

Title: Family solidarity in the face of stress: responses to drug use problems in Greece

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Authors and institutions

Maria Fotopoulou, Faculty of Social Sciences, University of Stirling

Tessa Parkes, Faculty of Health Sciences and Sport, University of Stirling

Corresponding Author:

Maria Fotopoulou

Faculty of Social Sciences

Colin Bell Building

University of Stirling

Stirling FK9 4LA

Email address: Maria.fotopoulou@stir.ac.uk

Telephone number: 00 44 1786 468849

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Abstract

Background: In the past, Greek drug-affected families have predominantly been conceptualised as one of the main causes of drug problems. This study explored the ways drug-affected families respond to, and cope with, a relative's drug problem by examining the perceptions of both Greek drug users and drug-affected families. **Method:** A qualitative study comprised of semi-structured in-depth interviews was conducted in two state drug agencies in Thessaloniki, Greece. A total of 40 adult problem drug-using men and women and eight parents of problem drug users were asked to reflect on the ways families respond to, and cope with, drug use. The method of data analysis involved a manual systematic identification of themes in participant narratives in line with analytic induction principles. **Results:** After discovery of the drug problem, all families were reported as coping with their adult children's drug problems in ways consistent with the stress-strain-coping-support model. The emergent high engagement and low withdrawal coping exhibited by study participants can be contextualised by situating these strategies within the Greek cultural milieu and the notion of familism. While the data illustrate the importance of family solidarity in the face of addiction, caution is invited in making generalisations as sample selection may provide an alternative explanation for study findings. **Conclusion:** The paper advocates for a non-pathological view of drug-affected families and highlights the importance of cultural context. The stress-strain-coping-support model helps to depathologise and better understand family reactions to problem drug use. Implications for non-stigmatising and culturally relevant policy and practice are outlined.

Keywords

Stress-strain-coping-support model, problem drug use, Greek drug-affected families, familism, family-orientated societies, family solidarity

Introduction

The dominant discourse regarding drug-affected families has historically viewed them in a pathological light (Orford et al. 2005). Within this discourse the family pathology model (including the co-dependency movement) and the family system perspective have been influential. The family pathology model attributes drug use onset, development and maintenance to a ‘family pathology’ (Nurco 1999; Barker and Hunt 2004), for example, where the onset, development and maintenance of a drug problem by a relative, most often offspring, is closely related to the pathology of his or her family environment, most commonly parents. The co-dependency movement suggests that family members may be ‘addicted’ to the substance user needing them (Cutland 1998). Co-dependence is viewed as a ‘disease entity similar to substance addiction, except that in this case the sufferer is addicted to or preoccupied and obsessed with a relationship with another person instead of a mood altering substance or behaviour’ (Gordon and Barret 1993, p. 309). Finally, the family system perspective has been closely linked to General System Theory, which attempts to explain how a system, such as a family, ‘functions through the interdependence of its members’ (Vetere 1998, p. 113).

Within the very limited literature pertaining to the views and experiences of families of drug users in Greece (Papadi 2006; Fotopoulou 2012) such conceptions have been influential. The emotional bonding between parents and offspring, drug use by family members, parenting practices, family structure, family roles, and relationships between parents, have all been highlighted as influencing onset of drug use in Greece (Theodorakis et al. 2004; Rousis 2005; Zotou & Kopanaki 2005; Pomini et al. 2014). Interestingly, however, Liapas and colleagues examined current and ex-users’ perceptions of the aetiology of their drug use and highlighted peer modeling, rather than family factors, as the main reason behind drug use onset (Liappas et al. 2000). Such conflicting views may reflect the prevailing pathological light within which drug-affected families have been historically viewed (Orford et al. 2005). The role of the Greek

family in the treatment of family members has also received some attention with Misouridou (2010) articulating the importance of family involvement in the treatment of drug-affected individuals.

