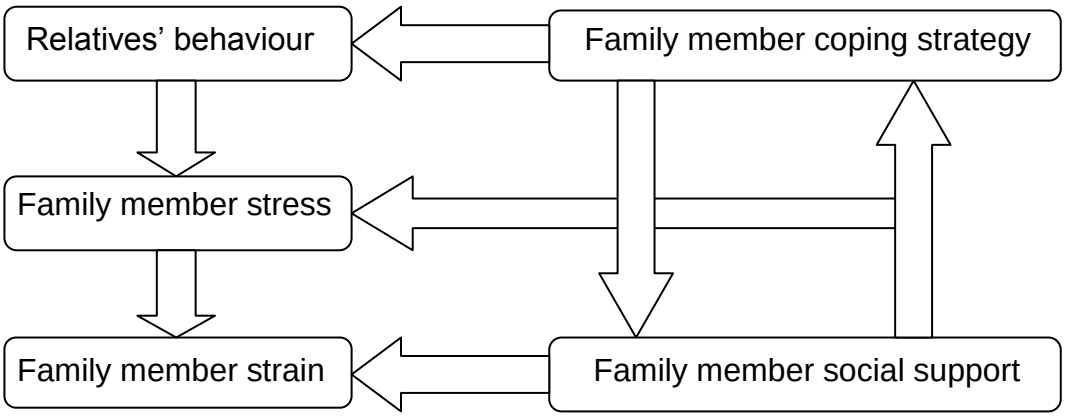

Figure 2.2: The SSCS model (Orford *et al.*, 2005a).

Overall, the model suggests that the stress and strain which together describe the impact of problem drinking and/or drug use on the other members of the family, are mediated by the positive or negative impact of these two other factors: the methods of coping used and the level and quality of social support (Velleman and Templeton, 2003). It should be noted that although there have been ADF related papers focusing on children who live in families where there is an alcohol and/or drug problem (for example, Kroll and Taylor, 2003; Taylor, Toner, Templeton, and Velleman, 2008; Toner, Hardy, and Mistral, 2008), the SSCS model, at the present time, is only applicable to how adult family members (16+) experience living within that environment.

2.4 Rationale for Undertaking the Study

Chapter 1 and the previous sections of this current chapter highlighted why both social support and substance related family problems are important areas to examine. Furthermore, an integrated model was presented identifying the salient constructs and dimensions in relation to ADF specific social support,

within the SSCS theoretical framework. The ADF specific social support conceptual determinants presented were evidenced by qualitative information gathered from family members by the ADF R&DG over a 35-year period (see for example, Orford *et al*., 1975; Orford *et al*., 1998; Orford *et al*., 1992; Velleman, 1987; Velleman *et al*., 1993; Velleman *et al*., 1998; Velleman and Templeton, 2003).

However, the theoretical detail provided in relation to the other main conceptual areas of the SSCS model (namely stress, strain and coping) has been supported by both qualitative and quantitative evidence. To date, there has not been a quantitative measure which has been deemed by the ADF R&DG as being appropriate to assess the ADF specific social support component of the SSCS model. Accordingly, it is of great theoretical and practical importance that ADF related social support is operationalised in the form of a useable and applicable quantitative measure, both to aid conceptual clarity and to address this major methodological gap within the SSCS theoretical approach.

Although there are many questionnaires available to assess the social support domain (see Section 3.4), the rationale for designing and developing a new measure in this study is due to the requirement for the instrument to capture the ADF specific theoretical dimensions discussed in Section 2.3.3iv. These most notably include the two ADF related social support facets of support for coping (for example, awareness of alternatives; and non-judgemental approach) and attitudes and actions towards the problem substance using relative.

The remaining chapters of this thesis are thus concerned with the design and development of a reliable and valid self-completion ADF specific social support scale, underpinned by the SSCS theoretical model and operationalising the perceived quality, availability and adequacy of functional social support. It also simultaneously captures the nuances of social support relevant to family members who have a problem alcohol and/or drug using relative, accounting for the multidimensional, dynamic and fluid nature of the concept of social support, and thus makes an original contribution to the field (Bowling, 1997).

Chapter 3: Methodology

3.1 Chapter Overview

Given the study rationale described in Section 2.4, this chapter clarifies the most appropriate methodological approaches required to design and develop an ADF specific measure of social support.

3.2 ADF Methodology

A 35-year research programme exploring problem substance use and the family has brought together a number of collaborators associated with the ADF R&DG. Currently, the ADF R&DG comprises a number of key researchers / practitioners, including Professor Richard Velleman and Lorna Templeton who are based at University of Bath and Professors Jim Orford and Alex Copello from the University of Birmingham. This collaboration between the two Universities is also supported by their associated Mental Health NHS Trusts.

The ADF R&DG has conducted considerable research into the way in which problem substance use affects family members and family life. The ADF R&DG has been primarily interested in obtaining detailed information about family members' experiences, applying this knowledge both to help practitioners and other health and social care workers respond to the needs of family members, and developing a clearer perspective on research, theory, practice and policy in this area. Ongoing development of the SSCS theoretical model (see Section 2.3.3) has underpinned this programme of work.

Ontology (understanding what is) accompanies epistemology (understanding what it means to know) which is inherent in the theoretical perspective (embodies an understanding of what is entailed in knowing) and is therefore reflected in the methodology (strategies utilised to acquire knowledge) (Crotty, 1998). The ADF R&DG philosophical stance has been broadly characterised by a critical realist approach.

This position acknowledges how individuals make meaning of their experience, and, in turn, how the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality' (Braun and Clarke, 2006). At the method level (techniques used to gather and analyse data), this interpretation views family members as dealing with a palpable situation and assumes that careful interviewing, for example, will reveal the 'truth' of the family members' experience (Copello, 2003). Statistical approaches are regulated by empirical science; however inferences are indicative of underlying mechanisms which structure individual actions (Hickey, 2005; Ron, 2002).

The ADF R&DG perceives much merit in utilising a mixed methodological approach, involving both quantitative and qualitative elements. This position is justified by an understanding that:

- These two main approaches to collecting data complement each other in a myriad of ways. Qualitative data can assist the quantitative component by aiding conceptual, intervention and instrument development (assessing instrument fidelity, for example, appropriateness and/or utility of existing measures, creating new instruments), and provides a means to enhance, elaborate and contextualise quantitative information (for example, interpreting, illustrating, clarifying, describing, determine meaning / explanation, verifying and validating). Additionally, statistical inference can facilitate the assessment of the generalizability of qualitative data and help illuminate qualitative findings (Collins, Onwuegbuzie, and Sutton, 2006; Sechrest and Sidana, 1995).

- Given the complexity of the social phenomena under investigation, by utilising combined quantitative and qualitative methods, the ADF R&DG can attempt to capture changes through well validated quantitative instruments and, in addition, gain an understanding of the participant's view of the process which can enhance and enrich interpretation (as well as cross-validating) to increase the acceptance of findings and conclusions by the diverse groups. It is also the case that different sub-questions within the ADF R&DG's overall areas of interest are better examined using one or other methodological approach (Copello, 2003; Orford, 1995).

- When methods are combined, there are a number of possible outcomes:

  Corroboration: Here similar findings are derived from both qualitative and quantitative methods on the target phenomenon, thus strengthening confidence in the conclusions and improving the analytic power of the study (between-methods triangulation / convergence - validate and explicate findings from another approach and produce more comprehensive, internally consistent and valid findings).

  Complementarity: The qualitative and quantitative results differ but *together* they generate insights that contribute to a fuller interpretation.

  Expansion / Development / Elaboration: These enhance the breadth, depth or scope of inquiry by using different methods for different inquiry components, thus capturing method-linked dimensions of a target phenomenon (this process can, for example, guide the use of additional sampling, data collection and analysis techniques), provide more elaborated understanding and greater confidence in conclusions, handle threats to validity and gain a fuller and deeper understanding (for example, qualitative data analysis exemplifies how the quantitative findings apply in particular cases), and provide richer, more meaningful / useful, valid and reliable answers to research questions.

Inconsistency / Contradiction: Qualitative data and quantitative findings diverge or conflict. By attending to paradoxes which emerge from the two data sources, new modes of thinking can be initiated, thus, raising further or reframed research questions which require exploration.

Whichever of these outcomes prevail, the researcher can construct superior explanations of the observed social phenomena (Brannen, 2005; Caracelli and Greene, 1993; Denzin, 1978; Greene, Caracelli, and Graham, 1989; Hammersley, 1996; Johnson, Onwuegbuzie, and Turner, 2007; Morgan, 1998; Peterson, 2000; Pope and Mays, 2000; Rossman and Wilson, 1985; Velleman and Templeton, 2003).

More specifically, the ADF R&DG have utilised qualitative approaches to collect and then analyse highly detailed information from family members. These methods include collecting and analysing biographical accounts and detailed vignettes (Miller *et al*., 1997; Velleman *et al*., 1998). The main qualitative method the ADF R&DG have used, however, is to conduct quite lengthy semi-structured interviews (following a topic guide, but otherwise quite unstructured and open-ended), each of which is then written up into a detailed report, summarising the key points and including examples and verbatim quotations. These reports are qualitatively analysed using either Grounded Theory (Strauss and Corbin, 1998) or Framework techniques (Ritchie and Spencer, 1994). Thematic analysis is common to both procedures (Velleman and Templeton, 2003).

The quantitative measures the ADF R&DG use are primarily standardised, structured and validated self-completion multi-item questionnaires. The main areas the ADF R&DG measure quantitatively (and the measures utilised in these areas) are family stress using the Family Environment Scale (FES) (Moos and Moos, 1981) or Family Impact Scale (FIS) (Orford *et al*., 2005b), symptoms using the Symptom Rating Test (SRT) (Kellner and Sheffield, 1973) and coping styles using the Coping Questionnaire (CQ) (Orford *et al*., 1975). Of those

measures, the CQ was also further developed by the ADF R&DG and assesses three key coping styles: engaged (i.e. engaging in trying to change the relative's behaviour), tolerant-inactive (i.e. putting up with the relative's behaviour) and withdrawal (i.e. withdrawing from the relative; engaging in activities independently from the relative) (Orford *et al*., 2005b).

Based on the SSCS theoretical approach (see Section 2.3.3), it is apparent that social support is a main area which the ADF R&DG do not currently assess quantitatively. However, this thesis reports on the development of a bespoke ADF-specific social support measure. The next section details generally accepted procedures of how to design and develop a psychometrically robust questionnaire.

3.3 Questionnaire Design and Development

A thorough exposition of the abundant literature on questionnaire design and development is beyond the scope of this thesis. However, this section addresses the salient methodological issues, consistent with the aims and rationale parameters of the current study, in relation to quantitative instrument construction, development and psychometric evaluation.

Quantitative measures, specifically self-completion questionnaires have key methodological strengths which include relatively economical and rapid administration to widely dispersed populations, different administration modes (i.e. mail and electronically), convenient for respondents, enabling participants to focus on a target experience (potentially sensitive) with time for cognition and assisting in articulating the inchoate thoughts of respondents. Having standardised questionnaire items eliminates the interviewer effects and variation, thus no potential distortion occurs, permitting comparability of responses and ease of analysis (Bryman, 2004).

Peterson (2000) reports that self-completion questionnaires commonly do not provide adequate details on why the information is being collected and how the resultant data will be treated. Couper (1997) empirically linked questionnaire introductions to subsequent question answers, for instance, through cover letters and information sheets. Successful self-completion questionnaire introductions include certain essential ingredients that collectively encourage participation and co-operation in both research and clinical environments. These include explaining your status and giving a clear rationale for the study, allowing potential recruits to make an informed decision about their involvement, emphasising the importance of participation in legitimising the work, and assurances of confidentiality and (if appropriate) anonymity (May, 1993; McColl *et al*., 2001; Peterson, 2000).

Typically, a self-completion questionnaire consists of two sections: classification and a substantive question section. Classification section questions concern general demographic information amenable to statistical analysis as well as helping to establish rapport and building respondent confidence due to being easiest to complete. This ordering is determined by framing questions in the most appropriate social-psychological sequence (i.e. having broader questions, before moving to more specific ones) (May, 1993; Peterson, 2000).

Multi-item scales are required when operationalising complex psychological concepts, such as social support, which cannot be defined or represented by a single rating scale or captured by a single question. A multi-item scale consists of a number of closely related individual rating scales which are combined to result in a single or composite score, which permits finer distinctions to be examined between respondents (Bryman, 2004). Most multi-item scales are simple additive scales in which a composite score is obtained by merely summing individual scale responses - hence the term ‘summated scale’. Occasionally, individual items in a multi-item scale are reverse-scored to permit the assessment of response styles or provide a more complete perspective on a concept. The entire discipline of psychometrics is devoted to multi-item

questionnaire design and development, so therefore it is inherent that this task requires considerable research expertise and technical sophistication. In a general sense, the initial phase of this process deals with scale construction, which is summarised in the figure below (Peterson, 2000).

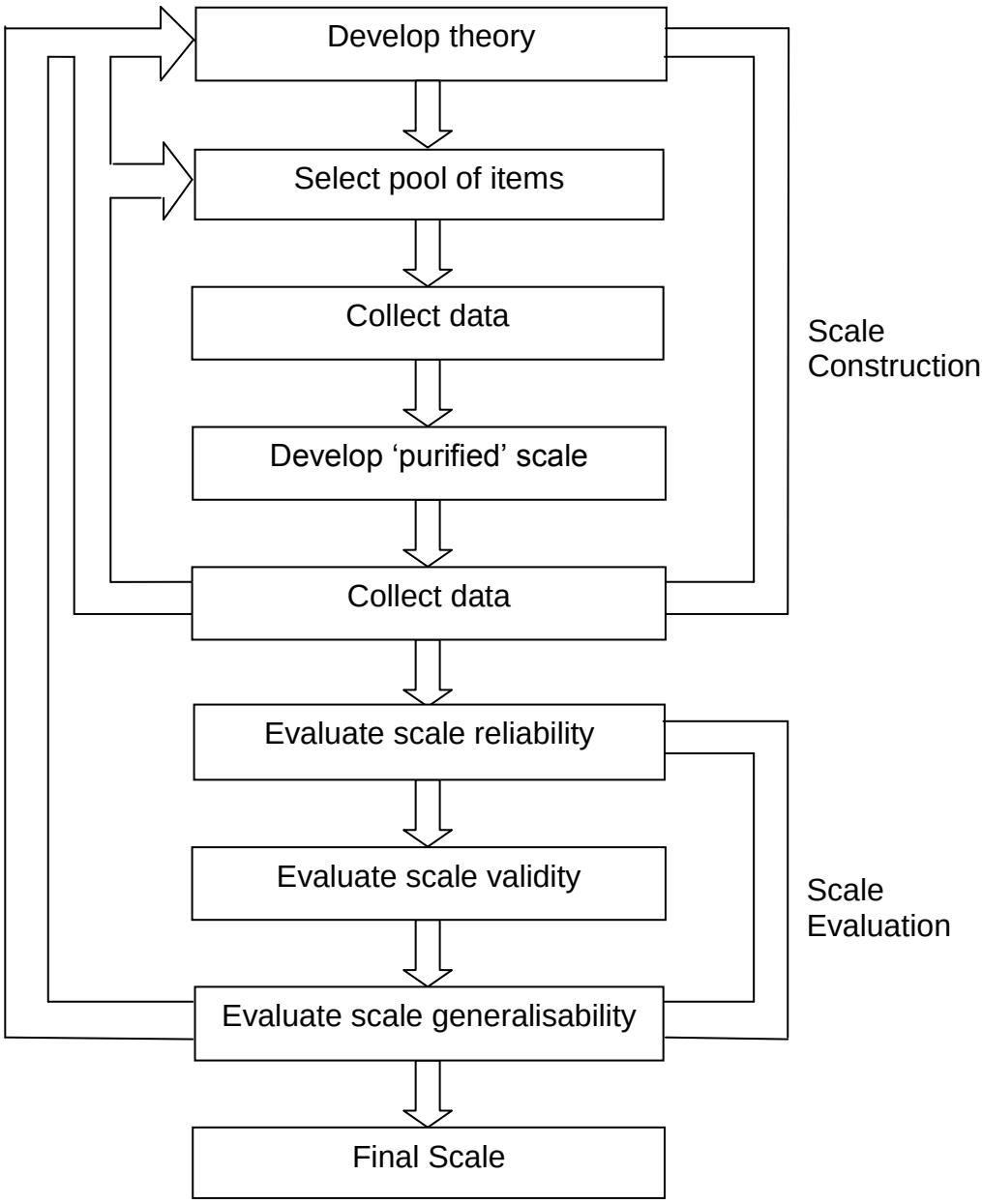

Figure 3.1: Constructing a multi-item measure (adapted from Peterson, 2000).

Figure 3.1 illustrates the iterative nature of constructing a multi-Item scale. The diagram emphasises the necessity of having a theoretical basis on which to construct a multi-item questionnaire, thus ensuring that the scale holds meaning and the scores given are interpretable. With a theoretical foundation in place, a pool of potential items are derived from a myriad of sources, including insights based on the theory, from related research projects and multi-item measures, and focus group and/or interview data. Every item should be critically appraised by asking how each question relates to the purpose of the research. The goal is to retain qualitative meaning in the development of instruments (Fleury, 1993). However, one item can only have one meaning to function well psychometrically (explicitly, it cannot mean different things at the same or different times to the same or different respondents) (Sandelowski, 2002). There are no specific guidelines on the number of items to incorporate into a multi-item scale. However, it is a requirement that the items are strongly related and adequately represent the operationalised concept domain for the questionnaire to function effectively (McColl *et al*., 2001; Peterson, 2000).

From the pool of potential items, a tentative multi-item scale is designed. Conventional wisdom dictates that items should consist of twenty words or less and should have no more than three commas present (Bryman, 2004). The items should be simple to understand and relevant, also ensuring the questions are not unclear, vague, leading, double or compound, or jargon laden. Appropriate pilot work is invaluable, to assist with any necessary deletions, additions or revisions to instructions, question phrasing, sequencing and response categories, as well as enhancing the overall structure, format and flow of the measure arriving at an instrument which is clear, unambiguous, lacking context and ballot effects, and amenable to analysis (May, 1993; Peterson, 2000).

A subset of scale items from the initial item pool is determined by administering the potential scale items to an adequate sample of the target population, factor analysing the results, calculating item-total score correlations and conducting an initial analysis of the internal consistency of the items. The collective application

of these techniques produces what is termed a 'purified' multi-item scale. Furthermore, the statistical and substantive salience of the measure is assessed. If a subset of the scale items forms a potentially viable multi-item measure, the extent to which the resulting questionnaire is reliable, valid and generalisable requires evaluation. All these characteristics have to be at a satisfactory level for a scale to be useful (Peterson, 2000). Of those characteristics, generalisability is the least amenable to quantification and requires the most subjectivity. Generalisability refers to questionnaire administrative viability and interpretation in different research and clinical settings (Peterson, 2000).

Table 3.1 below details the various agreed approaches to demonstrating questionnaire reliability and validity, commonalities and contrasts in their function, and whether this thesis employed the techniques reported. The information contained within the table was derived from a number of sources, including: Bowling, 1997; Carter, Shaw, and Thomas, 2000; Huck and Cormier, 1996; Kline, 1993; and Peterson, 2000.

Reliability: refers to whether a questionnaire is operationalising a concept in a consistent, dependable and reproducible manner.		
Types	**Description**	**Whether Tested in this Thesis**
Test-retest (Temporal / Longitudinal Stability)	Assesses whether the same item and scale outcomes are obtained by the same respondent at two points in time, during which period no real change has occurred for that individual in the relevant respects. It is important to choose an interval between the two administrations that is prolonged enough so that respondents are not simply recalling and repeating their initial answer, but not so protracted that change may have happened. In practice, it is difficult to apply a satisfactory test-retest check, in attempting to counteract both the effects of memory and intervening events.	YES

Internal Consistency	Refers to the extent to which the questions are correlated in measuring the same or a related concept. The idea here is that all questions suffer from some degree of response unreliability, but that the degree of logical and conceptual consistency found between responses to items designed to capture the same or a related concept provides an indication of the reliability of those responses. An internal reliability of Crobach's coefficient alpha (α) = 0.7 is a minimum for a good test. This threshold is necessary as the standard error of measurement of a score increases as the reliability decreases.	YES
Parallel-form (Alternate-form)	Involves employing differently worded items to measure the same concept. Questions and responses are reworded or their order changed, to produce two items that are similar but not identical. Alternative versions of the questionnaire, with differently worded items, are administered to the same population. However to make comparisons of scores viable, the correlations between the various forms should be high (as well as the means, standard deviations and distributions of scores).	NO
Split-halves	Refers to randomly selecting the items of a questionnaire to form two equal halves. However, the complete questionnaire is then administered to a sample, and the correlation coefficients between the scores of the two randomly divided halves are examined.	NO

Inter-rater (Inter-observer)	Is the degree of agreement (or concordance) between two or more raters. A score is derived on how much homogeneity or consensus there is in the ratings given by observers. For instance, it is a useful approach to refining measures assessed by expert judges. If various evaluators do not agree on whether a question is measuring a particular construct, then that question must be defective in some way.	NO

Similarities and Differences between forms of Reliability:

The five forms of reliability listed are usually dealt with separately. However, in actuality they are closely related. Internal reliability involves the relationship between items in a measure. These items are considered to be a random selection of a conceptual domain of items. Inter-rater reliability is concerned with assessments on whether potential items belong to the conceptual domain they purport to measure. Parallel-form reliability is essentially similar to internal reliability, but the items have been placed into two questionnaires rather than one, and for split-halves reliability the items are divided to form two parts of the same instrument. Test-retest reliability in common with internal reliability is a correlation of the items within a measure but, in this instance, of the items administered on two occasions. Thus high level reliability corroboration between internal and test-retest reliability reduces the likelihood of measurement errors, ensuring both approaches are integral to any comprehensive evaluation of reliability. However, each of the reliability assessments will derive a different value. In general, test-retest and inter-rater reliability will give a lower estimate than the parallel-forms, split-halves and internal reliability methods as they involve measuring at different times or with a number of evaluators.

Validity: Refers to the extent to which an instrument really measures the construct or concept of interest.		
Types	**Description**	**Whether Tested in this Thesis**
Face (Surface)	This is the least important aspect of validity based on visual inspection or intuitive judgement on whether the questionnaire appears to be measuring what it is supposed to measure.	YES
Content (Argument-ative)	Refers to whether a measure appears to consist of a representative and balanced set of items reflecting the concept being operationalised. It is assessed by those who have knowledge of the area, including members of the target population.	YES
Construct (Convergent, Divergent / Discriminant, Nomological)	Refers to whether the results obtained using a measure confirms expected inferential statistical relationships. These expectations are derived from underlying theory utilised for developing the questionnaire. The method involves administering more than one questionnaire purporting to measure similar concepts or facets of the same domain, or alternatively different concepts, and examining the correlations between the scores on the various instruments. Higher correlations between scores on domains measuring similar concepts (convergent validity), either within the one instrument or across questionnaires, and weaker correlations between domains measuring dissimilar concepts (discriminant validity) are indicative of construct (nomological) validity.	YES

Criterion (Concurrent, Predictive, Incremental, Differential)	Evaluates the extent to which a questionnaire yields results which correspond with a 'gold standard' measure in the conceptual area, applied simultaneously (concurrent validity) or which forecasts expected future outcomes (predictive validity). However, in practice the lack of a 'gold-standard' questionnaire is one of the key rationales for devising and developing a new domain specific measure. If a questionnaire posts a low correlation with all the other measures in the test battery, this low correlation would add in new information and would thus be of value. When this happens the measure is said to have incremental validity. Differential validity is not dissimilar, and is best demonstrated by interest questionnaires. These correlate only moderately with academic success, but they do so differentially for different subject areas.	NO
*Internal	Refers to controlling for interfering variables to determine whether a causal relationship exists between the independent variable and the dependent variable in an experimental study.	NO
*Statistical Conclusion	Refers to appraising the extent to which study variables are related in experimental research. Thus ascertaining whether to accept or reject the null hypothesis without making a Type I or II error.	NO
*External	Involves assessing the generalisability and applicability of results from the experimental sample to the population of interest.	NO
*Ecological	Refers to the extent to which the results from an experimental study can be applied to a 'real life' or naturalistic setting.	NO

Similarities and Differences between forms of Validity:

Face and content validity are similar assessments, with content validity having more rigor as the evaluators have some expert knowledge of the concept being measured by a questionnaire. Construct validity is closely related to the definition provided on demonstrating validity. Arguably it is the most important approach to validity, especially where measures are developed to extend psychological knowledge. Differential validity, somewhat distinctly, is aimed at indicating the validity of a questionnaire for a specific purpose, and is almost an operational definition of the utility of a measure. Demonstrating criterion validity is only possible where 'gold standard' measures exist: where they are not available, validity studies utilising other measures are more appropriately regarded as assessing aspects of construct validity. It is apparent that a set of findings over a period of time have to be considered to properly evaluate the validity of a questionnaire. Consequently, it is not surprising that relative few measures have sufficient evidence demonstrating their validity.

* The terms internal, statistical conclusion, external and ecological validity are most appropriately used when assessing the findings from an experimental study. As this thesis did not utilise an experimental design, these terms are only briefly outlined in the table, and not referred to in demonstrating the validity of the newly developed measure.

Table 3.1: Summary of the utility of different forms of reliability and validity, and whether they are assessed in this thesis.

Questionnaire evaluation is an iterative process involving refinements to produce an ever more reliable, valid and relevant measure. A multi-item questionnaire which allows for self-report should be psychometrically robust enough for use in practice, and sensitive enough to be able to detect subtle changes in the constructs under study. Overall, if a questionnaire is functioning well on the characteristics outlined, the outcomes can be analysed to assess whether the original theoretical propositions require modifying. This procedure involves inductive, retroductive and deductive techniques of social research (May, 1993; Peterson, 2000; Trigg, Wood, and Langton-Hewer, 1999).

3.4 Operationalising ADF Social Support

Having outlined the processes involved in developing any quantitative questionnaire, this thesis now turns to the specific issues relating to the measure being reported on here. The first step in developing an ADF specific social support measure was to operationalise what was meant by social support. Section 2.3.3iv detailed the main conceptual determinants of ADF specific social support, underpinned by the SSCS model. In sum, these included the main constructs of structural, received, perceived and functional support.

Operationally, structural support is synonymous with social network measures, such as the Provision of Social Relations Scale (Turner, Frankel, and Levin, 1987). As previously stated (see Section 1.2.2), social network variables pertaining to the structural properties of one's social environment are viewed as conceptually distinct from social support indices, and therefore not relevant to the current exposition. Indeed, minimal intercorrelation between the frequency of social interaction and quality of social support has been widely reported (Cohen *et al*., 2000; Orth-Gomer and Unden, 1990). In addition, achieving an adequate self-report measure of someone's social network poses practical problems, in terms of respondent recall and burden. In that it is difficult, especially for participants experiencing chronic stress, to recount unassisted all their potential social contacts. Notwithstanding the delineation, the presence of social ties and sources of contact have merit as structural support dimensions within the SSCS theoretical framework.

Received social support instruments, including the Inventory of Socially Supportive Behaviours (Barrera, Sandler, and Ramsey, 1981), are only weakly correlated to both structural and perceived measures and, most tellingly, are poor predictors of health outcomes (Chronister *et al*., 2006; Dunkel-Schetter and Bennett, 1990). In fact, Helgeson (1993) reported that received support was positively correlated with symptomatology. However, it may have been the case that people with more symptoms, subsequently received more support.

Furthermore, received support is confounded with need and may not accurately reflect the amount of support that is available to an individual (Sherbourne and Stewart, 1991).

The ADF specific social support scale designed and developed by the author was informed by the SSCS model. The researcher elaborated the most salient constructs and dimensions of social support relevant to the family members of problem alcohol and/or drug users (see Section 2.3.3iv). The measurement strategy was tailored to specific research aims and contexts. Therefore, given the arguments presented in Chapters 1 and 2, the instrument focused on the perceived availability, if required, of various dimensions of functional support (Cohen *et al*., 2000). More specifically, these facets are perceptions of the quality (i.e. subjectively positive and/or negative transactions), adequacy (i.e. congruence / satisfaction with the type and amount of support) and availability of different kinds of support.

A myriad of studies (for instance, Cohen *et al*., 2000; Furukawa, Harai, Hirai, Kitamura, and Takahashi, 1999) indicate that it is primarily perceived social support or subjective adequacy of social support, that demonstrate buffering effects, ameliorating psychological and physiological well-being, and reducing the impact of stress on adverse outcomes. This approach to operationalising social support derives from research that eloquently considered the outcomes from a generation of social epidemiology studies and suggested formulations of the concept of support as a generalized resistance factor (Cohen *et al*., 2000).

The functional measurement approach is inherently multidimensional as it is assumed that there are different kinds of supportive functions, and additionally that these functions may be differentially useful for dealing with various problems and stressors (Cutrona, 2000). Interestingly, the buffering model suggests that functional support has greater effects among individuals who are confronting stressors and challenges (Cohen *et al*., 2000). Several dimensions of functional support relating to both general and ADF specific support have been delineated (see Section 1.2.4 and 2.3.3iv).

There are numerous examples of measures of perceived social support with adequate psychometric properties (i.e. sufficient levels of reliability and validity), and thus are eminently usable as quantitative measures. These include the Social Support Questionnaire (Sarason, Levine, Basham, and Sarason, 1983), the Multidimensional Scale of Perceived Social Support (Canty-Mitchell and Zimet, 2000), the Social Provisions Scale (Cutrona and Russell, 1987) and Perceived Social Support from Family and Friends (Procidano and Heller, 1983).

Equally, there are many psychometrically sound functional measures, for example, the Interpersonal Support Evaluation List (Cohen, Mermelstein, Kamarck, and Hoberman, 1985), Social Support-B (Vaux, Reidel, and Stewart, 1987), the Support Functions Scale (Dunst and Trivette, 1990) and the Social Support Inventory (McCubbin, Patterson, Rossman, and Cooke, 1982). However, to reiterate the study rationale for developing a new social support measure, what sets the ADF SSS apart from the bespoke instruments is the inclusion of ADF specific items for the perceived general functional support categories (i.e. emotional, informational, social companionship and instrumental support) and, most pertinently, the addition of two ADF related perceived functional dimensions, namely support for coping (for example, awareness of alternatives; and non-judgemental approach) and attitudes and actions towards the problem substance using relative.

Chapter 4: Pilot Study: Method and Findings

4.1 Aims and Objectives

The pilot study undertaken by the author had the following aims:

- To explore the views of researchers and practitioners on measuring the salient aspects of social support for the family members of problem drug and/or alcohol users.

- To analyse qualitative data from family members in a rigorous and systematic manner to design an initial version of the social support measure.

- To pilot the Alcohol, Drugs and the Family Social Support Scale (ADF SSS) and refine its contents in the light of qualitative and quantitative information from family members, practitioners and researchers.

The objective of the pilot study was to design an applicable test version of the ADF SSS suitable for administration in self-completion form to the family members of problem alcohol and/or drug users. Instrument development aspects involved testing the language and format of the measure, and piloting an initial version of the questionnaire in order to conduct a preliminary assessment of item performance.

4.2 Design

The pilot work employed a mixed methodological approach (Caracelli and Green, 1993). Qualitative and quantitative methods corroborated and complemented each other to establish the main determinants of social support specific to family members, thus, facilitating the production of a test version of the ADF SSS.

4.2.1 Qualitative Methodology

Assessing the content validity of the newly constructed ADF SSS was central to the design of the pilot study. Thus, family members, practitioners and the ADF R&DG provided feedback on the measure throughout the research process.

In the design phase, a focus group was held with the pre-eminent members of the ADF R&DG (see Section 4.5 Procedure, which also contains details of the ethical approval obtained for the pilot work). Focus group methodology involves engaging a medium quota of seven participants in an informal group discussion, focused on a particular topic or set of issues (Morgan, 1997; Wilkinson, 2008). The informal group discussion centres on a number of questions (the focus group schedule), and the researcher performs the task of moderating the group, posing the questions, facilitating the discussion, and encouraging participation and interaction (Wilkinson, 2008). The focus group technique inherently permits observation of group dynamics, and insights into the respondents' opinions (Mahoney, 1998).

A less structured method such as a focus group discussion enables the researcher to concentrate on issues which have salience for those being studied and, thus, allows different perspectives to be explored (Barbour, 2007). In comparison with individual interviews, focus groups are more naturalistic, in that

they typically include a range of communicative processes. The dynamic quality of group interaction, as participants discuss, appraise views, debate and disagree about key issues, is a striking feature of focus groups (Wilkinson, 2008). The focus group meeting provided clarification on the conceptual dimensions captured by the pilot ADF SSS, sampling and operationalisation strategy.

A second component of the qualitative methodology involved the transcripts of interview reports with family members of problem substance users. Refinements to the conceptual determinants identified in previous research (Toner, 2002), and the potential items for the social support measure were generated from the transcripts of two hundred interview reports of lengthy semi-structured interviews (i.e. includes some pre-determined questions asked in a manner which affords the interviewee the opportunity to expand and elaborate their replies) (Smith, 1995) conducted by the ADF R&DG, as part of both the Primary Health Care Project and World Health Organisation research, with family members in England, Mexico (those reports which were translated from Spanish to English) and Aborigine communities in Australia (these reports were also written in English).

From the extensive range of interviews, care was taken to theoretically sample and select a representative cross-section of reports, particularly in terms of demographic background, primary drug issue, and relationship between the family member and problem substance user (Strauss and Corbin, 1998). The interview and transcribed verbatim focus group data were augmented and triangulated with a thorough review of both general and ADF related social support literature, including appraising existing social support interview schedules and questionnaires.

Thematic analysis was utilised to analyse the range of qualitative data sources. This qualitative interpretive process, which enabled methodical systematisation of data, involved the following stages:

- Data immersion, listening to audiotapes, transcribing data (if necessary), reading and re-reading transcripts, noting initial ideas and identifying patterns or themes to form a coding framework;

- Analysing the data using the coding framework (i.e. themes identified by the researcher from the transcript), adding new themes as they are identified, elaborating and linking related dimensions into subthemes, all instances in the text where these themes occur are coded;

- An over-arching list of themes or thematic map is developed, in which data within themes cohere and integrate meaningfully, and there are identifiable distinctions between the themes. Include extracts of text in your report which capture the essence of the salient themes identified (Boyatzis, 1998; Braun and Clarke, 2006).

This analysis was completed using the computer assisted qualitative data analysis software package QSR NVivo version 2.0.

This work produced a pool of 90 items related to ADF related social support. The ADF R&DG provided qualitative interpretive comments, mainly via email, to help reduce the initial pool of 90 items to 75 (see Section 4.4.1, for details). During the piloting phase, the 75-item pilot version of the ADF SSS, received qualitative feedback from ten family members and three practitioners who were in close liaison with the researcher throughout the pilot study (see Section 4.6).

4.2.2 Quantitative Methodology

Nine questionnaires and feedback sheets were subjected to descriptive quantitative analysis. The resultant information, along with the qualitative data outlined in the foregoing paragraph, was utilised to refine the 75-item pilot version of the ADF SSS to a 58-item test version (see Section 4.6). The

Statistical Package for the Social Sciences (SPSS) was used to analyse the quantitative data (which were treated as ordinal).

4.3 Sample

Three distinct groups of participants were purposively sampled. They included:

- Ten family members were recruited to complete and provide detailed qualitative comments on the pilot version of the ADF SSS. Four family members attending the Cardiff Alcohol and Drug Team (CADT), three attending the (Wigan) Alcohol and Drugs Advisory Service (ADS), two from the (Bristol) Addiction Recovery Agency (ARA) and a research colleague who is also a family member.

Socio-demographic information was not supplied for one of the family members. However, the nine family members accounted for, had the characteristics detailed in Table 4.1. It is striking that the sample was predominantly female, white and well educated.

	Frequency	**Percentage**
Sex		
Male	**1**	**11.1%**
Female	**8**	**88.9%**
Age		
25-35	**4**	**44.4%**
36-49	**2**	**22.2%**
50-64	**3**	**33.3%**
Ethnic Origin		
White	**9**	**100%**

Activity		
Employed	**5**	**55.6%**
Housework	**1**	**11.1%**
Student	**1**	**11.1%**
Unemployed	**2**	**22.2%**
Higher Education		
Yes	**6**	**66.7%**
No	**3**	**33.3%**
Family Member		
Husband	**1**	**11.1%**
Wife	**5**	**55.6%**
Daughter	**2**	**22.2%**
Mother	**1**	**11.1%**
Relative		
Husband	**5**	**55.6%**
Father	**1**	**11.1%**
Wife	**1**	**11.1%**
Daughter	**1**	**11.1%**
Mother	**1**	**11.1%**
Recently Residing with Family Member		
Yes	**7**	**77.8%**
No	**2**	**22.2%**

Table 4.1: Socio-demographic characteristics of participating family members.

- Three service lead practitioners, one from Cardiff Alcohol and Drug Team, Alcohol and Drugs Advisory Service and Addiction Recovery Agency respectively, identified and coordinated the recruitment of family members (see Section 4.5). These practitioners also provided qualitative feedback on the workability of the pilot measure (see Section 4.6). In analysing questionnaire responses, no comparisons were made between different geographical regions or intervention orientations.

- The four principal members of ADF R&DG who provided expert feedback and scrutinised the design and development of the pilot ADF SSS (see Section 3.2 for descriptive information on the group members, and Section 4.5 for their involvement in the pilot work).

4.4 Materials

Practitioners were provided with information and consent forms (see Appendix I and II) and family members received information, consent and brief instruction sheets (see Appendix III, IV and V). Informed consent was assumed for family members by completion of the pilot ADF SSS and feedback sheet. Pens and pre-paid envelopes were supplied to aid this process.

4.4.1 Pilot ADF SSS Scale

Thematic analysis performed on the qualitative data sources outlined in Section 4.2.1 resulted in a thematic map which detailed the most essential constituents of ADF specific social support, guided by the SSCS theoretical approach and verbatim accounts from family members. Inductive, deductive and retroductive approaches were applied to thematically analyse the qualitative dataset to produce a map which provided information on how the salient perceived functional support dimensions (i.e. emotional, informational and instrumental support, social companionship, support for coping and attitudes and actions towards the using relative; see Section 2.3.3iv for an in-depth exploration), consisted of further sub-dimensions, how the essence of these facets were captured by direct quotes from family members, and how the wealth of support examples provided by family members in their own words, with refinement,

served as potential questionnaire items (for branch diagrams of the social support dimensions: emotional, informational and instrumental support, social companionship, support for coping and attitudes and actions towards the using relative; see Appendix VI).

