Chapter 3
"Bad Parents," "Codependents," and Other Stigmatizing Myths About Substance Use Disorder in the Family

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A father calls us seeking treatment services for his son. "So sorry to bother you … I'm calling about my twenty-four-year old son. He got out of rehab a week ago. He and his girlfriend OD'd five days ago. He's still in the ICU. Unfortunately, she didn't make it." We could react to many aspects of this description of his situation. We could wonder whether the son left rehab with no medication-assisted treatment plan. We certainly could respond to this father's grief, and we could feel angry at the high toll of overdose deaths mounting in this country, partly as a result of the treatment industry ignoring

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evidence-based treatments. For the purposes of this chapter, however, notice especially: "So sorry to bother you." The apology speaks to the self-blame, shame, and presumed unworthiness of help for his "addict" child.

This father pushed through the stigma of having a family member struggling with substance use. Unfortunately, he represents a fraction of parents, those willing and able to step from isolation and culturally induced shame to get help.

Introduction

Substance use disorders (SUDs) exact emotional and physical tolls on the substance user. A significant part of this pain is attributable to stigma. People with substance problems are labeled ("liars," "losers," "junkies," "addicts"), judged amoral and immoral, and rejected socially. According to the twelve-step doctrine of Alcoholics Anonymous, substance users have flawed characters. Studies have found that substance users are presumed dangerous, blameworthy, infuriating, and repellent [1, 13]. According to various studies, compared with individuals with nonsubstance use mental disorders, individuals with substance use disorders are thought to be weak and incompetent [54], more responsible for their disorder [11], and less pitiable and worthy of help [13]. Insurance, housing, and employment policies that benefit people who are dependent on substances are unpopular [2]. Stigmatized people with substance problems are avoided, insulted, misunderstood, discriminated against, jailed, and abandoned [32].

Family members of those with SUDs face stigma by association. People who care about or are personally linked with a stigmatized person share the stigma [22, 27]. By being in a relationship with a person with a drug or alcohol problem, family members experience loss of respect and status. They are blamed as one cause of the problem or as a reason that the problem is not resolving [10, 34]. They are labeled with the "disease of codependency." They are seen as "contaminated," judged less competent, and are more ashamed of their loved one than are family members of people with other

mental illnesses [13, 27]. They are suspected of being at risk of contagion, and they are more likely to abuse substances themselves or engage in other behaviors that make them socially unappealing [4].

Family members suffer silently as they overhear people talk about substance users—people they love, care for, and identify with—in derogatory ways. A large survey of US health consumers found that 80% had overheard hurtful or offensive comments about mental illness [60]. Family members also see depictions of substance users in the media that are rife with misconceptions and evince little knowledge of effective treatment. Family members themselves are often treated with suspicion or pity. As they try to help their loved ones, they face discrimination in navigating schools, work, the treatment system, and the justice system. Since they are often distracted or managing an urgent crisis or both, they lose jobs and are seen as unreliable. When they do open up about the problem, they face criticism and advice that runs counter to their values and goals ("kick them out," "cut them off," "let them hit rock bottom"). They are "diagnosed" as "codependent" and told that they are powerless to help their loved ones, the thing they most want to do. They are physically stressed and emotionally drained by their experiences and have profound negative feelings about themselves. They agonize, "What will people think? How will our family be treated? Am I a bad parent?" Adding insult to the insult and injury, the strong cultural message of "once an addict, always an addict" can cause a family to be stigmatized long after a problem has resolved.

The outcome for families, as well as for their loved ones using substances, often is isolation, reluctance to seek help [7], and prolonged suffering. This is concerning as research has shown that family members can play a critical role in change by supporting and advocating on behalf of their loved ones [8, 47] and helping facilitate better engagement with treatment [36, 53]. In other words, a key consequence of stigma is the loss of perhaps our most powerful motivating force in a substance user's life: family.

How Stigma Runs in the Family

Approximately 21.5 million people in the United States have substance use disorders, including 1.3 million aged 12–17 [59], and likely live with parents or guardians. Estimates are that for every person with a substance use problem, at least one family member and as many as *five* other individuals are negatively impacted [14, 47, 65]. Other studies indicate that half of American adults have a close family member who has struggled with alcohol dependence [15], a staggering number reaching well above 100 million adults.