The stress-strain-coping-support model

The stress-strain-coping-support model (SSCS) can be seen as having its origins in investigations dating back to the late 1950s by those who wanted to put forward a perspective that would contrast with the dominant family pathology model (Orford 1998). The model seeks to shift attention away from an approach that pathologises the family to one that aims to better understand how families navigate extremely stressful and difficult situations. In its first iteration it was expressed as an eight-fold typology of coping: ‘emotional coping, inaction, avoidance, tolerance, control, support, confrontation and independence’ (Orford et al. 1992, p. 176). This model expressed a clear a shift in research interests since before its advent almost no research had been conducted that examined the impact of problem drug use on families (Velleman 1993, p. 1281). International studies have since aimed to fill this highlighted gap in knowledge by reporting on the far-reaching negative impact problem drug use has on family life, especially on parents, from family finances to family relationships, social life, emotional and physical health (Orford et al. 1998a; Pearson 2000; Toumbourou et al. 2001; Scottish Executive 2002; Barnard 2005; 2007; Butler & Bauld 2005; Oreo & Ozgul 2007; Copello et al. 2009a; Ray et al. 2009).

Currently expressed in terms that include discussion of the stress and strain experienced by family members of problem substance users, as well as the sources of support available to them, the SSCS model proposed that the ways that drug-affected families cope with a member’s drug use can be conceptualised as falling within three broad categories of action (Orford et al. 2010a). The first category, ‘standing up to’, involves actions and stances aimed at trying to regain some control over family and home life, or changing the rules of engagement which govern family

members' lives with their relatives. The second broad category of coping, 'putting up with it', includes positions ranging from resignation or inaction in the face of the problem, to acceptance of the status quo, to accommodation of the drug-taking, often through some form of self-sacrifice. Finally, 'withdrawing or gaining independence', involves all those actions aimed at gaining more independence from the drug-affected relative and their problems, such as putting physical and/or emotional distance between the relative and the family member. Research within the realms of the SSCS model has also developed instruments to quantitatively assess its components, including the Family Member Impact Scale (FMI) (Orford et al 2010b), the Alcohol, Drugs and the Family Social Support Scale (ADF SSS) (Toner and Velleman 2014), and the Coping Questionnaire (Orford et al., 2010b). The SSCS model has also provided the basis for the development of a five-step intervention to support drug-affected family members, tested for its feasibility (Templeton et al. 2007; Copello et al. 2009b) and post-intervention effects at 12 months (Velleman et al. 2011).

The SSCS model has been used in different countries and cultures to explore how families cope with substance use by a relative (Velleman & Orford, 1990; Orford et al. 1992, 1998a; 1998b; 1998c; 2005; Velleman et al. 1993; Ahuja et al. 2003; Arcidiacono et al. 2010). Cross-cultural studies (Orford et al. 2005) conducted within the realm of the model have concluded that living with excessive drinking or drug taking in a close relative may be seen as a good example of a variform universal: 'variform universals are basic human characteristics common to all members of the species, albeit influenced in relation to their development and display by culture' (Orford et al. 2005, p. 220). More specifically, the relative absence of familial withdrawal responses from drug-affected relatives' lives has been reported in studies in collectivist cultures (Orford et al. 2001; Arcidiacono et al. 2010). Choice of support sources for drug-affected family members has also been shown to be influenced by culture (Orford et al. 2005). A reluctance to share the

problem with people not living in the immediate household has been proposed as a common reason why support can fail (Orford et al. 2010a).

The current paper explores how Greek families cope with problem drug use, using the SSCS model to support analysis and interpretation of data while also highlighting how the specific Greek cultural context shapes these coping styles and responses. The findings presented here are from a study exploring the progression of problem drug-using careers in Greece, and family reactions towards drug-using relatives (Fotopoulou, 2012; 2014; Fotopoulou et al. 2015).

Methods

A qualitative research design was used to explore the experience of becoming a problem drug user in Greece, from initial involvement with drugs, to entering treatment, as well as family responses to unfolding drug-using careers. Semi-structured, in-depth interviews were conducted with adult problem drug users and parents of problem drug users. The research took place in two Greek state-run, non-fee paying drug treatment agencies for adults; the multi-disciplinary Consultative Centre and the Drug Residential Detoxification Unit, both part of the Psychiatric Hospital of Thessaloniki. Ethical approval for the study was obtained from the Ethics Committee of the Faculty of Law, Business and Social Sciences at the University of Glasgow, Scotland, where the lead author was based at the time the study was carried out.