Items were systematically written to ensure comprehensive coverage of all the 'branches' or relevant areas were included. In framing items, great precision was used in adopting appropriate and clear language, coverage (i.e. ADF specific, but also taking account of salient general social support issues), grammatical consistency and singleness of purpose. Thus, double negatives, repetitions, multifarious, complex, ambiguous or leading statements and technical terms were avoided.

Initially, a large pool of 90 potential items were posited to represent (with a provisional list of the most appropriate items) the various sub-dimensions and consequently the main perceived functional support dimensions. However, on the basis of ADF R&DG discussions, the potential item pool was reduced, through clarifying representative exclusive sub-dimensions for each functional support facet, ensuring that duplicate items were omitted, and item phraseology which included ensuring that each item referred to a single event and that the wording was clear and appropriate for a self-completion measure, to 75 (see Appendix VII for the ADF SSS prototype items which were removed). Concurrently, through successive iterations of the prototype ADF SSS, the potential questions and response categories were modified and formalised, to produce the most salient closed-ended response questions and options.

The 75-item self-completion pilot questionnaire (see Appendix VIII) was designed to assess the extent and quality of family members' social support. Devised for concerned and affected others over the age of sixteen responding to the excessive alcohol and/or drug use of a close relation, the measure commenced with clear explanatory instructions, including definitions and examples where required throughout, on completing the pilot ADF SSS.

The exclusive response categories were presented in a four-point Likert partition (tick box) scale relating to the last three months (recent time-frame comparable with other ADF standardised quantitative measures). Consistent with the theoretical exploration of salient ADF specific social support facets outlined in Chapters 1 and 2, they examined the Frequency (A questions), Ideal (D questions) (response categories labelled: Never, Once or Twice, Sometimes, Often), Importance (B questions) (N/A, Not Important, Important, Very Important) and Satisfaction (C questions) (N/A, Dissatisfied, Neither Satisfied Nor Dissatisfied, Satisfied) aspects of 75 perceived support items tapping into the six perceived functional support dimensions mentioned previously in this section.

In the pilot version of the measure, different support sources were captured by the items (for example, health and/or social care professionals, employer and faith community). Key phrases within the items were emphasised using bold type. The item order was determined using a random number table, so that subsequent item influence or bias was reduced. Target completion time was 20-30 minutes. Socio-demographic information was collected by means of a question sheet appended to the pilot ADF SSS (see Appendix IX). Question content and wording was determined by salient information collated during previous ADF R&DG research.

4.4.2 Feedback sheet

A feedback sheet (the format was modified from previous ADF R&DG research evaluating a self-help manual, see Appendix X) with both quantitative (three-point option scale) and open-ended qualitative components posited specific questions (for instance, questionnaire interpretation and relevance) relating to the process of completing the prototype questionnaire. Additionally, more general questions regarding the format, content, burden and flow of the pilot

ADF SSS were included. The information gleaned by the feedback sheets complemented the completed pilot measures to aid refinement of the ADF SSS.

4.5 Procedure

The pilot study was undertaken from October 2002 until September 2004. A running reflexive diary was kept which elucidated the key processes involved throughout this time period. Before commencement of the pilot work, ethical approval from both the South West Local Research Ethics Committee (SWLREC) and the AWP NHS Trust Clinical Governance Committee was sought and gained (see Appendix XI and XII for letters of approval). Research sponsorship, indemnification cover and data protection notification was provided by the University of Bath, and a licence to practice was granted from the AWP NHS Trust. The SWLREC and AWP NHS Trust applications included a detailed research protocol, and the materials utilised for the project (see Section 4.4).

Confidentiality procedures ensured that no identifying personal information would be collected and that a securely kept anonymised coding system, which only the author as the principal investigator had access to, was used to determine the agency source and response rate. Tapes and transcripts were kept in separate locked drawers. Inclusion criteria for family members included that they were over 16 years old, functionally literate in the English language and not impaired in a way which would prohibit completing questionnaires, such as visual problems, infirmity, severe dyslexia and cognitive difficulties. Family members who had current serious substance use or mental health problems themselves were excluded from participating for two main reasons. It would be difficult to separate the responses given, due to their own use of substances, and it was important to avoid further burdening them by having to complete the questionnaire. Also it was important that participating family members were not currently experiencing a crisis situation.

The literature and measure review material mentioned in Section 4.2.1 was generated through searching electronic databases and indexes such as ISI Web of Science, PsycInfo, Medline and Dissertation Abstracts, covering a period from the mid 1970s until present. Only publications and instruments which were available in the English language were included. Questionnaires which were not published in their full length were obtained from the responsible authors. Thematic analysis of this review material, including family member interview reports from previous ADF R&DG research, occurred both before and after the ADF R&DG focus group (see Section 4.2.1 for further description).

Fieldwork began with a focus group with the four pre-eminent members of the ADF R&DG on Thursday the 5th of December 2002 from 3:15 to 4:30pm at the Mental Health Research and Development Unit. The meeting room was relatively comfortable and quiet with participants' seated around an adequately sized table with refreshments available. An omnidirectional, flat microphone was placed at the centre of the table to record the proceedings. The focus group was semi-structured in nature and generally followed a question schedule (see Appendix XIII). Notes were taken by the moderator on any events which were not captured on the audiotape, such as interactions and body language. The rationale for the focus group meeting and subsequent ADF R&DG involvement during pilot ADF SSS design and development is detailed in Section 4.2.1.

Initially, as a result of the preliminary focus group discussion with the ADF R&DG, the author attempted to design a scenario type measure. Vignettes composed from the support examples supplied by family members were used to form the basis of this instrument to capture the essence of ADF related social support. When the prototype scenarios were produced it was apparent that each contained numerous facets of structural and perceived functional support sub-dimensions. Therefore, it was unclear what the question sequence was referring to, and thus potential responses were confounded.

Also, due to the extent of ADF specific perceived functional constructs, dimensions and sub-dimensions required to be incorporated into the pilot measure, the instrument was much too unwieldy. Furthermore, the vignette measure would have been unable to be utilised alongside other standardised self-completion ADF quantitative questionnaires, as instructions for family members elucidating responses, and practitioner training in administration and scoring were necessary. From a methodological standpoint, there were issues in demonstrating adequate reliability and validity which did not arise when adopting a traditional item based approach.

Significant time and resource were spent on designing and developing a scenario type measure (including exploring the decision-making, risky behaviour and the therapeutic literature for examples of similar questionnaire formats). However, thematically analysing family member interview reports was directly transferable to item development of a more conventional item based measure (see Sections 4.2.1 and 4.4.1, for a detailed exploration of the process of designing and developing the pilot ADF SSS). Successive questionnaire drafts were dated and numbered and, to ensure the prototype ADF SSS was ready for piloting, the measure was proof read and completed by members of the ADF R&DG and Mental Health Research and Development Unit research teams. This was a salutary experience with deletions, additions and improvements incorporated.

Three specialist family focused alcohol and drug agencies (both statutory and non-statutory; CADT, ADS and ARA) formed a convenience purposive sample. Services were selected on the basis of previous co-operative ADF R&DG research collaborations, and managers were identified as the main contacts. Letters (Appendix XIV) explaining the rationale and requirements of the pilot study were sent out to service managers on Monday the 12th of April 2004. This correspondence was followed by a detailed telephone conversation (see Appendix XV for script) and, for two of the managers, a subsequent meeting at the New Directions in the Study of Alcohol Group conference in London (CDAT and ADS) and, in the case of ARA, a meeting at the service in Bristol.

All three agencies approached agreed to participate in the pilot study, and on Monday the 3rd of May 2004 a research pack was sent out to each service manager, including a covering letter (see Appendix XVI), information and consent forms for staff, information, consent and instruction sheets for family members, six pilot questionnaires (three copies of each version: font size 8, 13 pages; and font size 10, 17 pages), feedback sheets, pens and freepost addressed envelopes.

The three participating lead practitioners (one from each service, briefed by the principal researcher) were instructed that it was preferable for the family members (selected as appropriate recruits from the practitioners' current caseload) to read the information and instruction sheets and complete the distributed pilot ADF SSS and feedback form, either supervised or unsupervised, within the agency. However, if the family member agreed to participate but wished to complete the instruments outside the service context, this was permissible as long as the family member agreed not to consult others when responding to the measures. Wherever the pilot material was completed, the family member had to return the disseminated forms to the agency staff who were responsible for sending them in the pre-paid envelopes to the researcher.

As well as recruiting family members, practitioners also provided qualitative comments, through close liaison with the researcher (no more than three weeks between telephone contacts), on how the pilot measure was performing in practice, its utility and any suggested improvements. The pilot data collection phase occurred from May until mid August 2004. The data were then entered, and/or transcribed and checked on appropriate software programmes before analytical techniques were employed (see Sections 4.2.1 and 4.2.2 for specific details).

4.6 Findings

The preliminary data collection for the piloting phase contained qualitative information from the ADF R&DG, practitioners and family members. Quantitative data were also gathered from family members. In the agency context, eighteen pilot questionnaires were distributed to services and nine measures returned, thus representing a response rate of fifty percent. However, two of the nine returned instruments were only partially complete. The only discernable difference from socio-demographic information available was that the non-completion occurred for the only known male participant who had a problem substance using wife. One pilot ADF SSS was distributed to a research colleague who had experience of being a family member and who provided annotated qualitative comments on each questionnaire item. NVivo and SPSS software packages were used to analyse the qualitative and quantitative pilot data respectively.

4.6.1 Pilot Questionnaire Item Analysis

Pilot study data were analysed with the purpose of modifying and refining the ADF SSS. Each individual questionnaire item was examined in a systematic fashion, triangulating both the quantitative and qualitative feedback from family members. The scores of each item were analysed and items discarded if they performed badly. Reasons for item removal included: poor completion rate, indicators such as omitted, erroneous, incomplete, inappropriate, inconsistent, N/A responses, poor distribution of item scores and item repetitions.

Table 4.2 details the specific reason(s) for item rejection. Also incorporated into the process of questionnaire modification and refinement was improving the phrasing of items which caused respondents difficulties without altering the item meaning. Item frequency distributions were determined by modal item score for

the nine participants. In cases where there was item duplication, the item with the most response variance was selected. However, when similar distributions were derived, the best phrased item, based on qualitative information, was retained.

Item Number	Action	Quantitative	Qualitative
Q2	Removed	Repetition with Q16, modal distribution comparable (Q2 Once or Twice, Important, Satisfied, Sometimes; Q16 Sometimes, Important, Satisfied, Sometimes). Q2d missing for 1 respondent.	Item phrasing for Q16 much simpler and clearer.
Q5	Reworded	2 respondents failed to complete the item. However, those were from the 2 partially completed pilot ADF SSSs.	Family member annotated that they have split up due to their relatives' drinking, so this isn't a relevant question.
Q6	Removed	Repetition with Q1, modal distribution comparable (Q1 Sometimes, Very Important, Satisfied, Often; Q6 Sometimes, Important, Satisfied, Often). 1 respondent completed the response sequence incorrectly.	Q1 more straightforward.
Q7	Removed	Lack of modal distribution (Never, N/A, N/A, Never). 2 participants completed the response sequence incorrectly.	Difficult to understand item.
Q8	Reworded	Item missing for 1 respondent and Q8d missing for another. 2 participants completed the response sequence incorrectly.	

Q9	Reworded	1 participant completed the response sequence incorrectly.	
Q10	Reworded		Item tense phrasing required changing.
Q11	Reworded	1 participant completed the response sequence incorrectly.	
Q15	Removed	Repetition with Q18, modal distribution comparable (Q15 Never, N/A, N/A, Sometimes; Q18 Never, N/A, N/A, Sometimes).	Q18 more straightforward.
Q21	Reworded	1 participant completed the response sequence incorrectly.	
Q24	Removed	Repetition with Q51, modal distribution comparable (Q24 Never, N/A, N/A, Sometimes; Q51 Never, N/A, N/A, Once or Twice).	
Q25	Reworded	1 participant completed the response sequence incorrectly.	
Q29	Reworded	Q2d missing for 1 respondent and completed N/A for another.	Item phrasing required to be made simpler and clearer.
Q30	Removed	Repetition with Q39, modal distribution comparable (Q30 Never, N/A, Neither, Sometimes; Q39 Never, N/A, N/A, Sometimes).	Item phrasing complex.
Q31	Removed	Ambiguously phrased item the modal distribution reflects this (Never, Important, Dissatisfied, Often). 1 participant completed the response sequence incorrectly.	Phrasing too general in relation to the other informational items.
Q32	Reworded	1 participant completed the response sequence incorrectly.	

Q33	Removed	Lack of modal distribution (Never, N/A, N/A, Never). 1 participant completed the response sequence incorrectly.	Phrasing too specific in relation to the other instrumental items.
Q35	Reworded	1 participant completed the response sequence incorrectly.	Not relevant if the relative is not living at the family members' home.
Q37	Removed	Lack of modal distribution (Never, N/A, N/A, Never). Q37d missing for 1 respondent. 1 participant completed the response sequence incorrectly.	Phrasing too general in relation to the other social companionship items.
Q40	Reworded	Q40d missing for 1 respondent. 1 participant completed the response sequence incorrectly.	
Q41	Reworded	1 participant completed the response sequence incorrectly.	
Q42	Reworded	1 participant completed the response sequence incorrectly.	
Q43	Reworded	1 participant completed the response sequence incorrectly.	
Q44	Removed	Lack of modal distribution (Never, N/A, N/A, Never). Q44 missing for 1 respondent. 1 participant completed the response sequence incorrectly.	Family member annotated that they didn't know.
Q45	Removed	Repetition with Q32, less variance in modal distribution (Q45 Once or Twice, Important, Dissatisfied, Never; Q32 Often, Not Important, Dissatisfied, Never). 1 participant completed the response sequence incorrectly.	Q32 more straightforward.
Q46	Reworded	1 participant completed the response sequence incorrectly.	

Q49	Reworded	2 participants completed the response sequence incorrectly.	Item phrasing required to be made more specific.
Q50	Reworded	1 participant completed the response sequence incorrectly.	
Q55	Removed	Lack of modal distribution (Never, N/A, N/A, Once or Twice).	Q20 more straightforward.
Q62	Removed	Repetition with Q67, modal distribution comparable (Q62 Sometimes, Important, Satisfied, Often; Q67 Often, Very Important, Satisfied, Often).	
Q63	Removed	Repetition with Q74, modal distribution comparable (Q63 Sometimes, Important, Dissatisfied, Once or Twice; Q74 Often, Important, Dissatisfied, Never).	
Q64	Removed	Repetition with Q73, less variance in modal distribution (Q64 Never, N/A, N/A, Once or Twice; Q73 Once or Twice, Important, Satisfied, Once or Twice).	Phrasing too specific in relation to the other instrumental items.
Q68	Removed	Lack of modal distribution (Never, N/A, Dissatisfied, Never). 3 participants completed the response sequence incorrectly.	Badly phrased item, with a double negative used.
Q71	Removed	Repetition with Q35, modal distribution comparable (Q71 Never, N/A, N/A, Never; Q35 Once or Twice, N/A, N/A, Never).	Family member annotated that the relative has moved out.
Q73	Reworded	1 participant completed the response sequence incorrectly.	

Table 4.2: Information on questionnaire item reduction and refinement. Items not included in the table were retained unchanged.

4.6.2 Pilot Questionnaire Feedback

Interpreting both qualitative and quantitative information about the clarity, usability and applicability of the pilot ADF SSS in general, also formed part of the modification process. Family members gave scores and comments retrospectively via a feedback sheet (see Section 4.4.2) on the content and experience of completing the pilot ADF SSS. This information is detailed in Table 4.3.

	Scores	Comments
Layout	3 FMs* – Pleased	"It was easy with the boxes." "It was easy to complete." "Tick boxes are helpful, but can feel at times to be ambiguous in answering, when choosing certain boxes." "It was easy to complete."
	3 FMs – Mixed	"The layout was fine, but too many questions."
	1 FM – Unhappy	"A lot of questions."

Style	2 FMs – Pleased	"Tick boxes are best, I really did not have to think too hard, as my mental energy is elsewhere, alongside emotional / physical energy to keep going." "Easy to understand."
	2 FMs – Mixed	"Fairly straightforward."
	3 FMs – Unhappy	"More spacing would be helpful and easier on the eye."
Length	2 FMs – Pleased	"Only if you get the results that are needed to help substance misusers / families etc."
	1 FM – Mixed	"In some of the questions, I found that the same thing was being asked, but just in another way."
	4 FMs - Unhappy	"A lot of questions seemed the same." "Over long." "Very over long."
Time Taken	3 FMs – Pleased	"Not as long as one thought, 40 minutes." "Not long at all." "About 30 minutes. I trusted my instincts and ticked the box that was the most relevant, instead of thinking too much about the answers."
	2 FMs – Mixed	"20 minutes, however, I started to lose interest and had to think and become focused."
	2 FMs – Unhappy	"Did not finish, too hard."

Font Size		
Font 8	2 FMs – Pleased	"Just right."
	1 FM – Unhappy	
Font 10	2 FMs – Pleased	"Legible, good idea to do in 'bold'." "OK."
	1 FM – Mixed	"OK for most people, but could be too small of a font for people with eyesight problems."
	1 FM – Unhappy	"This could be enlarged for easy reading."
Level of Detail	1 FM – Pleased	"Just right."
	5 FMs – Mixed	"Very detailed." "Questions need to be included regarding the amount of help from other members of family / health / social care personnel." "I did have to think about what is going on."
	1 FM – Unhappy	"As is usual, you asked me to look at me, does not go down well with feelings of inadequacy, isolation etc."

Words Used	2 FMs – Pleased	
	4 FMs – Mixed	"At times felt confusing, one has to remember that the family members can be upset, fragile and feel the words can 'trip' us up sometimes. " "Some of the wording could be made simpler." "Some questions were more straightforward to answer than others." "Okay."
	1 FM – Unhappy	"Hard to relate D questions to D answers."
Understanding	1 FM – Pleased	"It was fine."
	3 FMs – Mixed	"Again, sometimes shorter questions can be most to the point." "It was fairly easy to cope with." "Easy to understand when in a calm state, but if nervous would be too much to take in."
	3 FMs – Unhappy	"Some hard questions." "Very long, not able to understand what I was to respond to, in some of them."

Relevance	3 FMs – Pleased	"I felt it very relevant to my daughter who has been shunted from pillar to post by health professionals who for whatever reason have not helped her. She would have been better off blind / deaf / dumb - a caring profession - sorry, wrong again!!!" "Some of the questions were more appropriate than others. The D sections were difficult to answer at times."
	4 FMs – Mixed	"I found it to be fairly relevant, but the majority of help I received came directly from other close family members and not from outsiders." "Some of the questions were irrelevant in my actual position because he does not live with me anymore, and at the moment, I am still very angry towards him with regards to what he has put me and my family through. So maybe in a few months time my answers would be different."

*FM = Family member.

Table 4.3: Family member feedback sheet scores and comments.

Professionals also provided qualitative feedback on the utility of the pilot ADF SSS and whether it was capturing the complexities of social support for family members. The three service lead practitioners who coordinated distribution of the pilot questionnaires to family members liaised closely with the principal researcher throughout the piloting phase. The practitioners' perspective on measure triangulated much of the qualitative information provided by family members, including that the pilot ADF SSS should be relatively succinct with clear and concise wording to be most appropriate for a practice setting, and the measure contained areas of overlap where items with similar meanings but different phrasing were used.

The professionals also provided insight into why there was missing data for particular family members. One respondent felt the measure was not relevant to her or his needs because it asked questions about her or him and not their relative who required help. Another respondent got quite agitated by the length of the process of completing the questionnaire, and five items were missed by a respondent due to two pages being stuck together on the measure. One practitioner felt that, although the D (Ideal) questions for each item were proving problematic for family members to understand, there were arguments for inclusion on therapeutic grounds, especially looking at goal setting for service users. Suggestions for other inclusions or improvements were all considered and integrated into the test version of the ADF SSS. However, those pertaining to over involvement with the using relative were not featured, as the author was clear that, theoretically, this facet was captured under the coping domain.

The various data sources explored were collated to enable the production of a 58-item test version of the ADF SSS (see Section 5.5.1) which was subjected, in the main study, to a much wider and more in-depth mixed method analysis.

Chapter 5: Main Study: Method

5.1 Aims and Objectives

Overall, this programme of work aimed to construct and develop a psychometrically robust and valid self-completion social support measure applicable to family members of problem alcohol and/or drug users. It is envisaged that the ADF SSS developed will be implemented as an effective social support assessment instrument for research (to sit alongside the other ADF specific self-completion questionnaires), practice and self-help interventions with family members, and thus be amenable to further empirical and psychometric examination.

To achieve this overall aim an evolving research process was undertaken to operationalise the concept of social support specific to the family members. From a theoretical standpoint, social support is a key component of the SSCS model (Orford *et al*., 2005a), which is not assessed quantitatively. The ADF R&DG have effectively utilised quantitative measures to complement and corroborate qualitative data in the other important areas of the model.

The study had the following key objectives:

- To develop a self-completion ADF SSS, and assess the reliability, validity and psychometric properties of the measure.

- To ascertain the views of family members, researchers and practitioners on measuring the salient aspects of social support.

- To establish whether the ADF SSS adequately captures how family members experience social support by adopting a mixed methodology approach.

- To explore social support in a systematic manner to inform and assess theoretical constructs and therapeutic interventions (see Chapter 8) specific to the family members of problem substance users.

5.2 Research Questions

The main study addressed two overarching research questions:

1) Is the ADF SSS reliable and valid?

2) Is the ADF SSS applicable (i.e. comprehensible, clear, relevant and user-friendly) to family members?

5.3 Design

5.3.1 Mixed Methodology

Consistent with pilot work (see Section 4.2), the main study also utilised a mixed methodological approach (Caracelli and Greene, 1993). Both quantitative and qualitative elements were required to address the research questions outlined in Section 5.2. A mixed methodological approach enabled the findings from each method to be complemented (triangulation) and corroborated, strengthening the analytic power of the research outcomes. Thus, both psychometric and experiential information enabled the complex concept of social support to be explored from different vantage points, and hence, provided deeper insights to facilitate the development of a reliable and valid ADF SSS.

5.3.2 Quantitative Methodology

5.3.2i Reliability

Kline (1993) states that the minimum sample required to conduct a test of internal reliability is one hundred participants. A Principal Components Analysis (PCA) was considered appropriate as the main study sample size of one hundred and thirty two respondents was larger than this minimum.

A principal components exploratory factor analysis, with varimax rotation and kaiser normalisation, was used to determine the factor structure of the test ADF SSS. Both parallel analysis (Lattin, Carrol, and Green, 2003) and oblique rotation techniques were also applied to strengthen the validity of the factor structure derived from the principal components with varimax rotation procedure. The resultant factor scales were labelled in accordance with the data output and the theoretical conceptualisation of social support within the SSCS model, and the author's analysis outlined in Chapters 1 and 2.

An item analysis was conducted on the test ADF SSS to eliminate weak loading questionnaire items. Cronbach's alpha reliability coefficients were calculated to test the internal reliability of the ADF SSS and composite subscales, derived from the principal components analysis. Item-to-total correlations and ADF SSS total scale scores were explored to assess the internal consistency of the measure.

The Cohen Kappa equation (Cohen, 1960) of sequential analysis was performed on over ten percent of the overall sample who completed the ADF SSS twice. Correlation coefficients were examined to establish the test-retest reliability of the measure.

5.3.2ii Validity

The Significant Others Scale (SOS)B (see Section 5.5.2 and Appendix XVII) (Power, Champion, and Aris, 1988) was administered to a twenty percent subset of family members to assess the construct validity of the ADF SSS. The correlation coefficients, means, standard deviations and distribution of scores were calculated.

5.3.2iii Statistical Tests

The quantitative data from the completed questionnaires were treated as ordinal. Missing data were accounted for by using mean item substitution on items. However, items with over fifteen percent of missing responses were discarded. Frequencies and distributions were calculated to explore the relationship between socio-demographic characteristics and ADF SSS scores. Pearson product-moment correlation coefficient (*r*) was used to calculate the correlation between family members' self-reported extent and quality of social support and ADF SSS subscale and total scores. The statistical tests outlined were conducted with the aid of SPSS.

5.3.3 Qualitative Methodology

Assessing the content (argumentative) validity of the ADF SSS was central to the main study design. Family members, practitioners and the ADF R&DG provided their perspectives on the content and process of completing the measure throughout the testing phase, ensuring that the ADF SSS remained applicable.

A thematic approach (see Section 4.2.1) was utilised to analyse qualitative interpretative (cognitive interview) comments from one hundred and ten family members about the content, relevance and user-friendliness of the ADF SSS. Furthermore, the family members' perspectives were obtained on what the ADF SSS items are measuring, and whether the questionnaire captures their salient social support issues. The views of fifty practitioners on how the self-completion measure performed within the agency were also sought and analysed.

The ADF R&DG assessed whether the ADF SSS adequately operalisationalised (in terms of reliability, validity and applicability) the concept of social support for family members. All the qualitative data analysis was completed using the computer assisted software QSR NVivo version 2.0.

5.4 Sample

Three distinct groups of participants were purposively sampled for the main study:

- The family members of problem alcohol and/or drug users.

One hundred and thirty two family members who displayed a diverse spectrum of relationships to the relative, but were predominately white, female, middle-aged and well educated, completed the test version of the ADF SSS from the four hundred and sixty five measures circulated (a twenty eight percent completion rate). Table 5.1 outlines the socio-demographic details of the family member total sample.

	Frequency	Percentage
Sex		
Male	**25**	**19.8%**
Female	**101**	**80.2%**
Missing	6	
Age		
16-24	**3**	**2.3%**
25-35	**19**	**14.7%**
36-49	**40**	**31%**
50-64	**55**	**42.6%**
65+	**12**	**9.3%**
Missing	3	
Ethnic Origin		
White	**125**	**97.7%**
Chinese	**1**	**0.8%**
Hispanic	**1**	**0.8%**
Other: not stated	**1**	**0.8%**
Missing	4	
Activity		
Employed	**67**	**51.9%**
Volunteer	**4**	**3.1%**
Housework	**21**	**16.3%**
Student	**7**	**5.4%**
Retired	**22**	**17.1%**
Unable to work	**3**	**2.3%**
Seeking work	**4**	**3.1%**
Unemployed	**1**	**0.8%**
Missing	3	

Higher Education		
Yes	**78**	**61.9%**
No	**48**	**38.1%**
Missing	6	
Family Member		
Husband	**7**	**5.6%**
Wife	**36**	**28.6%**
Partner male	**5**	**4%**
Partner female	**5**	**4%**
Son	**3**	**2.4%**
Daughter	**11**	**8.7%**
Father	**8**	**6.3%**
Mother	**39**	**31%**
Brother	**1**	**0.8%**
Sister	**5**	**4%**
Wife and Mother	**1**	**0.8%**
Wife, Mother and Sister	**1**	**0.8%**
Mother and Sister	**1**	**0.8%**
Grand-daughter	**1**	**0.8%**
Aunt	**1**	**0.8%**
Friend male	**1**	**0.8%**
Missing	6	

Relative		
Husband	**37**	**28.7%**
Wife	**7**	**5.4%**
Partner male	**5**	**3.9%**
Partner female	**5**	**3.9%**
Son	**31**	**24%**
Daughter	**14**	**10.9%**
Father	**5**	**3.9%**
Mother	**9**	**7%**
Brother	**4**	**3.1%**
Sister	**1**	**0.8%**
Husband and Son	**1**	**0.8%**
Son and Brother	**1**	**0.8%**
Husband, Son and Brother	**1**	**0.8%**
Son, Daughter, Brother and Sister	**1**	**0.8%**
Son and Daughter	**2**	**1.6%**
Brother and Sister	**1**	**0.8%**
Grand-father	**1**	**0.8%**
Niece	**1**	**0.8%**
Friend male	**1**	**0.8%**
Friend female	**1**	**0.8%**
Missing	3	
Recently Residing with Family Member		
Yes	**80**	**63%**
No	**47**	**37%**
Missing	5	

Table 5.1: Socio-demographic information on the total family member sample.

There were two further subsamples derived from the total family member sample. Eighteen family members were administered the test-retest version of the ADF SSS.

	Frequency	Percentage
Sex		
Male	**3**	**17.6%**
Female	**14**	**82.4%**
Missing	1	
Age		
25-35	**5**	**29.4%**
36-49	**4**	**23.5%**
50-64	**7**	**41.2%**
65+	**1**	**5.9%**
Missing	1	
Ethnic Origin		
White	**16**	**94.1%**
Hispanic	**1**	**5.9%**
Missing	1	
Activity		
Employed	**9**	**52.9%**
Housework	**2**	**11.8%**
Student	**1**	**5.9%**
Retired	**4**	**23.5%**
Unemployed	**1**	**5.9%**
Missing	1	
Higher Education		
Yes	**10**	**58.8%**
No	**7**	**41.2%**
Missing	1	

Family Member		
Wife	**3**	**17.6%**
Partner female	**1**	**5.9%**
Son	**2**	**11.8%**
Daughter	**2**	**11.8%**
Father	**1**	**5.9%**
Mother	**5**	**29.4%**
Sister	**1**	**5.9%**
Mother and Sister	**1**	**5.9%**
Grand-daughter	**1**	**5.9%**
Missing	1	
Relative		
Husband	**3**	**17.6%**
Partner male	**1**	**5.9%**
Son	**4**	**23.5%**
Daughter	**1**	**5.9%**
Father	**1**	**5.9%**
Mother	**3**	**17.6%**
Sister	**1**	**5.9%**
Son and Brother	**1**	**5.9%**
Son and Daughter	**1**	**5.9%**
Grand-father	**1**	**5.9%**
Missing	1	
Recently Residing with Family Member		
Yes	**5**	**29.4%**
No	**12**	**70.6%**
Missing	1	

Table 5.2: Socio-demographic characteristics of the test-retest subsample.

Also twenty nine family members completed the SOS(B) from the eighty distributed (a thirty six percent completion rate).

	Frequency	Percentage
Sex		
Male	**8**	**27.6%**
Female	**21**	**72.4%**
Age		
16-24	**1**	**3.4%**
25-35	**5**	**17.2%**
36-49	**10**	**34.5%**
50-64	**11**	**37.9%**
65+	**2**	**6.9%**
Ethnic Origin		
White	**27**	**96.4%**
Hispanic	**1**	**3.6%**
Missing	1	
Activity		
Employed	**17**	**58.6%**
Volunteer	**1**	**3.4%**
Housework	**3**	**10.3%**
Student	**2**	**6.9%**
Retired	**4**	**13.8%**
Seeking work	**1**	**3.4%**
Unable to work	**1**	**3.4%**
Higher Education		
Yes	**21**	**72.4%**
No	**8**	**27.6%**

Family Member		
Husband	**2**	**6.9%**
Wife	**8**	**27.6%**
Partner male	**2**	**6.9%**
Partner female	**1**	**3.4%**
Son	**1**	**3.4%**
Daughter	**3**	**10.3%**
Father	**2**	**6.9%**
Mother	**7**	**24.1%**
Brother	**1**	**3.4%**
Wife, Mother and Sister	**1**	**3.4%**
Grand-daughter	**1**	**3.4%**
Relative		
Husband	**8**	**27.6%**
Wife	**2**	**6.9%**
Partner male	**2**	**6.9%**
Partner female	**1**	**3.4%**
Son	**4**	**13.8%**
Daughter	**5**	**17.2%**
Father	**1**	**3.4%**
Mother	**3**	**10.3%**
Brother	**1**	**3.4%**
Husband, Son and Brother	**1**	**3.4%**
Grand-father	**1**	**3.4%**
Recently Residing with Family Member		
Yes	**17**	**60.7%**
No	**11**	**39.3%**
Missing	1	

Table 5.3: Socio-demographic details of the SOS(B) subsample.

Table 5.4 provides summary modal information (i.e. the most commonly occurring value for each socio-demographic category) on how the two subsamples outlined reflect the total sample, in terms of socio-demographic characteristics. However, as mentioned previously the total sample had inherent biases with white, middle-aged and well educated females over represented.

	Modal Value
Sex	
Total sample	**Female**
Reliability sample	**Female**
SOS sample	**Female**
Age	
Total sample	**50-64**
Reliability sample	**50-64**
SOS sample	**50-64**
Ethnic Origin	
Total sample	**White**
Reliability sample	**White**
SOS sample	**White**
Activity	
Total sample	**Employed**
Reliability sample	**Employed**
SOS sample	**Employed**
Higher Education	
Total sample	**Yes**
Reliability sample	**Yes**
SOS sample	**Yes**
Family Member	
Total sample	**Mother**
Reliability sample	**Mother**
SOS sample	**Wife**

Relative	
Total sample	**Husband**
Reliability sample	**Son**
SOS sample	**Husband**
Recently Residing with Family Member	
Total sample	**Yes**
Reliability sample	**No**
SOS sample	**Yes**

Table 5.4: Comparative information on total sample and two subsamples.

In terms of qualitative work, one hundred and ten family members provided interpretative comments on the measure. A cognitive interviewing technique was utilised in which participants were asked to think aloud (which was noted down and/or tape recorded by the researcher) as they went through the items and response questions of the ADF SSS. This included how family members were interpreting the content, what they were thinking about whilst giving their responses, whether they experienced any difficulties with the measure, how the questionnaire could be made more salient to their social support needs and whether the family members felt supported by the process of completing the ADF SSS. Annotated notes written by family members on the questionnaires were also analysed qualitatively.

- Practitioners who work therapeutically with family members.

The total population of alcohol and drug agencies which provided a service for family members in England and Wales were approached (see Section 5.6) to participate in the study. The national provision of specialised family focused agencies was identified by Robinson and Hassall (2000) and augmented and updated by Williams (2004). AWP NHS Trust generic alcohol and drug agencies were also surveyed. Additional statutory and non-statutory alcohol and drug agencies and self-help groups were involved through contact via

conferences, colleagues and the Internet, as research details appeared on the Adfam, Alcohol Concern, National Association for Children of Alcoholics (NACOA) and Daily Dose websites. No comparisons were made between different intervention orientations or therapeutic models.

Overall, the agency survey frame contained forty services. The response rate from agencies agreeing to participate was ninety eight percent, with sixty eight percent of services returning completed questionnaires. The collaborating agencies who recruited family members are detailed in Table 5.5.

Agency Name	Completed Questionnaires					
	Total Sample		Reliability Sample		SOS Sample	
	No	%	No	%	No	%
ADF Conferences / Colleagues	16	12.1	3	16.7	3	10.3
Clouds Families Plus	11	8.3	0	0	10	34.5
Parent Support Link Hampshire	9	6.8	9	50	0	0
Aquarius	9	6.8	0	0	0	0
PATCHED Brighton	8	6	0	0	0	0
Cardiff Alcohol and Drug Team	7	5.3	0	0	5	17.2
Trafford Alcohol Service	7	5.3	0	0	4	13.8
Alcohol and Drugs Service	7	5.3	0	0	0	0
Isle of Man Alcohol Advisory Service	7	5.3	0	0	0	0
Spotlight Fareham	6	4.5	6	33.3	0	0
Solution Based Family Service	5	3.8	0	0	0	0
Alcohol and Drugs Advisory Service	4	3	0	0	2	6.9
Alcohol Problems Advisory Service	4	3	0	0	1	3.5
Barking Alcohol Advisory Centre	4	3	0	0	1	3.5
ARA / Bristol Alcohol Service	3	2.3	0	0	0	0
Bristol Specialist Drugs Service	3	2.3	0	0	0	0
CDAT Worthing	3	2.3	0	0	0	0
Gloucestershire DAS	3	2.3	0	0	0	0
Family and Friends	3	2.3	0	0	0	0
CASA Alcohol Services	2	1.5	0	0	2	6.9
Advisory Service on Alcohol	2	1.5	0	0	0	0
Carers in Hertfordshire	2	1.5	0	0	0	0
Family Alcohol Service	2	1.5	0	0	0	0
SPIN Sheffield	1	0.8	0	0	1	3.4
Children & Family ADS	1	0.8	0	0	0	0
NACOA	1	0.8	0	0	0	0
Knowle West Against Drugs	1	0.8	0	0	0	0
Parents For Prevention	1	0.8	0	0	0	0

Table 5.5: Agencies which recruited, and numbers of completed measures.

Forty five practitioners provided feedback on how the measure performed in reality, in the twenty seven agencies which returned questionnaires (see Appendix XVIII for further details on the participating services who provided information). There were interpretative comments given on the measure by a further five practitioners involved in the recruitment of family members for the qualitative aspect of the main study. Collaborating services were Cardiff Alcohol and Drug Team, (Bristol) Knowle West Against Drugs, Parent Support Link Hampshire, Spotlight Fareham, Clouds Families Plus residential course (Warminster) and the Emotional Rollercoaster conferences in Brighton organised by the Sussex Drug and Alcohol Action Teams.

- The ADF R&D Group.

The four pre-eminent members of the ADF R&DG (see Section 3.2 and 4.3) gave continual feedback on the development of the test version of the ADF SSS throughout the main study.

5.5 Materials

Information and consent forms were sent to practitioners (see Section 4.4 and Appendix I and II, dates were amended) and family members received information, consent and brief instruction sheets (see Appendix XIX, IV - date amended, and XX). Informed consent was assumed for family members by completion of the test ADF SSS. Pens and pre-paid envelopes were supplied to aid this process. For family members who participated in the qualitative aspect, they also completed a consent form which included assurances regarding confidentiality, and that refusal to take part would not affect their intervention.

5.5.1 ADF SSS Test Version

Piloting the ADF SSS enabled modification of the measure into a 58-item self-completion test version (see Appendix XXI). Section 4.4.1 reports on the design and development of the initial questionnaire, and Section 4.6 details the process of reduction to a more limited selection of the best quality items and refinement of item content and grammar. Introductory instructions were improved as were directions throughout the test ADF SSS. An expression of appreciation to respondents for completing the questionnaire was emphasised. The questionnaire was written in size ten font with bold and underlined type used to illuminate the key words and/or phrases for each item. As before, a random number table was used to decide item order, thus reducing subsequent item bias.