Dictionary definitions of *family* refer to a social unit consisting of a father, mother, and their children and other blood relatives including aunts, uncles, cousins, and grandparents. More modern definitions include same-sex couples and their children and single-parent households, and many people consider close friends to be more like "family" than their blood relatives. But in fact, any close other who cares about and identifies with a person struggling with a substance use disorder is likely to experience the effects of stigma. The family is, as the saying goes, in this together. In the succeeding section, we note some primary ways that stigma is understood to be conveyed through family relationships.

Closeness

Theorists have noted multiple pathways leading to the general phenomenon of stigmatization of family members. Goffman [22] observed that stigma tends to "spread from the stigmatized individual to his close connections." This type of stigma is essentially guilt by association, so that even though a family member does not share the behaviors or characteristics of their loved one (e.g., behaviors related to substance abuse), they are close enough to be touched by the stigma and suffer its effects. The social heuristics or automatic processing we use to categorize other people before we get to know them can lead us to stigmatize by association on the basis of physical proximity alone. In a study titled "Known by

the Company We Keep," [26] found that merely being seen talking to a stigmatized coworker was enough for the stigma to rub off, so much the more so for close family members.

Unusualness

Others have focused on the overall "unusualness" of the family [48, 63] as a particular dynamic of association. Families that are outside the norm within a community, such as single parent, minority, or same-sex families, face discrimination and are marginalized in various ways. As social creatures, we tend to see the world through the lens of "us" and "them," judging and rejecting those who don't seem "normal." If a person or family is like "us," we perceive them to be familiar and trustworthy. If they are different, they may be regarded with suspicion; at worst, they are stigmatized, rejected, and sometimes even punished. It is not uncommon for families struggling with substance use disorders to be seen by others as "different," especially since they experience more negative events, including ones that nonfamily members are likely to observe, such as arrests, hospitalizations, and verbal and physical assault [29, 48]. A family that is known to be different, troubled, and unpredictable may become known to members of the community as information passes between groups.

Blame

As well as the stigma that comes from simply being associated through closeness or unusualness with a person abusing substances, family members are often blamed for their loved ones' problems. They are perceived as somehow complicit or culpable [19]. When compared with families who have a loved one with a mental illness like schizophrenia, family members of an individual with SUD are more often deemed responsible for the disorder [13]. They are blamed for causing the problem and held responsible for not fixing it quickly enough.

Stigma and Parenting

While all family members of people with substance use disorders suffer from the effects of stigma, parents of children using substances are perhaps hit the hardest. Since one ubiquitous understanding of substance abuse attributes it to character defects, parents of substance users are assumed to have failed at teaching good morals and instilling proper values in their child. Francis [19] found that parents assume that others blame them for their children's problems, and they are not incorrect in making this assumption. In a survey of public attitudes concerning substance abuse, a quarter of those surveyed blamed parents for not preventing their children's drug dependence [55]. Other studies indicated that parents of children with "invisible" disabilities (like mental illness, including SUDs) feel labelled as "bad parents" [19, 58]. When they ask for help, family members typically receive inculpating if not well-meaning advice, such as "You need to stop enabling him." The message is clear: you are doing something wrong; you are too lax, too strict, too involved, and the list goes on. The burden of blame weighs on mothers in particular as they assume greater responsibility for their children's conditions and behaviors [19].

The Language and Logic of "Codependency"

Directly or indirectly, family members of individuals struggling with substance use are assumed to be part of the problem [30], and in North America this assumption is built into the language. "Codependency," a word that has been used for more than thirty years to explain the behaviors of family members around the substance user (e.g., [3, 44]), represents a Pandora's box of theories unsupported by empirical research. Dr. Timmen Cermak [6] argued in his 1986 book *Diagnosing and Treating Co-Dependence: A Guide for Professionals* that codependency should be included in the DSM-III as a distinct personality disorder. While Cermak's recommendation has not been followed, many people in the

treatment field nonetheless accept the idea of a disease of codependency, and it continues to be common parlance in twelve-step support groups for family members, such as Al-Anon and Nar-Anon.

Family members may not understand what "codependent" means, but they know that it is a stigmata for dysfunction. We reviewed the codependency literature and found that descriptions of a supposed codependent include controlling behavior, perfectionism, excessive caretaking, repressed emotions, mistrust of others, and hypervigilance. "Codependents" are assumed to have "bad boundaries," to live in "denial," and to derive their self-esteem from "rescuing" their loved one.

