Article I

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Hrafnsdóttir, H. & Ólafsdóttir, J. (2016) Substance use disorder, family cohesion, and communication [Vímuefnafíkn, samskipti og fjölskylduánægja]. *Tímarit félagsráðgjafa, 1*(10). Available at file:///C:/Users/Jona%20Olafsdottir/AppData/Local/Temp/2125-2760-1-PB.pdf

Abstract

The aim of this research project was to examine family cohesion and communication in families where one or more family members are struggling with substance use disorder. Two ten-item scales, the Family Communication Scale (FCS) and the Family Satisfaction Scale (FSS), were given to 115 participants at the beginning of a four-week family therapy program at the Icelandic National Centre for Addiction Treatment (SÁÁ) between October 2014 and June 2015. The study investigated whether differences were present in the average reported responses to the FCS and the FSS in families with a parent, sibling, spouse/partner, or child suffering from substance use disorder. The results indicate that the participants experienced low family cohesion and closeness overall, and they were concerned about family relations and the quality of their communication. Participants who had parents with an addiction ranked family cohesion and communication lower compared to those who had a spouse/partner, siblings, or children with an addiction.

Keywords: Substance use disorder, families, family therapy, family cohesion/satisfaction, family relations/communication.

Introduction

Harmful use of addictive substances is considered to be one of the key risk factors for poor health, not only for the user themselves but also for their families (World Health Organization [WHO], 2010). When interactions within the family are based on trust and intimacy, a healthy identity and self-confidence can develop. Children who grow up in a trusting environment find it easier to trust others and to form close relationships in their adult years (Park, Crocker & Mickelson, 2004). In their research, Johnson and Stone (2009) conclude that adult children of a parent with substance use disorder (SUD) are more likely to experience anxiety and to avoid difficult situations, compared to a control group who were not brought up under these circumstances. Furthermore, research has shown that people who grew up with SUD in the family find it significantly harder to build trust and intimacy in their relationships, and experience less satisfaction in family relations, than those without a chemically-dependent family member (Margasinski, 2014; Johnston & Stone, 2009).

This research measures family cohesion and communication/relations in families where a family member has SUD. It also examines whether the role of that person within the family makes a difference to family cohesion and communication/relations[1].

The influence of substance use disorder on family cohesion, communication, trust, and intimacy

Research has shown the following factors to be crucial in how individuals rate family cohesion and a good relationship between spouses/partners: (1) family members' ability to resolve problems, (2) adaptability, (3) the ability to trust, (4) experiencing intimacy/closeness in relationships, (5) the ability to control one's emotions, and (6) individual family members having confidence in themselves (Dethie et al., 2011). Children who grow up experiencing intimacy and trust with their parents find it easier to form relationships and build trust in their adult years (Park et al., 2004). On the other hand, if children grow up with insufficient trust and emotional intimacy due to SUD in the family, this can lead to difficulties in forming relations, trusting others, and feeling secure in their relationships in their adult years (Forrester & Harwin, 2011; Mikulincer & Shaver, 2007). Experts have suggested that couples define their intimacy and emotional connection by each member evaluating their partner's behaviour and how s/he relates to them. In addition, it has been shown that when couples can resolve their disagreements and disputes through negotiation, it indicates good relations and family cohesion in the future i.e. for the couple's and children. Thus, the degree of intimacy and successful communication within a couple's relationship gives a good indication of family cohesion and closeness (Dumont et al., 2012).

Research into couple relationships where there is no chemical dependency shows that individuals' self-confidence is linked to the family and family cohesion and closeness. However, those who live with family members with SUD report lower levels of family cohesion and closeness and also present less self-confidence (Laghi et al., 2012; Dethie et al., 2011). Research carried out in 2014 using the FACES IV self-evaluation scale and the FSS and FCS scales showed similar results. Family cohesion and relations were rated significantly lower for those families living with SUD than for those families that did not (Margasinki, 2014).

The influence of substance use disorder on psychosocial wellbeing and communication/relations

When children grow up with a parent suffering with SUD, they are more likely to be subject to violence in the home, and they are more likely than other children to develop psychosocial problems (Sunday et al., 2011; Barnard & McKeganey, 2004; Harter, 2000). The term 'strain' is used to describe the stress experienced by children growing up in these circumstances. The 'strain' of living with a parent's SUD can

[1] With thanks to SÁÁ for their support with data collection and promotion of the research.

result in short- and long-term harm to the individual and can manifest itself in emotional distress; it can also contribute to substance abuse during teenage years (Velleman et al., 2008; Anderson & Baumberg, 2006; Norström, 2002).