The 58-items captured the six perceived functional social support dimensions identified previously (see Section 2.3.3iv). Response categories and questions remained consistent with the previous version of the ADF SSS (see Section 4.4.1). The test ADF SSS comprised six pages (print on both sides of the tan coloured paper with clear instructions) and guide completion time was 15-20 minutes. Socio-demographic information was gathered on the reverse side of a cover sheet (see Appendix IX), the front of which contained introductory instructions, a question on general social support and one relating to specific sources (i.e. friends, family, professionals, self-help groups) of support available to family members (see Appendix XXII).

5.5.2 Significant Others Scale(B)

The SOS(B) was devised to assess the level and quality of perceived emotional and practical functional support (two emotional - 1 and 2 - and two practical

- 3 and 4 - items) provided by up to seven key individuals whom the respondent selects as their most important relations (Power *et al*., 1988). Respondents rate the level of perceived received support and the level of support they would ideally wish to receive from each person chosen. Responses are recorded on a seven point Likert-type scale from "never" (one) to "always" (seven). Power and colleagues (1988) state that the SOS(B) generates three indices - perceived actual support, ideal support and the calculated discrepancy between the ideal and actual scores. Essentially the discrepancy score provides an index of adequacy of available support. The self-administered instrument has been designed to be flexible, and takes about ten minutes to complete.

Satisfactory levels of reliability and validity have been reported (Power *et al*., 1988), with test-retest reliability over a six-month interval ranging from 0.73 to 0.83 across the four summary scores (actual versus ideal x emotional versus practical). Due to these favourable psychometric properties, and the fact that the measure was previously successfully administered in self-completion form to family members and other populations under chronic stress, the SOS(B) was selected to assess the construct validity of the ADF SSS, as opposed to the many other general social support questionnaires available (see Section 3.4).

5.6 Procedure

The main study was undertaken from October 2004 until March 2009. Section 4.5 details how a reflexive diary was kept, the process of obtaining University of Bath sponsorship for the study and acquiring both SWLREC and AWP NHS Trust ethical approval. A notice of substantial amendment form with updated consent and information sheets were completed to account for adjustments in study duration (Appendix XXIII). Confidentiality procedures and inclusion criteria remained consistent with those outlined in Section 4.5. ADF SSS test version development is detailed in Sections 4.4.1 and 5.5.1.

Furthermore, the measure was proof read and completed by members of the MHR&DU research team, and feedback was provided by the ADF R&DG and service managers across the AWP NHS Trust Drug and Alcohol Teams. This salutary process enabled deletions, additions and improvements to the measure. Dr. Gordon Taylor, medical statistician was consulted about the sample size required to conduct statistical analyses on the test ADF SSS. Additionally, permission was sought and gained from Professor Mick Power to utilise his SOS(B) scale for the main study.

The total population of family focused alcohol and drug agencies in England and Wales were approached to participate in the main study (see Section 5.4 for details). Letters or emails (Appendix XXIV) introducing and explaining the rationale and requirements of the main study were sent out to service managers or key practitioners from October 2004 until October 2006. This initial contact was followed up with a telephone conversation (for earlier script see Appendix XV) to enquire whether the agency wished to be involved with the project.

From December 2004 until December 2006 second letters (Appendix XXV), with enclosed test ADF SSS, information sheet and consent form, were sent to participating service managers or identified lead practitioners, and informed consent was gained from them on behalf of their agency to collaborate in the study. Also included in this letter was the researcher's offer of a visit to the consenting agencies to discuss with practitioners issues around the project aims and objectives, family member recruitment and consent. Where this visit was not deemed necessary, a full briefing was conducted via telephone calls.

From January 2005 until February 2007 research packs were sent out to collaborating agencies. Typically, these packs contained a detailed covering letter (Appendix XXVI), study précis (including explanation of the questionnaire coding system, see Appendix XXVII), information and consent forms for practitioners, two A3 agency posters for waiting areas (Appendix XXVIII), five ADF SSSs with biros, information and brief instruction sheets, two SOSs and five pre-paid addressed envelopes for completed questionnaires.

Practitioners who agreed to recruit family members read an information sheet and signed a consent form. The practitioners were responsible for distributing the test ADF SSS (and optionally the SOS(B)) to family members within the service. Instructions indicated that it was preferable for family members to complete the questionnaire(s) either supervised or unsupervised in the agency (or, if not possible, outside the service context, providing the family member agreed not to consult others about completion), and for the measure(s) to be returned to the researcher either by the practitioner or family member directly in the freepost envelope provided. As well as recruiting family members, practitioners also provided qualitative comments, through close liaison with the researcher (no more than a month between telephone contacts and/or emails), on how the test measure was performing in practice, applicability and any suggested improvements.

During the course of quantitative data collection clear guidelines were specified on the time period within which responses were expected. Also, both targeted follow-up and disengagement letters (Appendix XXIX and XXX) were utilised to increase recruitment rates within agencies. Due to a slow test ADF SSS completion rate within agencies from March 2006 the researcher changed tack somewhat and also began to recruit family members directly through a snowball sampling strategy. A myriad of potential avenues were explored including approaching self-help family member groups and residential family member programmes, attending the recruiting services in person, accessing community samples via conferences, family member and colleague contacts, and using an online version of the test ADF SSS (Appendix XXXI) with instructions and socio-demographic questions advertised on ADF related websites. No comparisons were made between different orientations or interventions.

Having direct access to family members enabled the researcher to articulate the rationale behind the questionnaire and that quantitative information was required to refine the measure to produce a concise, simplified and user friendly scale. For the test-retest version of the ADF SSS, family members were requested to

complete two ADF SSSs, with a gap of two to four hours between each one. This timeframe was selected in order to minimise the likelihood that the participants' responses were due to the true change in the response to a given item (i.e. an actual increase in the frequency of an event). The timeframe was also long enough to minimise practice effects from the respondents' ability to recall their prior responses. However, it was stressed to family members that it was important not look at their answers to the first questionnaire when completing the second (see Appendix XXXII for instruction sheet). Completed measures were cross-referenced using an anonymous coding system for identification.

Qualitative data collection from a subsample of one hundred and ten family members occurred between November 2005 and April 2007. Family members were required to read an information sheet and sign a consent form before they could participate in the qualitative aspect of the main study. Data protection and anonymity was assured and permission given to audiotape the semi-structured cognitive interviews (see Section 5.3.3 for details). The researcher accompanied family members as they completed the measure, and the family members elucidated their interpretations whilst working through the questionnaire. Issues such as whether the items were comprehensible, helpful, salient and suggested improvements, deletions or additions were discussed with each respondent. Annotated notes were also taken on any problems experienced with the measure (to complement the annotated qualitative comments made by family members on the completed questionnaires which were part of the quantitative dataset), and non-verbal behaviour.

Practitioners and the ADF R&DG also provided qualitative feedback (via meetings, phonecalls and emails) on the applicability of the measure throughout the main study. In a general sense this qualitative information was used to appraise the test ADF SSS's content validity. The data were entered and/or transcribed, checked and cleaned on appropriate software programmes before analytical techniques were employed (Section 5.3 details these processes).

After these procedures were preliminarily conducted and the ADF SSS refined, fifty family members (part of the overall qualitative sample of one hundred and ten) provided interpretative feedback on the emerging items. Finally, a research briefing summarising the study findings was sent to each of the collaborating agencies, and outcomes were disseminated and illuminated through national conference presentations.

Chapter 6: Main Study: Findings: ADF SSS Test Version

6.1 Principal Components Analysis of the Test ADF SSS Frequency Scale

In view of the research question, is the ADF SSS reliable and valid? The internal consistency of the test measure was assessed by conducting a exploratory factor analysis. A Principal Components Analysis (PCA) with varimax rotation was performed on the 58-item test version of the ADF SSS (n=132). Varimax rotation is an orthogonal rotation procedure which has the advantage of producing maximum variance between factors and aiding identification (Tabachnick and Fidell, 1989).

Orthogonal rotation is the traditional method used for Factor Analysis. However, because conceptually there may be shared variance between factors, especially when examining a concept such as social support where overlap between constructs may exist, it was important to perform an oblique rotation method as a validity check. The results from the promax rotation (see Appendix XXXIII) showed that the same items loaded most heavily on the same factors as found using varimax rotation (see Table 6.4), thus corroborating the varimax results and indicating that the extracted factors are reasonably orthogonal. Therefore, this chapter reports on findings utilising traditional factor analytic procedures.

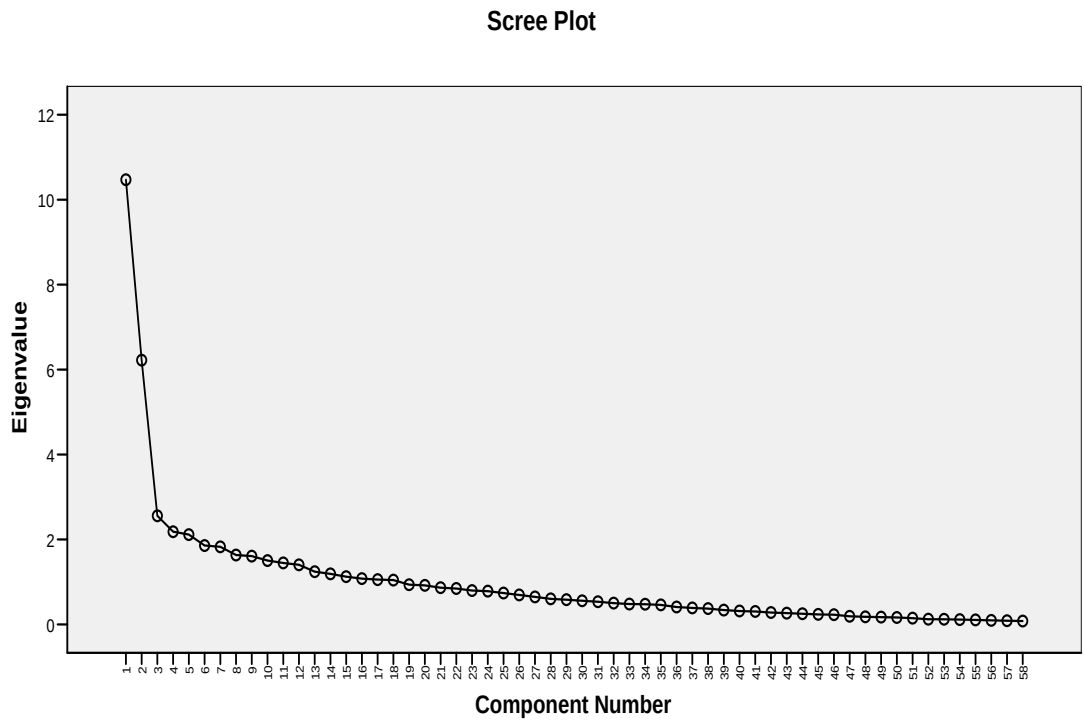

Figure 6.1: Scree test for the PCA of the test ADF SSS Frequency scale.

As illustrated in Figure 6.1 above, the scree plot shows that factors 1, 2 and 3 extracted from the PCA of the test ADF SSS Frequency scale all fall vertically above the tilted baseline. This demonstrates a readily observable change in direction, thereby producing a different scree slope (Cattell, 1978). Examination of the scree plot suggested three factors all with eigen values greater than 2.5, which together explained 33.2% of the total variance. Eigen values are the variances for each of the composites, providing information on the dimensionality of the data.

Factor 1		Factor 2		Factor 3	
Eigen Value	% Variance	Eigen Value	% Variance	Eigen Value	% Variance
10.469	18.051	6.220	10.725	2.558	4.411

Table 6.1: Unrotated factor matrix values for the test ADF SSS Frequency scale.

As displayed in Table 6.1, the first principal component, factor 1, contained 10.5 units of variance, which accounted for 18% of the original variance. Factor 2 contained 6.2 units of variance which explained 10.7% of the overall variance. Factor 3 contained 2.6 units of variance, accounting for 4.4% of the total variance.

Factor	Actual Eigen Values	Mean of Random Eigen Values	95 Percentile of Random Eigen Values
1	10.469	2.59777	2.75413
2	6.220	2.43162	2.55058
3	2.558	2.31679	2.41380

Table 6.2: Parallel analysis of the test ADF SSS Frequency scale.

As can be seen in Table 6.2, a parallel analysis (Lattin *et al*, 2003) performed on the test ADF SSS Frequency scale indicated that three factors should be extracted, which triangulated the findings obtained from the scree test.

Table 6.3 presents the eigen values and variance percentages for the varimax rotated three factor matrix.

Factor 1		Factor 2		Factor 3	
Eigen Value	% Variance	Eigen Value	% Variance	Eigen Value	% Variance
9.062	15.625	6.585	11.353	3.601	6.208

Table 6.3: Rotated factor matrix values for the test ADF SSS Frequency scale.

In contrast with Table 6.1, values for factor 1 decreased (9 units of variance, 15.6% total variance, versus 10.5 units, and 18%), whilst values for both factor 2 (6.2, and 10.7%, versus 6.6, and 11.4%) and 3 (2.6, and 4.4%, versus 3.6, and 6.2%) increased.

Table 6.4 shows the items on the ADF SSS Frequency scale with the highest correlation coefficient loadings (>0.3) for each of the three rotated factors.

ADF SSS Items	Factor 1	Factor 2	Factor 3
Q1a	.523		
02a	.649		
Q3a			.653
Q5a	.417		
Q6a	.610		
Q7a	.620		
Q8a	.424		
Q9a	.753		
Q11a	.650		
Q12a	.671		
Q13a	.529		
Q14a	.545		
Q15a		.657	
Q16a	.458		
Q17a	.383		
Q19a	.455		
Q20a		.549	
Q21a	.315		
Q22a	.569		
Q23a	.535		
Q24a		.449	

Q25a		.653	
Q26a	.714		
Q27a		.502	
Q28a		-.334	
Q29a		.497	
Q30a	.429		
Q31a		.680	
Q32a		.619	
Q33a			.690
Q34a		.654	
Q36a	.559		
Q38a		.415	
Q39a		.516	
Q40a	.402		
Q41a	.301		
Q42a	.360		
Q43a	.555		
Q44a		.490	
Q45a		.408	
Q46a	.363		
Q47a		.665	
Q48a			.389
Q49a		.351	
Q50a			.485
Q51a			-.552
Q52a	.741		
Q54a	.684		
Q55a	.722		
Q57a		.670	
Q58a			.791

Table 6.4: Factor loadings from the PCA of the test ADF SSS Frequency scale.

The factor matrix shows that 28 items on the test ADF SSS Frequency scale produced largest loadings (all >0.3) on the first factor, 17 items loaded significantly on the second factor and 6 items loaded on the third factor. Seven items (4a, 10a, 18a, 35a, 37a, 53a and 56a) failed to load substantially on any of the three available factors, and thus were discarded.

6.2 Internal Consistency of the Refined ADF SSS Frequency Scale

Cronbach's coefficient alpha (α) (Cronbach, 1970), which is based on the average intercorrelations of items, was used to assess internal consistency of the test ADF SSS Frequency scales. Cronbach's alpha provides an assessment of how well items relate to each other and to the total. This ranges from 0 to 1.0, with acceptable levels of coefficient alpha for test ranging from a low of 0.65-0.7, with 0.7 or above being indicative of a good level of internal consistency (Cortina, 1993).

Initially, for factor 1 derived from the PCA (n=132), Cronbach's alpha was calculated at 0.915 for the ADF SSS Frequency scale (28 items which loaded highest on factor 1). Subsequently items which showed a lack of distribution and/or did not correlate significantly (<0.3) with the total, and thus did not improve the scale alpha value were omitted (see Appendix XXXIV). The resultant alpha value for the refined factor 1 subscale of ADF SSS Frequency was 0.913.

Internal reliability item-to-total correlation estimates for refined factor 1 of the ADF SSS Frequency scale are presented in Table 6.5 below, together with the consequence for alpha of removing each scale item.

ADF SSS Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
1a	.571	.910
2a	.664	.905
7a	.641	.906
9a	.773	.900
11a	.685	.904
12a	.586	.910
13a	.534	.912
26a	.681	.904
52a	.766	.899
54a	.676	.904
55a	.783	.899

Table 6.5: Final item analysis of factor 1 of the ADF SSS Frequency scale.

It is apparent from Table 6.5 that the item-to-total correlations for refined factor 1 (11 items) of the ADF SSS Frequency scale were found to be greater than 0.53 and, if any of the remaining scale items were to be omitted, the alpha value would be lower.

For factor 2 (initially 17 items) which emerged from the PCA of the Frequency scale, the alpha value was 0.853 (see Appendix XXXIV). Items were eliminated using the same rationale as outlined previously for factor 1, leaving an 8 item scale. The alpha value for the refined factor 2 was 0.851. Table 6.6 displays item-to-total correlations for refined factor 2, and the adjusted alpha values, if scale items were omitted.

ADF SSS Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
15a	.568	.836
25a	.634	.828
27a	.568	.838
31a	.641	.827
32a	.542	.840
34a	.484	.845
47a	.650	.828
57a	.674	.823

Table 6.6: Final item analysis of factor 2 of the ADF SSS Frequency scale.

As detailed in Table 6.6, item-to-total correlations for refined factor 2 (8 items) were all above 0.48, and removal of any of the scale items reduced the alpha coefficient.

Factor 3 (initially 6 items) generated by the PCA on the ADF SSS Frequency scale was unchanged as item deletion procedures reduced the robustness of the scale, as discussed below. The alpha value for factor 3 was 0.727. It is clear from Table 6.7 that removal of item 48a increases the alpha level, however, when this item was removed it had a detrimental impact on the scale, as subsequent item analyses indicated that omission of item 50a (0.747), and then item 51a (0.817), again increased the internal consistency of the scale. Obviously, a scale containing only three items would not be sustainable, thus the initial 6 item scale was retained. However, the factor 3 Frequency subscale should be treated with more caution, as the scale items have lower correlations with the total (starting at 0.3), than the more reliable factors 1 and 2.

ADF SSS Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
3a	.500	.677
33a	.598	.644
48a	.300	.734
50a	.360	.715
51a	.395	.707
58a	.615	.638

Table 6.7: Final item analysis of factor 3 of the ADF SSS Frequency scale.

Table 6.8 provides descriptive detail on the three ADF SSS Frequency subscales (overall 25 items) which resulted from both factor and item analyses performed on the test version of the ADF SSS.

Factor Labels	**ADF SSS Items**	**Cronbach's Alpha**
Positive Functional Support (Emotional and Instrumental Support, Social Companionship and Support for Coping).	1 Friends/relations have **understood what it is like for me to live with my relative's drinking or drug taking**. 2 Friends/relations have **helped to cheer me up**. 7 I have friends/relations **whom I trust**. 9 Friends/relations have **listened to me when I have talked about my feelings**. 11 Friends/relations have **backed the stance that I have taken towards my relative and their substance misuse**. 12 Friends/relations have **put themselves out for me when I needed practical help** (i.e. aid or assistance). 13Friends/relations have **advised me to focus on myself and my own needs**. 26 Friends/relations have **given me space to talk about my problems**. 52 Friends/relations have **been there for me**. 54 Friends/relations have **provided support for the way I cope with my relative**. 55 Friends/relations have **talked to me about my relative and listened to what I have to say**.	0.913

Negative ADF Specific Support (Support for Coping and Attitudes and Actions towards the Using Relative).	15 Friends/relations have **undermined my efforts to stand up to my relative's problem drinking or drug taking**. 25 Friends/relations have been **unduly critical of my relative**. 27 Friends/relations have said that **my relative should leave the family home**. 31 Friends/relations have **said things about my relative that I do NOT agree with**. 32 Friends/relations have **avoided me because of my relative's substance misuse**. 34 Fiends/relations have **blamed me for my relative's behaviour**. 47 Friends/relations have said that **my relative does NOT deserve help**. 57 Friends/relations have **said nasty things about my relative**.	0.851
Positive ADF Specific Support (Informational - both formal and informal - and Emotional Support, Support for Coping and Attitudes and Actions towards the Using Relative).	3 Health/social care professionals have given me **helpful information** about substance misuse. 33 Health/social care professionals have **made themselves available** for me. 48 I have **identified with the information contained within books/booklets** about people living with a substance misuser. 50 Friends/relations have **told my relative off on my behalf**. 51 Friends/relations have **advised me to leave my relative**. 58 I have **confided in my health/social care professional about my situation**.	0.727

Table 6.8: The 25 items divided into the three ADF SSS Frequency subscales, along with suggested factor labels, and Cronbach's alpha values.

The findings for the ADF SSS Frequency scales guided both principal components and item analyses for the remaining scales of the ADF SSS, as other questionnaires utilised by the ADF R&DG use Frequency as the primary outcome measure.

6.3 Principal Components Analysis of the Test ADF SSS Importance Scale

The scree test illustration is presented below in Figure 6.2 for the PCA of the test ADF SSS Importance scale. Consistent with the Frequency scale, the scree slope suggested three factors for extraction, as a readily observable change in direction producing a different slope was clear from the third factor onwards (Cattell, 1978).

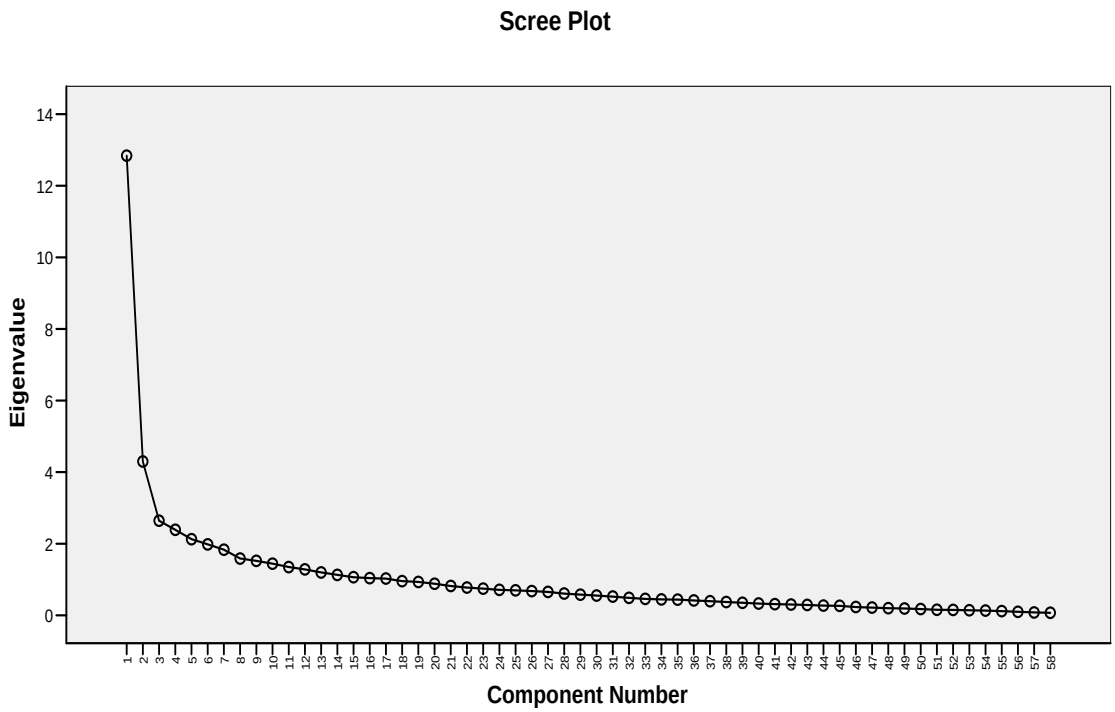

Figure 6.2: Scree plot for the PCA of the test ADF SSS Importance scale.

Examining the factor matrix, 34.103% of the variance was explained by the three factors extracted. As displayed in Tables 6.9 and 6.10 eigen values obtained were greater than 2.6.

Factor 1		Factor 2		Factor 3	
Eigen Value	% Variance	Eigen Value	% Variance	Eigen Value	% Variance
12.839	22.136	4.298	7.410	2.643	4.557

Table 6.9: Unrotated factor matrix values for the test ADF SSS Importance scale.

Factor 1		Factor 2		Factor 3	
Eigen Value	% Variance	Eigen Value	% Variance	Eigen Value	% Variance
8.329	14.360	7.443	12.833	4.008	6.910

Table 6.10: Rotated factor matrix values for the test ADF SSS Importance scale.

The factor matrix presented below in Table 6.11 clearly indicates that the 25 items which emerged as salient for the refined Frequency scales also loaded significantly conforming to the same factor structure for the ADF SSS Importance scales. Eleven items produced significant loadings on the first factor, 8 items loaded heavily on the second factor and 6 items loaded on the third factor. These items were all consistent with the previous PCA Frequency scale factor loadings.

ADF SSS Items	Factor 1	Factor 2	Factor 3
Q1b	.627		
02b	.607		
Q3b			.747
Q7b	.575		
Q9b	.750		
Q11b	.678		
Q12b	.516		
Q13b	.590		

Q15b		.658	
Q25b		.568	
Q26b	.706		
Q27b		.533	
Q31b		.600	
Q32b		.602	
Q33b			.766
Q34b		.659	
Q47b		.575	
Q48b			.329
Q50b			.349
Q51b			-.443
Q52b	.739		
Q54b	.586		
Q55b	.679		
Q57b		.582	
Q58b			.748

Table 6.11: Factor loadings from the PCA of the refined ADF SSS Importance scale.

6.4 Internal Consistency of the Refined ADF SSS Importance Scale

Item analysis was conducted on the ADF SSS Importance scales, the Cronbach's alpha value derived for factor 1 was 0.886. Internal reliability item-to-total correlation estimates for factor 1 of the ADF SSS Importance scale are detailed in Table 6.12 below, together with the consequence for alpha of removing each scale item.

ADF SSS Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
1b	.632	.875
2b	.593	.877
7b	.540	.880
9b	.686	.872
11b	.667	.872
12b	.520	.886
13b	.598	.877
26b	.630	.875
52b	.706	.870
54b	.539	.881
55b	.646	.874

Table 6.12: Item analysis of factor 1 of the ADF SSS Importance scale.

The alpha value for Importance subscale factor 2 was 0.838. Table 6.13 presents item-to-total correlations for factor 2, and the adjusted alpha values, if scale items were omitted.

ADF SSS Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
15b	.624	.811
25b	.483	.829
27b	.583	.817
31b	.616	.813
32b	.549	.821
34b	.588	.816
47b	.578	.817
57b	.522	.824

Table 6.13: Item analysis of factor 2 of the ADF SSS Importance scale.

As shown in Table 6.14, the alpha value for factor 3 Importance subscale was 0.721. As was the case with factor 3 on the Frequency scale, elimination of item 48b increased the alpha value. However, it was retained for the same reasons as outlined in Section 6.2.

ADF SSS Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
3b	.602	.637
33b	.568	.646
48b	.238	.739
50b	.324	.720
51b	.427	.691
58b	.594	.635

Table 6.14: Item analysis of factor 3 of the ADF SSS Importance scale.

6.5 Principal Components Analysis of the Test ADF SSS Satisfaction Scale

In regards to the scree plot for the PCA of the ADF SSS Satisfaction scale, in Figure 6.3 below it is apparent that three factors have higher eigen values than the remaining factors extracted from the data. The lowest eigen value from those three salient factors was 2.85. Together the three factors accounted for 32.359% of the total variance.

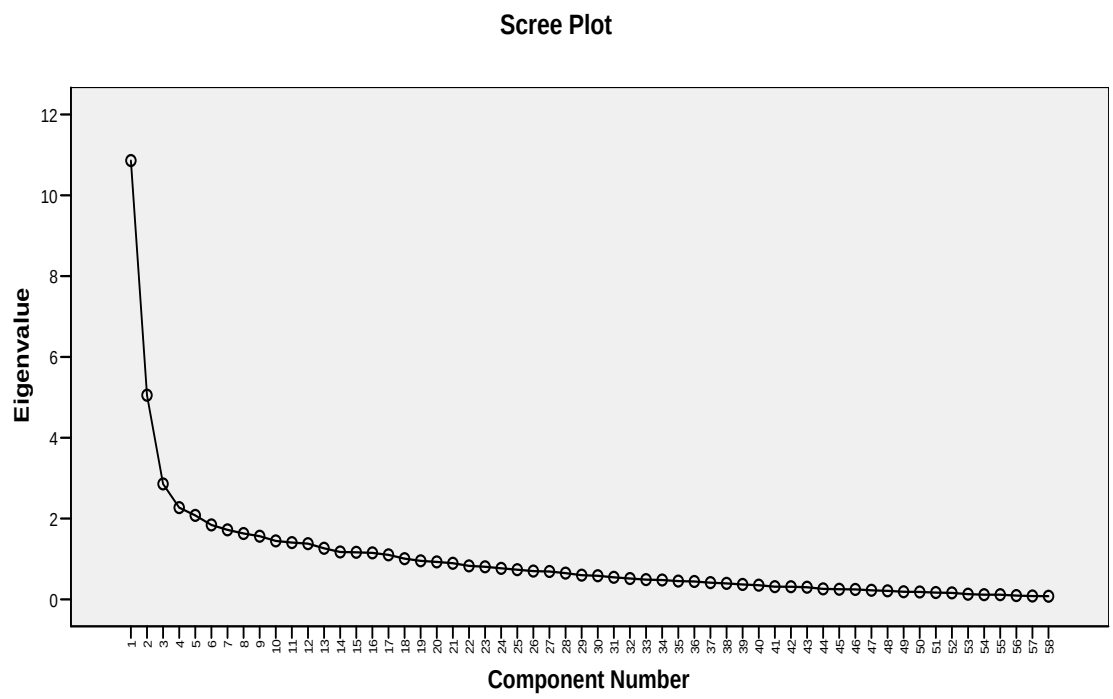

Figure 6.3: Scree plot for PCA of the test ADF SSS Satisfaction scale.

In addition to the Scree test, Tables 6.15 and 6.16 provide a detailed breakdown of the eigen values and the variance explained by individual factors.

Factor 1		Factor 2		Factor 3	
Eigen Value	% Variance	Eigen Value	% Variance	Eigen Value	% Variance
10.858	18.721	5.053	8.711	2.857	4.926

Table 6.15: Unrotated factor matrix values for the test ADF SSS Satisfaction scale.

Factor 1		Factor 2		Factor 3	
Eigen Value	% Variance	Eigen Value	% Variance	Eigen Value	% Variance
7.409	12.774	7.343	12.660	4.016	6.924

Table 6.16: Rotated factor matrix values for the test ADF SSS Satisfaction scale.

Table 6.17 clarifies that the items on the ADF SSS Satisfaction scale, all load consistently with both Frequency and Importance scales, forming 11, 8 and 6 item distributions with factors one, two and three respectively.

ADF SSS Items	Factor 1	Factor 2	Factor 3
Q1c	.660		
02c	.648		
Q3c			.719
Q7c	.671		
Q9c	.735		
Q11c	.667		
Q12c	.521		
Q13c	.601		
Q15c		-.482	
Q25c		-.439	
Q26c	.739		
Q27c		-.479	
Q31c		-.443	
Q32c		-.599	
Q33c			.791
Q34c		-.582	
Q47c		-.575	
Q48c			.367
Q50c			.385
Q51c			-.421
Q52c	.792		
Q54c	.681		
Q55c	.709		
Q57c		-.412	
Q58c			.744

Table 6.17: Factor loadings from the PCA of the refined ADF SSS Satisfaction scale.

6.6 Internal Consistency of the Refined ADF SSS Satisfaction Scale

Item analysis conducted on factor 1 of the ADF SSS Satisfaction scale yielded an alpha of 0.889. Internal reliability item-to-total correlation figures for factor 1 are given in Table 6.18, including alpha values for rejecting each scale item. Deletion of item 12c indicated a very slight increase in overall factor 1 subscale alpha.

ADF SSS Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
1c	.609	.879
2c	.612	.879
7c	.618	.879
9c	.665	.877
11c	.628	.878
12c	.500	.890
13c	.546	.883
26c	.649	.877
52c	.753	.870
54c	.602	.880
55c	.634	.878

Table 6.18: Item analysis of factor 1 of the ADF SSS Satisfaction scale.

Cronbach's alpha for factor 2 of the Satisfaction subscale totalled 0.838. Correlations for each item with the total scale are displayed in Table 6.19, with alpha values for item elimination.

ADF SSS Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
15c	.624	.811
25c	.483	.829
27c	.583	.817
31c	.616	.813
32c	.549	.821
34c	.588	.816
47c	.578	.817
57c	.522	.824

Table 6.19: Item analysis of factor 2 of the ADF SSS Satisfaction scale.

Table 6.20 extrapolates the information from the item analysis of factor 3 of the Satisfaction subscale. The total scale alpha was 0.712. As on the previous Frequency and Importance subscales for factor 3, removal of 48c increased the alpha value of factor 3, but the item was retained to ensure subscale integrity.

ADF SSS Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
3c	.549	.640
33c	.626	.612
48c	.203	.744
50c	.360	.699
51c	.374	.693
58c	.584	.625

Table 6.20: Item analysis of factor 3 of the ADF SSS Satisfaction scale.

6.7 Principal Components Analysis of the Test ADF SSS Ideal Scale

Before presenting the PCA results obtained from the test ADF SSS Ideal scale, it is necessary to state that the strict criteria for mean item missing data substitution (only items with <10% missing data included in the analyses) for the Frequency, Importance and Satisfaction scales was relaxed to <15% missing data (as there was substantially more missing data) for each item retained in the inferential statistics of the Ideal scale. Consequently, this impacted on variances, increasing the likelihood of distorting estimated variances and correlations.

The scree plot produced from the PCA of the test ADF Ideal scale in Figure 6.4 shows that the three factors extracted were less pronounced than on the previous scales. This is supported by the slightly lower cumulative variance percentage of 30.056 for the three ideal factors combined.

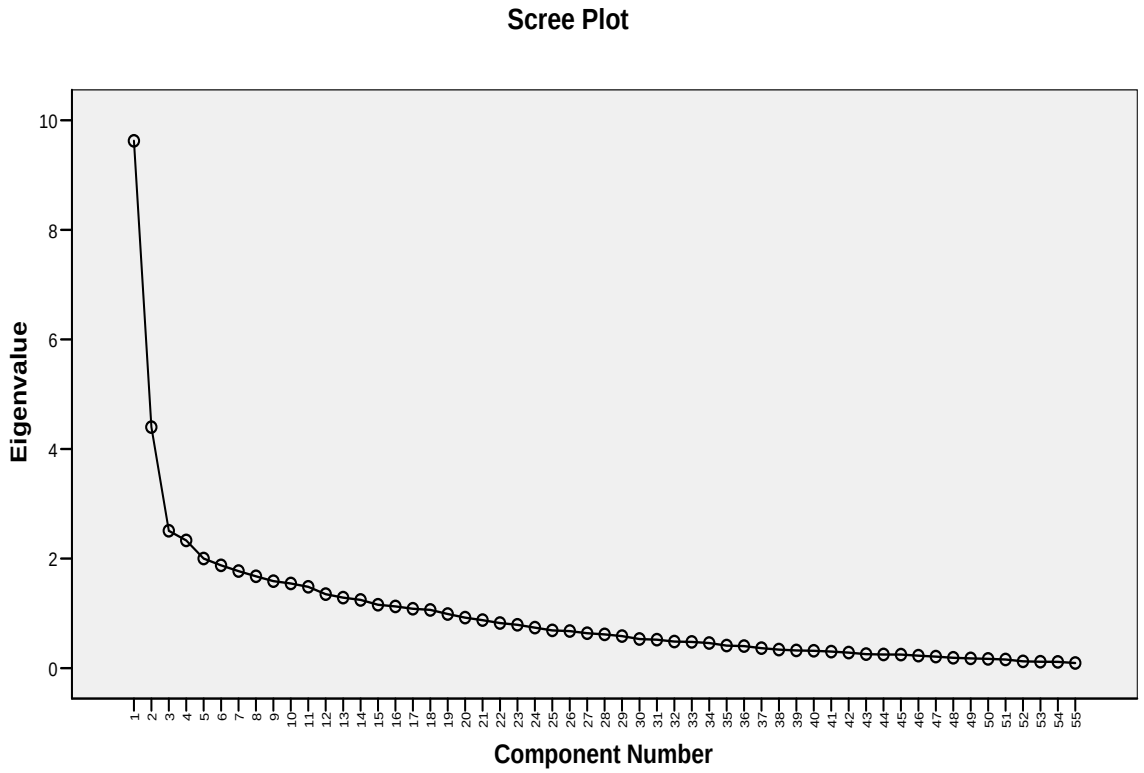

Figure 6.4: Scree test for PCA of the test ADF SSS Ideal scale.

However, as detailed in Tables 6.21 and 6.22 all the eigen values remained over a threshold of 2.5 units of variance.

Factor 1		Factor 2		Factor 3	
Eigen Value	% Variance	Eigen Value	% Variance	Eigen Value	% Variance
9.625	17.500	4.398	7.997	2.507	4.559

Table 6.21: Unrotated factor matrix values for the test ADF SSS Ideal scale.

Factor 1		Factor 2		Factor 3	
Eigen Value	% Variance	Eigen Value	% Variance	Eigen Value	% Variance
7.856	14.283	4.350	7.910	4.325	7.863

Table 6.22: Rotated factor matrix values for the test ADF SSS Ideal scale.

Table 6.23 reveals that, although the PCA performed on the ADF SSS Ideal scale led to items loading on the same associated factors as on previous scales, the correlation coefficient loadings were lower, and this was most apparent on factor 2 where three items (34d, 47d and 57d) failed to reach *r* =0.3.

ADF SSS Items	Factor 1	Factor 2	Factor 3
Q1d	.317		
02d	.488		
Q3d			.462
Q7d	.400		
Q9d	.599		
Q11d	.579		
Q12d	.512		
Q13d	.466		
Q15d		.414	
Q25d		.393	
Q26d	.475		
Q27d		.307	
Q31d		.500	
Q32d		.430	
Q33d			.472
Q34d		.237	

Q47d		.208	
Q48d			.254
Q50d			.585
Q51d			-.614
Q52d	.640		
Q54d	.672		
Q55d	.609		
Q57d		.201	
Q58d			.617

Table 6.23: Factor loadings from the PCA of the refined ADF SSS Ideal scale.