In the early stages of the study, recruitment of problem drug users was opportunistic and rested upon two selection criteria: Greek nationality and status as a problem drug user based on participants' own self-definition but also on participation in drug treatment. The study design was revised some months later to purposively sample drug-using women who were under-represented in the sample. Initially the aim was to recruit participating problem drug users' parents. Despite these participants agreeing to provide access to their parents, the latter were

largely reluctant to participate. The study design was therefore revised again and parents of problem drug users more generally, not of the drug user participants, were recruited through the organised parent group facilitated by staff in the Consultative Centre. The final study sample consisted of 40 problem drug users (23 men, 17 women) and eight parents. The mean age of problem drug user participants was 28.7 years (ranging from 23 to 47 years), and the primary drug of use for all was heroin. The mean age of heroin use onset was 19 years and the mean length of heroin use was 8.5 years. Most of the adult problem drug users were living with their parents at the time of the study (n=33/40), commensurate with reports of living arrangements of problem drug users in Greece (Greek Reitox National Focal Point 2012; 2013). Six mothers, one step-mother, and one biological father were interviewed (from seven separate families). This over-representation of mothers was reflected in the composition of the parent group and is indicative of traditional gender roles relating to child-rearing practices in Greece (Mousourou 2004).

Prospective participants were provided with a study information sheet that detailed the nature, aims and procedures of the study. The information sheet clearly stated that the researcher had no connection with Greek drug agencies, that participation was voluntary, and that the research was independent from the programme/group that the problem drug user (or if a parent their adult child) was attending. In addition, participants were assured that interviews would be strictly confidential. Problem drug users and parents who were interested in participating approached the researcher who was available to further discuss the study and/or conduct an interview. Full written consent was received before the interview. All interviews lasted between one and two hours and were conducted in private rooms within the two agencies. Interview data with problem drug users were collected using an open-ended interview guide that asked about their perception of the ways in which their families responded to, and coped with, their drug problem, from point of discovery till the time of the study. Similarly, parents were asked about their perception of

ways in which they, as well as other family members, reacted to and coped with the affected member's drug problem, from point of discovery till the time of the study. [All interview guides are available by applying to the lead author].

Interview data were digitally audio-recorded, transcribed verbatim and anonymised. Data analysis was initially performed in Greek and the findings then translated into English. The decision to conduct a preliminary analysis of data while data was still being collected allowed for 'a dialectic interaction between data collection and data analysis' to be achieved (Hammersley & Atkinson 1995, p. 205). Preliminary analysis also led to additional interview questions being generated by the collected narratives. A more comprehensive analysis was then carried out after the interview stage involving the line-by-line, and case-by-case, manual systematic identification of themes in participant narratives, in line with the assumptions of analytical induction (Becker 1998). These analytic concepts were then used to develop typologies, in relation to the research questions of the study, which were tested in terms of their validity on each recorded account. In cases where the emergent typologies did not apply to the narrative, typologies would be reconsidered, with the final aim being the production of a multi-layered picture of the stories participants had provided. As Seale (2000) states: 'Seeking out and attempting to account for negative instances that contradict emerging or dominant ideas is a core approach in a fallibilistic analytic strategy devoted to improving the quality of research accounts' (p. 73). A focus on such deviant, or 'weird' (Becker, 1998: 207), cases can also guard against bias in the analysis that might stem from researcher attachments to his/her perspectives or pre-existing ideas. Such bias was also dealt with by means of reflecting on the researcher's own beliefs and preconceptions, and through triangulation of data from both drug-affected relatives and drug users (see Fotopoulou 2012 for more information). Given the sample of parents was significantly smaller than the drug user sample we would like to note that exactly the same approach was used for both sets of participants: representative quotes were chosen from both

parents and drug users to illustrate the major themes emerging from the close reading of the data sets.

Quotations from interviews are presented anonymously and all names used within quotes are fictitious; in the case of problem drug users gender and age are given for each participant and for parent interviews the relationship to the drug-affected relative and a research identity is stated.