When these children reach adulthood, they often find conflict in relationships difficult, including in couple relationships (Sunday et al., 2011; Springera et al., 2007; Cummings & Davies, 2002). In a couple relationship, individuals' distress can manifest itself in negative emotions such as anxiety or anger, which can result in them avoiding difficult situations, such as intimacy and communication, in the couple relationship (Skowron & Dendy, 2004). Klosterman et al. (2011) compared two groups of secondary school-age students: one group (n=136) had a parent with SUD and the other group (n=436) did not. The aim of the research was to examine whether individuals who had grown up with an individual in the family with SUD showed more psychosocial symptoms of depression than those who had grown up in families without SUD. The results showed that those who had grown up with a parent with SUD had more behavioural issues and interpersonal problems, experienced more distress, and had less insight into their wellbeing than the control group. The results also showed that participants who had grown up with a parent with SUD made decisions from an emotional state and used more alcohol and/or other substances than those who had not grown up with SUD (Klosterman et al., 2011). These research results indicate that parents suffering with SUD have an impact on how their children fare in adulthood.

Klosterman et al. (2011)'s study supports the research conclusions drawn by Springera et al. (2007) and Skowron and Dendy (2004). The findings also support the research results of Johnston and Stone (2009), who examined how children growing up with a parent with SUD experience happiness as adults in their relationship with their partner, as well as how they experience their role as parents. These results were compared with a control group who had grown up in a normal family environment. The former group reported a lack of communication and satisfaction in their relationship with their partner as well as in their relationships with their children. Significantly more members of the control group reported that they were satisfied with their relations with their family. Other research has shown that adult children of parents with SUD do not always experience a lower quality of life than those who did not have parents suffering with SUD (Sher, 1997). As a result, it is not possible to claim that children who were brought up by a parent with SUD will always fare worse in terms of their mental health or their capacity to maintain healthy relationships in their adult years, compared to children who have not been brought up by a parent with SUD (Hunt, 1997; Sher, 1997). Nevertheless, there is still a higher chance that those who were brought up in such circumstances will experience difficulties.

Methods

The aim of this research was to examine family cohesion and communication/relations in families where a family member has SUD. It also examines whether the role of that person within the family makes a difference to family cohesion and communication/relations.

Two scales of measurement were used in this research: the *Family Communication Scale* (FCS) and the *Family Satisfaction Scale* (FSS). The FCS is intended to measure healthy relations within families, and the FSS measures participants' experience of happiness within the family. Participants respond on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Higher scores on these two scales indicate higher levels of happiness in the family and better relations between family members. On the FCS, participants can score between 10 and 50; ratings are reached by adding together the scores from the 10 questions on the scale.

The families are then divided into five groups, according to their ratings. The lowest group have ratings of 10-29; this group is very concerned about the quality of their family relations. The next group has ratings of 30-35; they are concerned about the quality of their family relations. The group with ratings of 36-39 is generally satisfied with their family relations but has some concerns. The group with ratings of 40-43 is generally satisfied with their family relations and has few concerns. The highest rated group is 44-50, and this group experiences very positive family relations. The FSS has a similar rating system to the FCS. Those who score 10-29 are very dissatisfied and have concerns about their family; the next rating is 30-35, and this group is rather dissatisfied and has some concerns about their family. The middle rating is 36-39, and this group is reasonably satisfied with family relations and enjoys their family to some extent. Those with a rating of 40-44 are to a large extent satisfied with their family, and those with the highest rating of 45-50 are very satisfied with their family in most respects.

Alpha coefficients have been used to evaluate the internal stability of FCS and FSS; these are based on responses from 2,465 family members in research carried out in the United States during the 1980s in order to develop the measures (Olson, 1986). The average score on the FCS in these research projects was 36.2 ($SD = 9.0$, $\alpha = 0.90$). The average score on the FSS in these research projects was 57.5 ($SD = 8.5$, $\alpha = 0.92$). Reliability and validity coefficients of the measuring device on both FCS and FSS measure what is expected (Olson & Gorall, 2006; Lavee & Olson, 1991; Olson, 1986).