6.8 Internal Consistency of the Refined ADF SSS Ideal Scale

As with the PCA, item analysis for the ADF SSS Ideal scale also suffered from the more flexible approach of including cases with over the recommended <10 missing data imputation. Although factor 1 subscale achieved an adequate alpha of 0.818, it can be seen in Table 6.24 that item-to-total correlations were reduced from those acquired for factor 1 on the Frequency, Importance and Satisfaction scales. Additionally, deletion of item 7d indicates a slight increase in overall factor 1 subscale alpha.

ADF SSS Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
1d	.357	.814
2d	.415	.809
7d	.297	.820
9d	.616	.794
11d	.563	.795

12d	.477	.805
13d	.449	.808
26d	.421	.809
52d	.591	.794
54d	.567	.795
55d	.630	.790

Table 6.24: Item analysis of factor 1 of the ADF SSS Ideal scale.

Table 6.25 below also includes the missing data percentages for each item, as the item analysis on factor 2 Ideal subscale only achieved an alpha value of 0.697. However, there were no suggested redundant items as they all contributed to the overall alpha figure.

ADF SSS Items	Missing Data Percentage	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
15d	9.1	.330	.682
25d	10.6	.463	.649
27d	12.9	.483	.646
31d	10.6	.295	.688
32d	10.6	.335	.679
34d	12.1	.340	.681
47d	12.9	.341	.678
57d	9.1	.559	.631

Table 6.25: Item analysis of factor 2 of the ADF SSS Ideal scale.

As is clear in the previous sections of this chapter (see Sections 6.2, 6.4 and 6.6), factor 3 has been the weakest subscale in terms of item-to-total correlations and alpha outcomes. However, as Table 6.26 highlights, although factor 3 Ideal subscale only posted an alpha of 0.687, all the items were internally consistent and values were similar with those found, in particular, for factor 2 of the Ideal scale.

ADF SSS Items	Missing Data Percentage	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
3d	9.8	.497	.631
33d	9.1	.439	.639
48d	9.8	.315	.685
50d	11.4	.386	.659
51d	12.1	.366	.663
58d	10.6	.553	.599

Table 6.26: Item analysis of factor 3 of the ADF SSS Ideal scale.

6.9 ADF SSS Scoring System

6.9.1 Frequency Scale

On the test version of the ADF SSS, all 58 Frequency items were scored in the following way: 0=Never; 1=Once or Twice; 2=Sometimes; and 3=Often. Table 6.27 outlines the number of items which formed the three subscales for the Frequency score. On the test ADF SSS, Frequency subscale one was composed of 32 items, subscale two consisted of 19 items and subscale three contained 7 items. Maximum possible scores were 96, 57 and 21 respectively.

For the refined ADF SSS, which emerged from the PCA and item analysis of the test ADF SSS, the 25 frequency items were scored as previously on the larger test version (i.e. 0=Never; 1=Once or Twice; 2=Sometimes; and 3=Often). Refined Frequency subscale one numbered 11 items, subscale two 8 items, with 6 items on the third subscale. Accordingly, potential maximum scores were 33, 24 and 18 for each of the refined Frequency subscales.

Frequency Scales	Test ADF SSS		Refined ADF SSS	
	Number of Items	Maximum Score	Number of Items	Maximum Score
Positive Functional Support Subscale 1	32	96	11	33
Negative ADF Support Subscale 2	19	57	8	24
Positive ADF Support Subscale 3	7	21	6	18

Table 6.27: Number of items and maximum scores for the three Frequency subscales for both test and refined versions of the ADF SSS.

The three Frequency subscales on both versions of the ADF SSS were summed as follows:

Positive Functional Support Frequency score +
Positive ADF Support Frequency score –
Negative ADF Support Frequency score =
Total ADF SSS Frequency score

Applying the equation above, Table 6.28 displays the maximum and minimum scores obtainable for the refined and test ADF SSS Frequency scales.

Total Score	Test ADF SSS	Refined ADF SSS
Maximum	117	51
Minimum	-57	-24

Table 6.28: Maximum and minimum scores derivable for the test and refined ADF SSS Frequency scale.

Within the spectrum of these score thresholds outlined above, Table 6.29 provides descriptive detail on the scoring distribution patterns for the quantitative sample of family members (n=132) who completed the relevant ADF SSS Frequency items.

Frequency Scales	Mean	Standard Deviation	Minimum	Maximum	25th Percentile	75th Percentile
Test Positive Functional Support	37.67	16.049	1	78	26.25	47.97
Test Negative ADF Support	-18.22	-8.948	-2	-39	-11	-25
Test Positive ADF Support	9.34	5.008	0	20	6	13
Total Test ADF SSS	28.79	19.109	-30	67	17.25	43
Refined Positive Functional Support	20.79	8.11	0	33	28	16
Refined Negative ADF Support	-7.16	5.683	0	-21	-2.25	-11
Refined Positive ADF Support	8.03	4.511	0	17	4.66	11
Total Refined ADF SSS	21.66	11.155	-17	45	14.92	30

Table 6.29: Actual scores and distributions for the test and refined ADF SSS Frequency sub and total scales.

6.9.2 Importance Scale

The ADF SSS Importance items were attributed the following values: 0=N/A; 1=Not Important; 2=Important; and 3=Very Important. Table 6.30 details the number of items (and maximum scores) on the three Importance subscales for both the test and refined versions of the ADF SSS.

Importance Scales	Test ADF SSS		Refined ADF SSS	
	Number of Items	Maximum Score	Number of Items	Maximum Score
Positive Functional Support Subscale 1	21	63	11	33
Negative ADF Support Subscale 2	29	87	8	24
Positive ADF Support Subscale 3	8	24	6	18

Table 6.30: Item numbers and associated maximum scores for test and refined ADF SSS Importance subscales.

ADF SSS Importance total scale scores were derived using the simple equation below:

Positive Functional Support Importance score +
Negative ADF Support Importance score +
Positive ADF Support Importance score =
Total ADF SSS Importance score

Given this calculation, the highest and lowest total ADF SSS Importance scores possible are presented below in Table 6.31.

Total Score	Test ADF SSS	Refined ADF SSS
Maximum	174	75
Minimum	0	0

Table 6.31: Largest and smallest scores obtainable for the test and refined ADF SSS Importance scale.

Table 6.32 provides summary variance scores for the test and refined ADF Importance sub and total scale(s), for all completed importance items.

Importance Scales	Mean	Standard Deviation	Minimum	Maximum	25th Percentile	75th Percentile
Test Positive Functional Support	39.02	12.359	1	59	33	47.55
Test Negative ADF Support	27.25	17.001	0	78	15	37
Test Positive ADF Support	11.88	5.609	0	23	8	15.91
Total Test ADF SSS	78.15	29.356	3	157	58.25	94.84
Refined Positive Functional Support	24.59	7.219	0	33	20.68	30
Refined Negative ADF Support	8.73	6.229	0	22	3.06	12
Refined Positive ADF Support	9.60	4.510	0	18	7	13
Total Refined ADF SSS	42.92	13.926	0	72	35	52.31

Table 6.32: Test and refined ADF SSS Importance sub and total scale distributions.

6.9.3 Satisfaction Scale

ADF SSS Satisfaction items were allocated scores as outlined: 0=N/A; 1=Dissatisfied; 2=Neither Satisfied nor Dissatisfied; and 3=Satisfied. The three subscales for both test and refined versions of the ADF SSS, in terms of item composition and highest potential score, are displayed in Table 6.33.

Satisfaction Scales	Test ADF SSS		Refined ADF SSS	
	Number of Items	Maximum Score	Number of Items	Maximum Score
Positive Functional Support Subscale 1	18	54	11	33
Negative ADF Support Subscale 2	31	93	8	24
Positive ADF Support Subscale 3	9	27	6	18

Table 6.33: Item numbers and maximum scores for test and refined ADF SSS Satisfaction subscales.

Satisfaction scale scores on both versions of the ADF SSS were generated utilising the following straightforward mathematical procedure:

Positive Functional Support Satisfaction score +
Negative ADF Support Satisfaction score +
Positive ADF Support Satisfaction score =
Total ADF SSS Satisfaction score

The above calculation elicits the Satisfaction scale ranges for test and refined ADF SSS versions as shown in Table 6.34.

Total Score	Test ADF SSS	Refined ADF SSS
Maximum	174	75
Minimum	0	0

Table 6.34: Highest and lowest scores achievable for the test and refined ADF SSS Satisfaction scale.

Central tendency descriptive score statistics are detailed in Table 6.35 for the ADF SSS Satisfaction sub and total scale(s).

	Mean	Standard Deviation	Minimum	Maximum	25th Percentile	75th Percentile
Test Positive Functional Support	36.12	11.634	0	53	29.25	45
Test Negative ADF Support	25.90	15.021	0	64	14	35.75
Test Positive ADF Support	13.13	6.134	0	27	9.25	17.82
Total Test ADF SSS	75.14	26.446	2	134	58	91.5
Refined Positive Functional Support	24.51	7.724	0	33	20	30.86
Refined Negative ADF Support	6.86	4.572	0	18	3	10
Refined Positive ADF Support	9.67	4.702	0	18	6.34	13
Total Refined ADF SSS	41.04	12.585	0	64	34.44	49

Table 6.35: Test and refined ADF SSS Satisfaction sub and total scale distributions.

6.9.4 Ideal Scale

The ADF SSS Ideal items were scored in the same way as those dealing with Frequency: 0=Never; 1=Once or Twice; 2=Sometimes; and 3=Often. Table 6.36 gives a breakdown of the number of items and maximum potential scores for each of the three Ideal subscales formed on both test and refined versions of the ADF SSS.

Ideal Scales	Test ADF SSS		Refined ADF SSS	
	Number of Items	Maximum Score	Number of Items	Maximum Score
Positive Functional Support Subscale 1	31	93	11	33
Negative ADF Support Subscale 2	18	54	8	24
Positive ADF Support Subscale 3	9	27	6	18

Table 6.36: Number of items and highest scores obtainable for the Ideal subscales on test and refined versions of the ADF SSS.

Overall, the equation for scoring the Ideal scale for both test and refined versions of the ADF SSS was as follows:

Positive Functional Support Ideal score +
Positive ADF Support Ideal score –
Negative ADF Support Ideal score =
Total ADF SSS Ideal score

Consequently, ideal scale scores fell within the ranges outlined in Table 6.37.

Total Score	Test ADF SSS	Refined ADF SSS
Maximum	120	51
Minimum	-54	-24

Table 6.37: Maximum and minimum scores derivable for the test and refined ADF SSS Ideal scale.

Table 6.38 below displays the distribution of scores for the test and refined versions of the ADF SSS for sub and total Ideal scales. However, the figures should be viewed with caution as there was a high proportion of missing data for Ideal items as discussed in Section 6.7.

	Mean	Standard Deviation	Minimum	Maximum	25th Percentile	75th Percentile
Test Positive Functional Support	56.90	13.671	15	86	49	64.99
Test Negative ADF Support	-10.31	6.146	0	-32	-5.88	-13.39
Test Positive ADF Support	13.90	4.482	1	24	11	17
Total Test ADF SSS	60.49	15.865	15	99	51.43	70.48
Refined Positive Functional Support	26.26	4.564	9	33	23.23	29.89
Refined Negative ADF Support	-3.75	3.398	0	-15	-0.54	-6
Refined Positive ADF Support	10.75	3.416	0	18	8.65	13
Total Refined ADF SSS	33.26	6.297	14	45	29	37.13

Table 6.38: Test and refined ADF SSS Ideal sub and total scale distributions.

6.9.5 Discrepancy Scale

Atypical from other scales, Discrepancy score does not have its own unique items, but is a composite of Frequency and Ideal ADF SSS items. This score

gives an indication of the difference between the perceived amount of functional support family members are currently getting, and how much support ideally they would like to be receiving. Respective number of items and maximum scores for test and refined versions of the ADF SSS are shown in Tables 6.39 and 6.40.

Discrepancy Scales	Test ADF SSS		
	Frequency Items	Ideal Items	Maximum Score
Positive Functional Support Subscale 1	32	31	96
Negative ADF Support Subscale 2	19	18	57
Positive ADF Support Subscale 3	7	9	21

Table 6.39: Number of items and highest scores obtainable for the three Discrepancy subscales on the test ADF SSS.

Discrepancy Scales	Refined ADF SSS		
	Frequency Items	Ideal Items	Maximum Score
Positive Functional Support Subscale 1	11	11	33
Negative ADF Support Subscale 2	8	8	24
Positive ADF Support Subscale 3	6	6	18

Table 6.40: Number of items and highest scores obtainable for the three Discrepancy subscales on the refined ADF SSS.

ADF SSS Discrepancy scores were derived using the following formula:

ADF SSS Frequency subscale item scores –
ADF SSS Ideal subscale item scores

Then to extrapolate Discrepancy total score:

Positive Functional Support Discrepancy score +
Positive ADF Support Discrepancy score –
Negative ADF Support Discrepancy score =
Total ADF SSS Discrepancy score

Applying the above procedure gives the Discrepancy scale range displayed in Table 6.41.

Total Score	Test ADF SSS	Refined ADF SSS
Maximum	120	51
Minimum	-177	-75

Table 6.41: Highest and lowest scores achievable for the test and refined ADF SSS Discrepancy scale.

Table 6.42 reveals the variance for ADF SSS Discrepancy scores for completed questionnaires. Note that, as was the case with the ADF SSS Ideal scale, these scores are impacted upon by mean item substitution missing data imputation.

	Mean	Standard Deviation	Minimum	Maximum	25th Percentile	75th Percentile
Test Positive Functional Support	-19.23	15.546	-63	20	-30.58	-7.78
Test Negative ADF Support	7.91	7.622	-22	29	3	12.93
Test Positive ADF Support	-4.56	4.285	-17	6	-7.91	-2
Total Test ADF SSS	-31.70	19.821	-99	19	-44	-16
Refined Positive Functional Support	-5.47	6.858	-29	10	-9	-0.79
Refined Negative ADF Support	3.41	4.828	-10	17	0	6
Refined Positive ADF Support	-2.72	3.619	-12	7	-5	0
Total Refined ADF SSS	-11.60	10.353	-46	20	-18.42	-4.09

Table 6.42: Test and refined ADF SSS Discrepancy sub and total scale distributions.

Chapter 7: Main Study: Findings: ADF SSS Refined Version

7.1 Content Validity of the ADF SSS

7.1.1 Qualitative Feedback

Qualitative feedback from family members led to an informed judgement of what should be retained within the refined ADF SSS, thus ensuring a high level of content validity. The qualitative data on the items removed from the test ADF SSS (see Appendix XXXV), supports the values obtained in the quantitative data set which suggested omission. For all items removed there were both quantitative and qualitative reasons for their exclusion. In the case of some items, the decision to omit was based on the fact that there was already a very similar item in the measure which performed better both psychometrically and qualitatively.

The qualitative information gleaned from family members also helped to illuminate some surprising results found in the quantitative dataset. Table 5.1 details that well educated family members were overrepresented in the total sample. However, qualitative comments indicated no discernable differences in reported difficulties in understanding the items and completing the test ADF SSS. Conversely, it was the case that chronologically older family members described more problems in completing the measure, both physically (for instance, reading the type) and cognitively (for example, grasping what some items were asking). Additionally, Section 6.9 reports some very low scores obtained on the various scales of both test and refined versions of the ADF SSS. This finding can be explained by the fact that one family member annotated that her sister was no longer taking drugs, and that the family member was no longer

concerned about the problem substance use, but by health problems resulting from long-term drug use.

Although quantitative data took precedence in guiding the refinement of the test ADF SSS, based on the reliability and validity analysis detailed in Chapters 6 and 7, from a long test version to a shorter more manageable and user friendly questionnaire, qualitative data were collected throughout the study to achieve triangulation. From analysing the qualitative data, it was clear that there were many more problems identified by family members with the items which the quantitative data suggested removing (see Appendix XXXV). During the test phase of the study, the qualitative information provided by family members on the retained ADF SSS items are detailed in Table 7.1.

Refined ADF SSS Items	Qualitative Comments
Q1	"It is alright you trying to explain to people what it is like, but whether they fully understand it, they have got to be in the situation to know exactly what is going on." "If someone does understand it is very important." "The D question, what would your ideal be, no I don't understand what you mean by that one. Surely people always want to be understood."
Q2	
Q3	"Health and Social care professionals... emm obviously they are there for advice..." "I haven't appreciated them."
Q7	"Trust sometimes." "Extremely, yeah." "Surely this relates to number of people? Question D doesn't make sense."

Q9	"I would like the situation to arise where I do not need to talk about my feelings." "Quality relationship."
Q11	"What do you mean by back the stance? How I have been with my child do you mean? Like do they agree with how I have been - some have - quite a few haven't." "Agreed yeah, with the action more or less I have taken, isn't it?" "Reaction support?" "What stance? There is not much I can do about it."
Q12	"I don't like asking for help or 'owing' anyone anything." 1 family member annotated N/A for question D.
Q13	"KWADS (agency) does that. That is the whole point of this group for us to focus on ourselves, and the support that we need to help deal with the user." 1 family member annotated N/A for question D.
Q15	"Have undermined my efforts? I would say yeah, a couple of times they have." "Questioned my efforts?" "Question B is confusing. It is very important that they don't undermine my efforts and that they have never undermined my efforts, but is the question asking about the importance of undermining or the importance of the fact that my friends haven't undermined?" 1 family member annotated N/A for question D.

Q25	"Unduly critical... mmm anyone can look up and criticise a person for what… I wouldn't say unduly, by that do you mean not true? I wouldn't say they have been unduly critical, if they have been critical, they have had their right to." "The manner, if it is justified?" "Because it made me rethink." 1 family member did not understand questions C and D.
Q26	1 family member annotated N/A for question D.
Q27	"A few have said that, and eventually it did happen." "Upset. For question B very significant as a choice?" "Not living with me. Not always a family home."
Q31	
Q32	"No, I wouldn't say they have avoided me at all."
Q33	"They haven't willingly, if I had phoned to speak to the doctor about something like say, if it was information or a bit of advice in the past, this was not in the last three months, this was at the very beginning. My GP would phone me back personally and speak to me on the phone." "D question - I would seek them." "I have not sought support, but if I did, it would need to be once or twice." 1 family member annotated N/A for question D.

Q34	"No not at all, if anything you blame yourself. No-one else has blamed me, but you ask yourself could I have done something different? Should I have seen the signs before, so yeah, you get all that, but no-one has actually blamed me." "D question – stupid question. These questions are really difficult to understand, are they double negatives?"
Q47	"In the heat of the moment when things have been really bad, a couple of people have said that he doesn't deserve the help. Help him, and then he goes and does something else wrong, a few people have said that."
Q48	"What books?"
Q50	"He was too violent for that." 1 family member annotated N/A for question A. 1 family member annotated N/A for question D.
Q51	"I am not saying it would be easier to leave your partner, but to try and leave your child... mmm I couldn't. You could walk away from your partner, but do you walk away from your child? Some parents would say yes they would, but me no, I couldn't. I didn't have my kids to disown them." "Make her leave home, not me." 3 family members annotated N/A for question A.
Q52	"I don't talk about it."
Q54	

Q55	
Q57	"Important that they don't."
Q58	"D question - if necessary." "Not sure if included under the heading of professionals, as a charitable organisation? They have given excellent advice and support."

Table 7.1: Qualitative feedback on the refined ADF SSS items.

7.1.2 Frequency Scale

Content validity of the items was ensured by involving family members, practitioners and the ADF R&DG at every stage of development. The final questionnaire contained 25 items which are representative of the larger pool of 58 items. The Pearson's correlation between the total Frequency scale scores on the test and refined versions of the ADF SSS was calculated at r=0.88, which was significant at the 0.01 level.

Frequency subscale scores within the refined ADF SSS measure were explored. Correlations for the refined ADF SSS Frequency scale scores are displayed in Table 7.2. It can be seen in Table 7.2 that positively perceived functional support and negatively perceived ADF specific functional support failed to correlate significantly. This may be due to the reverse scoring system used, or perhaps, there may need to be a distinction made between general and ADF related social support. However, this result will require further investigation with a larger and more diverse sample of family members.

	Positive Functional Support	Negative ADF Support	Positive ADF Support	Total Score
Positive Functional Support				
Negative ADF Support	.078			
Positive ADF Support	.383**	.289**		
Total Score	.842**	-.336**	.536**	

**Correlation significant at the 0.01 level.

Table 7.2: Frequency subscale score correlations within the refined ADF SSS.

7.1.3 Importance Scale

The correlation coefficient for the consistency between the two versions of the ADF SSS, in terms of total Importance scale score, was calculated at r=0.935 (p<0.01).

Table 7.3 details the correlations between refined ADF SSS Importance subscale scores.

	Positive Functional Support	Negative ADF Support	Positive ADF Support	Total Score
Positive Functional Support				
Negative ADF Support	.366**			
Positive ADF Support	.435**	.382**		
Total Score	.823**	.761**	.720**	

**Correlation significant at the 0.01 level.

Table 7.3: Importance subscale score correlations within the refined ADF SSS.

7.1.4 Satisfaction Scale

The total Satisfaction scale score correlation between the test and refined ADF SSS was r=0.904 (p<0.01). Satisfaction sub and total scale score correlations for the refined ADF SSS are shown in Table 7.4.

	Positive Functional Support	Negative ADF Support	Positive ADF Support	Total Score
Positive Functional Support				
Negative ADF Support	.274**			
Positive ADF Support	.301**	.338**		
Total Score	.826**	.657**	.681**	

**Correlation significant at the 0.01 level.

Table 7.4: Satisfaction subscale score correlations within the refined ADF SSS.

7.1.5 Ideal Scale

Despite the fact that the total Ideal scale score had substantially more missing data mean item substitution than the Frequency, Importance and Satisfaction scales, the correlation between the test and refined ADF SSS was r=0.845 ($p<0.01$).

Table 7.5 indicates how well the Ideal scale scores within the refined ADF SSS related to each other.

	Positive Functional Support	Negative ADF Support	Positive ADF Support	Total Score
Positive Functional Support				
Negative ADF Support	.241**			
Positive ADF Support	.398**	.401**		
Total Score	.810**	-.147	.614**	

**Correlation significant at the 0.01 level.

Table 7.5: Ideal subscale score correlations within the refined ADF SSS.

7.1.6 Discrepancy Scale

As the Discrepancy scale score is a composite of the Ideal and Frequency scale scores, the Discrepancy scale was also impacted upon by missing data mean item substitution. However, the correlation coefficient between the two versions of the ADF SSS for total Discrepancy scale score was $r=0.852$ ($p<0.01$). Discrepancy subscale scores within the refined ADF SSS were explored. Table 7.6 shows the correlation values obtained.

	Positive Functional Support	Negative ADF Support	Positive ADF Support	Total Score
Positive Functional Support				
Negative ADF Support	-.054			
Positive ADF Support	.483**	.109		
Total Score	.856**	-.464**	.619**	

**Correlation significant at the 0.01 level.

Table 7.6: Discrepancy subscale score correlations within the refined ADF SSS.

7.1.7 Total and Sub Scale Intercorrelations

Table 7.7 provides a breakdown of the intercorrelations between the refined ADF SSS Frequency and Importance scale scores. This information is useful in establishing the extent to which the scales are measuring the same constructs.

	Frequency of Positive Functional Support	Frequency of Negative ADF Support	Frequency of Positive ADF Support	Total Frequency Score
Importance of Positive Functional Support	.842**	.212*	.360**	.649**
Importance of Negative ADF Support	.145	.783**	.225**	-.202*
Importance of Positive ADF Support	.323**	.312**	.874**	.429**
Total Importance Score	.606**	.561**	.570**	.385**

**Correlation significant at the 0.01 level.

* Correlation significant at the 0.05 level.

Table 7.7: Intercorrelations between the refined ADF SSS Frequency and Importance scales.

Intercorrelations between the refined ADF SSS Frequency and Satisfaction scale scores are detailed in Table 7.8.

	Frequency of Positive Functional Support	Frequency of Negative ADF Support	Frequency of Positive ADF Support	Total Frequency Score
Satisfaction with Positive Functional Support	.858**	-.015	.214*	.718**
Satisfaction with Negative ADF Support	.343**	.620**	.287**	.049
Satisfaction with Positive ADF Support	.326**	.182*	.858**	.491**
Total Satisfaction Score	.773**	.284**	.556**	.642**

**Correlation significant at the 0.01 level.

* Correlation significant at the 0.05 level.

Table 7.8: Intercorrelations between the refined ADF SSS Frequency and Satisfaction scales.

Table 7.9 shows the intercorrelations between the refined ADF SSS Frequency and Ideal scales.

	Frequency of Positive Functional Support	Frequency of Negative ADF Support	Frequency of Positive ADF Support	Total Frequency Score
Ideal Positive Functional Support	.535**	.113	.181*	.405**
Ideal Negative ADF Support	.226**	.532**	.344**	.032
Ideal Positive ADF Support	.162	.252**	.614**	.238**
Total Ideal Score	.354**	-.069	.279**	.405**

**Correlation significant at the 0.01 level.

* Correlation significant at the 0.05 level.

Table 7.9: Intercorrelations between the refined ADF SSS Frequency and Ideal scales.

The intercorrelations between the refined ADF SSS Frequency and composite Discrepancy scales are detailed in Table 7.10.

	Frequency of Positive Functional Support	Frequency of Negative ADF Support	Frequency of Positive ADF Support	Total Frequency Score
Discrepancy with Positive Functional Support	.827**	.018	.333**	.727**
Discrepancy with Negative ADF Support	-.067	.803**	.098	-.418**
Discrepancy with Positive ADF Support	.325**	.122	.667**	.443**
Total Discrepancy Score	.692**	-.320**	.408**	.831**

**Correlation significant at the 0.01 level.

Table 7.10: Intercorrelations between the refined ADF SSS Frequency and Discrepancy scales.

7.2 Construct Validity of the ADF SSS

7.2.1 Frequency Scale

The measure utilised to validate that the ADF SSS was capturing facets of the social support theoretical construct was the SOS(B). Table 7.11 outlines the correlations between the subscales of the SOS(B) and subscale 1 (positively perceived functional support) and total score for the refined ADF SSS Frequency scale. Refined ADF SSS subscales 2 and 3 are not reported, as no significant results were observed. The strongest correlation was found between the refined ADF SSS Frequency of positively perceived functional support and the SOS(B) emotional support subscale, and is displayed in Figure 7.1.

	ADF SSS Frequency of Positive Functional Support	ADF SSS Total Frequency
Emotional Support SOS(B)	.503**	.394*
Practical Support SOS(B)	.385*	.262
Emotional Support Ideal SOS(B)	.139	.164
Practical Support Ideal SOS(B)	.063	-.017
Emotional Support Discrepancy SOS(B)	.417*	.282
Practical Support Discrepancy SOS(B)	.384*	.324

**Correlation significant at the 0.01 level.

* Correlation significant at the 0.05 level.

Table 7.11: Correlations for the refined ADF SSS Frequency scale against SOS(B) subscales.

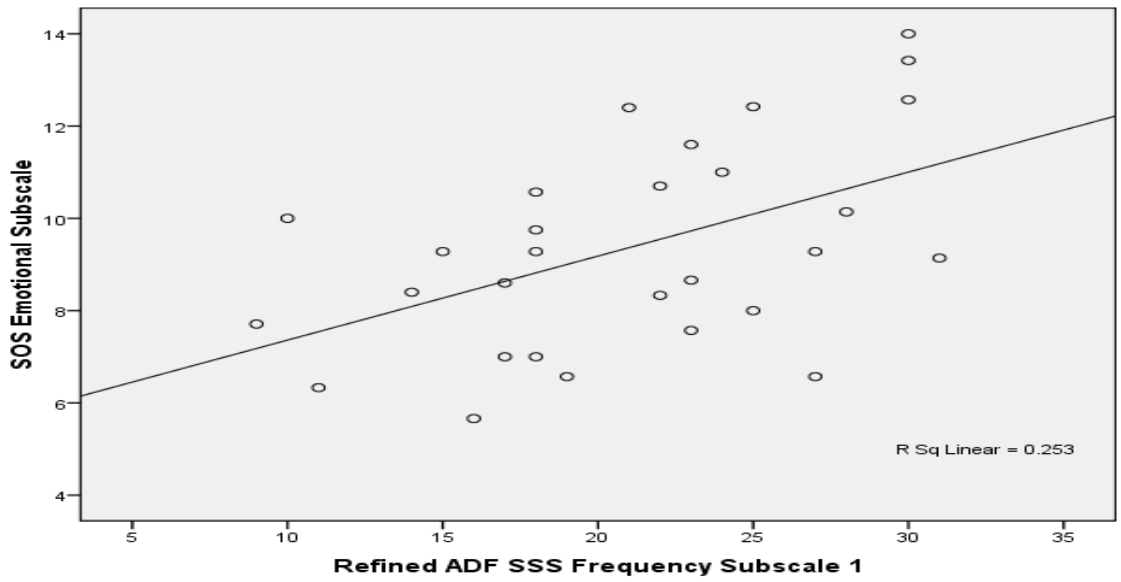

Figure 7.1: Scatterplot of refined ADF SSS Frequency subscale 1 and SOS(B) emotional subscale.

The test version of the ADF SSS contained a general social support question (see Appendix XXII) which merely asked family members to indicate (on a line scale: 0=No Support; 50=Adequate Support; and 100=Full Support) how much support they currently have. Table 7.12 shows the correlations between this general question and sub and total Frequency scale scores on the refined version of the ADF SSS.

Refined ADF SSS Frequency Scales	Support Question
Positive Functional Support	.224*
Negative ADF Support	-.112
Positive ADF Support	.257**
ADF SSS Total Frequency	.349**

**Correlation significant at the 0.01 level.

* Correlation significant at the 0.05 level.

Table 7.12: Correlations between the general social support question and the refined ADF SSS Frequency scales.

The test ADF SSS also contained a question relating to sources of support (i.e. friends, family, professionals and self-help groups) (see Appendix XXII) available to family members. The source question contained eight available sections, and each section completed by the family member was assigned a score of one. Thus the highest total score possible was eight. The total score could be broken down further into a score for the friends, family, professionals and self-help group categories. However, the total score was utilised for statistical analysis, as it provided the best indication of the extent of family members' social support. Table 7.13 outlines the correlations between the basic structural support question and the Frequency scale scores for the refined ADF SSS.

Refined ADF SSS Frequency Scales	Structural Support Question
Positive Functional Support	.290**
Negative ADF Support	-.157
Positive ADF Support	-.078
ADF SSS Total Frequency	.273**

**Correlation significant at the 0.01 level.

Table 7.13: Correlations between the structural social support question and the refined ADF SSS Frequency scales.

Interestingly, the refined ADF SSS total Frequency scale score correlated significantly with both the general support questions. Also it is important to note that both general support questions correlated with each other (0.328; $p<0.01$).

7.2.2 Importance Scale

The refined ADF SSS Importance subscale 1 (positively perceived functional support) correlated significantly with emotional support SOS(B) (0.410; $p<0.05$). However, this correlation was the only significant one observed between the SOS(B) and the refined ADF SSS Importance scale scores.

For the general support question, there were no significant correlations with the refined ADF SSS Importance scales. In terms of the structural support question, the refined ADF SSS Importance subscale 1 (positively perceived functional support) produced a significant correlation (0.247; $p<0.05$).

7.2.3 Satisfaction Scale

Examining the correlations between the refined ADF SSS Satisfaction scales and the SOS(B), there were a number of significant results. Practical support SOS(B) correlated with both the refined ADF SSS satisfaction subscale 1 (positively perceived functional support) (0.449; $p<0.05$) and 3 (positively perceived ADF support) (-0.400; $p<0.05$). The refined ADF SSS Satisfaction with positive functional support scale also showed a significant correlation with practical support discrepancy SOS(B) score (0.454; $p<0.05$).

Table 7.14 displays the relationships between the refined ADF SSS Satisfaction scale scores and the general social support question. As can be seen in Table 7.14, the refined measure produced significant correlations with the support question on subscales 1 (positively perceived functional support), and 3 (positively perceived ADF support) and total Satisfaction scale score.

Refined ADF SSS Satisfaction Scales	Support Question
Positive Functional Support	.216*
Negative ADF Support	-.059
Positive ADF Support	.260**
ADF SSS Total Satisfaction	.209*

**Correlation significant at the 0.01 level.

* Correlation significant at the 0.05 level.

Table 7.14: Correlations between the general social support question and the refined ADF SSS Satisfaction scales.

The structural support question did not produce as many significant correlations as the general support question. However, the refined ADF SSS Satisfaction subscale 1 (positively perceived functional support) correlated with the basic structural support question (see Table 7.15).

Refined ADF SSS Satisfaction Scales	Structural Support Question
Positive Functional Support	.270*
Negative ADF Support	.044
Positive ADF Support	.007
ADF SSS Total Satisfaction	.182

* Correlation significant at the 0.05 level.

Table 7.15: Correlations between the structural social support question and the refined ADF SSS Satisfaction scales.

7.2.4 Ideal Scale

The Ideal scales on the refined ADF SSS did not correlate significantly with any of the SOS(B) subscales, nor did the Ideal scale scores register a significant correlation with the general social support question. Nevertheless, Table 7.16 displays that the Ideal subscale 1 (positively perceived functional support) and total Ideal score on the refined ADF SSS correlated with the basic structural support question.

Refined ADF SSS Ideal Scales	Structural Support Question
Positive Functional Support	.331**
Negative ADF Support	-.033
Positive ADF Support	-.050
ADF SSS Total Ideal	.241*

**Correlation significant at the 0.01 level.

* Correlation significant at the 0.05 level.

Table 7.16: Correlations between the structural social support question and the refined ADF SSS Ideal scales.

7.2.5 Discrepancy Scale

For the composite Discrepancy scale, the refined ADF SSS correlated significantly with the SOS(B). Specifically, as can be seen in Table 7.17, the refined ADF SSS Discrepancy subscale 1 (positively perceived functional support) and total Discrepancy scale correlated with the SOS(B) practical support Discrepancy score. Additionally, the refined ADF SSS positively perceived functional support Discrepancy score correlated significantly with the SOS(B) emotional support Discrepancy scale.

	Refined ADF SSS Positive Functional Support Discrepancy	Refined ADF SSS Total Discrepancy
Emotional Support SOS(B)	.326	.285
Practical Support SOS(B)	.319	.215
Emotional Support Ideal SOS(B)	-.097	-.062
Practical Support Ideal SOS(B)	-.075	-.116
Emotional Support Discrepancy SOS(B)	.461*	.351
Practical Support Discrepancy SOS(B)	.450*	.371*

* Correlation significant at the 0.05 level.

Table 7.17: Correlations between the refined ADF SSS Discrepancy scales and the SOS(B) subscales.

The refined ADF SSS Discrepancy scales correlated significantly with the general social support question. Table 7.18 shows that the refined ADF SSS Discrepancy subscales 1 (positively perceived functional support), and 3 (positively perceived ADF support) and total Discrepancy score all correlated significantly with the social support question. However, the basic structural

social support question did not correlate strongly with the refined ADF SSS Discrepancy scale scores.

Refined ADF SSS Discrepancy Scales	Support Question
Positive Functional Support	.237*
Negative ADF Support	-.138
Positive ADF Support	.278**
ADF SSS Total Discrepancy	.329**

**Correlation significant at the 0.01 level.

* Correlation significant at the 0.05 level.

Table 7.18: Correlations between the general social support question and the refined ADF SSS Discrepancy scales.

7.3 Test-retest Reliability of the ADF SSS

7.3.1 Frequency Scale

The test-retest reliability coefficients for the refined ADF SSS Frequency scales are displayed in Table 7.19. All values were strong with a low of 0.891 ($p<0.01$) for subscale 3 (positively perceived ADF support) and a high of 0.970 ($p<0.01$) for the refined ADF total Frequency scale.

Refined ADF SSS Frequency Scales	
Positive Functional Support	.934
Negative ADF Support	.894
Positive ADF Support	.891
Total	.970

Table 7.19: Test-retest correlation coefficients for the refined ADF SSS Frequency scales.

Test-retest reliability kappa values for the refined ADF SSS Frequency subscale 1 (positively perceived functional support) items ranged between 0.385 and 0.749 indicating a moderate to good level of agreement. Mean difference in scores for individual items comprising the Frequency of positively perceived functional support scale ranged from 0 to 0.222 (see Table 7.20).

Refined ADF SSS Frequency of Positive Functional Support Items	Mean difference in scores	Kappa values
1a	.055	.615
2a	.02	.385
7a	.16	.724
9a	.06	.749
11a	.11	.526
12a	.11	.690
13a	.11	.722
26a	.11	.526
52a	.166	.748
54a	.222	.554
55a	.0	.681

Table 7.20: Mean difference in scores and kappa values for the refined ADF SSS Frequency of positively perceived functional support items.

Table 7.21 shows that the mean difference in scores for the refined ADF SSS Frequency subscale 2 (negatively perceived ADF support) items varied from 0 to 0.333. Kappa values for the same items ranged from 0.402 to 0.806 signifying good levels of agreement.

Refined ADF SSS Frequency of Negative ADF Support Items	Mean difference in scores	Kappa values
15a	.055	.534
25a	.277	.447
27a	.333	.514
31a	.000	.402
32a	.05	.726
34a	.111	.806
47a	.222	.429
57a	.000	.567

Table 7.21: Mean difference in scores and kappa values for the refined ADF SSS Frequency of negatively perceived ADF support items.

As displayed in Table 7.22, the refined ADF SSS Frequency subscale 3 (positively perceived ADF support) items produced adequate test-retest reliability kappa levels of agreement from 0.390 to 0.727. Mean difference between item scores for the refined ADF SSS Frequency of positively perceived ADF support scale ranged from 0.055 to 0.277.

Refined ADF SSS Frequency of Positive ADF Support Items	Mean difference in scores	Kappa values
3a	.070	.390
33a	.222	.699
48a	.277	.422
50a	.055	.727
51a	.222	.658
58a	.277	.684

Table 7.22: Mean difference in scores and kappa values for the refined ADF SSS Frequency of positively perceived ADF support items.

7.3.2 Importance Scale

Test-retest correlation coefficients were calculated for the refined ADF SSS Importance scales. Table 7.23 displays that the refined ADF SSS Importance scales retained good levels of test-retest reliability, with Importance subscale 1 (positively perceived functional support) producing the highest coefficient consistency value of 0.956 ($p<0.01$), and Importance subscale 3 (positively perceived ADF support) giving the lowest value of 0.787 ($p<0.01$).

Refined ADF SSS Importance Scales	
Positive Functional Support	.956
Negative ADF Support	.887
Positive ADF Support	.787
Total	.917

Table 7.23: Test-retest correlation coefficients for the refined ADF SSS Importance scales.