Within this framework, a stigmatized understanding of substance use disorders and their impact on relationships forms a circular trap. It starts with the idea that substance abuse is a "disease" characterized by permanent, personal flaws that make users "powerless" to control their use. Their resistance to changing is labeled "denial." The "addict" is by definition—genetically, mentally, spiritually, incurably—a liar and a manipulator, such that any attempts by a family member to change the person are taken as both misguided and evidence of their "disease of codependency." The family member is called an "enabler," as if the only explanation for trying to fix the supposedly unfixable is a hidden agenda to help the person to keep using [47]. Anyone in a relationship with a substance user can be "diagnosed" with codependency, but parents of children and female partners of men are more often given the label [47]. The logic of codependency leads to only two recommendations for family members: force compliance from the substance user through an "intervention" [24] or go to a self-help group like Al-Anon/Nar-Anon and learn to "detach with love" and "take care of yourself" while you wait for your loved one to "hit rock bottom."

In fact, many so-called codependent behaviors are normal responses to being in a relationship with someone misusing substances. It's normal to try and be helpful when loved ones are hurting themselves. It's normal to want to protect people we love from the consequences of their behavior, especially when the outcome might be incarceration or death. It's nor-

mal to be anxious and distrustful of others when we are stigmatized and discriminated against for simply being in a relationship with someone using substances. It's normal to hope against hope that things aren't as bad as they look. The language and logic of codependency, however, stigmatizes family members by branding these behaviors as abnormal and sick.

However conferred—implicitly or explicitly through judgment, avoidance, blaming, or the logic of codependency—the stigma of substance abuse stands in the way of true, helpful understanding. We think, "they're not like us," and by extension, "that's *why* they have a substance problem and we don't." We say, "it's bad parenting" and think we know what's really going on in another family's struggle. We call it "codependency" and think that it explains *everything* we see. Unfortunately, such thinking prevents family members and treatment providers from embracing evidence-based approaches to substance use disorders. Stigma also prevents family members from being the powerful resource and support for their loved one that research has shown time and again they can be [8, 37, 47].

Layer Upon Layer of Stigma

Making matters worse, families dealing with substance problems often face multiple sources of stigma. Substance disorders cause (or coexist with) all sorts of other problems for the substance user and the people who care about them, and many of these problems are also stigmatized. Sexually transmitted disease; unemployment; cooccurring psychiatric issues; medical, financial, and housing problems; domestic violence; broken families; and racism compound the stigma of substance abuse.

Many family members also face stigma associated with being involved in the criminal justice system. Of the 2.3 million people incarcerated in the United States, more than 65% met criteria for a substance use disorder [43]. In 2016, the

most recent date for which federal offense data are available, 47% of sentenced federal prisoners were serving time for a drug offense [5], and a study conducted by CASA [43] found that only 11% of inmates receive treatment for their substance use disorder. There is a significant chance that a person with a substance use disorder will interact with the legal system, possibly go to jail, and in the process be stigmatized for their substance use problem and their history of incarceration. Their family will share in all of this stigma.

The Impact of Stigma on Family Members

Shame

Family members of people with substance problems have many experiences, thoughts, and emotions that can lead to feeling shame, all of them caused or exacerbated by stigma. Because of stigma, they feel embarrassed by their loved one's problem and embarrassed about their loved one as a person—in studies of families of people with substance use problems, even those who understand that they are not responsible often feel ashamed and embarrassed anyway [13, 16, 34].

Family members often do feel (and are) blamed, and they are at risk for internalizing the blame. In a survey of over 600 parents who had a child with an emotional or behavioral problem, 72% of parents blamed themselves for causing their child's problem. Interestingly, 97% of these parents felt that they did not deserve the blame of others [16]. Family members frequently feel guilty—and deeply ashamed—for things they have said or done to their loved ones with SUDs. Family members in caretaking roles feel pressure to be strong, rational, calm, and kind. Failing that, they feel ashamed. Unfortunately, it's nearly impossible to be strong, rational, calm, and kind all the time, especially under the prolonged stress attendant to substance use.