Results

Coping with the drug problem: a family affair

After discovering the drug problem all the families whose stories informed this study were reported as standing up to their adult children's drug use by actively trying to change the course of the latter's life. Although these efforts took many forms, confronting the drug users and trying to control and orchestrate their treatment efforts, largely by rallying exclusively around the resources of the family, was dominant. Indicative of this central role, but also of the fact that such efforts were perceived of as a joint endeavour, was the way in which both parents and problem drug users spoke in terms of 'we' [*εμείς*] rather than 'I' [*εγώ*]:

So, we [mother and son] would stay in the house, the two of us, and go through the whole thing together. We [mother and son] would clean up, stay clean for a week or a month and then relapse again. That's how we [mother and son] spent the first few years.
(Mother, Interview 1)

Such initial efforts also involved the help of private practitioners, usually psychiatrists or psychologists. The engagement of private practitioners should be considered in the context of trying to protect both child and family from stigmatisation attached to drug service attendance but also the fact that parents still believed that they could 'solve' the problem on their own.

The turn to state services seemed to signal a change for families when they realised that they could no longer cope on their own. However, even when state services were accessed, families continued to be actively engaged in drug user's treatment efforts, with all parents in this study expecting to assume responsibility for their children's lives:

But what can I do? He's my son, whatever he does, he is my responsibility, my flesh and blood, and I need to sort him out. (Mother, Interview 1)

A further way for families to stand up to their adult children's drug use and regain control of family life involved efforts to refuse children's demands, often monetary ones, resist and limit their access to drugs, and control their contact with other drug users. Also prominent in the accounts of parents were efforts to try to 'direct' problem drug users' lives by arranging education or employment opportunities:

So when he completed his army service we started looking for a job, something good, not whatever came along. (Mother, Interview 2)

Such opportunities were undoubtedly viewed by problem drug users as sources of support, despite also being acknowledged as tangible efforts on behalf of their family to control their behaviour.

Although the narratives convey a picture where families were trying to control drug users' lives, periods where the latter's drug use was tolerated were also recounted. A significant minority (n=10/40) of problem drug users described periods where they felt their families were tolerating their drug use, with the majority of these participants using heroin for longer than most people in

this study (mean = 13 years in comparison to the sample mean = 8.5 years). Looking more closely into the narratives of these 10 participants revealed that during those times where they felt their drug problem was tolerated, they did not engage in what can be deemed as transgressive behaviours, such as stealing. Indeed, the majority of these 10 were in paid employment during those times. Drug user participants referred to such periods as times when their parents did not pressure them to get treatment. Such periods were also not characterised particularly by conflict or being inactive because of the family clearly distancing themselves. Similarly, three parents spoke of periods where they were resigned to, and tolerated, their children's drug use, as this father recounts:

Lately, Vlasis comes here to the house. Doesn't do anything... help out or something. Goes in his room, sleeps, wakes up, doesn't talk to anybody. Sometimes he will have a cup of coffee, sometimes not, he will go out. Now how he gets it, where he gets it.... Comes back home at night, 10-11 o'clock, goes to bed again. I mean, before he was working, it wasn't like this. Sometimes, when he hasn't had his hit I see him restless let's say, restless, pacing, doing stuff inside his room. But I can understand because as soon as I look in his eyes I know. And very rarely he would tell me 'give me some money to get some'. (Father, Interview 5)

Echoing the extant literature, (Orford et al. 2005; 2010a) coping strategies adopted by families in this study did not form clear-cut categories (Orford et al. 2010a). The extract below illustrates how the lines between the category 'putting up with the drug problem' and 'trying to control the drug user' can become blurred:

I was working at their bookshop, they made me so they would keep an eye on me [...] Maybe they knew [of continued drug use] but they could see that it was sort of controlled. Like I know my Dad checked the register and saw that money was missing and they would see me after I got home and [had] used, but at least I was in the house and with them in the bookstore all morning [...]. They didn't accept it, I mean the drugs, not really. But working in the bookstore was a way of controlling me. They were afraid of what might happen to me if I am out on the streets all day. (Woman, 24)

Interestingly, this account echoes the principles of harm reduction: targeting the risks and harms that can arise from drug use, while meeting people's needs where they are at in their lives (Harm Reduction International 2016). The non-judgmental attitude informing the ethos of harm reduction is thus also present within families where love and close bonds allow safety to be created in immensely challenging and risky circumstances. According to parents, trying to keep their drug-using child out of harm's way was also one of the main reasons that the vast majority of problem drug users in this study had never been expelled from the family home. This fear was closely intertwined with a desire or need to control in order to manage parental anxiety:

To be honest, I think that I was thinking of myself too. To a point it suited me to have him in the house, sort of control him. I would let him in and feel more reassured, if he was on the streets I wouldn't have been able to relax. (Mother, Interview 2)