7.3.3 Satisfaction Scale

As Table 7.24 shows, the test-retest correlation coefficient for the refined ADF SSS Satisfaction total score was high 0.935 ($p<0.01$), indicating a good level of agreement between total score on replicate measures. The refined ADF SSS Satisfaction subscales also demonstrated reasonably high levels of reliability, with Satisfaction subscale 1 (positively perceived functional support) performing best 0.966 ($p<0.01$), and Satisfaction subscale 3 (positively perceived ADF support) having the lowest value of 0.770 ($p<0.01$).

Refined ADF SSS Satisfaction Scales	
Positive Functional Support	.966
Negative ADF Support	.800
Positive ADF Support	.770
Total	.935

Table 7.24: Test-retest correlation coefficients for the refined ADF SSS Satisfaction scales.

7.3.4 Ideal Scale

Table 7.25 illustrates that the test-retest reliability coefficients for the refined ADF SSS Ideal scale were quite reasonable, with Ideal subscale 3 (positively perceived ADF support) producing the highest correlation of 0.945 ($p<0.01$), and subscale 2 (negatively perceived ADF support) performing least well 0.842 ($p<0.01$).

Refined ADF SSS Ideal Scales	
Positive Functional Support	.848
Negative ADF Support	.842
Positive ADF Support	.945
Total	.890

Table 7.25: Test-retest correlation coefficients for the refined ADF SSS Ideal scales.

7.3.5 Discrepancy Scale

Table 7.26 shows that, despite the fact that Discrepancy scores are a composite of both Frequency and Ideal scales, all Discrepancy scales on the refined version of the ADF SSS posted significant test-retest correlations at the 0.01 level.

Refined ADF SSS Discrepancy Scales	
Positive Functional Support	.905
Negative ADF Support	.867
Positive ADF Support	.867
Total	.956

Table 7.26: Test-retest coefficients for the refined ADF SSS Discrepancy scales.

7.4 ADF SSS Qualitative Findings on Scales

From the qualitative data (see Appendix XXXV and XXXVI) there were many issues with questions B (Importance) and C (Satisfaction) for each item, indicating that family members had difficulty following the instructions on completing those questions. The qualitative feedback also triangulates the findings of the significant amount of missing quantitative data for the D (Ideal) questions, in that a high proportion of the sixty family members reported difficulty and confusion over answering the Ideal question.

Given the problems with questions B, C and D, only the A (Frequency) question was retained for the final ADF SSS, keeping the refined instrument (Appendix XXXVII) consistent with other ADF R&DG quantitative measures. The author is confident about suggesting retaining the Frequency scale as it performed best psychometrically and family members had much more ease both understanding

and completing it. However, although the other three scales performed satisfactorily in quantitative terms, family members reported too many problems completing them in practice. Perhaps the three scales could be reintroduced on a measure which is practitioner assisted, but in present form, they are not feasible as part of a self-completion measure.

A further qualitative exploration was undertaken with fifty family members after the preliminary factor analysis of the ADF SSS, and family members reported that the items emerging from this analysis all made sense and were relevant experientially to them. Also they reported that there was nothing of significance to their experience missing from the pool of items. All of this qualitative data informed the final refined set of items presented in Table 7.27.

Factor Labels	ADF SSS Items
Positive Functional Support (Emotional and Instrumental Support, Social Companionship and Support for Coping).	1 Friends/relations have **understood what it is like for me to live with my relative's drinking or drug taking**. 2 Friends/relations have **helped to cheer me up**. 4 I have friends/relations **whom I trust**. 5 Friends/relations have **listened to me when I have talked about my feelings**. 6 Friends/relations have **backed the decisions that I have taken towards my relative and their drinking or drug taking**. 7 Friends/relations have **put themselves out for me when I needed practical help** (i.e. aid or assistance). 8 Friends/relations have **advised me to focus on myself and my own needs**. 11 Friends/relations have **given me space to talk about my problems**. 21 Friends/relations have **been there for me**. 22 Friends/relations have **provided support for the way I cope with my relative**. 23 Friends/relations have **talked to me about my relative and listened to what I have to say**.
Negative ADF Specific Support (Support for Coping and Attitudes and Actions towards the Using Relative).	9 Friends/relations have **questioned my efforts to stand up to my relative's problem drinking or drug taking**. 10 Friends/relations have been **too critical of my relative**. 12 Friends/relations have said that **my relative should leave home**. 13 Friends/relations have **said things about my relative that I do NOT agree with**. 14 Friends/relations have **avoided me because of my relative's drinking or drug taking**. 16 Fiends/relations have **blamed me for my relative's behaviour**. 17 Friends/relations have said that **my relative does NOT deserve help**. 24 Friends/relations have **said nasty things about my relative**.

Positive ADF Specific Support (Informational - both formal and informal - and Emotional Support, Support for Coping and Attitudes and Actions towards the Using Relative).	3 Health/social care workers have given me **helpful information** about problem drinking or drug taking. 15 Health/social care workers have **made themselves available** for me. 18 I have **identified with the information within books/booklets** about people living with a problem drinker or drug taker. 19 Friends/relations have **told my relative off on my behalf**. 20 Friends/relations have **advised me to leave my relative**. 25 I have **confided in my health/social care worker about my situation**.

Table 7.27: Final subscales and items comprising the refined ADF SSS. All completed using a 4-point scale, 0 (Never) – 3 (Often).

7.5 Socio-demographic Outcomes

Preliminary descriptive analysis indicated that question A (Frequency) on the refined ADF SSS provided a distribution of scores on the salient socio-demographic variables examined during the testing phase of the study. Table 7.28 details the breakdown of total Frequency scores and distributions using the socio-demographic characteristics of the test sample (n=132) (i.e. in that sample, the mean refined ADF SSS total Frequency score for males was 20.14, and that for females was 22.19).

	Number of Participants	ADF SSS Frequency Scores	
		Mean	SD
Sex			
Male	**25**	**20.14**	**11.46**
Female	**101**	**22.19**	**11**
Overall	**126**	**21.78**	**11.1**
Age			
16-24	**3**	**9.31**	**5.99**
25-35	**19**	**22.78**	**10**
36-49	**40**	**19.55**	**11**
50-64	**55**	**23.54**	**10.5**
65+	**12**	**22.49**	**13.5**
Overall	**129**	**21.76**	**10.98**
Ethnic Origin			
White	**125**	**21.86**	**10.91**
Chinese	**1**	**38**	**-**
Hispanic	**1**	**10**	**-**
Other: not stated	**1**	**4.86**	**-**
Overall	**128**	**21.76**	**11**
Activity			
Employed	**67**	**21.98**	**10.1**
Volunteer	**4**	**16**	**12.75**
Housework	**21**	**20.1**	**12.68**
Student	**7**	**30.24**	**8.1**
Retired	**22**	**22.56**	**12.62**
Unable to work	**3**	**23.95**	**4.28**
Seeking work	**4**	**14.48**	**8.2**
Unemployed	**1**	**11**	**-**
Overall	**129**	**21.76**	**10.99**

Higher Education			
Yes	**78**	**22.41**	**9.51**
No	**48**	**20.6**	**12.93**
Overall	**126**	**21.72**	**10.92**
Family Member			
Husband	**7**	**18.6**	**15.4**
Wife	**36**	**25.7**	**10.3**
Partner male	**5**	**28**	**7.73**
Partner female	**5**	**28.17**	**6.68**
Son	**3**	**14.3**	**3**
Daughter	**11**	**19.27**	**7.63**
Father	**8**	**20.78**	**10.05**
Mother	**39**	**19.55**	**12.36**
Brother	**1**	**22**	**-**
Sister	**5**	**17**	**7.97**
Wife and Mother	**1**	**22**	**-**
Wife, Mother and Sister	**1**	**32**	**-**
Mother and Sister	**1**	**14**	**-**
Grand-daughter	**1**	**10**	**-**
Aunt	**1**	**38**	**-**
Friend male	**1**	**2**	**-**
Overall	**126**	**21.78**	**11.11**

Relative			
Husband	**37**	**24.54**	**12.325**
Wife	**7**	**18.6**	**15.3**
Partner male	**5**	**27.17**	**5.7**
Partner female	**5**	**29**	**8.35**
Son	**31**	**21.13**	**11**
Daughter	**14**	**19.32**	**10.45**
Father	**5**	**22.78**	**5.87**
Mother	**9**	**15.67**	**6.69**
Brother	**4**	**22**	**1.4**
Sister	**1**	**3**	**-**
Husband and Son	**1**	**22**	**-**
Son and Brother	**1**	**14**	**-**
Husband, Son and Brother	**1**	**32**	**-**
Son, Daughter, Brother and Sister	**1**	**20**	**-**
Son and Daughter	**2**	**21.2**	**0.484**
Brother and Sister	**1**	**19**	**-**
Grand-father	**1**	**10**	**-**
Niece	**1**	**38**	**-**
Friend male	**1**	**2**	**-**
Friend female	**1**	**17.32**	**-**
Overall	**129**	**21.76**	**10.98**
Recently Residing with Family Member			
Yes	**80**	**21.85**	**11.7**
No	**47**	**21.54**	**9.985**
Overall	**127**	**21.73**	**11**

Table 7.28: The refined ADF SSS Frequency scores (means and standard deviations) for family members divided by key socio-demographic characteristics.

Chapter 8: Discussion

8.1 Study Overview

As detailed in Chapters 1 and 2, social support is a key area within the SSCS model which hitherto was not assessed in a quantitative fashion by the ADF R&DG. Although a great deal of qualitative information was accumulated and integrated into the SSCS conceptual framework in the form of lengthy semi-structured interviews with the family members of problem substance users, the other main facets of the model (stress, strain and coping) had mixed methodological support. Thus via the present study the author aimed to address this issue by operationalising social support for family members and subsequently developing a reliable and valid self-completion measure.

In terms of operationalisation, Chapter 2 detailed the salient social support theoretical constructs relevant to family members who have a problem drinking or drug taking relative. To summarise, these included the general functional support constructs of emotional, informational, social companionship and instrumental support. Additionally, there were two ADF specific functional support constructs of support for coping and attitudes and actions towards the using relative. Emphasis was placed on perceived functional support, specifically examining valence, salience, satisfaction, adequacy and congruence. Structural social support assumed less prominence, however, sources, frequency and availability were considered.

The opening paragraph of this section makes it clear that adopting a mixed methodological approach to research and theory building is a particular tenet adhered to by the ADF R&DG, and Chapter 3 provides historical and descriptive detail of why this position is assumed. Ultimately the ADF R&DG believe that, by utilising both qualitative and quantitative methods in combination, this

enables the researcher to construct superior explanations of observed social phenomena (Velleman and Templeton, 2003). Consequently, applying this perspective to the SSCS model means that having mixed methods available for all four salient elements will strengthen the model making it more robust and useful. Psychometric procedures for ensuring the questionnaire developed for the social support component achieved adequate levels of reliability and validity were examined. Descriptive detail on all the different forms of reliability was given, focusing on internal consistency and test-retest reliability which were assessed in this thesis. For validity, all techniques including: face, content, construct and criterion validity were discussed.

Chapter 4 contains information on how the pilot work was conducted to systematically analyse qualitative data thematically from family members to produce, using principles of traditional questionnaire development, an initial (75-item) self-completion version of the ADF SSS to assess perceived availability, quality and adequacy of functional social support. Preliminary mixed method feedback from ten family members guided the refinement of the measure to enable the production of a shorter 58-item test version of the ADF SSS.

The test version (58-item) of the ADF SSS was subjected to rigorous mixed methodological processes described in Chapter 5. In terms of quantitative data, one hundred and thirty two family members completed the test ADF SSS, eighteen completed the test-retest version of the ADF SSS and twenty nine completed the SOS(B) questionnaire to provide validation information. For the qualitative, 'cognitive interview' aspect, one hundred and ten family members gave interpretive feedback. Practice based feedback from fifty professionals was also integral to the qualitative information. Both large data sets complemented and corroborated each other to enable the development of a psychometrically robust self-completion ADF SSS.

Chapters 6 and 7 elaborate the actual mixed method techniques utilised to explore the internal (PCA and item analysis) and test-retest (correlation coefficients and kappa values) reliability, and content (Pearson's scale and

subscale correlations, interviews and correspondence from family members, practitioners and the ADF R&DG) and construct (correlations with SOS(B), general social support and sources questions) validity.

In summary, the refined (25-item) ADF SSS achieved good levels of internal consistency. Cronbach's alpha for ADF SSS Frequency of positively perceived functional support (subscale 1) was 0.913, 0.851 for Frequency of negatively perceived ADF related support (subscale 2) and 0.727 for Frequency of positively perceived ADF specific support (subscale 3). Additionally, Importance (0.886, 0.838 and 0.721) and Satisfaction (0.889, 0.838 and 0.712) scales posted similar levels of internal reliability as the Frequency scale. However, primarily due to missing data, the Ideal scale (0.818, 0.697 and 0.687) fared less well.

The refined ADF SSS also obtained satisfactory levels of test-retest reliability. The ADF SSS Frequency scale achieved a correlation coefficient of 0.970, with values of 0.934, 0.894 and 0.891 respectively for Frequency subscales 1, 2 and 3. The Items comprising each Frequency subscale produced reasonable kappa values (from 0.385 to 0.749 for Frequency of positively perceived functional support, 0.402 to 0.806 for Frequency of negatively perceived ADF support and 0.390 to 0.727 for Frequency of positively perceived ADF support). Refined ADF SSS Importance (0.917), Satisfaction (0.935) and Ideal (0.890) scales also produced adequate levels of test-retest reliability.

In examining the content validity of the ADF SSS, the Frequency scale score for the refined ADF SSS correlated significantly with the larger 58-item pool of the test version at 0.888 ($p<0.01$). Refined ADF SSS Frequency subscale scores correlated significantly with the total Frequency score (0.842 for Frequency of positively perceived functional support, -0.336 for Frequency of negatively perceived ADF support and 0.536 for Frequency of positively perceived ADF support). ADF SSS Importance (0.934), Satisfaction (0.904) and Ideal (0.845) scale total scores also correlated satisfactorily between test and refined measures.

Moreover, the SOS(B) questionnaire was utilised as a measure of construct validity for the ADF SSS. The refined ADF SSS Frequency scale total score correlated significantly with SOS(B) Emotional scale (0.394, $p<0.05$), and Frequency of positively perceived functional support registered correlations with SOS(B) Emotional (0.503, $p<0.01$) and Practical (0.385, $p<0.05$) scales, and with both respective SOS(B) Discrepancy scores (0.417, $p<0.05$; 0.384, $p<0.05$). Refined ADF SSS Frequency total score also correlated with general (0.349, $p<0.01$) and structural (0.273, $p<0.01$) support questions contained within the test version of the ADF SSS.

The only correlation found for the SOS(B) and refined ADF SSS Importance scale, was between Importance of positively perceived functional support and SOS(B) Emotional (0.410, $p<0.05$) score. The refined ADF SSS Satisfaction with positively perceived functional support correlated with both SOS(B) Practical (0.449, $p<0.05$) and Discrepancy (0.454, $p<0.05$) scales, and Satisfaction with positively perceived ADF support posted a negative correlation with SOS(B) Practical score (-0.400, $p<0.05$). The refined ADF SSS Ideal scale failed to correlate significantly with any of the SOS(B) scale scores. However, the refined ADF SSS positively perceived functional support Discrepancy score (a composite of ADF SSS Frequency and Ideal scores) managed to correlate significantly with SOS(B) Emotional (0.461, $p<0.05$) and Practical (0.450, $p<0.05$) Discrepancy scores.

The qualitative data fed into the validity checks to ensure that the items retained in the refined instrument captured experiential social support phenomena for the family members of problem substance users. It is interesting to note that the qualitative information corroborated and added an extra dimension to the psychometric results. Specifically, qualitative information from family members identified further issues with the items rejected due to PCA and item analysis techniques. Problems with this set of items were much more pronounced than those cited for items which were retained after quantitative procedures. The qualitative comments also showed that family members had difficulty in following

the instructions for self-completing the Importance (B) and Satisfaction (C) questions for each item. This was particularly apparent for the Ideal (D) questions where qualitative feedback by family members reporting confusion with the D questions corroborated the large amount of missing data for the Ideal scale in the quantitative dataset.

Further qualitative exploration on the retained items assisted fine tuning of item wording and provided more descriptive detail to confirm that the content of the refined ADF SSS was applicable to family members. This supplemented the psychometric findings outlined above which indicated that the refined ADF SSS was both reliable and valid. Thus a short, user-friendly, reliable and valid self-completion ADF SSS was developed to complement the other quantitative measures used to assess the main theoretical components of the SSCS model.

8.2 Study Findings in Context

This thesis set out to operationalise the concept of social support specific to the family members of problem drinkers and/or drug takers, primarily in order to strengthen the SSCS theoretical model. As stated, although the SSCS model is a useful approach to account for the experiences of family members, methodologically it lacked a quantitative measure of the social support component. Thus the study sought to develop a psychometrically robust self-completion Social Support Scale applicable to family members. This programme of work aimed to design and develop an ADF specific SSS to complement the reliable and valid self-completion quantitative questionnaires for the other main aspects of the SSCS model. These included the Family Environment Scale (Moos and Moos, 1981) or Family Impact Scale (FIS) (Orford *et al*., 2005b) for family stress, the Symptom Rating Test (Kellner and Sheffield, 1973) for strain and the Coping Questionnaire (Orford *et al*., 1975) for coping styles.

The strong psychometric performance of the ADF SSS Frequency scale, especially in terms of the reliability and validity scores obtained (see Section 8.1), strongly intimated that the work undertaken was important and significant from a methodological standpoint. The final (25-item) ADF SSS illustrated that it was possible to utilise 35 years of qualitative data collected by the ADF R&DG (see Section 2.4) directly from family members about their experiences of social support, convert the resultant themes into items and questions and subject this information to stringent mixed methodological techniques to produce a robust measure.

Throughout the duration of the study, the researcher adhered to the traditional questionnaire development rationale of retaining a large pool of items for each theoretical construct until there were either psychometric or qualitative grounds for item elimination (Carmines and Zeller, 1979). Thus, the measure encapsulated as carefully as possible the original source qualitative information from family members regarding the extent and quality of their social support. This objective could only have been achieved by adopting a truly mixed methodological approach to the dataset. Specifically, thematic analysis and inferential statistical techniques complemented and corroborated each other to produce a sensitive ADF specific social support instrument.

The decision to omit the Importance (B) and Satisfaction (C) questions on the final ADF SSS was taken primarily to ensure that the self-completion measure was straightforward, relevant and as short as possible to reduce the response burden for family members who are experiencing chronic stress. Also psychometrically it was the case that the Frequency scale correlated most significantly with construct outcome indices and was consistent with other standardised questionnaires utilised by the ADF R&DG.

Furthermore, distributions of Satisfaction measurements tend to be negatively skewed and positively biased (Peterson, 2000). Previous attempts by the ADF R&DG to develop a measure of salience on a standardised self-esteem

questionnaire did not lead to fruition (Velleman, 1987). Also importantly, salience issues for concerned and affected family members can be captured by using a concurrent symptoms measure, such as the Symptom Rating Test (Kellner and Sheffield, 1973).

From a theoretical perspective, the programme of work illuminated the social support elements salient for family members. To recap, functional social support refers to the type, quantity and quality of aid and assistance available or actually provided by interpersonal relationships (Glazer, 2006). Pertinently, it is the perceived availability of functional support which has been shown to be the most important determinant of stress mediation and well-being, and thus the most essential aspect of social support (Pinkerton and Dolan, 2007).

The first theoretical label to emerge from both PCA and item analysis procedures was that of positively perceived functional support, which comprised the construct elements of emotional and instrumental support, social companionship and support for coping. The second factor label was that of negatively perceived ADF specific functional support, which included support for coping and attitudes and actions towards the using relative. Finally, positively perceived ADF related functional support, which contained the functional dimensions of support for coping, attitudes and actions towards the using relative, formal and informal informational and emotional support, formed the third factor captured by the refined ADF SSS.

The study findings clarified the salient social support facets relevant experientially to family members and extrapolated, in a focused manner, the perceived functional construct dimensions which are most meaningful to this particular population. Thus the thesis built upon and advanced the ADF R&DG's understanding of the most important social support processes which impact upon family members. Specifically, as previously outlined in Chapters 1 and 2, the perceived functional support facets highlighted as noteworthy in the lives of concerned and affected family members dealing with chronic stressful experiences were: emotional, informational and instrumental support, social

companionship, support for coping and attitudes and actions towards the using relative (Orford *et al.*, 2005a; Hogan *et al*., 2002; Hartney *et al*., 1998).

Although conceptually the functional components separated on valency, and to an extent (however as expected there was some overlap) on general versus ADF specific grounds, the functional dimensions did not emerge as distinct. This mirrors previous findings which stated that efforts to develop definitions of supportive behaviour have served to highlight the complexity of categorising the social support domain. Additionally, the functional dimensions are often couched in idiosyncratic labels and are difficult to delineate, compare or integrate (Sarason *et al*., 1994). However, this is not a major issue as perceived functional dimensions are not mutually exclusive and influence each other in important ways (Glazer, 2006). More significantly, many researchers consider perceived functional dimensions to capture the true nature and meaning of social support and that qualitative, subjective measures of potential intangible (interpersonal) and tangible assistance are more strongly related to stress amelioration and health outcomes (Chronister *et al*., 2006; Kim and McKenry, 1998).

In a wider theoretical sense, the study findings strengthen the SSCS model posited by the ADF R&DG. Conceptually and operationally, researchers recognise that the social support domain consists of distinct constructs and specific dimensions within constructs (Haber *et al*., 2007). It was apparent that the ADF R&DG had much insight into the main social support constructs which related to the needs of concerned and affected family members. However this thesis signified more specific research into the links between specific stressors and forms of pertinent social support, and thus extended and clarified the ADF R&DG's focused knowledge about salient social support for family members dealing with the alcohol and/or drug problem of a close relative.

Pertinently, the ADF specific perceived functional support facets of support for coping and attitudes and actions towards the using relative both emerged as significant theoretical dimensions of how family members experienced social

support. It is important to note that, as with the other more general dimensions of functional support processes, these ADF related aspects can be perceived both positively and negatively by the family members.

Given the social support insights derived from this current study, a fuller picture is now available to re-appraise the social support component of the model (see Section 8.5), and thus provide more focused descriptive detail and exemplar material on this central tenet of the SSCS model. Having the level and quality of ADF specific social support successfully operationalised means that a powerful factor, with the potential both to mitigate the effects of stress on health and mediate coping strategies, can now be assessed (Orford *et al*., 2005a). Thus the SSCS model can be further enhanced with the availability of a complete set of quantitative measures. Furthermore, research data relating to the model can be triangulated in the context of having a holistic perspective with both qualitative and quantitative information available. This study, therefore, represents a major contribution to the work in this field.

Equipped with this information it will be possible to further explore the relationship between particular facets of social support and coping styles. Additionally, it will be possible to explore the dynamics between family stress and social support, and the interaction between social support and physical and psychological symptomatology. Therefore, tests of mediation or moderation can be performed on the main elements of the SSCS model using sophisticated statistical modelling techniques. Consequently, these research findings could be utilised to further inform, hone and assess the evidence-based 5-step intervention for family members which emerged from the SSCS theoretical model. The intervention provides support for family members in their own right and corresponds to the main concepts of the SSCS perspective. The steps of the intervention include strategies for exploring three key areas: the stress experienced by family members, their coping responses and the social support available to them.

Now that there are standardised psychometric instruments available for all of the major components of the intervention, its overall effectiveness can be assessed, with particular emphasis on demonstrating change on the three main factors (stress, coping and social support). Apart from the fact that the ADF SSS Frequency scale performed best in terms of completion rate, internal and test-retest reliability, and content and construct validity, another prominent consideration for retaining this scale, whilst discarding the others, was keeping the assessment criterion measure consistent with the other questionnaires utilised to test the SSCS model and subsequent intervention.

Being able to assess the entire intervention will provide more triangulated evidence about the efficacy of the approach. Potentially, this evidence-based intervention could be expanded in scope from primary (Copello *et al*., 2009) and secondary (Templeton, Zohhadi, and Velleman, 2007) care trials to be implemented in routine practice both nationally and perhaps internationally. This is important because there exists a serious gap in service provision for the large numbers of family members in the UK, and it would give practitioners an approach to conceptualise and help meet the needs of concerned and affected family members.

8.3 Study Limitations

Although the author was meticulous with the planning and execution of the project, with any large scale piece of work numerous weaknesses occurred whilst implementing the study protocol. This section and Section 8.4, describe the many issues which arose while conducting the work.

A major drawback in attempting to generalise from the study findings was that the study sample was UK focused for both pilot and testing phases, in that the vast majority of participants were white British. Nonetheless, the qualitative data utilised to construct the questionnaire items were drawn from at least three

different socio-cultural groups (Mexico City, South West England and Northern Australia). That qualitative dataset in which accounts were compared and contrasted using the principles of grounded theory (Strauss and Corbin, 1998), suggested that there appears to be a core experience shared by family members throughout the world, who worry for close relatives who are drinking and/or taking drugs excessively (Orford *et al*., 2005a). However, this does not negate the fact that there was very little ethnic diversity within the UK centric study sample. The refined ADF SSS will need to be administered to different ethnic groups within the UK, and tested with different cultural groups around the world to achieve generalisability.

It was also the case that the study participants were predominantly female. Although this mirrors previous ADF R&DG samples, increasing male participation is of major concern for the research group. A theoretical sampling approach (Strauss and Corbin, 1998; Willig, 2001) would need to be adopted to ensure that males are represented more significantly within the programme of work. Nevertheless, the current research did achieve a good spread of relationships (i.e. partners, parents and siblings) for both the family members and the problem drinking or drug taking relatives, and thus was generalisable to the entire gamut of relations. Also the sampling was wide in terms of including agencies with different service model approaches towards intervening with family members. Finally, in relation to the study sample, the bulk of family members involved were engaged with an agency or a self-help group. Family members drawn from a community setting did not show any discernable differences in questionnaire scores with the practice based participants. However, they only formed a very small percentage of the overall sample size.

A single imputation method was used for missing data which can distort data distributions (estimated variance and standard deviations) and relationships (estimated covariances and correlations). Even if single imputation preserves marginal and joint distributions, there is no simple way to reflect missing data uncertainty, although some more complex model based procedures show promise (Little and Rubin, 1987). However, preliminary investigations suggest

that the mean item substitution method can be reasonably well behaved (Raaijmakers, 1999). Furthermore, the Frequency scale which was retained for the final measure had very little missing data, and certainly not over five percent for any of the test ADF SSS's completed.

The study involved utilising postal questionnaires in both the piloting and testing stages, and there are inherent issues when adopting this procedure. Unless the participant annotates the questionnaire, the researcher has no understanding of the considerations of family members in interpreting and answering the questions, or indeed, whether the family member is completing the measure unassisted. Research participants may be motivated to complete a questionnaire through interest, boredom, a desire to help others, because they feel pressurised to do so, through loneliness or for an unconscious ulterior motive. All of these introduce potential biases into the recruitment and data collection process (Boynton and Greenhalgh, 2004). Response rates are usually low and the figure of 40 percent completion rate is not uncommon - a phenomenon observed in the current study.

Poor response rates are likely to be a source of bias, as non-respondents tend to differ from respondents in systematic ways that are relevant to the purpose of the enquiry (Peterson, 2000). For instance, Taylor and Lynn (1998) gave examples where item non-response rates were higher for males, less well educated and qualified people and lower social classes. Concomitantly, it was observed in the current study that completion rates of the ADF SSS for chronologically older respondents were lower than that of their younger counterparts.

8.4 Research Learning from Conducting the Study

The foregoing section highlighted the weaknesses incurred while conducting the study. However, there was also much learning that occurred throughout the duration of the study. The researcher had such a difficult time recruiting adequate numbers of volunteer family members for PCA techniques and consequently had to extend the data collection phase for over twelve months.

This experience is comparable to previous findings by the ADF R&DG, especially when family member access is via practitioners. There is much enthusiasm for the research, but factors such as time, work pressures, staff turnover and attempting to recruit during busy or vacation periods have all been cited as potential barriers to recruitment (Templeton *et al*., 2007). Even though the most well documented strategies to improve response rate were utilised, such as stamped addressed envelopes, covering letters, clear instructions and multiple reminders (by letter, telephone and email), it may be the case that monetary incentives or remuneration for both practitioners and family members should be a standard aspect of the research protocol and looked upon more favourably by ethics committees, especially for pilot work where respondent burden tends to be high.

Linked to respondent burden, the initial prototype pilot questionnaire and subsequent versions were quite unwieldy, as the researcher was eager to cover the evidence-based ADF specific salient dimensions of the multifaceted concept of social support. Although this process was necessary in order to uncover what worked both psychometrically and qualitatively, and thus narrow the scope of the measure to the most essential constituents, the length and complexity of the pilot and test instruments no doubt contributed to the erroneous, missing and perfunctory responses observed on a number of questionnaires.

The author was rather ambitious with the initial content of the measure as, although from a theoretical perspective there were good grounds to include many different facets of the social support domain, this was not conducive in a

practical sense to a self-completion questionnaire. In hindsight, the correct decision was made not to focus primarily on structural aspects, as the qualitative and quantitative data bore out that a prototype question, with prompts, asking respondents to recall sources of support was not understood easily nor completed fully (left blank or other measurement errors) in some cases.

Additionally, there were theoretical reasons to include a question relating to family members' ideal extent and quality of social support. Explicitly, if a family members' appraisal of support is discrepant from 'ideal' or 'ought' beliefs, then emotional distress is implicit (Pierce *et al*., 1999). However, the dataset confirmed the view of Peterson (2000) that asking participants to predict their response to a future or hypothetical situation should be done with considerable caution, as it introduces potential response bias. Concordantly, participants reported much confusion over the Ideal (D) questions, and significant missing data were observed in the quantitative dataset for Ideal responses.

Performing test-retest checks on a subsample of the completed measures was a necessary part of reliability testing of the ADF SSS. However, specifying the duration between administrations of the measure proved problematic. Given the difficulty of getting only one test ADF SSS completed, it was felt prudent not to leave too much time between administrations, as attrition rate may have been high, if not completed within a short period of time. Questionnaire items were randomly assigned within the ADF SSS to protect against order effects. Notwithstanding this, having time to think about the items between administrations may explain some score variability. Instructions indicated an interval of two to four hours between completing the two measures. However, as mail questionnaires were used, the researcher did not have control over the exact time between completing both instruments.

This is not an uncommon issue as Peterson (2000) states that, in practice, it is difficult to apply a satisfactory test-retest check, in attempting to counteract both the effects of memory (recalling and repeating initial answers) and intervening events (where actual change may have happened). Unfortunately, the fact that

the guide time between administrations was not too prolonged may mean that the memory or practice effect did have some impact on the test-retest results. Nevertheless, family members were provided with strict instructions not to look at their answers to the first questionnaire whilst completing the second. Additionally, Bruhn and Philips (1987) emphasise the dynamic and complex nature of social support and suggest that a high test-retest correlation may have little meaning.

Maintaining contact and consultation with the ADF R&DG and keeping the group informed of progress throughout the development process of the ADF SSS was immensely useful. Particularly in the design phase of the study, it was important to incorporate the views of the principal academics to ensure that the measure produced was consistent with the SSCS theoretical approach. However, as the study unfolded, the author committed a great deal of independent thought to the work to advance the group's understanding of the social support component of the SSCS theoretical model, and was also given the scope to be creative with routes through complex stimuli, such as the material included, format and scoring system of the ADF SSS developed.

One of the main learning points from undertaking the work was adapting to changes to the initial protocol. The research process was by no means linear for a myriad of reasons. Some tasks took much longer than envisaged, especially in the design and data collection phases. Consequently, a multitasking strategy had to be utilised to ensure progress. From the outset the researcher attempted to produce a novel measure of social support for family members cradled in experiential data from their accounts of living with a problem substance user. The study objective was achieved of producing a reliable, valid and applicable measure of social support for concerned and affected family members. However, it was quite frustrating when creative ideas from a theoretical perspective did not translate well in a practical sense. The author only discovered what worked from conducting and reflecting upon the research. Ultimately to ensure that a self-completion instrument is practical, it has to be easy to administer, so that erroneous responses are avoided.

A very positive aspect of the study was the discovery, in terms of having to cast a wide net for recruiting participants, that many more agencies exist which attempt to meet the needs of family members than are reported in official service provision publications. However, the majority of the identified services were small scale and localised and usually comprised self-help forms of intervention, as opposed to more structured therapeutic approaches. Thus this suggests that, it is still the case that family centred interventions are not mainstream within specialist alcohol and drug agencies in the United Kingdom (Copello, Velleman, and Templeton, 2005; Copello and Orford, 2002). Nevertheless, there appears to be a continual evolution in services to intervene directly with concerned and affected family members (for example, Copello, Templeton, and Velleman, 2006; McGillicuddy, Rychtarik, Duquette, and Morsheimer, 2001; Toumbourou, Blyth, Bamberg, and Forer, 2001), in contrast to the earlier approaches which perceived family members as adjuncts to the using relative and not deserving of help in their own right for high morbidity and distress.

8.5 Implications for Theory

There is much scope for advancing ADF related theory. The refined ADF SSS provides more clarity on the salient constructs and dimensions which comprise ADF specific social support. Provisionally, these are positively perceived functional support which contains elements of emotional and instrumental support, social companionship and support for coping. Negatively perceived ADF specific support which is composed of support of coping and attitudes and actions towards the using relative, and positively perceived ADF related support which includes emotional and informational support, support for coping and attitudes and actions towards the using relative. It is an interesting finding that three constructs emerged from the PCA, and not the six facets suggested from the review of the literature in Chapters 1 and 2. However, it does seem to support the contention by Sarason and colleagues (1994) that it is difficult to delineate functional categories. Nevertheless, the current three component

typology can be further investigated by performing a confirmatory factor analysis on a larger sample of family members.

Possessing a measure which is sensitive to the extent and quality of family members' social support and can distinguish between particular facets of the support dynamic has many potential benefits for advancing theoretical knowledge. At a general theoretical level, the interaction between social support, family stress, physical and psychological morbidity, and coping strategies can be explored and examined. Thus, the suggestion that the perception that social support is available exerts an ameliorative effect on health by influencing appraisals of potential stressors and coping resources known as the stress buffering model could be tested fully (Glazer, 2006). Furthermore, the mechanisms and specific predictions of the stress-support matching hypothesis (Cutrona, 2000) which posits that perceived availability of social support will be effective in promoting coping and reducing the effects of a deleterious stressor, insofar as the perceived functional expressive and/or instrumental support is matched optimally to the needs elicited by the stressful event, could be investigated in detail.

This high level conceptual mode-specific work will also have an immense impact upon the development of the SSCS model of addiction in the family, providing insight and understanding into the interrelationships and processes between the four major components of the perspective. With stress, strain, coping and support accounted for from a methodological standpoint, model dynamics can be studied. Accordingly, triangulated empirical testing with the existing standardised questionnaires can lead to more sophisticated procedures, such as structural equation modelling and hierarchical multiple regression, being utilised to assess moderation or mediation models involving the four main theoretical concepts. This would further illuminate conceptual salience between and within the theoretical domains, and provide understanding for the complex nature of influence and interactivity for each dimension. Cross-sectional correlation findings will have to be enhanced by longitudinal testing of the model dynamics over multiple time points. Also it will be important to reproduce modelling results

in new contexts, with new datasets that differ as much as possible from the original ones, ensuring nomological validity and a coherent and robust model (Pratschke, 2003).

8.6 Further Research

The study described was important and significant research which was of immense value to the ADF R&DG, and in general to the ADF field. However, there are several areas which could be expanded upon in the work outlined in the current thesis. The most immediate issue to address is that of further validation of the refined ADF SSS. The sample size, scope and diversity should be extended. The refined ADF SSS has yet to be administered to concerned and affected family members in its final 25-item form. This is required in order to confirm the psychometric properties of the ADF SSS and subscale structure, as reported previously.

One hundred and thirty two family members was very much a lower threshold sample size for PCA. It is very much recommended to perform a confirmatory factor analysis with a much larger sample. Concordantly, the test-retest sample of eighteen family members should be substantially increased with a longer duration (at least two days) between administrations. Within the limits of the cross sectional data, the ADF SSS appears to be a valid and reliable instrument capable of capturing the psychological reality of how family members experience social support. However, further longitudinal work is required to confirm this conclusion. Longitudinal studies would also help determine the nature of social support for families at various points in transition. Without longitudinal data, it is impossible to identify the processual mechanisms and dynamics of change, and therefore the indissoluble link between structure and process (Tracy and Abell, 1990).

In terms of further enhancing the development and applicability of the ADF SSS, empirical testing is required on a number of fronts. By conducting larger scale studies, scoring norms and construct validity can be established. The SOS(B) was selected to demonstrate construct validity for the current study. However, correlations were not highly significant due to the fact that the SOS(B) addressed only general support, and the perceived functional support facets were assessed through sources, which are prone to measurement errors on self-completion instruments. Additionally, a subsample size of twenty nine was not large enough to establish the full extent of the relationship between the SOS(B) and the ADF SSS.

Future validation work will require other self-completion social support measures to be administered alongside the ADF SSS. Therefore, the utility of existing social support instruments needs to be evaluated (Ducharme *et al*., 1994). It is also extremely important to administer the ADF SSS in wider contexts. Particularly important would be to establish the measures' utility and generalisability within different age, relationship, community based, socio-cultural, ethnic and gender groups. A strategy for addressing contextual measurement issues and fine tuning may lie in applying mixed methodological research designs. Questionnaire development is a dynamic process and needs to respond not only to new discoveries in the field, but also to changes in psychosocial conditions (Peterson, 2000).

As well as being subjected to rigorous reliability and validity psychometric testing with diverse family member samples, the ADF SSS should also be adopted and utilised in routine clinical practice to assess the measures' ability to produce normative data as a therapeutic instrument. There are a number of criteria which the ADF SSS will have to fulfil to be considered a useful practice based tool. These include sensitivity to and demonstrating therapeutic change during interventions, being able to differentiate between different levels of perceived functional support for engaged family members, and reliably reflecting intuitive judgements from practitioners about how much social support family members currently have (for instance, a family member with a low level of social support

assessed by a practitioner, also obtaining a low score on the ADF SSS). Family members should also recognise their social support situation within the scoring, utilising valency and subscale scores and the corresponding psychological meaning to screen, monitor and evaluate the nuances of intervention work, and to ensure the measure is practice relevant, feasible and appropriate for everyday routine use.