Social Isolation

The shame felt by many family members, especially parents, is full of self-judgment and fear that others are judging them just as harshly. While some attribute other people's judgment to lack of knowledge and negative attitudes [34], nonetheless, when faced with the prospect of misunderstanding, blame, and shame, family members understandably pull away and move toward isolation [29, 34]. They may compare themselves to families that seem more "normal" and withdraw to protect themselves. Withdrawal is a self-protective response to the shame that family members feel; it can also guard against opinions and advice that are unhelpful or against their values, such as pressure to ask a child using substances to leave the family home. While the impact varies across groups, family members in studies report strained or distant relationships with extended family and friends because of their loved one's mental health problems [58, 61]. In other words, given the choice between stigma and isolation, many family members choose isolation.

Not Seeking Help

Stigma undermines people's willingness to seek treatment. This is true for both substance users and their family members. The expectation of stigma prolongs and worsens the course of substance use and mental health problems as people who feel stigmatized have a harder time accepting their illness, put off or resist getting treatment, and drop out of treatment sooner than do less stigmatized populations [8]. The same is true for their families. Studies have shown that secrecy prevents family members from seeking and receiving both informal and formal support and increases the burden of helping their loved one with a mental health issue (Gerson et al. [20, 64]). In fact, stigma contributes to delays in seeking help more than structural barriers such as lack of funds [57].

The stigma of substance abuse gives people understandable reasons to do privately whatever it takes to hold their

lives together rather than seek help and be exposed to judgment and concrete life consequences. For example, parents may minimize or hide their child's substance problem if they fear that the child will be treated differently at school. Spouses may try to ignore or even help cover up a problem because the whole household depends on the substance user not losing his or her job. And just as substance users resist treatment because they don't want to be labeled addicts, family members understandably want to avoid the label of codependent. The reality is that family members can be crucial agents of positive change for the substance user: family influence is the most commonly cited reason for treatment entry among help-seeking substance users [33]. Their stigma-induced reluctance to reach out and be involved is doubly unfortunate as stigma makes them less likely to help their loved one get help and less likely to get help for themselves.

Unhelpful Attitudes in Treatment Settings

Moyers and Miller [41] described how the very people trained to help often hold negative attitudes about substance users and their families and contribute to their stigmatization. In one study, surveyed addiction counselors endorsed judgments like "alcoholics are liars and cannot be trusted" [41]. This may impact quality of care [42] as it disrupts trust and rapport building between the professional and the patient. When they do seek help, family members often endure well-intentioned but uninformed advice that implies that they are part of the problem and puts them in a position of having to justify or explain themselves and challenge misconceptions about their loved one and the family [34]. Family members feel judged by unsympathetic health care professionals [34, 47] and regularly report that they are not listened to and are excluded from important treatment decisions by treatment providers [23, 47]. Family members fear gossip and loss of confidentiality and anonymity [34], especially in small rural towns [21]. They deal with treatment providers who make assumptions about their mental health and accuse them of

"enabling." The intrinsically blaming diagnosis of codependency may prevent them from getting assessed and treated for the slew of mental health impacts on families of loved ones struggling with substances—commonly anxiety disorders such as posttraumatic stress disorder or generalized anxiety disorder, or mood disorders that would respond to evidence-based therapies and medications.

Additionally, treatment providers who hold biased views may be unnecessarily pessimistic about the psychological well-being of family members. A study conducted by Burk and Sher [4] found that mental health professionals predicted that teenagers of parents who had a drinking problem would be more likely to have substance problems, mood disorders, and dissatisfaction with life (specifically intimacy problems) as they aged. Family members being treated for codependency are encouraged to "stop enabling," "focus on yourself," and "surrender control," which, as well as being unsupported by evidence, are the opposite of what they want to hear as they try to help a loved one. Many family members report a sense of hopelessness in response to clinical feedback [34, 47].

Stress

For families, the shame, social isolation, and poor treatment or lack of help associated with the stigma of substance abuse adds stress to an already stressful situation. Families may internalize prejudice [10, 12], which has a profound negative impact on self-esteem. Family members of people misusing substances are frequently on the receiving end of arguments, abuse, aggression, and violence [28, 35] and experience marital distress and social and financial problems [52]. At the same time, they are faced with providing financial, practical, and emotional support for their loved ones. The demands of the caretaking role can negatively affect their physical, psychological, social, and financial well-being, and many report that their coping resources are exhausted [45–47]. Stigma further complicates the caretaking role as many family mem-

bers also live with more anger as they have internalized a blaming, shaming, stigmatized view of the problem.