Such claims seem to be reflected in the fact that the majority of problem drug-using interviewees reported living with their parents at the time of study (33/40). Staying involved with their children's lives was a parental strategy to avoid public exposure of behaviours that could endanger family honour and a resultant strained 'modus vivendi'. This accommodation between disagreeing parties to allow life to go on frequently involved compromises involving an

accommodation of the drug problem (see Fotopoulou et al. 2015 for a more detailed discussion). Indeed, almost half (n=18/40) of the men and women interviewed had never even been threatened with expulsion from the family home. Of the 22 participants who had been threatened with expulsion, two participants deviated from this overall picture by being homeless at the time of interview. A thorough analysis of both these accounts revealed that these individuals attributed the withdrawal of their family to their betrayal of these families, and to family values more generally, as one of the men describes here:

The worst thing that I did was betray their trust because we used to be very close to each other. We faced everything together... clung together like a fist. This is how we got over everything because we have no [extended] family here, it's always been the three of us against the world. I don't think that I can ever set that straight.... even if I stay clean for say five years, I can never set that straight because I betrayed them. (Man, 25)

Looking closely at the 20 who were living in the family home but had been threatened with leaving also revealed differences between them and those who had never been threatened with expulsion; the former reporting more stealing from the family home and situations where they had been arrested and/or charged with crimes. The fact that such behaviours clearly clashed with expected roles, or involved public disclosure of problematic behaviours, may be the reason behind these threats of expulsion.

Although the data convey a picture of unceasing engagement and support, this should not be taken to mean that parents, and even more so siblings and extended families, did not make efforts to manage their own reactions to the situation or improve their own quality of life. The interview extract below reflects a category of action termed withdrawing or gaining independence, which refers to 'small scale and time-limited actions, such as hiding in the

bedroom or locking oneself in the shower or another room, to those that were on a larger scale and represented potentially longer term solutions, such as living apart in the same home, leaving home or asking the relative to do so' (Orford et al. 2005, p. 135).

This might sound funny but I used to go to open air markets so I could be around people... and I would see the colours from the fruit, the vegetables, the clothes and I would start looking through stuff in order to get rid of the anxiety. (Mother, Interview 3)

Another example of the blurring of categories is the fact that in all cases where participating problem drug users reported living on their own, which could be seen as an effort by families to gain a degree of independence, families were actively supporting them by incurring the monetary cost of these living arrangements.

Sources of support: yet another family affair

Families turned to extended family members for support first and foremost. Parents reported reaching out to professionals for support for themselves only *after* their children had approached state services, and did so with the aim of attending to the needs of their child. This is evident in the extract below, where a mother recounts how she stopped attending a parent support programme:

...when I got home the boys did something and I got really angry at them and said to myself 'I am going to this programme so you can get better and you guys are doing the same things or even worse?'. So I stopped going. (Mother, Interview 3)

Extended family members supported drug-affected families in various ways and narratives convey the importance of the role of the kin, from providing emotional and financial support to

parents to helping families to stand up to the drug-using relatives. The extract below was provided by a mother and describes the support her husband received after disclosing the problem of their son to her husband's extended family members.

They hugged him [husband] and said 'we are here for you, don't worry' and he knew that they would help him and not reject him.. so they also helped out, all of our relatives did, even financially... (Mother, Interview 2)

The tendency to turn to family for support was also evident in drug users' accounts.

My mum didn't know what to do next so she went to her brother and they sort of talked it over. My uncle got all the info about what we could do and then they sat me down and sort of laid down my choices. (Woman, 28)

I mean it couldn't go on like that... we needed help that would have to come from the family because who else is there to help? (Man, 26)

Immediate and extended family members were reported as helping out in various facets of drug users' lives. Accounts of relationships having broken down because of drug use were rare with no parents reporting these types of problems and only six problem drug users (6/40) stating that their drug problem had been a factor in them not having close relationships with their extended families. The fact that family members were crucial support sources is undeniable, yet a more nuanced understanding of extended family support was also revealed. Not all extended family members were told of the drug problems and, when they were, some were critical and unsympathetic. Disclosing could be humiliating:

What can I say to my sister? He stole? I can't say that, I am ashamed. What can I say about my children? Because another person will take it differently, he will look at them differently afterwards [...] I mean my sister knows my children, she raised them with me and she knows them, but still I can't say anything bad about them. The serious stuff I have told nobody. (Mother, Interview 3)

So while sources of support were, first and foremost, found within families this should not be taken to mean that unconditional, uncritical support was always available, nor that such support did not come at a price.