If the ADF SSS proves successful in achieving the practice based criteria outlined above, then the argument could be made that the measure is a means of assessing the social support needs of concerned and affected family members, thus providing practitioners with a method of evaluating the adequacy of family interventions. In fact, in agencies where intervening with family members is not well developed, the ADF SSS could form the basis of family work. Thus utilising the measure and the social support component of the 5-step intervention approach to help improve positive general and ADF specific social support, and reduce negative ADF related support for engaged family members.

Additionally, there are many ways in which social support assessment could be expanded with practitioner assistance. For example, as the ADF SSS was circumscribed, some of the items which were on the borderline for inclusion could augment the existing measure to form a more comprehensive practice based social support interview schedule. Diagrams, maps or dyadic representations could be utilised to examine concerned and affected family members' personal support structures, focusing on improving positive sources upon whom family members can rely for assistance, and negating or neutralising negative, hostile or conflictual social relationships.

The practitioner assisted material for family members could be integrated with Social Behaviour and Network Therapy (SBNT) (Copello, Orford, Hodgson, and Tober, 2009). SBNT intervenes by exploring new avenues of support for the using relative, while encouraging more open communication within the family, with the aim of developing a more coherent and unified approach to the problem

substance use, and promoting change in using behaviour to reduce harm to the family. Combining 5-step and SBNT approaches into a single form of flexible intervention which tracks the responses of both family members and relatives, will address an issue which arose within the current study. Namely, a number of family members (because their attention was focused on the problem substance user) found it difficult to acknowledge that family members require help in their own right, and consequently felt the ADF SSS was less relevant to their needs.

Potentially, with practitioner assistance, the extra support dimensions based upon the ADF SSS could be implemented in couple or group work with families. They could utilise a version of the ADF SSS with the Ideal scale re-introduced to establish family members' satisfaction with their current extent and quality of social support and/or integrate more complex and/or open ended questions within the measure. This information would be very useful for practice based assessments, however, great care would have to be taken by practitioners in assisting family members with completion, as the current study reported that the Ideal scale is not suitable for self-completion administration. Also other potential facets of support could be explored in detail in the fourth step of the brief intervention for family members, such as intimate and aggressive relations, domestic violence, advocacy, contact with employers, police, criminal justice, primary and secondary health care and self-help.

It would be fascinating to test the predictive validity of the ADF SSS with two distinct samples. This could involve concerned and affected family members who are engaged with an agency and undergoing an intervention, and family members who do not receive any therapeutic input. Both samples could complete the ADF SSS over time, thus giving a naturalistic baseline measure of social support to compare and contrast with those receiving formal support. It remains a task for the future to extend the present research to include family members who themselves are experiencing substance use problems, while at the same time living with relatives who share such problems. Furthermore, many family members who participated in the current study could nominate more than one close relative with a drinking and/or drug problem.

Future validation work will include measurement of the reliability of the ADF SSS when administered by different methods. Supervised completion with a practitioner and practical innovations have already been discussed. A manualised self-help version of the 5-step approach could include pre, mid and post intervention measures to assess changes in the quality of social support for family members. The ADF SSS could also be administered via telephone interview, interactively online - in either written or speech electronic form, so it is accessible for family members with sight disabilities.

If the ADF SSS continues to display sound psychometric properties in research and practice contexts, the measure should be translated into different languages for family members whose first language is not English and for testing the instrument in other cultures. It will also be important to have support material in manualised form for the ADF SSS and extended practitioner assisted social support aspects, for example, on completion, scoring and norms. In fact, depending on how complex the additional social support work is, practitioners may require training to conduct the intervention.

In terms of a direction for future research, it also remains a task to adapt the ADF SSS into a form that is applicable for children and young people. It is apparent that the current study was very much adult focused, so therefore, it remains a priority for further work to design a developmentally appropriate measure to assess the support needs of children who are exposed to problem alcohol and/or drug taking within the family. However, the issue of having developmentally sensitive measures also extends to the SSCS theoretical approach in general, and to the questionnaires used to assess the stress, strain and coping components of the model.

Another methodological challenge will be to revisit the feasibility of designing a vignette type measure based on the ADF SSS which is applicable to routine practice. However, more work generally will be required to develop methodological techniques to overcome problems with non-item based measures. Also, the content of the social support scale could be adapted for

other populations living under chronically stressful situations. The most immediate would be family members of relatives who have gambling related problems. Finally, whether it would be prudent to have separate measures based on the type of problem drug use (i.e. having an alcohol and drug version of the social support scale) or for different relationships to the using relative (for instance, parent and partner versions) remains to be explored.

8.7 Conclusion and Implications

The current thesis reported on the creation, design and development of a quantitative measure which addressed the salient social support issues of a particular population - concerned and affected family members dealing with the excessive alcohol and/or drug use of a close relative. The study examined, in a rigorous and systematic fashion, a substantial number of direct accounts from family members in relation to their experiences of social support. This qualitative information was triangulated with the existing social support literature in both the general and ADF specific domains. This large qualitative dataset was analysed thematically to produce items, questions and response categories for a prototype ADF specific social support questionnaire.

The measure was progressively refined utilising the inherent strengths of a mixed methodological approach. The quantitative aspect aided the reduction of the instrument initially from 75 items, to 58, and finally to 25 items, and provisionally from a four scale measure to one focusing on Frequency of perceived functional support. The qualitative facet ensured that the ADF SSS was addressing the essence of how family members experienced social support, whilst capturing the complexity of the concept and their psychological reality.

Preliminary assessment of the ADF SSS's psychometric properties is very encouraging. There was a good distribution (means and standard deviations) of total scores for the different socio-demographic groups of the study sample (see

Table 7.28) which indicates that the measure has the potential to discriminate well between participants. The findings of correlational analyses suggest that dividing the ADF SSS into subscales provides a fuller picture of social support processes than simply taking the score as a whole. Internal consistency was high, as was test-retest reliability. Additionally, both content and construct validity values were satisfactory. Qualitative feedback echoed the quantitative findings, in that family members reported that not only was the instrument relevant to their situation, but also they found it beneficial that the ADF SSS was asking salient questions regarding their experiences. These were clearly relevant questions, which family members had not been asked before in either formal or informal contexts.

The ADF SSS differs from existing social support questionnaires in that its content deals with the particular support dynamics involved when a family member has to live with the problem drinking and/or drug taking of a close relative. The final version of the ADF SSS is a simple, brief, self-completion measure. Internal consistency of the measure was indicated by high item-to-total correlations. There was a strong correlation between scores on the 58-item and 25-item versions. This suggests that the 25 items are representative of the initial 58 item pool derived from the qualitative dataset.

The mixed method analyses indicate the 25-item ADF SSS assessment provides a brief, reliable and valid measure of social support. It contains items referring not only to indices of perceived availability of positive functional support and but also examines both subjective negative and positive ADF specific functional support. Thus the measure sharpens understanding of the relevant aspects of social support for concerned and affected family members.

The foregoing paragraphs of this section detail the central findings of the current thesis. However, the work had a wider rationale, and the study of the development of a social support measure for the family members of problem substance users contributes significantly to research, theory, practice and policy in the field.

There were several implications for research with particular emphasis on methodology. The content of the ADF SSS signified a sustained effort by the author to acknowledge and operationalise the multifaceted nature of the social support domain. However, some constructs within the concept of social support lend themselves more optimally to self-completion assessment (i.e. functional support dimensions) than others (i.e. structural support elements). Initially, substantial time and effort was spent by the researcher in attempting to create an innovative scenario type measure, and although the work fed into the eventual measure designed, finite conceptual clarity would have to be achieved to produce exemplar vignettes for a non-item based assessment.

The primary focus of the ADF SSS was the perceived availability of functional support which has been shown to impact most on symptomatology (Orford *et al*, 2005a). Both qualitative and quantitative elements of the research method were necessary to arrive at an appropriate self-completion instrument. The assessment of Frequency performed best both psychometrically and qualitatively. Also a Frequency measure was amenable to self-completion administration, and was consistent with the other questionnaires utilised to assess the SSCS theoretical model.

From a theoretical point of view, the work provided a deeper phenomenological insight and helped clarify the salient dimensions of social support relevant to concerned and affected family members which built upon the underlying qualitative information collected by the ADF R&DG. Identifying the features of effective and ineffective social support in the specific context of responding to having a close relative with a drinking or drug problem, assists the ADF R&DG in integrating the material about stress, strain, coping and social support for family members into a more detailed depiction. Thus a complete picture of the dynamics involved is available now that all the main areas of the SSCS model are accounted for both qualitatively and quantitatively. Additionally, having a reliable and valid means to assess the social support component of the SSCS model makes the perspective more robust and resistant to criticism, as the entire theoretical approach can be evaluated quantitatively.

Examining theoretical implications more closely, the current study helps consolidate the work, replicated nationally and internationally, which provided the grounding for the development of the SSCS model. In having a quantitative measure of social support for concerned and affected family members the SSCS theoretical approach can be advanced by confirming links between the constituent elements, especially the links between coping and social support for people living under stress.

Qualitative feedback from both family members and practitioners throughout the study was essential to ensure an understanding of what works in practice was achieved. Consequently, the ADF SSS produced was practice sensitive, appropriate and applicable. Additionally, it was shown that the measure provides a reliable and valid assessment of social support for family members. Therefore, practitioners now have a model of understanding and a complete assessment package, to get involved with or further their knowledge of working with concerned and affected family members.

Importantly for practice, the ADF SSS developed is a brief, relatively straightforward tool in self-completion format, and relevant to practice based needs, in that it can be utilised as a routine assessment and evaluation measure by therapists. Under conditions in which assessment time is a concern, it is essential to select a questionnaire that provides a summary indication of the characteristic of interest, has acceptable psychometric properties, and minimizes the time and effort involved in administration (Longabaugh and Clifford, 1992). Furthermore, the content of the questionnaire assists practitioners in disseminating advice about the impact of specific support processes on family members' coping strategies and wellbeing. Finally, the measure has the potential to be utilised by self-help groups, as family members reported the process of completing the ADF SSS was therapeutic, as the items signified empathy with and an opportunity to reflect upon their situation.

In the context of service provision for family members, the current thesis mirrors previous findings that many alcohol and drug agencies do not have a specific remit to work with family members. There is often a complex combination of different projects, teams, practitioners, inter-agency partnerships, funding periods and remits (Williams, 2004). Although there were more ad hoc services for family members uncovered by the study, it is still the case that the level of service provision for family members does not match the needs of this vulnerable group (Velleman and Templeton, 2003; Copello and Orford, 2002).

Thus a wider commitment to the unmet needs of family members is essential, both in relation to bottom-up service provision and top-down national policy priorities and guidelines. However, attaching a cost to impact on families was an identified gap in the National Alcohol Harm Reduction Strategy (Williams, 2004). This situation is attributable partly to the lack of a model of problem drinking and family functioning which is widely accepted, and would sit happily within developing public services (Copello *et al*., 2005). It is clear that the current research strengthens the SSCS theoretical approach and accordingly the 5-step brief intervention, which could potentially serve as a national and perhaps international model of good practice for intervening with concerned and affected family members.

In summary, the current thesis signifies the development of a brief, efficient, reliable, valid and applicable self-completion social support measure for family members who have a close relative who drinks and/or takes drugs excessively. Thus the primary research aim was achieved, alongside additional objectives by adopting a mixed methodological approach to produce a measure assessing the salient facets of social support with sound psychometric properties, and which captures the essence of how family members experience support. The systematic manner in which the complex concept of social support for family members was explored within the study, assisted in completing the missing link of having a standardised quantitative measure of the support component for the SSCS theoretical model and consequently the 5-step intervention approach.

Being in possession of a measure of perceived functional support which accounts for the multidimensional nature of the complex concept, will no doubt advance understanding for family members, researchers (particularly the ADF R&DG) and practitioners of the role of social support in the lives of family members. A significant strength of the study was the central involvement of concerned and affected family members, as this population, despite incurring many problems, are largely ignored in the general substance use related literature. It is important to remember that we all originate from a family, and even estranged single men have or had relations.

In conclusion, by utilising mixed methods, the research accomplished its ultimate goal of producing a 25-item measure which encapsulates the conceptual complexity of the social support domain, but is straightforward enough in format and content for practitioners to use, and for concerned and affected family members to comprehend and complete. The ADF SSS provides a short, reliable and valid assessment of the most salient dynamics of the social support process applicable in general to the family members of problem drinking and/or drug taking relatives. Thus it addresses the methodological void within the SSCS theoretical model, producing a quantitative measure of social support directly usable in evaluating research, family interventions and self-help services for the foreseeable future.

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Appendix I: Pilot Study: Practitioner Information Sheet

Study title

The development of an Alcohol, Drugs and the Family (ADF) specific social support measure for the family members of substance misusers.

My name is Paul Toner, and I work in the Mental Health Research & Development Unit at the University of Bath.

Thank you for expressing interest in taking part in this PhD research study which has been funded by the Economic and Social Research Council (ESRC), and has received approval from the Bath Local Research Ethics Committee, the Avon and Wiltshire Mental Health Partnership (AWP) NHS Trust and the University of Bath. I hope this information sheet will provide you with some basic information about the study and what participation involves.

What is the purpose of the study?

We need to understand more about social support, and the types of support that family members receive when they live with someone with a serious alcohol or drug problem.
I have developed a questionnaire which measures specific elements of social support: the ones which family members of people with alcohol or drug problems have told me and my colleagues are the most important for them.
The main purpose of this study is to see if this new questionnaire provides helpful and useful answers.
I may also want to ask clinicians some questions about the questionnaire, and about how family members felt about completing it.

Why should you become involved in the study?

As you are aware, family members of people with alcohol or drug problems can be helped (or hindered) by other family members, friends, associates of the problem substance user, neighbours, clinicians and members of self-help groups. What is particularly important about the support which these others can provide is the help they give the family members in arriving at and maintaining ways of coping which can help to mediate physical and psychological morbidity.

Currently, there are many social support evaluative questionnaires available to assess the impact of social support on substance misusers, but there are no specific measures for close family members, and this study aims to address this imbalance and to inform therapeutic practice. By taking part in this research you

will get the opportunity to collaborate in the development of a new ADF Social Support Scale to ensure that the measure is both relevant to needs of family members and clinically useful.

Why have I been chosen?

You have been chosen because you are a clinician who works therapeutically with the family members of substance misusers.

What do I have to do?

You will have received this information sheet because:

You are a clinician who works therapeutically with the family members of substance misusers, and I would like to ask you to select family members from your caseload and ask them to complete a consent form allowing me to ask them questions about completing the questionnaire and whether they find it relevant. The only exclusion criteria for selection is that the family members are literate enough to understand the questionnaire.

I would like you to recruit these family members between May and August 2004.

What are the risks and benefits of taking part?

As far as I am aware, there are no risks involved for you or your client in taking part in this study. The research aims to inform therapeutic interventions for family members, particularly by looking at and assessing the impact of social support on mediating the problems that family members face from drinking or drug taking by their relative.

What happens when the research study stops?

At the end of the study the researcher will be writing about how the ADF Social Support Scale performed in practice, whether it was found to be both psychometrically sound and useful to family members and clinicians. The researcher will provide each agency that took part in the study with a written summary and also give a presentation to illuminate the key outcomes.

What will happen to the results of the study?

The findings of the study will be written up as part of a PhD thesis, and may also be published. There will be no information about individual people, and you will not be identified in any report or other publication.

Contact for further information

If you would like to talk more about the project and ask any questions you can talk/write to me at the University of Bath:
Paul Toner – Tel: 01225 384053 or email: P.Toner@bath.ac.uk

Appendix II: Pilot Study: Practitioner Consent Form

Title of Project: The development of an Alcohol, Drugs and the Family (ADF) specific social support measure for the family members of substance misusers.

Name of Researcher: Paul Toner.
University of Bath,
April 2004.

Please tick box

1. I confirm that I have read and understand the Information Sheet dated April 2004 describing the study. I have had the opportunity to ask questions and I am satisfied with the answers that I have been given. ☐

2. I understand that my participation in the study is voluntary. I am free to withdraw at any time, without giving any reason. ☐

3. I understand that the information I give will be confidential. The information I give will be used to reach general research conclusions. ☐

4. I understand that by taking part in the study, I will be asked to:
   - Give informed consent for my agency to take part in the study **OR**
   - Recruit family members to complete the ADF Social Support Scale
     AND / OR
   - Be interviewed by the researcher, which will be audiotaped. ☐

5. I agree to take part in the above study. ☐

_____	_____	_____
Name of manager/clinician	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix III: Pilot Study: Family Member Information Sheet

Study title

The development of an Alcohol, Drugs and the Family (ADF) specific social support measure for the family members of substance misusers.

My name is Paul Toner, and I work in the Mental Health Research & Development Unit at the University of Bath.

You are being invited to take part in a research study. Before you decide if you will take part, it is important for you to understand why the research is being done and what it will involve. Please take some time to read through the following information and discuss it with your clinician, and your family if you wish. Do please ask us if there is anything that is not clear, or if you would like further information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

It is common for families where someone has an alcohol or drug problem to often experience a range of difficulties. Previous work in the UK has found that support from other people helps the close family members of substance misusers to cope better with their situation. This may help to protect them from health problems of their own.

I have developed a questionnaire which measures aspects of social support. The questionnaire items were developed from interviews, where family members of people with alcohol or drug problems told me and my colleagues what they thought were the most important aspects of social support for them.

The main purpose of this study is to see if this new questionnaire provides helpful and useful answers, and if it does, to see how the questionnaire can be made even better.

This knowledge will be used to improve the advice that family members are given by clinicians, about the effect of social support on their well being, and about how best to get social support.

Why have I been chosen?

You have been chosen because you have been identified as someone who has a close relative who misuses alcohol and/or drugs. This study hopes to get the views of family members between May and August 2004.

Do I have to take part?

It is up to you to decide whether or not to take part. The best thing to do is to read this Information Sheet carefully and discuss it with your clinician, and your family if you want. Ask any questions that you want to. If you decide to take part you will be asked to read and sign a Consent Form, but you will be still be able to withdraw at any time and you do not have to give a reason for doing so. If you decide to drop-out it will not affect the help that you are currently getting.

What will I have to do, if I take part?

1. You will be asked to fill out a questionnaire about the support you get from others.
2. You will be asked questions by me about how relevant you found the questionnaire, your responses will be noted down.

What are the risks and benefits of taking part?

We do not think that there will be any risks at all to you, if you take part in this study.

We hope that you will find it useful to think about the support that you receive from others. It is also hoped that you will find it helpful to provide feedback to the researcher, so that he can develop the questionnaire further.

What happens when the research study stops?

At the end of the study the researcher will be writing about:

- The extent to which family members found the questionnaire to be useful.
- Also, how well the questionnaire was able to account for the support that family members receive.

These writings will be part of my PhD thesis, and may also be published. There will be no information about individual people and you will not be identified in any report or other publication.

If you would like, we will send you a copy of the findings of the study.

Will taking part in this study be kept confidential?

All information that you provide to the researcher will be strictly confidential. When the results are written up, no-one will be identified by name or by any other such detail. Your name will not appear on any questionnaires that you fill in. You will be assigned a code to prevent you being identified by anyone else.

Who is organising and funding the study?

This study is funded by an Economic and Social Research Council (ESRC) scholarship grant. As I say at the start, I am Paul Toner, and I work in the Mental Health Research & Development Unit at the University of Bath. This research has received approval from the Bath Local Research Ethics Committee, the Avon and Wiltshire Mental Health Partnership (AWP) NHS Trust and the University of Bath.

Contact for further information

If you would like to talk more about the project and ask any questions, you may talk to the researcher at the University of Bath:
Paul Toner – Tel: 01225 384053

Thank you for your time. If you have read and understood this Information Sheet, and you have asked any questions and are happy to take part, then please read and complete a Consent Form.

Appendix IV: Pilot Study: Family Member Consent Form

Title of Project: The development of an Alcohol, Drugs and the Family (ADF) specific social support measure for the family members of substance misusers.

Name of Researcher: Paul Toner.
University of Bath,
May 2004.

Please tick box

I confirm that I have read and understand the Information Sheet dated May 2004 describing the study. I have had the opportunity to ask questions and I am happy with the answers that I have been given.	☐
I understand that my participation in the study is voluntary. I am free to withdraw at any time, without giving any reason. My medical care or legal rights will not be affected.	☐
I understand that the information I give will be confidential. The information I give will be used to reach general research conclusions. It will not identify myself by name.	☐
I understand that by taking part in the study, I will be asked to complete a questionnaire and will be asked questions about it by the researcher, responses will be noted down and/or audiotaped.	☐
I agree to take part in the above study.	☐

_____	_____	_____
Name of family member	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix V: Pilot Study: ADF SSS Brief Instruction Sheet

Brief Instructions for completing the ADF Social Support Scale

Please ensure that you read the opening two paragraphs of the questionnaire carefully. These briefly explain what the questionnaire is measuring and how you should complete the questions for each statement.

The 4 questions relating to each of the 75 statements must be filled in by ticking the relevant box.

If the statement has not occurred in the last 3 months the appropriate response to question A is Never and questions B and C are ticked as N/A. Question D for each statement refers to your ideal and is filled in regardless of whether the statement occurred or not in the last 3 months.

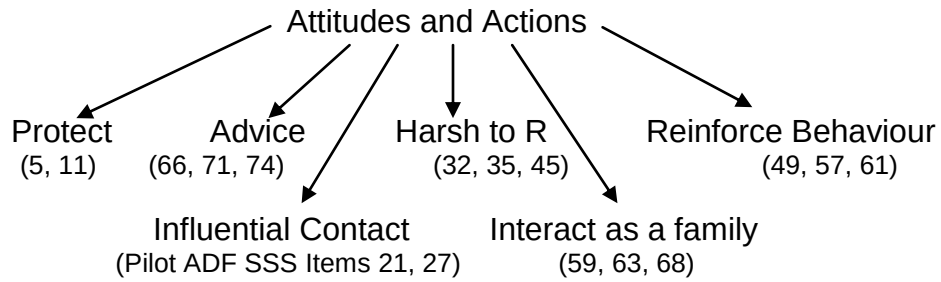
If the statement has occurred in the last 3 months, question A for each statement asks how frequently. Then you should think of the single most important time when the statement happened to you in the last 3 months, and fill in question B in relation to how important this was to you, and question C in relation to how satisfied you were on this occasion with the event described in the statement occurring.

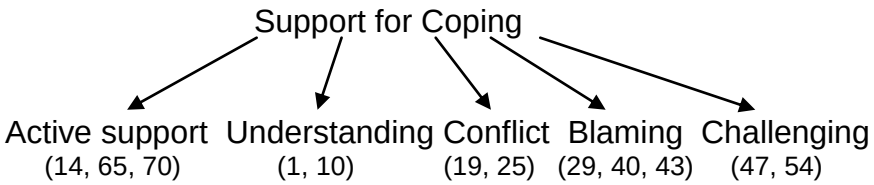
Brief Instructions for completing the Feedback Sheet

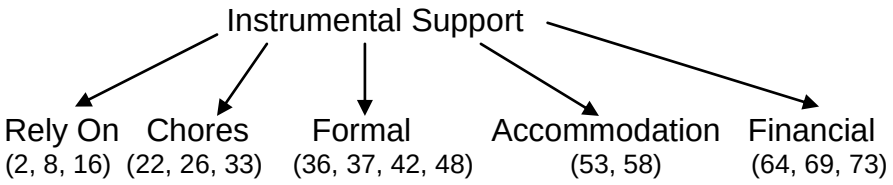
Please read the opening instructions carefully, paying particular attention to example provided. Written comments on how you found the process of completing the questionnaire would be greatly appreciated for each of the areas the feedback sheet specifically asks about.

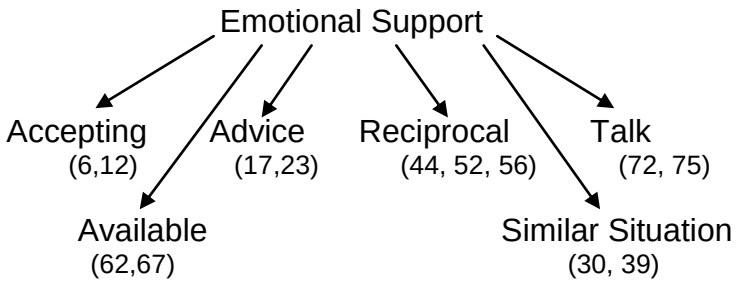
Many thanks for your time in helping with this work aimed at getting a better understanding of the impact of social support on family members' coping with an alcohol and/or drug problem in the family and its impact on their physical and psychological well being.

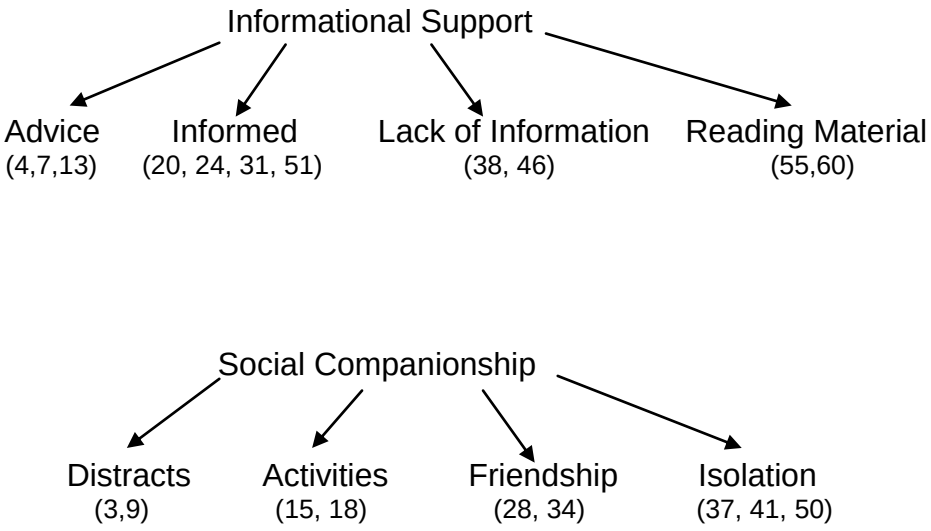
Appendix VI: Pilot Study: ADF Social Support Branch Diagrams










Informational Support
Advice
(4,7,13)
Informed
(20, 24, 31, 51)
Lack of Information
(38, 46)
Reading Material
(55,60)
Social Companionship
Distracts
(3,9)
Activities
(15, 18)
Friendship
(28, 34)
Isolation
(37, 41, 50)

Appendix VII: Pilot Study: ADF SSS Prototype Items removed

People have worried about my relative and have kept them safe in the face of aggression.

There are people who have been set against my relative.

There are people who have been non-judgemental and accepting of my stance towards my relative.

There are people who have criticised me for not sufficiently supporting my relative.

People have said things about my relative that are at odds with my instincts as a close family member.

People have provided me with companionship.

People have told me that I have done all that I can.

Health / Social care professionals have offered me the advice to get rid off the problem by telling my substance misusing relative to move out.

I know people who have been though it themselves [relative of a substance misuser] and I have identified with them.

There are people who know what my relative is like and have not involved themselves with me.

Close family and/or friends have had my relative living with them, when I could not cope.

There are respected members of the community who my relative has listened to about the alcohol and/or drug problem.

I have friends who I have spent time with doing fun things.

People have distracted me from the problems at home.

Reading material about alcohol and/or drugs has helped me to see in black and white the things that I am going through.

Appendix VIII: Pilot Study: 75-item ADF SSS

Alcohol, Drugs and the Family (ADF) Social Support Scale

The following questionnaire looks at the extent and quality of social support that you (the Family Member) actually receive in general, and in relation to living with an alcohol or drug misuser in the family.

Question **(A)** for each statement, relates to the number of times the event referred to in the statement has **happened in the last three months**. If the statement has not occurred in the previous three months, then questions **(B)**, and **(C)** need to be filled in as not applicable (N/A). If the statement has happened in the last three months, then fill in Questions **(B)** and **(C)** with reference to **the single most important time when it occurred**. Please tick the most appropriate response to each question.

1. People have **understood what it is like for me to live with my relative's drinking or drug taking.**

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people understanding the situation that I am in)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

2. I have **relied on someone to provide me with practical help** (i.e. aid or assistance) in an emergency.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having someone on hand when I needed practical help)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

3. People have **helped to cheer me up.**

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people helping to cheer me up)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

4. Health / Social care professionals have given me **helpful bits of information.**

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. professionals giving me helpful information)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

5. People have **brought my relative home safely to me,** after my relative has been drinking / drug taking.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people bringing my relative home safely to me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

6. People have **understood my situation rather than providing sympathy.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having people understand my situation and not just giving me sympathy)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

7. Health / Social care professionals have given me **conflicting advice**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. professionals giving me conflicting advice)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

8. **Someone took care of my relative** when I had to go away for two or more days (for example, with activities of daily living such as cooking, cleaning, washing etc).

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. someone taking care of my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

9. People have organised things to **take my mind off my relative's alcohol or drug problem.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people taking my mind off my relative's alcohol or drug problem)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

10. There are **people whom I have trusted**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people with whom I trust to disclose my feelings)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

11. People have **looked out for my relative**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people looking out for my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

12. People have **listened to me when I have talked about my feelings**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having people listen to me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

13. Reading material about family members living with a substance misuser is like **someone talking to me and offering me advice about certain things**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. reading material providing me with advice)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

14. People have **backed the stance that I have taken towards my relative and their substance misuse**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people backing the stance I have taken towards my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

15. People have been **available to do activities with me** (for example, bike rides, shopping trips etc).

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people being available to do activities with me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

16. **People have put themselves out for me** when I needed practical help (i.e. aid or assistance).

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people putting themselves out when I needed practical help)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

17. People have **advised me to focus on myself and my own needs**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting advice to focus on myself)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

18. I have **met up with people for relaxation**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having people to relax with)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

19. People have **undermined my efforts to stand up to my relative's problem drinking or drug taking**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people undermining my stance towards my relative's drinking or drug taking)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

20. People have **provided me with information about substance misuse**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people providing me with information about alcohol or drug misuse)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

21. **My relative has listened to people about the alcohol or drug problem.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. my relative listening to people about the alcohol or drug problem)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

22. Someone has **given me a car lift at short notice**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting a car lift at short notice when I need it)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

23. People have **encouraged me to tell health and/or social care professionals about the stress that I am under.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting encouraged to talk with professionals)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

24. People have **directed me to information about alcohol and/or drugs.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people directing me to sources of information about substance misuse)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

25. People have **criticised me for trying to put some distance between myself and my relative's drinking or drug problem.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people criticising me for trying to put some distance between myself and my relative's drinking or drug problem)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

26. People have given me **help with chores** around the house.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting help with chores)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

27. People have **offered both myself and my relative advice** about my relative's substance misuse.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people offering both myself and my relative advice about the drink or drug problem)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

28. I have **let off steam with people.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having people available to let off steam with)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

29. **Health and/or Social care professionals have not been very interested in my substance misusing relative** because they believe that my relative's problem is self inflicted.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. professionals not being interested in my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

30. I have **identified with family members with an alcohol and/or drug misusing relative who have gone through similar things to myself.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. identifying with people in a similar situation to me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

31. People have **explained the nature of my relative's drinking or drug problem to me.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people explaining the nature of my relative's substance misuse to me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

32. People have been **over critical of my relative.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people being unduly critical of my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

33. People have **helped me to complete forms and/or letters** when I needed it.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting help with forms and/or letters when I need it)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

34. People have **given me space to talk about my problems.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people giving me space to talk about my problems)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

35. People have said that **my relative should leave home and live somewhere else.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people saying my relative should leave home)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

36. My doctor has **prescribed medication** for me.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having medication prescribed for me when I need it)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

37. I have found it **difficult to meet new people.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. finding it difficult to meet new people)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

38. Health and/or Social care professionals **have not given me all the information** about my relative's substance misuse.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. professionals not providing me with all the information about my relative's drinking or drug taking)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

39. There are **people in the same situation [have a substance misusing relative] with whom I have talked about my problems**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. talking with people in a similar situation about my problems)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

40. People have **said things about my relative that are at odds with my instincts as a close family** member.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people saying things about my relative that are at odds with my thoughts)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

41. People have **distanced themselves from me because of my relative's substance misuse.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people distancing themselves from me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

42. **Health care professionals have been accessible** (for example, they have been prepared to see me even when the problem has not been directly health related).

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having health care professionals who are accessible)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

43. People have **blamed me for not doing more to control my relative's behaviour.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people blaming me for my relative's behaviour)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

44. People have **prayed for or with me.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people praying for or with me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

45. People have had an **overly harsh attitude towards my relative.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people being overly harsh towards my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

46. Health and/or Social care professionals **have not talked through strategies for dealing with my relative's substance misuse.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. professionals not talking through strategies for dealing with my relative's substance misuse)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

47. People have **helped me to change my outlook towards my relative.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people helping me to change my outlook towards my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

48. My employer has given me **time off work when I needed it.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting time off work when I need it)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

49. People have **supported my relative's substance misuse.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people encouraging my relative to drink and/or take drugs)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

50. I have found it **difficult to talk with people about my problems**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having difficulty talking with people about my problems)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

51. People have **provided me with a plan to deal with my relative's substance misuse**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people providing me with a plan to deal with my relative's drinking and/or drug taking)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

52. There are **people within my organised religion and/or faith who have offered me support**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people within my faith offering me support)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

53. People have **offered me temporary accommodation** (i.e. up to two weeks) **away from my relative, because of my relative's behaviour**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. accommodation offered for respite from my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

54. People have **suggested alternative ways to react to my relative and their substance misuse**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people suggesting alternative ways to react towards my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

55. People have **lent me useful reading material about family members living with an alcohol and/or drug problem in the family.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people provicing me with useful reading material about family members living with an alcohol and/or drug problem in the family)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

56. I have offered support to people but **have not received it in return.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. not receiving help from people in return for my support)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

57. **People have said my relative is doing nothing wrong** by drinking and/or taking drugs.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people saying my relative is entitled to drink and/or take drugs)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

58. **Someone had my relative stay with them** for a short time (i.e. up to two weeks) and gave me some respite from my relative.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having my relative stay with someone to give me a break)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

59. People have **said that my relative does not deserve help.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people saying my relative does not deserve help)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

60. I have **identified with the information contained within books and/or booklets** about family members living with a substance misuser.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. identifying with the information contained within books and/or booklets about family members living with a substance misuser)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

61. People have insisted that **I should let my relative continue drinking and/or drug taking.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people saying that I should let my relative drink and/or take drugs)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

62. People who know about my situation **have made themselves available to me.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people making themselves available to me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

63. People have **nagged my relative too much**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people nagging my relative too much)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

64. Someone has **paid for me to go out socially** when I was short of money.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting money to go out when I was short of it)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

65. People have **told my relative off on my behalf**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people telling my relative off when I wanted them to)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

66. Helping agencies have **advised me to leave my relative**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. agencies telling me to leave my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

67. People **have been there for me**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people being there for me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

68. People have **not told my relative off for drinking and/or taking drugs**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people not telling my relative off for drinking and/or taking drugs)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

69. People have put work my way to **help me out financially**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting financial help from people)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

70. People have **provided active support** (e.g. agreed to a common tactic such as not bringing alcoholic drinks to a party) **for my coping efforts towards my relative**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people providing support for the way I cope towards my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

71. People have **advised me to throw my relative out of the house**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people telling me to throw my relative out)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

72. People have **talked to me about my relative and listened to what I have to say**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people talking to me about my relative and listening to what I have to say)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

73. People have **lent me money** when I needed it.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. being lent money when I need it)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

74. People have **said nasty things about my relative**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people saying nasty things about my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

75. I have **confided in my health and/or social care professional about my situation**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. being able to confide with professionals about my situation)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

Appendix IX: Pilot Study: Socio-demographic Questions

It would really help us to know a few anonymous details about you. Please complete the following:

1) Age: ☐ 16 – 24 ☐ 25 – 35 ☐ 36 – 49 ☐ 50 – 64 ☐ 65+

2) Are you: Male ☐ Female ☐

3) Which of the following describes your main activity?

☐ In employment or self-employed
☐ Student
☐ Retired
☐ Seeking work
☐ Housework
☐ Other (please specify)

_____

4) Did your education continue after the minimum school leaving age?

Yes ☐ No ☐

5) What is your ethnic origin?

☐ White
☐ Bangladeshi
☐ Indian
☐ Chinese
☐ Black (Caribbean)
☐ Pakistani
☐ Black (African)
☐ Other ethnic origin
☐ Black (Other)

Please state:

_____

6) My relative is: Male ☐ Female ☐

7) Has your relative lived with you at any time in the last 6 months?

Yes ☐ No ☐

8) He/she is my:

☐ Father / Mother
☐ Husband / Wife / Partner
☐ Brother / Sister
☐ Son / Daughter
☐ Other (e.g. father-in-law, aunt, nephew). Please state his/her relationship to you.

_____

Appendix X: Pilot Study: Feedback Sheet

Here are some faces expressing various feelings (pleased, mixed, unhappy). Below each is a number.

1
Pleased

2
Mixed

3
Unhappy

There are a number of boxes; each containing a question about the questionnaire. Please assign a rating to each of these questions using the method illustrated below.

EXAMPLE Which face comes closest to express how you feel about:
The style of the questionnaire: …**2**….
Comments: *You will find that there is room for comments below each box. Please feel free to write comments. I welcome your views, as they will allow me to change the questionnaire, so it can be used with other family members who have a drug or alcohol misusing relative in their family.*

Which face comes closest to express how you feel about:

The layout of the questionnaire: …….

Comments:

The words used in the questionnaire: …….

Comments:

How easy the questionnaire was to understand: …….

Comments:

The length of the questionnaire: …….

Comments:

The size of the writing on the questionnaire: …….

Comments:

How much time the questionnaire took to fill in: …….

Comments:

How detailed the questionnaire was:	…….

Comments:

The style of the questionnaire:	…….

Comments:

How relevant the questionnaire was to your life:	…….