The psychometric properties of the Icelandic translation of FACES IV were examined in Iceland. The aim was to examine how the three elements are constructed, to check for reliability, and to compare this to the

American version. The FCS and FSS were used to measure relations within the family and how satisfied participants were with their families. The participants were 335 parents with children in years 8-10 in schools in Reykjavik and neighbouring boroughs. The average for this sample was 42.92 for the FCS and 43.51 for the FSS, and the alpha co-efficient was 0.86, which corresponds to the US version of the questionnaires (where it was 0.92) (Guðbrandsdóttir & Guðmundsdóttir, 2011).

Quantitative research methods were used to assess the influence a substance use disorder has on other members of the family. Purposive samples were used to choose participants. This research project examined the influence of a person's SUD on other members of their family. The questionnaire was completed by 115 clients in family therapy at the Icelandic National Centre for Addiction Treatment (SÁÁ) between October 2014 and June 2015. All participants received the questionnaire at the start of their therapy, and the response rate was 100%. The SÁÁ bioethics and scientific committees granted permission for the research project.

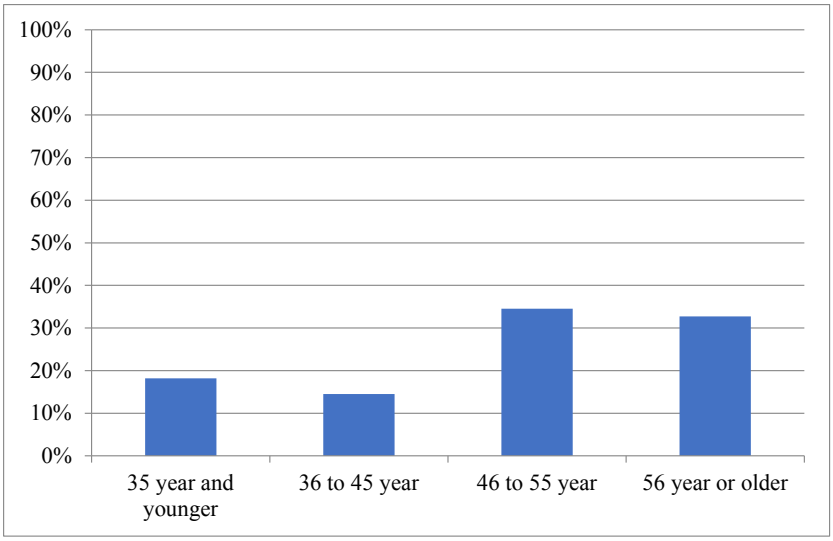
All statistical analyses were carried out using SPSS (Statistical Package for Social Science); descriptive statistics were used to describe all parameters of the study, including demographics of gender, age, monthly income, and marital status. An ANOVA was used to study responses on the FCS and FSS using the average scores, to see whether differences depended on which family member presented with a chemical dependence: parent, sibling, partner, or child.

Results

Gender, age, level of education, income, and accommodation

115 people taking part in family therapy at SÁÁ participated in this research project. The group consisted of 27 men (23.5%) and 87 women (75.7%); one of the participants did not record their gender, and three did not record their age. Not all the participants responded to every question on both the FSS and FCS questionnaires, and this was accounted for in the statistical analysis by only including participants who answered each specific question. The majority of the participants (81.8%) lived with their partner and/or children; 13.9% lived alone, and 4.3% lived with their parents.

The average age of the participants was 49 (SD = 14). The youngest was 19 and the oldest was 81. The participants were divided into the following age groups to simplify the statistical analysis. As can be seen in Graph 1, most of the participants (67.2%) were aged 46-55.