Stress and strained relationships

The SSCS model states that if one person has a serious drug problem this is likely to be highly stressful for close family members as well as for the individual (Orford 2010a). Data demonstrated this point with instances of extreme stress and strained relationships, described by both parents and drug users.

I mean, imagine living in a house like ours, nerves tensed all the time. Of course there are fights... at some points there was nothing but fights. (Woman, 25)

Disagreement on how to handle the drug-affected child was one main source of strain, especially pronounced between parents, with accounts describing couples drifting away from each other at times. Given the degree of involvement of the wider family, instances of extreme stress and strained relationships was also recounted between immediate and extended family members:

My father can't realise. How do I get through to them [grandparents of drug user]? Last time I had a fight with them, 'This is what you want? To bury her now? [...] OK, then

keep giving her money!’ (Mother, Interview 4)

The financial costs that families faced was not inconsiderable either. In addition, the family resources, whether these referred to money, time or effort, dedicated to support a drug-using child, inevitably meant that non drug-using siblings and their needs could be neglected. Although siblings were reported as largely supportive of both problem drug users and parents, this imbalance did not go unnoticed:

His brother got married and we could not offer anything. They bought furniture, stuff for the house and we as parents had nothing to give... I know it sounds bad but in essence there was nothing left for us to give because everything we had was going to cover Stavros’s expenses... the things he stole, lawyers. (Mother, Interview 2)

Both parents and drug users recounted extremely stressful experiences that impacted upon all aspects of family life, including finances, family integrity and even the professional lives of family members. Parents spoke of the social isolation that resulted from embarrassment and the time required to deal with the various situations stemming from the behaviour of their children:

I lost my friends, I didn’t want to go out at all... I could hardly go to work. (Mother, Interview 3)

One mother used the word ‘haunted’ to describe her emotional state from the moment she found out about her daughter’s drug problem. Living under such conditions inevitably took its toll on the health of parents who reported emotional or physical health problems attributed to stress:

I would spend the whole night by his side to check, is he sleeping? Is he dead? Is he

breathing? Because I used to go by his side very often and count his breaths. [...] What should I do? I was ready at any given time to... scream and grab him, run and save him, do something. (Mother, Interview 2)

The collected narratives of parents described years of negotiating with their adult children, trying to control, manage and cope with their drug problems. At the same time, families tried to navigate impossible and highly stressful situations. Although the price of trying to manage extremely challenging situations was undoubtedly high, the families whose stories informed this study remained largely at the side of drug-using adult children, painting a picture of long-standing family solidarity.

Discussion

Discussing findings within the context of the SSCS model, this study makes a departure from the discourse, dominant previously in Greece, that has viewed drug-affected families in a pathological light by instead describing families as trying to cope as best they can with extremely stressful circumstances. Study findings paint a picture where all aspects of family life are adversely affected by problem drug use including family finances, family relationships and social and professional lives. Similarly, the profound effects on the emotional and physical health of families through living and caring for a problem drug user, were noted by all study participants. Study findings support the SSCS model where family reactions fall within three broad categories; ‘standing up to’, ‘putting up with it’ and ‘withdrawing or gaining independence’.

Although resonant with findings on the coping of drug-affected families in other cultural contexts (Barnard 2005; 2007), it is the degree of involvement in problem drug users’ lives and the relative absence of withdrawal approaches that differentiate our findings. Such ways of