Comments:

Appendix XI: Pilot Study: SWLREC Approval

Royal United Hospital Bath NHS
NHS Trust

BATH LOCAL RESEARCH ETHICS COMMITTEE
Direct tel/fax: 01225 825725 e-mail: research.ethics@rub.nath.swest.nhs.uk

Royal United Hospital
Combe Park
Bath
BA1 3NG

Tel: 01225 428331

27th March 2003

Mr P Toner
Mental Health R & D Unit
Wessex House, Room 7.23
University of Bath
Bath
BA2 7AY

Dear Mr Toner

BA441 ***(please quote this reference in all correspondence)***
The Development of an alcohol, drugs and family (ADF) specific social support measure for the family members of substance misusers

Thank you for your letter, dated 24th March, enclosing the amended Staff Information Sheet. I am pleased to inform you that your project now has full approval to proceed.

This Committee is organised and operates according to ICH/GCP Guidelines and the applicable laws and regulations. Any changes or extensions to the protocol, or additional investigators should be notified to the Committee for approval. Serious and unexpected adverse events should also be notified to the meeting. May we remind you of the Data Protection Act 1998 and the need to conduct the trial in accordance with the Good Clinical Practice Guidelines.

The Committee is required to audit progress of research and to produce a yearly report to the Health Authority and Department of Health. You are therefore required to provide a brief yearly report and a short final report.

Yours sincerely

S.V. Coffield

Sara Coffield
Research Ethics Co-ordinator

Appendix XII: Pilot Study: AWP NHS Trust Approval

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Mr Paul Toner
PhD Student
Mental Health R&D Unit
Wessex House Level 7 (Room 7.21)
University of Bath
Bath, BA2 7AY

Research and Development
Avon & Wiltshire Mental Health Partnership NHS Trust
Centre for Research, UWE
Glenside Campus, Blackberry Hill
Bristol S16 1DD

Tel:0117 344 8839
Fax:0117 344 8848
Email: tony.soteriou@uwe.ac.uk

21 February 2003

Dear Paul

Re: Development of an Alcohol, Drugs and the Family (ADF) specific social support measure for family members of substance misusers
Date R&D project form received at R&D office: 18th February 2003

Thank you for the R&D form for the above project – this has been reviewed by the R&D Office and I am very pleased to be able to confirm that your project has been **APPROVED TO PROCEED**. It was considered that for this particular R&D project, approval could be given without the need for additional review of scientific quality by the R&D committee, as the project is part of a PhD in Psychology, at the University of Bath with a formal supervisor. Professor Richard Velleman.

- **Trust approval is given subject to the appropriate NHS research ethics committee approval.** Please forward confirmation of full LREC approval to the R&D Office as soon as possible.
- Please ensure that both you and your supervisor are aware of the Department of Health's Research Governance Framework (available from the Internet: http://www.doh.gov.uk/research/rd3/nhsrandd/researchgovernance/govhome.htm), Trust Intranet and the R&D Office).
- Confirmation from the University that they will fulfil the responsibilities of 'Research Sponsor' should be provided.
- You will need to apply to the Trust for a License to Practice if you do not already have one.

The R&D office is required to monitor the progress of all research in the Trust under the Department of Health's Research Governance Framework. Therefore we will need to contact you in due course with a request for reports of progress, and for a brief final report of research findings. If you have any questions about any of the above, or if I can be of any other assistance then please feel free to contact me.

Best wishes and I hope the research proceeds well.

Dr Tony Soteriou,
Associate Research and Development Director

Appendix XIII: Pilot Study: ADF R&DG Focus Group Schedule

1. To what extent do you agree with the interpretation of the main constructs related to the concept of social support for the family members of substance misusers?

2. Do you feel that there are any main constructs or social support themes missing from the interpretation?

3. If there are six or more main social support constructs, what do you consider to be the minimum number of items one should list under each heading? Where should these items be drawn from (e.g. examples in the ADF literature, source interview data in England)?

4. In terms of psychometric testing, what type(s) of reliability measure should one work into the design (i.e. internal consistency; test-retest; alternative form; split-halves)? Do you think one should test for concurrent criterion validity as well as content validity?

5. In your experience what is the relationship between the initial constructs measured by a questionnaire and those that might emerge from a factor analysis of it (e.g. gestalt of Coping Questionnaire)?

6. If a more detailed clinically based social support measure was to be developed, how could one ensure that clinicians accepted it as valid (in terms of research design)?

7. What do you think are the essential features that should be included in a social network diagram for family members? Which kind of measure do you think it should appear on (e.g. self-completion questionnaire, clinical interview schedule, both)?

8. In relation to development/piloting of ADF specific social support measures, are you aware of (or involved with) any alcohol and drug agencies that would be ideal for this purpose? What are your thoughts about the sample size for piloting the measure(s)?

Appendix XIV: Pilot Study: Service Manager Letter

Dear .....,

Re: Alcohol, Drugs and the Family Social Support Questionnaire.

I am a PhD researcher working with Professor Richard Velleman within the Alcohol, Drugs and the Family (ADF) Research Group which is part of the Mental Health Research and Development Unit, at the University of Bath. Your agency participated in some research that I did on the attitudes of staff towards working with the family members of problem substance misusers, which I fed back to your agency at the time. I would now like your service to take part in a different but related project. As you will be aware, a lack of social support has been shown to be associated with both physical and psychological health problems for family members living with a problem drinker / drug user. However, its impact has not been evaluated in a systemic way.

At the ADF Group we have developed a measure of social support specifically for family members and we will want to ask a number of agencies, including yours to participate in getting family members to complete this. Initially, however, this new measure needs to be piloted and we would like to ask you and your agency to work with us in piloting the questionnaire. If you agree to participate, it will involve piloting the ADF Social Support Scale (ADF SSS) with at least 6 family members. The family members will also be asked to complete a feedback sheet to give their views on the pilot version of the ADF SSS.

I will be in touch by telephone within the next week to address any queries or questions that you may have about the planned work and to establish whether your agency would be interested in collaborating with the ADF Group on this project. I would also be happy to meet with you and/or attend a staff team meeting if appropriate.

I look forward to talking / meeting with you soon,

Sincerely,

Appendix XV: Pilot Study: Service Manager Telephone Script

Hello would it be possible to speak to .....

If no,

Leave message and ask when they are free arrange a telephone meeting –
I call them back.

If yes,

Hi my name is Paul Toner, and I am a PhD student working with Professor Richard Velleman at the University of Bath.

(Alcohol Drugs and the Family)
You received a letter from me requesting your participation in a research project looking at social support, are you free to briefly discuss this? I am ringing to see whether your agency would be interested in collaborating with us to develop a social support measure which looks at the types of support which family members receive when they live with a relative who has a serious alcohol or drug problem.

I don't anticipate any problems with the research as it is non-intrusive for family members, and they should find it helpful.

Always available and happy to help! And of course I will visit your agency after the study to explain how helpful work was in developing the questionnaire and how the measure could be used in clinical practice.

So, if you have no objections to taking part in the study I will send you a number of questionnaires to be completed by family members with pre-paid envelopes.

Many thanks for your time and help it is most appreciated.

Appendix XVI: Pilot Study: Service Manager Cover Letter

Dear .....,

Re: Alcohol, Drugs and the Family (ADF) Social Support Scale.

Many thanks for taking my call on Friday, I am very grateful for your time and help in piloting the ADF SSS. I hope this letter reaches you in better health than when we last spoke. Enclosed are:

- 6 instruction sheets.
- 6 pilot versions of the ADF SSS. (3 font 10; 3 font 8).
- 6 questionnaire feedback sheets.
- 6 pre-paid envelopes for completed questionnaires and feedback sheets.

It would be immensely helpful if you were able to pilot the measure with at least 5 family members. I am available if any assistance or further information is required.

Sincerely,

Appendix XVII: Main Study: SOS(B)

SIGNIFICANT OTHERS SCALE (B)

NFER-NELSON

Name: .....

Date: ..... **Record Number:** .....

Instructions

Please list below up to seven people who may be important in the individual's life. Typical relationships include partner, mother, father, child, sibling, close friends, plus keyworker. For each person please circle a number from 1 to 7 to show how well he or she provides the type of help that is listed.

The second part of each question asks you to rate how individuals would like things to be if they were exactly as they hoped for. As before, please put a circle around one number between 1 and 7 to show what the rating is.

		Never			Sometimes			Always
Person 1 –								
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
Person 2 –								
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
Person 3 –								
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

PLEASE CIRCLE ONE NUMBER ONLY FOR EACH QUESTION

2

		Never			Sometimes			Always
Person 4 –								
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
Person 5 –								
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
Person 6 –								
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
Person 7 –								
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

PLEASE CIRCLE ONE NUMBER ONLY FOR EACH QUESTION

Appendix XVIII: Main Study: Information on Participating Agencies

Quotes:

"Before I was told about the local Carer Support Group I felt it was my fault and that I was alone with the problem..." Jane

"Since going to see key worker at the prescribing service I now feel involved and able to help my son by having boundaries around his behaviour. I will not be bullied any more..." Sheila

"I attend the family groups at the detox unit cos I know I need to change as well as my wife..." John

IMPORTANT CONTACT DETAILS

PARENT SUPPORT LINK
For family members, friends and concerned others affected by someone else's drug use: 24-7 telephone contact, individual and group support
023 8039 9764
parentsupportlink@ntlworld.com
www.parentsupportlink.org.uk

HEARSAY
A weekly group for adult carers living in the shadow of addiction
01329 237014 Barbara Cooper

First Steps Family Support Group
ANA Treatment Centre
161 Elm Grove, Southsea, Hants PO5 1LU
023 9283 7837

The Hampshire Drug & Alcohol Action Team
Capitol House, 12 13 Bridge Street,
Winchester, Hants SO23 0HL
01962 826025
Email: Hampshire Drug and Alcohol Action Team

M.O.R.P.H. Service User Group
023 8021 6009 or 023 8021 6006
Email: morphin@southamptonvs.org.uk

HCC Equality and Diversity
Information Centre
0800 028 0888

Spotlight
(Pheonix House/Addiaid Partnership)
Open Access Service
01329 237014 Barbara Cooper

Cranstoun DIP Services
023 9241 5650

Baytrees Residential Detox Services
St James Hospital, Locksway Road, Portsmouth PO4 8LD
A 23 Bedroom unit for specialist detoxification from drugs and alcohol
023 9268 3370

Phoenix House/Alpha Services
Wickham Road, Droxford, Hants SO32 3PD
01489 878527

Adfam
25 Corfham Street, London N1 6DR
020 75537640
Email: admin@adfam.org.uk

Frank Helpline
0800 776600
www.drugs.gov.uk/frank

DrugScope
32 36 Loman Street, London SE1 0EE
020 7928 1211
www.drugscope.org.uk

Hampshire Carers' Forum

This leaflet provides information, guidance and some responses to questions frequently asked by carers and significant others in relation to treatment services.

The leaflet has been produced by people affected by someone else's substance use, to support others who may be in the same position.

Our aim & mission statement:
"To enable Carers to meet, inform, and share ...."

The Carers Forum is committed to providing the opportunity for those affected by someone else's substance misuse, to meet, gain information and act as a bridge between carers' and policy making organisations. Also we are committed to supporting drug services to recognise, respect and respond to Carer's needs as separate to the treatment service user.

Sponsored by

NHS
HAMPSHIRE DAAT
Drug & Alcohol Action Team
TACKLING DRUGS CHANGING LIVES

TREATMENTS

Your local treatment agency will offer a range of interventions, either at home or at a local treatment centre or residential unit. The interventions range from controlling consumption (Substitute prescribing is another way of treating drug dependency with Methadone and Buprenorphine (Subutex) programmes), counselling, detox, residential rehab and if appropriate relocation to another area.

THOUGHTS ABOUT WORKING ALONGSIDE THE TREATMENT SERVICE

Forming a positive relationship with all those involved in your loved ones treatment is important. You may wish to become involved or informed about the treatment plans suggested for the person. Professionals can be reluctant to discuss a person's treatment with the carer, as there is a duty of confidentiality between the professional and the patient. However you should not be excluded ask the person you are caring for to sign a consent form. Professionals should be aware of the benefits of involving the carers in the patient's treatment as valued member of the care team.

YOUR FEELINGS ARE IMPORTANT TOO

- You might feel frustrated and hurt
- Unsure how to help
- Concerned for the person's safety and wellbeing
- Worried about what will happen in the future
- Afraid the police will be involved
- Frightened by the person's behaviour
- Feel that the person is beyond help
- Worried about the effects on the rest of the family
- Worried about financial consequences

These are common feelings to have when you are affected by someone elses drug use.

DON'T FORGET TO LOOK AFTER YOURSELF

- Don't bottle your feelings up find someone to talk to, this may be a trusted friend, family member or a local support group.
- See your own doctor, if you cannot sleep, are exhausted, anxious or depressed.
- Make sure that you find time and look after yourself you are not a one there are others who will help share the burden of care.

FREQUENTLY ASKED QUESTIONS

Q. What does treatment mean?

A. Treatment can be delivered in a variety of ways. Starting with an assessment where the needs of the drug user will be identified. A care plan is then agreed and a suitable treatment can begin. These can range from 1-1 counselling, day services, prescribing, home or in-patient detox & residential rehab. Remember its an ongoing process and things may change from time to time.

Q. What support can I get, for me?

A. Each agency has a duty to support the carer of someone entering treatment. So it is your right to ask what is available. Some agencies will refer you to an independent Carer/Family Support Group others may have support provision within their organisation.
Different agencies will have different ways of supporting families and friends. However, you should expect to be offered information and a listening ear. This could be a designated telephone line where your needs will be listened to, they might also refer on to the other services, for instance the opportunity to attend a support group (where you can meet others in a similar situations) or a face to face meeting with someone trained to support you in an emotional way, and even start a plan to help you cope with your circumstances.

Q. What should I do if I suspect the person I am caring for is using drugs again?

A. Don't keep it to yourself, you are not alone talk to your support group/help line for support with the situation

Q. Will I need to pay anything for these services?

A. No, you will not need to pay for support or the treatment

Q. Who will know my business?

A. All agencies have a policy around confidentiality; you can ask what it is. Usually it is something like; "No information will be shared without consent except in certain situations..."

Q. What do I do if things go wrong?

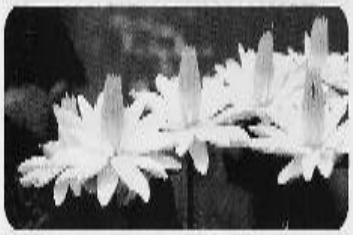
A. Its not unusual for things to "get out of control" relapse is part of recovery keep focused on the long term and seek support from the appropriate agencies

Q. How long will I get support?

A. You are entitled to support for as long as you feel you need it. As circumstances change, so might the type of support you need. Don't be afraid to ask for more or different support as your needs change

Q. Will the person I care about ever change or get better?

A. Yes. Often the will to change is encouraged by help, support, treatment and aftercare. So don't give up change is always possible.



Clouds' Services

Clouds offers a range of services designed to meet the needs of clients experiencing substance misuse.

Families Plus
A range of therapeutic support services for people personally involved with alcohol or drug dependent people. Training for practitioners seeking to work with families affected by addiction.

Clouds House Residential Treatment
A six week initial residential programme of treatment for alcohol and drug dependent people.

Aftercare
A post-treatment service for former patients with fortnightly group meetings over a structured day.

Professional Education and Research
Foundation degree in Addictions Counselling awarded by University of Bath; Addictions Counselling course verified by CPCAB. Further higher education qualifications in addictions counselling & professional accreditation with FDAP. Training workshops and consultancy also offered.

Pre-Treatment Project
A flexible programme of structured support for those awaiting treatment for their dependent drug or alcohol use.

Structured Day Treatment Programme
A community based first stage structured programme for individuals who wish to participate in an abstinence-based day programme.

Continuing Care
A post-treatment support service for individuals who have completed a course of treatment.

Working Recovery
A community training and work-based programme for those in the process of recovery from alcohol and/or drug dependency.

Family Support Groups
Facilitated evening support meetings for family members and carers, held weekly in various locations in the South and West.

Health Promotion
Working to protect people's health and safety from the effects of substance misuse by means of presentations, offering information and undertaking consultancy work.

Clouds' Mission Statement

To offer help, hope and freedom from alcohol and drug dependency by providing interrelated services of the highest quality and effectiveness which have a clear and ethical basis and which meet the real needs of our clients.

Working to ensure equality of opportunity

CLOUDS

Families Plus, 11b York Road, Salisbury, Wiltshire, SP2 7AP
Tel: 01722 340325 Fax: 01722 412717
e-mail: admin.familiesplus@clouds.org.uk

Company registered address:
Clouds House, East Knoyle, Salisbury, Wiltshire SP3 6BE
Tel: 01747 830703 Fax: 01747 830703
e-mail: admin@clouds.org.uk
website: www.clouds.org.uk

771 March 2005

familiesPLUS

Specialist help for families affected by alcohol & drug dependency

CLOUDS

OFFERING HELP, HOPE AND FREEDOM FROM ALCOHOL AND DRUG DEPENDENCY

You don't have to misuse alcohol or drugs to suffer from alcohol or drug misuse.

Families Plus is part of the charitable organisation, Clouds. The work of Families Plus is devoted to family members and others who want help in understanding and coming to terms with the effects of living with the substance misuse of others. The services provided are carried out by qualified and experienced staff.

Some of the questions you may be asking

Why me? Why our family? What did I do wrong?

If (s)he stopped using/drinking we'd all be all right ... wouldn't we?

If you are reading this the chances are that you are suffering the consequences of drug or alcohol misuse, you are feeling abandoned, rejected and completely frustrated. You are likely to have worn yourself out struggling to get a partner, colleague, friend or child not to drink or use.

We can help in a number of ways.

Brief Residential Family Programmes provide a safe environment in which participants learn how to cope more effectively and improve their quality of life (see box).

Aftercare provides follow up for those having completed one of the Residential Programmes, and may be one or two days, or longer.

Individual, Couples and Family Therapy are offered at our premises in Salisbury, and are carried out by staff fully trained and experienced in both addiction and systemic therapy.

Family Support Groups meet regularly and offer support to individual family members by providing the opportunity for personal growth and providing alternative coping strategies. Facilitated evening support groups are held once a week at various locations in the South and West. Please contact the office for further information. These groups are being partly funded through the Home Office Recovered Assets Fund.

The Brief Residential Family Programme

What happens?

In an atmosphere of care and support, participants develop their self awareness and learn how to help themselves. There are lectures and workshops on subjects related to alcohol and drug dependency. There is plenty of opportunity to share experiences with others who are in similar situations, thereby reducing the feelings of isolation.

How effective is it?

An independent outcome study has confirmed the effectiveness of this programme. The research showed that these five days can significantly change a life for the better. Copies of research (cost £4.00) available from Clouds. Participants previously experiencing very high levels of distress have found that these levels are significantly reduced.

91% of participants report that they are still satisfied with their experience after 12 months. 95% would recommend the programme to others.

Here are some comments from people who have attended the Family Programme:

"The week helped me immeasurably. I learned so much. It is still helping me a lot. I was told that the Clouds week would give me a head start and it certainly has. I feel so strong now and I'm quite sure that I am doing the right thing, which is such a relief."

"The Family Programme was great. It gave me support and confidence. This really does change lives."

The Family Programme is held regularly throughout the year at a Retreat Centre in Wiltshire. The programme runs from Monday lunchtime to Friday lunchtime.

Residential Training Week: Working with Families and Substance Misuse

This course provides experiential professional training for those already working with substance misusers. Some of the topics covered include: family systems, family roles and patterns, and therapeutic interventions with families. The course provides an opportunity for participants to explore their own beliefs, attitudes and issues around families.

Meeting Rooms

We are also able to offer rooms for hire at our offices in Salisbury which are situated conveniently near the town centre and railway station (please telephone for details).

Finance

We are a charitable organisation run by experienced professionals offering a therapeutic service to anyone affected by the misuse of alcohol or drugs. We are grateful to our benefactors for ongoing financial support for the administration of Families Plus. Some services, such as one to one counselling and the Family Support Group, may be offered FREE OF CHARGE. Funding for other services may also be available to those requiring financial assistance. Please telephone the office to discuss these options. Funding for Family Support Groups is through Local Providers and/or the Home Office Recovered Assets Fund and we are most grateful for this support.

To discuss your needs in complete confidence and/or for more details of any of our services please write or call:

Families Plus
11b York Road
Salisbury SP2 7AP
Tel: 01722 340325
Fax: 01722 412717
admin.familiesplus@clouds.org.uk

Equal Opportunities

CRI operates an equal opportunities policy which means that anyone using our services, or any employee, volunteer or mentor, will not be discriminated against on the basis of racial/ethnic or national origin, gender, marital status, disability, sexual orientation, age, religious beliefs, HIV/AIDS status, or criminal offences.

Confidentiality

Our services are confidential and we have an open access policy. However, situations may arise where we will be obliged to notify the relevant authority.

CRI Statement of Purpose

CRI aims to create safer communities by enabling people to develop the potential to lead purposeful, stable and crime free lives, reducing the incidence of crime and its adverse effects.

CRI prevents people from entering into, or helps people to break free from, damaging patterns of behaviour through the provision of a range of integrated services designed to address both social care and community safety issues.

Services are tailored to meet the individual needs of substance misusers and their families, prisoners both pre and post release, street homeless people and wider street populations, young people at risk and the victims of domestic abuse.

CRI is one of the few registered charities that bridge the gap between social care, criminal justice and community safety agendas. We work primarily with offenders and in particular with those whose criminal behaviour is linked to substance misuse. Our focus is on the prevention of further crime and on minimising the damage caused to individuals, families and communities by crime, substance misuse and social behaviour and social deprivation. Our integrated services are provided in partnership with organisations in the statutory and independent sector including the police, probation, prison service, local authorities and health services.

COMMUNITIES AGAINST DRUGS

Crime Reduction Initiatives

Registered office: 3rd Floor, North West Suite, Tower Point, 44 North Road, Brighton BN1 1YR www.cri.org.uk

Registered Charity Number: 1074327 Company Number: 3661208

November 2005 printed to 3000361

professional advice targeting communities and families helping eliminate drug misuse

PATCHED

- Advice and Information
- Drop-In Service
- Free and Confidential Helpline
- Local Adult Support Group
- Outreach

Free Phone:
0800 085 4450

Safer communities through purposeful lives

What is PATCHED?

At PATCHED we acknowledge that the whole family is directly affected by substance misuse.

PATCHED offers support and services for the families, friends and carers of substance misusers or anyone in the local community experiencing the effects of someone else's drug or alcohol problem.

Our services include:

- Free phone help line (0800 085 4450)
- Advice, information and support
- Support groups
- Outreach support
- Training courses

PATCHED

How to Contact Us

Free Phone Help Line 0800 085 4450

- 10am-10pm daily
- out of hours message service

PATCHED can be contacted through our Free Phone Helpline. When you contact PATCHED, we can discuss your concerns and we will work with you to find appropriate solutions. We can offer you a range of support options, further information and referrals to other services. An out-of-hours message service gives alternative numbers to call or you can leave a message so we can call you back.

How We Can Help

Advice, support and information PATCHED provides advice and support on a range of issues.

Referrals to other services PATCHED provides referrals to other services which can help both families, friends, carers and the substance misuser.

Support groups PATCHED provides supportive groups for families, friends and carers of substance misusers.

Outreach support PATCHED provides one to one support through home visits.

Accredited training PATCHED offers access to courses in basic and intermediate counselling, first aid and overdose training, drug and alcohol basic awareness training and self-assertiveness training.

Free Phone Help Line:

0800 085 4450

Call the Free Phone Help Line for more information on all our services.

When can I access these services?

After your initial assessment, a care plan will be designed with you to help meet your needs. Appointments can be made within ADAS opening hours;

Mondays 9.00am - 5.00pm
Tuesdays 9.00am - 8.00pm
Wednesdays 9.00am - 5.00pm
Thursdays 9.00am - 8.00pm
Fridays 9.00am - 5.00pm

Where are the ADAS premises?

You can find us at 118-122 The Stow, Harlow, Essex CM20 3AS. We are located above an estate agency, and our red entrance door is between this agency and the Essex Skipper Public House. There is an alternative entrance that can be accessed from the service bay at the rear of the shopping centre. Free car parking is available and is well signposted. The following buses run from Harlow Bus Station: 8, 59, Arriva 333, XL 333, 500, 501, 510. Please use the map to help you find your way to The Stow.

A D A S

A D A S

The Alcohol & Drugs Advisory Service
118-122 The Stow
Harlow, Essex
CM20 3AS
Tel: 01279 438716/641347
Fax: 01279 641140
Registered Charity number: 297932
Website: www.adasuk.org
Email: admin@adasuk.org

ADAS

The Alcohol & Drugs Advisory Service

01279 438716

Who is the service for?

ADAS is a service for people who may be concerned about their drug or alcohol use.

In addition, if you are a partner or relative who is affected by someone's drug or alcohol use, the service is available to you.

The service is open to anyone living within Essex.

What services do we provide?

- Advice and information
- Open Access Services
- Motivational Interviewing
- Brief Interventions
- Referral On/Liaison with other agencies
- Structured care-planned counselling
- Access to a range of complementary therapies.
- Structured Aftercare programmes, e.g. expressive art groups and other therapeutic options
- Stress & Anxiety Management courses
- Relapse Prevention groups
- Children's Play Therapy
- Referral for assessment for Detoxification and Rehabilitation programmes

How much does the service cost?

ADAS is a free service. However, as a registered charity we always welcome donations.

How do I get an appointment?

You can telephone us directly Monday to Friday between 9.00am - 5.00pm

Alternatively, we welcome referrals from GP's and other professional bodies.

Is the service confidential?

At ADAS we do our best to maintain confidentiality within the agency. However, there are situations when we would need to breach this confidentiality and they are:

- If we believe a child is being put at risk of neglect, emotional, physical and/or sexual abuse.
- If we believe that you are at serious risk of harming yourself or someone else.
- If you commit a criminal offence on our premises or against a member of staff.

What will happen at my first appointment?

The first appointment will be an assessment. This helps us understand what your needs are and provides the opportunity to explore the various treatment options available to you. You can use this opportunity to decide whether or not ADAS is the appropriate service for you.

How long will the counselling last?

The counselling sessions are fifty minutes each and a regular appointment time will be allocated to you each week with the same counsellor.

The number of sessions will be agreed between you and your counsellor, and regular reviews of progress will be undertaken.

A longer intervention can be planned if this is felt to be beneficial for you.

Where will I be seen?

Appointments are generally held at ADAS's offices in The Stow. ADAS also has satellite sites elsewhere.

Any referrals received by the Community Substance Misuse Services after the beginning of August 2002 will be passed on to the triage co-ordinator, who will ensure the person is seen, assessed, and passed on to the best agency promptly.

There is a lot of reorganisation associated with this. It will take some time for this to settle down and there will be some initial uncertainty, but we will try to keep this to a minimum. All the locality services across the county are listed on the West Sussex Drug Action Team website (www.westsussexdat.co.uk) as well as being published in a directory which can be obtained from:

The West Sussex Drug Action Team
1st Floor, City Gates
2-4 Southgate
Chichester
West Sussex
PO19 2DJ

Tel: 01243 – 382943 / 382944
Fax: 01243 - 382930

We hope that you will find help easier and quicker to obtain, with better results and more effective help for patients/ clients, their carers and referrers.

West Sussex Drug Action Team July 2002

West Sussex Health and Social Care NHS
NHS Trust

west sussex county council

West Sussex County Council
Drug Action Team

1st Floor, City Gates
2-4 Southgate
Chichester
West Sussex
PO19 2DJ

Phone: 01243 382943 / 382944
Fax: 01243 382930
Email: mike.george@westsussex.gov.uk
Web Site: www.westsussexdat.co.uk

West Sussex Health and Social Care NHS
NHS Trust

INFORMATION LEAFLET FOR CLIENTS

WAYS OF GETTING HELP FROM SUBSTANCE MISUSE SERVICES ARE CHANGING

PLEASE READ CAREFULLY

Appendix XIX: Main Study: Family Member Information Sheet

ref _____

Family Member Support Study

My name is Paul Toner, and I work in the Mental Health Research & Development Unit at the University of Bath.

You are being invited to take part in a research study. Before you decide if you will take part, it is important for you to understand why the research is being done and what it will involve. Please take some time to read through the following information and discuss it with your practitioner, and your family if you wish. Do please ask us if there is anything that is not clear, or if you would like further information. Take time to decide whether or not you wish to take part.

What is the aim of the study?

It is common for families where someone has an alcohol or drug problem to often experience a range of difficulties. Previous work in the UK has found that support from other people helps the close family members of substance misusers to cope better with their situation. This may help to protect them from health problems of their own.

I have developed a questionnaire which measures social support. The questionnaire items were developed from interviews, where family members told me and my colleagues what they thought were the most important parts of social support for them.

The main aim of this study is to see if this new questionnaire provides helpful and useful answers, and if it does, to see how the questionnaire can be made even better.

This knowledge will be used to improve the advice that family members are given by practitioners about the effect of social support on their well being and about how best to get positive support for coping with their situation.

What will I have to do, if I take part?

You will be asked to fill out a questionnaire about the support you get from others.

You will be asked questions by me about how relevant you found the questionnaire, your responses will be noted down.

Will taking part in this study be kept confidential?

All information that you provide to the researcher will be strictly confidential. When the results are written up, no-one will be identified by name or by any other such detail. Your name will not appear on any questionnaires that you fill in.

Who is organising and funding the study?

This study is funded by an Economic and Social Research Council (ESRC) grant. This research has received approval from the Bath Local Research Ethics Committee, the Avon and Wiltshire Mental Health Partnership NHS Trust and the University of Bath.

Contact for further information

If you would like to talk more about the study and ask any questions, please contact: Paul Toner – Tel: 01225 384053

Thank you for your time.

If you have read and understood this Information Sheet, and you have asked any questions and are happy to take part, then please choose whether you would prefer to take part in (please tick)

Group Setting ☐ One-to-one Interview ☐

Appendix XX: Main Study: ADF SSS Brief Instruction Sheet

General
Please make sure that you read the **first page and the first paragraph of page 3** of the questionnaire carefully. These briefly explain what the questionnaire is measuring and how you should complete the questions for each statement.

Page 1
This page asks **2 very general questions** about your social support. The first part is about how well supported you feel and the second is about giving an idea of where most of your support comes from i.e. family, friends, professionals etc.

Pages 3-14
If the statement has **NOT happened** in the last 3 months the response to **question A** is **Never** and questions **B and C** are **left blank**. **Question D** for each statement looks at your **ideal** and is **FILLED IN WHETHER OR NOT the statement has happened in the last 3 months.**

If the statement **HAS happened** in the last 3 months, **question A** for each statement asks **how often**. Then you should think of the **single most important time** when the statement happened to you in the last 3 months, and fill in **question B** thinking of **how important** this was to you, and **question C** thinking of **how satisfied** you were at this time with the event described in the statement happening.

We are still working on the questionnaire to make it better. We are using the things people have told us to improve it - so any comments written on it are really useful. You can go through it at your own pace, even leaving it and coming back to it later, if you don't want to do it in one go. But, please do remember to return it (even if you don't finish it) in the free post envelope provided.

Many thanks for your help.

Appendix XXI: Main Study: 58-item ADF SSS

Alcohol, Drugs and the Family (ADF) Social Support Scale

The following questionnaire looks at the extent and quality of social support that you (the Family Member) receive in general, and in relation to living with an alcohol or drug misuser (your Relative) in the family.

Question (A) for each statement, relates to the number of times the event referred to in the statement has **happened in the last three months**. If the statement has not occurred in the previous three months, tick never, and then move on to Question (D). If the statement has happened in the last three months, then fill in Questions **(B)** and **(C)** with reference to **the single most important time when it occurred** before moving on to Question (D). Please tick the most appropriate response to each question.

1. Friends/relations have **understood what it is like for me to live with my relative's drinking or drug taking**.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations understanding my situation)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

2. Friends/relations have **helped to cheer me up**.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations helping to cheer me up)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

3. Health/social care professionals have given me **helpful information** about substance misuse.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. professionals giving me helpful information)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

4. Friends/relations have **brought my relative home safely to me**, after my relative had been drinking or drug taking.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations bringing my relative home safely)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

5. Friends/relations have **taken care** of my relative (e.g. helped out with activities of daily living such as cooking etc).

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations taking care of my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

6. Friends/relations have organised events to **take my mind off** my relative's alcohol or drug problem.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations taking my mind off my relative's alcohol or drug problem)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

7. I have friends/relations **whom I trust**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations with whom I trust to disclose my feelings)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

8. Friends/relations have **defended** my relative in difficult situations.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations defending my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

9. Friends/relations have **listened to me when I have talked about my feelings**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having friends/relations listen to me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

10. Reading books/booklets about people living with a substance misuser is as useful as friends/relations talking to me and offering me advice.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. books/booklets providing me with advice)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

11. Friends/relations have backed the stance that I have taken towards my relative and their substance misuse.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations backing the stance that I have taken towards my relative)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

12. Friends/relations have put themselves out for me when I needed practical help (i.e. aid or assistance).

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations putting themselves out when I need practical help)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

13. Friends/relations have advised me to focus on myself and my own needs.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations giving me advice to focus on myself)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

14. I have met up with friends/relations for relaxation.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having friends/relations to relax with)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

15. Friends/relations have **undermined my efforts to stand up to my relative's problem drinking or drug taking**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations undermining my efforts to stand up to my relative's drinking or drug taking)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

16. Friends/relations have **provided me with information about alcohol or drug misuse.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations providing me with information about alcohol or drug misuse)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

17. **My relative has listened to friends/relations about his/her (my relative's) alcohol or drug problem.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. my relative listening to friends/relations about the alcohol or drug problem)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

18. Friends/relations have **given me a car lift at short notice**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting a car lift at short notice)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

19. Friends/relations have **encouraged me to tell health/social care professionals about the stress that I am under.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting encouraged to talk with professionals)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

20. Friends/relations have **criticised me for trying to put some distance between myself and my relative.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting criticised for trying to put some distance between myself and my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

21. Friends/relations have given me **help with chores** around the house.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting help with chores)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

22. Friends/relations have **offered both myself and my relative advice** about my relative's substance misuse

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations offering both myself and my relative advice)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

23. I have **let off steam with friends/relations.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having friends/relations available to let off steam with)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

24. Health/social care professionals have **NOT been interested in my substance misusing relative.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. professionals NOT being interested in my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

25. Friends/relations have been **unduly critical of my relative**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations being unduly critical of my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

26. Friends/relations have **given me space to talk about my problems**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations giving me space to talk about my problems)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

27. Friends/relations have said that **my relative should leave the family home**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations saying my relative should leave home)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

28. My doctor has **prescribed medication** for me.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having medication prescribed for me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

29. Health/social care professionals **have NOT given me information** about my relative's substance misuse.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. professionals NOT providing me with information)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

30. There are friends/relations **in the same situation** [have a substance misusing relative] with whom I have talked about my problems.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. talking with friends/relations in a similar situation about my problems)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

31. Friends/relations have **said things about my relative that I do NOT agree with**.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations saying things about my relative that I do NOT agree with)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

32. Friends/relations have **avoided me because of my relative's substance misuse**.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations avoiding me)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

33. Health/social care professionals have **made themselves available** for me.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having professionals who make themselves available)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

34. Friends/relations have **blamed me for my relative's behaviour**.

(A) Has this happened to you in the last three months?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?
☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?
☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations blaming me for my relative's behaviour)?
☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

35. Health/social care professionals **have NOT talked through strategies with me for dealing with my relative's substance misuse.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. professionals NOT talking through strategies)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

36. Friends/relations have **helped me to change my outlook towards my relative.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations helping me to change my outlook towards my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

37. My employer has given me **time off work when I needed it.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting time off work when I need it)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

38. Friends/relations have **actively encouraged my relative to drink or take drugs.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations encouraging my relative to drink or take drugs)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

39. I have found it **difficult to talk with friends/relations about my problems.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having difficulty talking with friends/relations about my problems)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

40. Friends/relations have **provided me with a plan to deal with my relative's substance misuse.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations providing me with a plan to deal with my relative's substance misuse)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

41. There are friends/relations **within my organised religion/faith who have offered me support.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations within my faith offering me support)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

42. Friends/relations have **offered me temporary accommodation away from my relative.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having accommodation offered for respite from my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

43. Friends/relations have **suggested alternative ways to react to my relative.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. people suggesting alternative ways to react towards my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

44. I have offered **support** to friends/relations but **have NOT received it in return.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. NOT receiving help from friends/relations in return for my support)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

45. Friends/relations have said **my relative is doing nothing wrong** by drinking or taking drugs.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations saying my relative is entitled to drink or take drugs)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

46. Friends/relations **had my relative stay with them** for a short time.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. having my relative stay with friends/relations to give me a break)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

47. Friends/relations have said that **my relative does NOT deserve help**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations saying my relative does NOT deserve help)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

48. I have **identified with the information contained within books/booklets** about people living with a substance misuser.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. identifying with the information contained within books/booklets)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

49. Friends/relations have insisted that I **should let my relative continue drinking or drug taking**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations insisting that I should let my relative drink or take drugs)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

50. Friends/relations have **told my relative off on my behalf**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations telling my relative off when I want them to)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

51. Friends/relations have **advised me to leave my relative**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations telling me to leave my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

52. Friends/relations have **been there for me**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations being there for me)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

53. Friends/relations have **put work my way to help me out financially**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. getting financial help from friends/relations)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

54. Friends/relations have **provided support for the way I cope with my relative**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations providing support for the way I cope with my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

55. Friends/relations have **talked to me about my relative and listened** to what I have to say.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations talking to me about my relative and listening to what I have to say)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

56. Friends/relations have **lent me money**.

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. being lent money when I need it)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

57. Friends/relations have **said nasty things about my relative.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. friends/relations saying nasty things about my relative)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

58. I have **confided in my health/social care professional about my situation.**

(A) Has this happened to you in the last three months?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

(B) Was this important to you?

☐ N/A ☐ Not Important ☐ Important ☐ Very Important

(C) Did you feel satisfied with this?

☐ N/A ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied

(D) What would your ideal be (i.e. being able to confide in professionals about my situation)?

☐ Never ☐ Once or twice ☐ Sometimes ☐ Often

Appendix XXII: Main Study: 58-item ADF SSS Cover Sheet

Alcohol, Drugs and the Family (ADF) Social Support Scale

The following questionnaire (which begins on page 3) is based on what people in the same position as you [have a substance misusing Relative] have told us about their social support. It may look long, however, it should take no more than 10-15 minutes to complete.