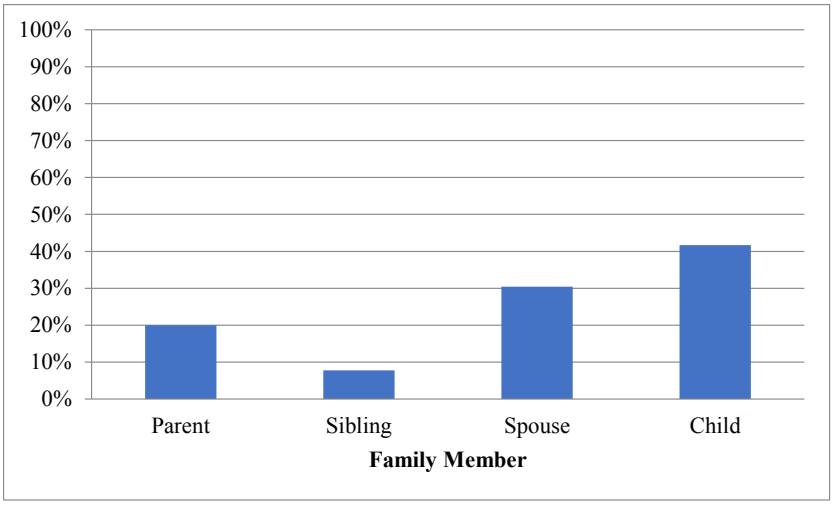


Graph 1. Distribution of participants by age, in percentages

The participants were asked about their education and total monthly income. About 27% had only completed their secondary education, while 29% had achieved further education qualifications and approximately 43% had university degrees. In a paper from the Organisation for Economic Co-operation and Development (OECD) about education, it was noted that in 2009, 34% of Icelanders aged 25-64 had further education qualifications and 36% of that age group had university degrees (OECD, 2011). In this research project, fewer participants had only further education qualifications and a higher number had university degrees than the national average would indicate. Most of the participants (43.5%) had a total monthly income between 250,000-500,000 ISK; 26% had a total monthly income of less than 250,000 ISK, and 29.7% had a total monthly income over 500,000 ISK. According to a sample study of total income in Iceland by Statistics Iceland in 2014, the average income of Icelanders was 555,000 ISK per month (Statistics Iceland, n.d.). These figures from Statistics Iceland correspond with the income of the participants in this research.

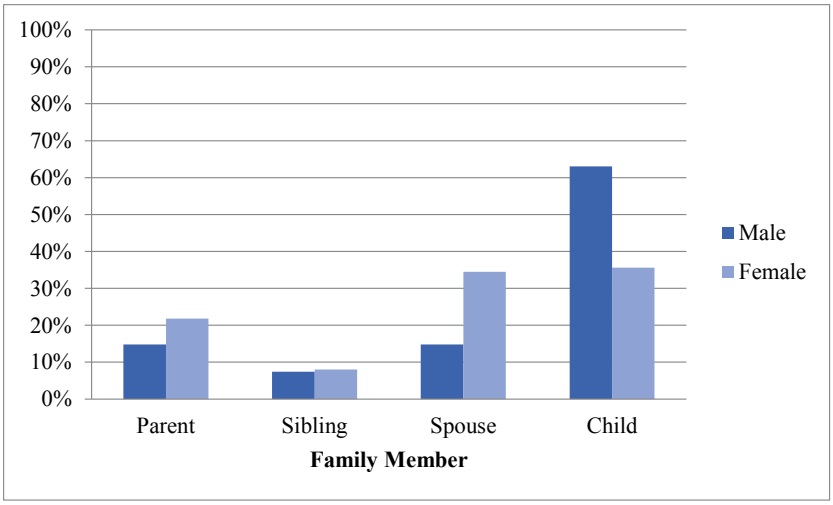
Status of participants in family therapy

Graph 2 shows that most of the participants (42%) who were attending family therapy were parents who had a child with a chemical dependency. The age of the person with a chemical dependency was not asked about in this research. Around 30% of participants were attending family therapy because of their partner, 20% because they had a parent with a chemical dependency, and 7.5% because they had a sibling with a dependency.



Graph 2. Total number of participants, grouped according to which family member had a chemical dependency (n=115).

Graph 3 shows the percentage of participants by gender—27 men (23.5%) and 87 women (76.5%)—and which family member had a chemical dependency. The distribution of the sample is similar for men and women regardless of which family member had a dependency, but women were more likely than men to attend therapy because of their partner.