coping can be better understood and interpreted by making reference to the specific cultural context within which they are enacted and, most specifically, to the centrality of the Greek family and the notion of familism. As in other collectivist cultures, the Greek family has been described as the primary social group where one places his/her affiliations (Campbell 1974; Herzfeld 1991), with Greek society described as ‘having elements of a progressive society with a traditional foundation’ (Kaldi-Koulikidou 2007, p. 399). Such suggestions are reflected in the consistently low crude divorce and births outside marriage rate amongst 27 EU member states (Eurostat 2013), the high percentages of cohabitation of adult children and their parents (Mandič 2010) and the level of parental involvement in their children’s future employment plans (Maloutas 2006). Familism, the ideological assumption that the family operates as the primary provider of welfare support (Papadopoulos 1996), is so prevalent in the Mediterranean, including Greece, that some have described a distinct Southern European model of welfare (Karamessini 2008), where Mediterranean families are broadly expected to manage their own affairs with only limited financial support from central government (Appleton and Hantrais 2000). In addition to the sense of obligation present in kin relations in Greece (Millar and Warman 1996), there is also the underlying notion of self-interest given that members of an extended family all form one unit in the eyes of society or ‘one blood’ (Du Boulay 2009, p. 202). It is therefore in everyone’s interest that all members contribute to the preservation, if not elevation, of its social standing.

Within the collectivist Greek culture the reported propensity exhibited by families to become and stay involved in drug-affected members’ lives can be viewed as being completely in line with traditional family functions and expectations, irrespective of the drug problem. The notion of duty to the child, and an associated unwillingness or even inability to conceive of an alternative course of action, alongside the fact that families remained largely responsible for the welfare of their children, must be discussed in the context of socially prescribed and culturally embedded roles that assume family solidarity and support. Our study findings confirm the view that social

support is an important resource for coping, especially so where family members are ‘backed up’ in their efforts (Orford et al. 2010a), yet also highlight that access to social networks that could provide support does not guarantee it given that family members can also be critical, disapproving or dismissive. Finally, the study supports the suggestion put forth by the SSCS model that while experiences of drug-affected family members are similar across countries and cultures they are also influenced by the cultural context within which they are enacted (Orford et al. 2005).

To our knowledge this is the first study to discuss Greek family responses to a drug-affected relative within the context of the SSCS model and, most importantly, the first to explain these responses as the reactions of caring family members who are trying to manage the ‘unmanageable’ under conditions of extreme stress. The shift in focus, a central tenant of the SSCS model, is not inconsequential. Commentators have argued that one of the reasons why drug-affected families have been so neglected in health and social care policy and provision (Velleman 2010) has been the absence of a ‘sound model of addiction problems and the family’ (Orford et al. 2010c, p. 37). The SSCS model provides a useful lens within which family responses can be understood and conceptualised in a non-pathological light something that is arguably, especially important in Greece where drug-affected families’ voices are rarely heard.

While the study provides a useful picture into Greek drug-affected families’ experiences there are some limitations that need to be discussed. For example, the study findings could be closely connected to the sampling strategy used. The families whose stories informed this paper were recruited from a group of people who could be viewed as unusual: as members of an organised parent group they might have been more highly engaged in their children’s lives than parents who were not motivated to join with other parents in this way. That said, the fact that our assertions in relation to family solidarity strongly resonated with the accounts of 40 problem

drug users also gathered as part of the study gives us confidence that our findings are robust and not simply a result of sampling bias. In addition to this point the sample of parents was small and no views from extended family members were sought. Although the significance of the reported findings lies in the fact that this is, to our knowledge, the first attempt to understand drug-affected family members' experiences through the lens of the SSCS model, we would therefore invite caution in making wider generalisations.

In this paper we have advocated for a non-pathological view of drug-affected families and highlighted the importance of cultural context. There are general implications here for policy, practice and research. Firstly, a greater awareness of the needs of drug-affected family members is essential in order to effectively support them. For example, raising awareness and dispelling myths around addiction may help to destigmatise drug-affected families. Secondly, the degree to which the lives of problem drug users and their families are interwoven should be recognised by creating services or interventions directed specifically towards family members. The fact that efforts to conceal drug problems may act a barrier to accessing treatment and support should also be acknowledged and addressed. The study took place when the current economic crisis was unfolding. The extreme austerity brought about in the aftermath of the economic crisis is still in effect, so much so that the need for social protection is more pressing than at any other point since the end of the Civil War in 1949 (Matsaganis 2012). Since 2008 the reduction of real income for Greek households has been estimated at almost 36%, and unemployment now stands at 24.5 % (Eurostat 2015). Further research is therefore needed to explore how efforts to address the needs of drug-affected family members are enacted within, and affected by, these new conditions. Another question emerges in this context: how does such an economic and social crisis affect long-established patterns of solidarity, care and provision?

Declaration of Interest

The authors report no conflicts of interest.

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