Please ensure that you read the opening two paragraphs of the questionnaire carefully. These explain how you should complete the questions for each statement.

Many thanks for your time in helping with this important work aimed at getting a better understanding of the impact of social support on family members' coping with an alcohol and/or drug problem in the family and its impact on their physical and psychological well being

It would really help us to know a little about your general level of support:

- How much support do you feel that you currently have? (Please circle)

0 10 20 30 40 50 60 70 80 90 100

No support Adequate support Full support

In the questionnaire you will see the words friends/relations used. This not only means your friends and family but also anyone else that you come into contact with. People, such as friends and associates of the problem drinker/drug taker, neighbours, professionals and members of self-help groups.

The following circles represent all of your social support:

- In the circles, please write using the numbers below (one number per circle), how much of your social support comes from:

1. Friends
2. Family
3. Professionals
4. Self-help groups

Example.

Appendix XXIII: Main Study: Notice of Substantial Amendment

Bath Research Ethics Committee
Forbes Fraser Building
Royal United Hospital
Combe Park
Bath
BA1 3NS

Tel/Fax: 01225 825725
research.ethics@ruh-bath.swest.nhs.uk

13 July 2004

Mr P Toner
Mental Health R&D Unit
Wessex House, Level 7
University of Bath
Bath BA2 7AY

Dear Mr Toner

Full title of study: The Development of an Alcohol, Drugs and Family (ADF) Specific Social Support Measure for the Family Members of Substance Misusers
REC reference number:BA441
Protocol number:
Amendment number: 1
Amendment date: 26/06/04

The above amendment was reviewed by the Sub-Committee of the Research Ethics Committee at the meeting held on 7 July 2004.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Substantial Notice of Amendment Form version 1 dated 26/06/04
Staff Information Sheet dated June 2004
Family Member Information Sheet dated June 2004
Family Member Consent Form dated June 2004

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Management approval

Before implementing the amendment, you should check with the host organisation whether it affects their approval of the research.

An advisory committee to Avon, Gloucestershire and Wiltshire Strategic Health Authority

Statement of compliance (from 1 May 2004)

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC reference number: BA441 **Please quote this number on all correspondence**

Yours sincerely

Anna Jenkins

Anna Jenkins
Research Ethics Administrator

Copy to: *Professor R Velleman, Mental Health R&D Unit*

Enclosures *List of names and professions of members who were present at the meeting and those who submitted written comments*

List of Names and Professions of Members who were Present at the Meeting and those who Submitted Written Comments

Dr Andrew Taylor
Consultant Biochemist/Chairman

Dr Gordon Taylor (written comments)
Medical Statistician

Appendix XXIV: Main Study: Introductory Service Manager Letter

Dear .....,

Re: Alcohol, Drugs and the Family Social Support Scale.

I am a PhD researcher working with Professor Richard Velleman within the Alcohol, Drugs and the Family (ADF) Research Group which is part of the Mental Health Research and Development Unit, at the University of Bath. I would like to ask your service to take part in a research project. As you will be aware, a lack of social support has been shown to be associated with both physical and psychological health problems for family members living with a problem drinker / drug user. However, its impact has not been evaluated in a systemic way.

At the ADF Group we have developed a measure of social support specifically for family members and we will want to ask a number of agencies, including yours to participate in getting family members to complete this questionnaire which has already been piloted. If you agree to participate, the study will involve testing the ADF Social Support Scale (ADF SSS) with 10 family members. The Significant Others Scale will also be used with a subset of family members for validation purposes.

I will be in touch by telephone within the next week to address any queries or questions that you may have about the planned work and to establish whether your agency would be interested in collaborating with the ADF Group on this project. I would also be happy to meet with you and/or attend a staff team meeting if appropriate.

I look forward to talking / meeting with you soon,

Sincerely,

Appendix XXV: Main Study: Second Service Manager Letter

Dear .....,

Re: Alcohol, Drugs and the Family Social Support Scale.

Many thanks for your telephone call which indicated that your agency would be interested in collaborating with the ADF Group on this project. The study will involve testing the ADF Social Support Scale (ADF SSS) with 10 family members. The Significant Others Scale (SOS) will also be used with a subset of family members for validation purposes.

As agreed it would be best in the first instance to send you the ADF SSS and a brief research protocol document, so that you could take a look at its content before completing the enclosed consent form and commencing the study.

I will be in touch by telephone to address any queries or questions that you may have about the planned work. I would also be happy to meet with you and/or attend a staff team meeting if appropriate.

I look forward to talking with you soon,

Sincerely,

Appendix XXVI: Main Study: Covering Letter

Dear .....,

Re: Alcohol, Drugs and the Family Social Support Scale.

Many thanks for agreeing that your agency would be interested in collaborating with the ADF Group on this project. Just to reiterate, the study will involve testing the ADF Social Support Scale (ADF SSS) with 10 family members. The Significant Others Scale (SOS) will also be used with a subset of family members for validation purposes.

Enclosed in this correspondence are 5 ADF SSS, 2 SOS and 5 pre-paid envelopes for completed questionnaires. This will enable you to begin testing the measure with family members, I will send subsequent questionnaires out in due course. The priority is to get family members to complete the ADF SSS, however, I would be most grateful if a few family members could also fill in the SOS. Please write the corresponding number on the SOS (e.g. ADFSSS 0001 = SOS 0001) so that the questionnaire responses can be cross-referenced for the same family member.

I will be in touch by telephone to address any queries or questions that you may have about the planned work. I would also be happy to meet with you and/or attend a staff team meeting if appropriate.

I look forward to talking with you soon,

Sincerely,

Appendix XXVII: Main Study: Précis

The overall aim of this work is to operationalise the concept of social support specific to Family Members (FMs) who live with a substance misusing relative.
It is envisaged that by looking at social support in a more systematic way this will help to **inform and evaluate therapeutic interventions for FMs in their own right.**

Social Support Categories
General
- **Emotional** (incl. **companionship**) support (e.g. FM having someone to listen to them)
- **Practical** support (e.g. someone offering accommodation for respite)
- **Informational** support (e.g. advice from professionals)

Alcohol, Drugs and the Family (ADF) Specific
- **Impact on coping support**
Help they give the FM in arriving at and maintaining ways of coping.

Whether the supporting person understands the stressors and dilemmas faced by the FM and understands the difficulty of finding a way of coping and reinforces the FM in their chosen ways.

Appreciates the ambivalence that the FM feels towards the problem substance user and does not inappropriately 'take sides'.

- **Attitudes and actions towards the using relative**

ADF Social Support Scale
The questionnaire is still in development and is not in a form that would be useful for practice. However, feedback is required from FMs in order to reduce it in size and make it less complicated.

FMs who are currently not experiencing crisis are the target recruits. They can complete questionnaire over many sittings (in the agency or at home), just as long as it is returned in the free post envelope provided.

Practitioners are in a good position to assess which FMs would be suitable to complete the questionnaire. However, I am more than happy to attend groups etc. to distribute, work through and answer questions about the measure.

Contact details: If you have any questions about the work or would like further copies of the ADF SSS, I would be glad to hear from you: Paul Toner p.toner@bath.ac.uk 01225 384053.

Appendix XXVIII: Main Study: A3 Poster Information

Do you have a relative with an alcohol or drug problem?

We at the University of Bath and the Avon and Wiltshire Partnership Trust are carrying out a survey looking into the level of support for the Family Members of substance misusers. We would really appreciate **your** views.

If you would like to take part, please help yourself to a questionnaire and a free-post envelope from reception.

Thank you for your help.

Appendix XXIX: Main Study: Follow-up Letter

Dear .....,

Re: Alcohol, Drugs and the Family Social Support Scale.

Many thanks for your support in collaborating with ADF Group in helping to develop a measure of social support specifically for the family members of substance misusers. The feedback given by family members attending your service has been incredibly helpful in arriving at a questionnaire which could potentially be used in practice. I would just like to thank you personally for all your efforts in distributing the questionnaires to staff/family members.

If you do have any questionnaires remaining it would be immensely helpful if you could hand them out, as I am still collecting data and every questionnaire received is extremely valuable to the work. It would also be great if you could contact me (details above) so that we can talk through the information to be included about your service in any publications emerging from the work.

I look forward to hearing from you soon.

Sincerely,

Appendix XXX: Main Study: Disengagement Letter

Dear .....,

Re: Alcohol, Drugs and the Family Social Support Scale.

Many thanks for your support in collaborating with ADF Group in helping to develop a measure of social support specifically for the family members of substance misusers. Unfortunately, in recent months I have found it difficult to maintain contact with your Agency. It is not my intention to hassle staff whom I know are already incredibly busy providing a service for family members and their using relatives. However, I would just like to re-iterate the importance of this work as this particular client group are largely ignored (with a few notable exceptions) from a research standpoint in the UK. This is further compounded by the fact that (not unusually for this area) I am struggling to access enough family members to complete the questionnaire, thus jeopardising the entire project.

With this in mind it would be immensely helpful if you could contact me (details above) to discuss further participation or withdrawal from the study. Also, we can talk through the information to be included about your service in any publications emerging from the work.

I look forward to hearing from you soon.

Sincerely,

Appendix XXXI: Main Study: Online ADF SSS

- He/she (substance misusing relative) is my:

☐ Father / Mother

☐ Husband / Wife / Partner

☐ Brother / Sister

☐ Son / Daughter

☐ Other (e.g. father-in-law, aunt, nephew). Please state his/her relationship to you.

- It would really help us to know a little about your general level of support:

• How much support do you feel that you currently have? (please mark)

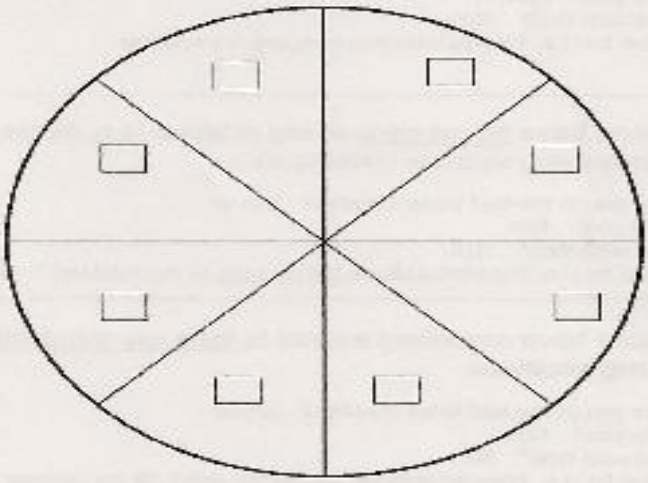
☐——☐——☐——☐——☐——☐——☐——☐——☐——☐——☐

0 — No support

50 — Adequate support

100 — Full support

- The following circle represents all of your social support:



• In each section, please write using the numbers below (one number per section), how much of your social support comes from:

1. Friends
2. Family
3. Professionals
4. Self-help groups

Alcohol, Drugs and the Family (ADF) Social Support Scale

The following questionnaire is based on what people in the same position as you [have a substance misusing Relative] have told me about their social support. It may look long, however, it should take no more than 10-15 minutes to complete.

In the questionnaire you will see the words friends/relations used. This not only means your friends and family but also anyone else that you come into contact with. People, such as friends and associates of the problem drinker/drug taker, neighbours, professionals and members of self-help groups.

It would really help me to know a few anonymous details about you. Please complete the following:

- Age: ☐ 16 – 24 ☐ 25 – 35 ☐ 36 – 49 ☐ 50 – 64 ☐ 65+

- Are you: ☐ Male ☐ Female

- Where do you currently live? - Please state country:

- What is your ethnic origin? - Please state:

- Is English your first language? ☐ Yes ☐ No

- Which of the following describes your main activity?

☐ In employment or self-employed ☐ Student

☐ Retired ☐ Seeking work

☐ Housework ☐ Volunteer

☐ Other (please specify)

- Did your education continue after the minimum school leaving age?

☐ Yes ☐ No

- My substance misusing relative is: ☐ Male ☐ Female

- Has your substance misusing relative lived with you at any time in the last 6 months?

☐ Yes ☐ No

1. Friends/relations have **understood what it is like for me to live with my relative's drinking or drug taking**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations understanding my situation)? Never

2. Friends/relations have **helped to cheer me up**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations helping to cheer me up)? Never

3. Health/social care professionals have given me **helpful information** about substance misuse.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. professionals giving me helpful information)? Never

4. Friends/relations have **brought my relative home safely to me**, after my relative had been drinking or drug taking.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations bringing my relative home safely)? Never

5. Friends/relations **have taken care of my relative** (e.g. helped out with activities of daily living such as cooking etc).

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations taking care of my relative)? Never

6. Friends/relations have organised events to **take my mind off my relative's alcohol or drug problem**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations taking my mind off my relative's alcohol or drug problem)? Never

7. I have friends/relations **whom I trust**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations with whom I trust to disclose my feelings)? Never

8. Friends/relations have **defended my relative** in difficult situations.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations defending my relative)? Never

9. Friends/relations have **listened to me when I have talked about my feelings**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. having friends/relations listen to me)? Never

10. **Reading books/booklets about people living with a substance misuser** is as useful as friends/relations **talking to me and offering me advice**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. books/booklets providing me with advice)? Never

11. Friends/relations have **backed the stance that I have taken towards my relative and their substance misuse**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations backing the stance that I have taken)? Never

12. Friends/relations have **put themselves out for me when I needed practical help** (i.e. aid or assistance).

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations putting themselves out when I need practical help)? Never

13. Friends/relations have **advised me to focus on myself and my own needs**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations giving me advice to focus on myself)? Never

14. I have **met up with friends/relations for relaxation**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. having friends/relations to relax with)? Never

15. Friends/relations have **undermined my efforts to stand up to my relative's problem drinking or drug taking**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations undermining my efforts to stand up to my relative's drinking or drug taking)? Never

16. Friends/relations have **provided me with information about alcohol or drug misuse**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations providing me with information about alcohol or drug misuse)? Never

17. **My relative has listened to friends/relations about his/her (my relative's) alcohol or drug problem**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. my relative listening to friends/relations about the alcohol or drug problem)? Never

18. Friends/relations have **given me a car lift at short notice**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. getting a car lift at short notice)? Never

19. Friends/relations have **encouraged me to tell health/social care professionals about the stress that I am under**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. getting encouraged to talk with professionals)? Never

20. Friends/relations have **criticised me for trying to put some distance between myself and my relative**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. getting criticised for trying to put some distance between myself and my relative)? Never

21. Friends/relations have given me **help with chores** around the house

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. getting help with chores)? Never

22. Friends/relations have **offered both myself and my relative advice** about my relative's substance misuse.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations offering both myself and my relative advice)? Never

23. I have **let off steam with friends/relations**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. having friends/relations available to let off steam with)? Never

24. Health/social care professionals have **NOT been interested in my substance misusing relative**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. professionals NOT being interested in my relative)? Never

25. Friends/relations have been **unduly critical of my relative**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations being unduly critical of my relative)? Never

26. Friends/relations have **given me space to talk about my problems**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations giving me space to talk about my problems)? Never

27. Friends/relations have said that **my relative should leave the family home**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations saying my relative should leave home)? Never

28. My doctor has **prescribed medication** for me.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. having medication prescribed for me)? Never

29. Health/social care professionals **have NOT given me information** about my relative's substance misuse.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. professionals NOT providing me with information)? Never

30. There are friends/relations **in the same situation [have a substance misusing relative] with whom I have talked about my problems.**

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. talking with friends/relations in a similar situation about my problems)? Never

31. Friends/relations have **said things about my relative that I do NOT agree with.**

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations saying things about my relative that I do NOT agree with)? Never

32. Friends/relations have **avoided me because of my relative's substance misuse.**

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations avoiding me)? Never

33. Health/social care professionals have **made themselves available** for me.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. having professionals who make themselves available)? Never

34. Friends/relations have **blamed me for my relative's behaviour.**

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations blaming me for my relative's behaviour)? Never

35. Health/social care professionals **have NOT talked through strategies with me for dealing with my relative's substance misuse**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. professionals NOT talking through strategies)? Never

36. Friends/relations have **helped me to change my outlook towards my relative**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations helping me to change my outlook towards my relative)? Never

37. My employer has given me **time off work when I needed it**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. getting time off work when I need it)? Never

38. Friends/relations have **actively encouraged my relative to drink or take drugs**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations encouraging my relative to drink or take drugs)? Never

39. I have found it **difficult to talk with friends/relations about my problems**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. having difficulty talking with friends/relations about my problems)? Never

40. Friends/relations have **provided me with a plan to deal with my relative's substance misuse**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations providing me with a plan to deal with my relative's substance misuse)? Never

41. There are friends/relations **within my organised religion/faith who have offered me support**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations within my faith offering me support)? Never

42. Friends/relations have **offered me temporary accommodation away from my relative**

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. having accommodation offered for respite from my relative)? Never

43. Friends/relations have **suggested alternative ways to react to my relative**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. people suggesting alternative ways to react towards my relative)? Never

44. I have **offered support** to friends/relations but **have NOT received it in return**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. NOT receiving help from friends/relations in return for my support)? Never

45. Friends/relations have said **my relative is doing nothing wrong** by drinking or taking drugs.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations saying my relative is entitled to drink or take drugs)? Never

46. Friends/relations **had my relative stay with them** for a short time.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. having my relative stay with friends/relations to give me a break)? Never

47. Friends/relations have said that **my relative does NOT deserve help**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations saying my relative does NOT deserve help)? Never

48. I have **identified with the information contained within books/booklets** about people living with a substance misuser.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. identifying with the information contained within books/booklets)? Never

49. Friends/relations have insisted that I **should let my relative continue drinking or drug taking**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations insisting that I should let my relative drink or take drugs)? Never

50. Friends/relations have **told my relative off on my behalf**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations telling my relative off when I want them to)? Never

51. Friends/relations have **advised me to leave my relative**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations telling me to leave my relative)? Never

52. Friends/relations have **been there for me**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations being there for me)? Never

53. Friends/relations have **put work my way to help me out financially**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. getting financial help from friends/relations)? Never

54. Friends/relations have **provided support for the way I cope with my relative**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations providing support for the way I cope with my relative)? Never

55. Friends/relations have **talked to me about my relative and listened to what I have to say**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations talking to me about my relative and listening to what I have to say)? Never

56. Friends/relations have **lent me money**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. being lent money when I need it)? Never

57. Friends/relations have **said nasty things about my relative**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. friends/relations saying nasty things about my relative)? Never

58. I have **confided in my health/social care professional about my situation**.

(A) Has this happened to you in the last three months? Never
(B) Was this important to you? N/A
(C) Did you feel satisfied with this? N/A
(D) What would your ideal be (i.e. being able to confide in professionals about my situation)? Never

Appendix XXXII: Main Study: ADF SSS Test-retest Instruction Sheet

This pack contains **two identical questionnaires**, which you are asked to complete one after the other, with a gap of **2 TO 4 HOURS** in between filling the first one in, and then filling in the second one.

We are still working on this questionnaire to make it better. One thing we need to look at is whether the questionnaire is understood and completed in the same way, each time it is filled in. That is why we need you to complete it twice.

The questionnaire takes about 20 minutes to complete, and it is important that you do not look at your answers to the first questionnaire when you are completing the second one (and if you compare them afterwards, it is important that you do not change any of your answers if you see that you answered differently on the two occasions).

Please do remember to **return this pack once you have completed BOTH questionnaires**, in the free post envelope provided.

General

Please make sure that you read the **first paragraph of page 3** of the questionnaire carefully. This briefly explains what the questionnaire is measuring and how you should complete the questions for each statement.

Pages 3-14

If the statement has **NOT happened** in the last 3 months the response to **question A** is **Never** and questions **B and C** are **left blank**. **Question D** for each statement looks at your **ideal** and is **FILLED IN WHETHER OR NOT the statement has happened in the last 3 months.**

If the statement **HAS happened** in the last 3 months, **question A** for each statement asks **how often**. Then you should think of the **single most important time** when the statement happened to you in the last 3 months, and fill in **question B** thinking of **how important** this was to you, and **question C** thinking of **how satisfied** you were at this time with the event described in the statement happening.

Many thanks for your help with this important work aimed at getting a better understanding of the impact of social support on: family members' responding to an alcohol and/or drug problem in the family; family members' physical and psychological well being.

Appendix XXXIII: Main Study: PCA with Promax Rotation

Factor 1	Factor 2	Factor 3
Eigen value	Eigen value	Eigen value
9.877	6.723	5.250

When components are correlated, sums of square loadings cannot be added to obtain a total variance.

ADF SSS Items	Factor 1	Factor 2	Factor 3
Q1a	.582		
02a	.667		
Q3a			.646
Q5a	.422		
Q6a	.599		
Q7a	.633		
Q8a	.420		
Q9a	.771		
*Q10a			.306
Q11a	.678		
Q12a	.669		
Q13a	.566		
Q14a	.493		
Q15a		.656	
Q16a	.454		
Q17a	.415		

Q19a	.483		
Q20a		.547	
Q22a	.585		
Q23a	.541		
Q24a		.446	
Q25a		.655	
Q26a	.730		
Q27a		.518	
Q28a		-.339	
Q29a		.496	
Q30a	.415		
Q31a		.689	
Q32a		.627	
Q33a			.698
Q34a		.654	
Q36a	.580		
Q38a		.416	
Q39a		.503	
Q40a	.388		
Q42a	.402		
Q43a	.600		
Q44a		.486	
Q45a		.410	
Q46a	.385		
Q47a		.673	
Q48a			.418
Q49a		.352	
Q50a			.554
Q51a			-.580

Q52a	.758		
Q54a	.712		
Q55a	.769		
Q57a		.681	
Q58a			.786

*10a – Narrowly loaded over the 0.3 threshold on factor 3 with oblique rotation, but not with orthogonal rotation. However the item did not perform well in a subsequent item analysis.

Items 21 and 41 narrowly loaded over 0.3 on factor 1 with orthogonal rotation, but failed to make this threshold value with oblique rotation. In the analysis reported in Chapters 6 and 7, both Items were subsequently removed due to the psychometric and qualitative findings.

Appendix XXXIV: Main Study: Item Analysis on the Frequency Scale

Subscale 1

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
SMEAN(Q1aR)	34.40	218.426	.518	.516	.912
SMEAN(Q2aR)	34.19	216.105	.602	.577	.910
SMEAN(Q5aR)	35.45	221.901	.405	.424	.914
SMEAN(Q6aR)	35.27	217.775	.547	.471	.911
SMEAN(Q7aR)	33.83	218.723	.567	.550	.911
SMEAN(Q8aR)	35.24	223.539	.395	.347	.914
SMEAN(Q9aR)	33.89	215.366	.709	.739	.909
SMEAN(Q11aR)	34.25	214.146	.618	.572	.910
SMEAN(Q12aR)	34.88	213.283	.617	.554	.910
SMEAN(Q13aR)	34.00	218.020	.517	.463	.912
SMEAN(Q14aR)	34.56	220.309	.422	.342	.913
SMEAN(Q16aR)	35.35	221.933	.417	.381	.913
SMEAN(Q17aR)	34.95	221.852	.376	.342	.914
SMEAN(Q19aR)	35.01	218.467	.451	.412	.913
SMEAN(Q21aR)	35.59	226.857	.271	.254	.915
SMEAN(Q22aR)	35.24	217.083	.561	.555	.911
SMEAN(Q23aR)	34.46	218.058	.499	.418	.912
SMEAN(Q26aR)	34.18	215.143	.675	.634	.909
SMEAN(Q30aR)	34.96	220.750	.363	.384	.915
SMEAN(Q36aR)	34.91	216.910	.555	.530	.911
SMEAN(Q40aR)	35.69	226.346	.368	.449	.914
SMEAN(Q41aR)	35.63	226.408	.271	.354	.916
SMEAN(Q42aR)	35.66	224.881	.378	.308	.914
SMEAN(Q43aR)	34.97	217.721	.583	.510	.911
SMEAN(Q46aR)	35.69	225.514	.367	.401	.914
SMEAN(Q52aR)	34.11	213.411	.695	.701	.909
SMEAN(Q54aR)	34.68	213.224	.655	.636	.909
SMEAN(Q55aR)	34.05	214.613	.714	.710	.909

Subscale 2

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
SMEAN(Q15aN)	33.75	66.758	.555	.398	.811
SMEAN(Q20aN)	33.55	68.694	.461	.462	.817
SMEAN(Q24aN)	33.98	68.508	.344	.294	.823
SMEAN(Q25aN)	34.27	64.538	.607	.532	.807
SMEAN(Q27aN)	34.25	65.227	.467	.459	.816
SMEAN(Q28aR)	35.42	79.580	-.256	.164	.856
SMEAN(Q29aN)	33.86	66.912	.410	.297	.819
SMEAN(Q31aN)	34.19	64.475	.661	.499	.804
SMEAN(Q32aN)	34.07	64.547	.545	.374	.810
SMEAN(Q34aN)	33.55	67.941	.553	.546	.813
SMEAN(Q38aN)	33.63	68.944	.376	.203	.821
SMEAN(Q39aN)	34.49	66.895	.409	.256	.819
SMEAN(Q44aN)	33.90	68.262	.381	.319	.821
SMEAN(Q45aN)	33.36	71.457	.359	.214	.822
SMEAN(Q47aN)	33.73	66.493	.598	.516	.809
SMEAN(Q49aN)	33.42	71.890	.290	.241	.825
SMEAN(Q57aN)	34.14	64.177	.628	.538	.805

Appendix XXXV: Main Study: Qualitative Data on the Removed Test ADF SSS Items

Removed test ADF SSS Items	Qualitative Comments / Issues
Q4 (Did not load strongly on the PCA)	"No, I wouldn't say no one had brought him home safely to me, not in the last 3 months. He brought himself back. It is an important thing, yeah." "He only drinks in the house garage." "Doesn't live with me now." "If it were necessary." 6 family members marked the item as not applicable to them. 5 family members did not complete the item as instructed.
Q5	4 family members marked the Item as not applicable to them. 7 family members did not complete the Item as instructed.
Q6	"Feeling I didn't want to take it up!" "I have not taken up opportunities, felt unable to." "Am I satisfied what they've tried or did it work?" "They have all tried." 9 family members did not complete the item as instructed.
Q8	What do you mean by defended? Defended directly is one thing, defending a relation over a legitimate issue, however, is another! Depends if the defence is necessary, if it isn't, then ok." "That's a hard one defended my relative? If anyone has defended him, it has probably been me as a mother." 9 family members marked the item as not applicable to them. 9 family members did not complete the item as instructed.

Q10 (Did not load strongly on the PCA)	"Not over and above friends, but as an addition to friends." "Less important." "Worked in rehab, and attended every course I can to learn how to deal with this problem for myself." "More help from the internet, FRANK." "Difficult question." "Professionals as well." "Obviously you are reading about it happening to someone else, so you can relate to how they are feeling because you are in that situation, so you know exactly where they are coming from, and sometimes you say some advice that is actually in that article could be applied." 1 family member marked the item as not applicable to them. 2 family members did not complete the item as instructed.
Q14	"I'd like to be on my own and have time / space to do this." 1 family member marked the item as not applicable to them. 5 family members did not complete the item as instructed.
Q16	"Obviously prefer not to have an addict." 1 family member marked the item as not applicable to them. 10 family members did not complete the item as instructed.
Q17	"I haven't got a clue who they talk to." "I don't know." "Drinkers' mother." "Yeah he listens, but does not always follow through." 1 family member marked the item as not applicable to them. 3 family members did not complete the item as instructed.

Q18 (Did not load strongly on the PCA)	1 family member marked the item as not applicable to them. 7 family members did not complete the item as instructed.
Q19	"I know to ask for help." "I have never actually gone to the doctor for any help for stress, I have always managed to sort of rise above it." 1 family member marked the item as not applicable to them. 6 family members did not complete the item as instructed.
Q20	"Except for my daughter." "They don't know." "Not physically, made changes." "You may have a bit of space, but I would never push him to one side to disown him." "They would not criticise me for that." 2 family members marked the item as not applicable to them. 23 family members did not complete the item as instructed.
Q21	"No, because they would offer, but they actually wouldn't do it for me." "If essential." 1 family member marked the item as not applicable to them. 16 family members did not complete the item as instructed.
Q22	"Now is that both together at the same time or separately?" "If necessary." 1 family member put a question mark beside the item. 2 family members marked the item as not applicable to them. 5 family members did not complete the item as instructed.
Q23	"Felt guilty." 1 family member marked the item as not applicable to them. 1 family member did not complete the item as instructed.

Q24	"Not." "I don't understand." "No, my GP would never turn me away, she has been very supportive." 16 family members did not complete the item as instructed.
Q28	"My GP was so concerned about patient confidentiality that he failed to take into account the serious impact of addiction on the family of the addict. I'm sure we would all have been given 'pills', if we asked for them!" "I have been offered, but didn't accept them." "Medication because of the substance misuse?" "No, I have never been prescribed medication." 1 family member marked the item as not applicable to them. 4 family members did not complete the item as instructed.
Q29	"I should have information." "Now by that do you mean general information about any drug or alcohol misuse or do you mean being given information regarding the user? Due to confidentiality the GP can't. They can give you general, but not information regarding the relative." 10 family members did not complete the item as instructed.
Q30	"Yes there is my husbands' sister, half brother and half sister are drug users, and he has cousins as well, with their children." 4 family members did not complete the item as instructed.
Q35 (Did not load strongly on the PCA)	"Double negative." "I have not had any talking." "They have talked through." 1 family member marked the item as not applicable to them. 13 family members did not complete the item as instructed.

Q36	"Change my outlook? I wouldn't say to change my outlook towards my relative... perhaps, I don't quite understand that question properly." "Some people have said he is still young, so he has plenty of time in front of him to grow out of this and hopefully change." 2 family members marked the item as not applicable to them. 3 family members did not complete the item as instructed.
Q37 (Did not load strongly on the PCA)	"Retired." "Only if essential." "Self-employed." "Retired." "My employer is very good, and she has said to me if ever I need the time off then I only have to ask her, but as of yet, I won't put my job in any jeopardy." 16 family members marked the item as not applicable to them. 3 family members did not complete the item as instructed.
Q38	"You could be satisfied, even if the event didn't happen!" "His dad, my ex-husband." "His friends, not mine." "Their friends." "Younger ones, not much older than my son, I would say yes they have been with my son and they have taken drugs together. Those ones, the friends / relations bit, are there to support me." 3 family members marked the item as not applicable to them. 12 family members did not complete the item as instructed.

Q39	"It is very important that I don't find it difficult to talk with friends." "No, I don't find it difficult. When I say difficult, hmm I can't talk to anybody about everything." 3 family members marked the item as not applicable to them. 7 family members did not complete the item as instructed.
Q40	"If asked." "No, I have never been given a plan or anything, I just deal with each day as it comes. Coming here (an agency) they give you certain strategies on how to sort of deal with things, but not a plan. Whether that comes under the same thing I don't know?" 11 family members did not complete the item as instructed.
Q41	"I am not religious, no organised faith." "No organised religion/faith." "Most don't understand." "I am not like a church goer or anything like that, so that really isn't applicable." 10 family members marked the item as not applicable to them. 4 family members did not complete the item as instructed.
Q42	"I would not leave him alone in my home during a binge." "If needed." 4 family members marked the item as not applicable to them. 7 family members did not complete the item as instructed.
Q43	1 family member marked the item as not applicable to them. 3 family members did not complete the item as instructed.

Q44	"I don't understand." "It is very important that this hasn't happened." "If I've asked for support, I usually get it. I don't always tell friends." "Ah no, never." 3 family members marked the item as not applicable to them. 4 family members did not complete the item as instructed.
Q45	"No-one has ever said that, no." "His friends, not mine." 3 family members marked the item as not applicable to them. 14 family members did not complete the item as instructed.
Q46	"To give me a break???" "Not necessary." "Yes they have." 4 family members marked the item as not applicable to them. 5 family members did not complete the item as instructed.
Q49	"I wouldn't say they have insisted that I should let... like I've said myself, people have said, if they are going to do it, they are going to do it, no matter what anybody says. They will only stop when they are ready to, and that's what I've learnt." 2 family members marked the item as not applicable to them. 11 family members did not complete the item as instructed.
Q53 (Did not load strongly on the PCA)	"This doesn't apply because I have got a job." 8 family members marked the item as not applicable to them. 9 family members did not complete the item as instructed.
Q56 (Did not load strongly on the PCA)	2 family members marked the item as not applicable to them. 8 family members did not complete the item as instructed.

Appendix XXXVI: Main Study: Qualitative Data on the Retained Test ADF SSS Items

ADF SSS Items	Issues
Q1	7 family members completed questions B and C, even though they selected never for question A. 1 family member completed question B N/A, even though they answered question a positively.
Q2	5 family members completed question B, even though they selected never for question A. It was 4 family members in the case of question C.
Q3	8 family members completed question B, even though they selected never for question A. 7 family members in the case of question C.
Q7	1 family member completed question B, even though they selected never for question A. 1 family member completed question B N/A, even though they answered question A positively. 2 family members completed question C N/A, even though they answered question A positively.
Q9	
Q11	1 family member completed questions B and C, even though they selected never for question A. 1 family member completed question C N/A, even though they answered question A positively.
Q12	4 family members completed questions B and C, even though they selected never for question A. 1 family member annotated N/A for question D.
Q13	1 family member completed question C N/A, even though they answered question A positively. 1 family member annotated N/A for question D.

Q15	13 family members completed questions B and C, even though they selected never for question A. 1 family member completed question B N/A, even though they answered question A positively. 1 family member completed question C N/A, even though they answered question A positively. 1 family member annotated N/A for question D.
Q25	6 family members completed questions B and C, even though they selected never for question A. 5 family members completed question B N/A, even though they answered question A positively. 4 family members completed question C N/A, even though they answered question A positively. 1 family member did not understand questions C and D.
Q26	3 family members completed questions B and C, even though they selected never for question A. 1 family member completed question C N/A, even though they answered question A positively. 1 family member annotated N/A for question D.
Q27	4 family members completed questions B and C, even though they selected never for question A. 1 family member annotated N/A for question A. 4 family members completed question B N/A, even though they answered question A positively. 6 family members completed question C N/A, even though they answered question A positively.
Q31	1 family member completed question B N/A, even though they answered question A positively. 3 family members completed question C N/A, even though they answered question A positively.

Q32	7 family members completed question B, even though they selected never for question A. It was 6 family members in the case of question C. 1 family member completed question B N/A, even though they answered question A positively. 5 family members completed question C N/A, even though they answered question A positively.
Q33	3 family members completed question B, even though they selected never for question A. It was 4 family members in the case of question C. 1 family member completed question B N/A, even though they answered question A positively. 1 family member completed question C N/A, even though they answered question A positively. 1 family member annotated N/A for question D.
Q34	10 family members completed questions B and C, even though they selected never for question A. 2 family members completed question B N/A, even though they answered question A positively. 1 family member completed question C N/A, even though they answered question A positively.
Q47	10 family members completed questions B and C, even though they selected never for question A. 2 family members completed question B N/A, even though they answered question A positively. 2 family members completed question C N/A, even though they answered question A positively.
Q48	2 family members completed questions B and C, even though they selected never for question A. 1 family member completed question C N/A, even though they answered question A positively.

Q50	4 family members completed questions B and C, even though they selected never for question A. 1 family member annotated N/A for question A. 1 family member completed question B N/A, even though they answered question A positively. 1 family member annotated N/A for question D.
Q51	7 family members completed question B, even though they selected never for question A. It was 6 family members in the case of question C. 3 family members annotated N/A for question A. 2 family members completed question C N/A, even though they answered question A positively.
Q52	2 family members completed questions B and C, even though they selected never for question A. 1 family member completed question C N/A, even though they answered question A positively.
Q54	2 family members completed questions B and C, even though they selected never for question A.
Q55	1 family member completed questions B and C, even though they selected never for question A. 1 family member completed question B and C N/A, even though they answered question A positively.
Q57	5 family members completed question B, even though they selected never for question A. It was 4 family members in the case of question C. 2 family members completed question B N/A, even though they answered question A positively. 1 family member completed question C N/A, even though they answered question A positively.
Q58	3 family members completed questions B and C, even though they selected never for question A. 1 family member completed question B and C N/A, even though they answered question A positively.

Appendix XXXVII: Main Study: Final ADF SSS

Alcohol, Drugs and the Family Social Support Scale

The questionnaire asks about what has happened to you in the last 3 months. The words friends/relations means anyone that you have met in that time, and relative means the person with the drinking and/or drug taking problem. Please tick one answer to each question.

	Never	Once or Twice	Sometimes	Often
1. Friends/relations have **understood what it is like for me to live with my relative's drinking or drug taking**				
2. Friends/relations have **helped to cheer me up**.				
3. Health/social care workers have given me **helpful information** about problem drinking or drug taking.				
4. I have friends/relations **whom I trust**.				
5. Friends/relations have **listened to me when I have talked about my feelings**				
6. Friends/relations have **backed the decisions that I have taken towards my relative and their drinking or drug taking**.				
7. Friends/relations have **put themselves out for me when I needed practical help** (i.e. aid or assistance).				
8. Friends/relations have **advised me to focus on myself and my own needs.**				
9. Friends/relations have **questioned my efforts to stand up to my relative's problem drinking or drug taking**.				
10. Friends/relations have been **too critical** of my relative.				
11. Friends/relations have **given me space to talk about my problems**.				
12. Friends/relations have said that **my relative should leave home**.				
13. Friends/relations have **said things about my relative that I do NOT agree with**				
14. Friends/relations have **avoided me because of my relative's drinking or drug taking**.				
15. Health/social care workers have **made themselves available** for me.				
16. Fiends/relations have **blamed me for my relative's behaviour**.				
17. Friends/relations have said that **my relative does NOT deserve help**.				
18. I have **identified with the information within books / booklets** about people living with a problem drinker or drug taker.				
19. Friends/relations have **told my relative off on my behalf**.				
20. Friends/relations have **advised me to leave my relative**.				
21. Friends/relations have **been there for me**.				
22. Friends/relations have **provided support for the way I cope with my relative.**				
23. Friends/relations have **talked to me about my relative and listened to what I have to say**.				
24. Friends/relations have **said nasty things about my relative**.				
25. I have **confided in my health/social care worker about my situation**.				