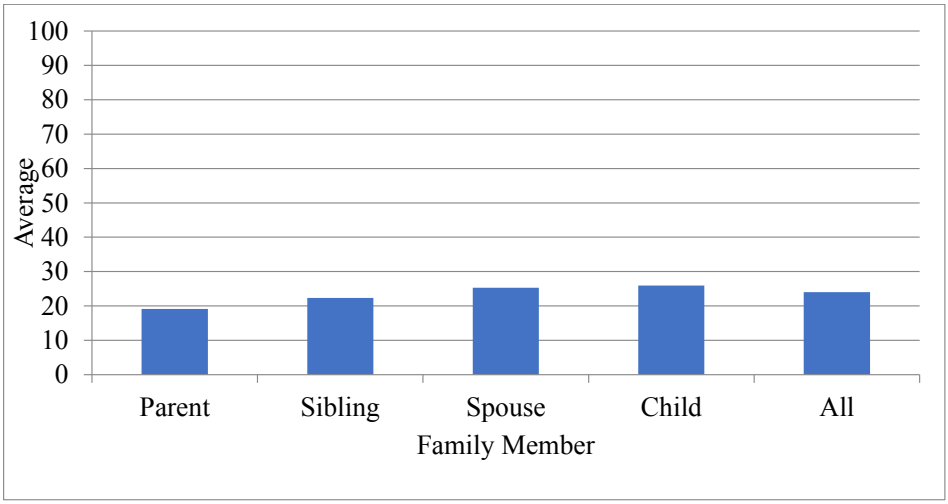


Graph 3. Numbers attending family therapy, grouped according to gender and which family member had a chemical dependency (n=115).

The influence of chemical dependency on family cohesion and family relations/communication

When all the groups were added together irrespective of which family member had a chemical dependency, participants' average scores were 23.96 for family cohesion (SD = 6.95, α = 0.90), which corresponds to the original English language questionnaire (α = 0.92) and the Icelandic version (α = 0.86). These results fall into the lowest category on the FSS (10-29), which shows that the participants experienced considerable dissatisfaction with their family and were concerned about their family unit.

Graph 4 shows the reported responses for family cohesion according to which family member had a dependency. There is no significant difference in the responses on family cohesion between those with a dependent sibling, partner, or child (the average of each group was around 23.96), but there is a significant difference between these groups and the group where a parent had a dependency. This group reported a lower level of family cohesion; on average 19.1.

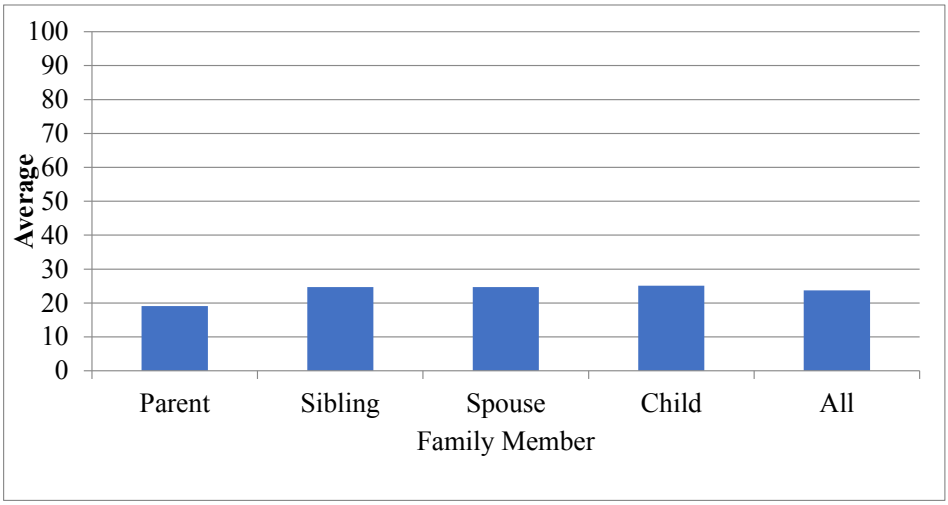


Graph 4. Average reported response on family cohesion, grouped according to which family member had a chemical dependency (n=109).

Average reported responses on the FCS were 23.7 (SD = 7.72, α = 0.89), which corresponds to both the original English language version (α = 0.90) and the Icelandic version of the questionnaire (α = 0.86). These results fall into the lowest category of the FCS (10-29), which means all participants had considerable concerns about the quality of their family relationships. These results are comparable to the overall finding indicating participants' satisfaction levels within their families.

There was little or no reported difference between the groups regarding family relations/communication, as can be seen in Graph 5, where the group average was 23.7. When the family member with a dependency

was a sibling or partner, the average was 24.7, and when the family member was a child, the average was 25.1. When a parent had a dependency the average was lower; 19.1. This is a similar finding to that of the family cohesion questionnaire. This finding is comparable to the difference found between the groups regarding family satisfaction, where participants with a chemically-dependent parent scored lowest.



Graph 5. Average reported response on family relations/communication, grouped according to which family member had a chemical dependency (n=109).

In order to better examine the results and to see whether the groups differed, a one-way ANOVA was used with 95% confidence, which showed that there was a difference between the groups with a confidence co-efficient of 95% (see Tables 1 and 2). Results showed that there was a difference both in family cohesion ($F(3.105) = 7.090$, $p < 0.001$) and in family relations ($F(3.105) = 3.168$, $p < 0.027$). The Bonferroni correction was used to determine where the differences between the groups lay (see Graphs 1 and 2). The findings show that family members with a parent with SUD experienced considerably less satisfaction in their family relationships compared to those with children with SUD.

Table 1. One-way analysis of variance on reported responses to family cohesion across the groups.

Cohesion

	Average	95% Confidence Level Lower Bound	95% Confidence Level Upper Bound	n
Parent	19.10a	15.95	22.25	22
Sibling	22.33a,b	18.67	26.00	9
Spouse	25.25b	22.66	27.84	32
Child	25.93b	24.17	27.69	46
All	23.96	22.64	25.28	109

*Averages with a different letter are evaluated differently with Bonferroni's test ($\alpha = 0.05$).

Table 2. One-way analysis of variance on reported responses to family relations across the groups.

Communication

	Average	95% Confidence Level Lower Bound	95% Confidence Level Upper Bound	n
Parent	19.10a	15.60	22.60	20
Sibling	24.67a,b	20.23	29.10	9
Spouse	24.72a,b	21.61	27.82	34
Child	25.13b	23.09	27.17	46
All	23.70	22.23	25.16	109

*Averages with a different letter are evaluated differently with Bonferroni's test ($\alpha = 0.05$).

Discussion

The results show that participants scored an average of 23.96 on the Family Satisfaction Scale (FSS), which means that family members felt dissatisfaction and discord within the family and were concerned about their family units. Participants scored an average of 23.70 on the Family Communication Scale (FCS), which tells us that family members were very concerned about the quality of communication within their families. These results are somewhat lower on both scales (FSS and FCS) than the results revealed in the research of Olson et al. (2011, 1991, and 1986). There, the FSS score was 37.5 (SD = 8.5), meaning that

family members were reasonably satisfied and content and enjoyed some aspects of their family life. Their results on the Family Communication Scale were slightly lower, on average 36.2 (SD = 9.0), meaning that family members had some concerns about communication within their families. In fact, these results are somewhat lower than those in an Icelandic research project on the psychometric characteristics of the FSC and FSS, which revealed that participants were in general satisfied with their families and had good relationships (see discussion above) (Guðbrandsdóttir & Guðmundsdóttir, 2011). The results of this study reveal that substance use disorder in one family member has an influence on the other family members, affecting how satisfied they are about their families and about communication within the family. These results support the research carried out by Margasinski (2014), which used the same FSS and FCS questionnaires as this study.

By using a one-way ANOVA, it is possible to see that the means on both the FSS and FCS differed depending on which family member had a chemical dependency. The results of both scales showed that participants attending family therapy because of a parent with a dependency experienced less family cohesion and poorer communication in their family than those in therapy due to a partner, child, or sibling with a dependency.

It is interesting to note that adult children of parents with SUD experienced little satisfaction within their own families and a lack of communication between their family members. This supports the research of Sunday et al. (2011), Springera et al. (2007), and Skowron and Dendy (2004), which found that adult children of parents with SUD can experience difficulty in family relations. This also reflects the results found by Johnson and Stone (2009) mentioned above, which showed that those brought up by a parent with SUD experience less satisfaction and communication with their partner and their children than control groups.

This research is limited by its sample size, which was too small to allow us to conclude that everyone who lives with substance use disorder in the family will experience limited family cohesion and poor communication within the family. However, it can be concluded that this is more likely to be the case in families with SUD. The results indicate that it would be worthwhile to split those attending family therapy into groups according to which member of the family has SUD.

According to research (Johnson & Stone, 2009; Park et al., 2004; Skowron & Dendy, 2004), those who have grown up with a parent with SUD have difficulty with relationships and communication in their adult years, and would perhaps benefit from a different kind of therapy and support than is offered by standard family therapy for those with a family member with SUD. The influence of substance use disorder on families warrants further research, such as carrying out a comparable research project with a larger sample

that also asks participants about their mental wellbeing, with reference to stress, anxiety, and depression. More extensive research is also needed on the short- and long-term effects of growing up with substance use disorder in the family; particularly with respect to prevention. It would also be valuable to ask those attending family therapy to fill in the FSS and FCS at the start and end of therapy, in order to examine whether this form of therapy results in better family cohesion and communication by the end of the sessions.

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