If someone in the family has a non-stigmatized illness like cancer, other people volunteer to help with household chores, bring food, or offer emotional support. The family doesn't get shunned or blamed; judgments are not questioned. But enter substance abuse, and stigma undercuts the reward and joy of parenting that could otherwise serve to offset some of the stress of illness in the family. It is impossible to separately measure stress due to stigma from other stressful aspects of substance abuse (fear for a loved one's safety, for example), but there is no question that living with stigma is stressful, and stress has a substantial independent negative impact. Family members of people with substance use disorders suffer from higher rates of physical illness because of stress, and stress adversely affects their ability to support their loved ones [20].

Stigma and Children

Based on data from the combined 2009–2014 National Surveys on Drug Use and Health, about 1 in 8 children (8.7 million) aged 17 or younger lives in households with at least one parent who has a past-year substance use disorder characterized by recurrent use of alcohol or other drugs (or both) that has resulted in significant impairment [31]. These children suffer: children whose parents abuse alcohol and other drugs are three times more likely to be abused and more than four times more likely to be neglected than children from non-substance-abusing families [50]. These children also tend to have lower socioeconomic status and more difficulties in academic, social, and family functioning when compared with children of parents who do not have a substance use disorder [49]. Many assume caretaking roles for their parent and any other children in the home, and through all this, they experience the effects of stigma. As noted, even when people change their relationship to substances they

often face ongoing stigma for having the problem in the first place. Children continue to suffer when their parents have a harder time finding and keeping jobs, getting licenses, and receiving benefits that help their children, like food stamps and education vouchers.

Children of parents with substance use disorders overhear peers and adults referring to their parents as "addicts" and "losers." They see prejudice in the media. They see how teachers and neighbors look at their parents and experience shame. They are also stigmatized by association and viewed as contaminated [13]. One-third of respondents to a survey on public attitudes toward substance use agreed with the statement: "Parents would be foolish to let their children play in the park with the children of someone who has a history of drug dependency" [55]. These aversive emotional, physical, and material experiences can reach into adult life. A landmark study conducted from 1995 to 1997 with more than 17,000 participants found a dose-response relationship between adverse childhood experiences (physical abuse, divorce or parental separation, or having a parent with a mental and/or substance use disorder) and numerous health, social, and behavioral problems throughout the lifespan, including substance use disorders. Specifically, when compared to people who experienced no adverse childhood events, people who experienced four events or more had a 4- to 12-fold increased risk for alcohol and drug problems, depression, and suicide attempts; a 2- to 4-fold increase in smoking, poor self-rated health; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity [17].

What to Do?

For every person stigmatized for having a substance use disorder, there are typically multiple family members impacted by this stigmatization. Stigma exacerbates the pain of one of the most painful experiences a family can have by adding shame, isolation, and stress, deterring people from getting help, as well as degrading the quality of help received.

Because of the cultural ubiquity of stigma, stigmatized views of addiction are often confused with truth about substance use disorders.

The widespread neglect of life-saving evidence-based treatments points directly to stigma. Much of what is called substance use disorder treatment in the United States is based on a moralizing, stigmatizing ideology of addiction that promotes false beliefs: that addiction is characterized by character defects, [39]; that families must step away and let their loved ones hit rock bottom, and that medications are just another escape from taking responsibility. These beliefs are not supported by empirical evidence. But the following is supported by evidence: what is commonly referred to as addiction is a multidetermined and variably severe disorder, medication-assisted treatment works and is lifesaving, and family members *can* help and do not need to step away. Yet a culture and treatment system that paint vast swaths of people and their problems with one brush and one color tend to resist the evidence for nuanced understanding and individualized care. As long as treatment professionals, legislators, and the media and colleagues, friends, and neighbors substitute stigma for understanding, we are failing people with substance problems and their families

So what to do? The dissemination of evidence-based ideas and strategies related to substance use disorders can play a significant role in unwinding stigmatized understandings and approaches. The more access and exposure people have to non-stigmatizing approaches, the less likely they will be to mistake the myths for real understanding of substance use disorders. Family members, national and state policy makers, health insurers, health care practitioners, the media, and individuals with substance use disorders all need better, evidence-based answers than they've been getting.

In the treatment world, we have evidence that can be part of this destigmatizing process for families, but even here, the battle is uphill. For instance, one of the most robust evidence-based approaches to family involvement is virtually unknown in the United States. The Community Reinforcement Approach and Family Training (CRAFT) approach is a behavioral and

motivational treatment for families [56] based on the empirically supported Community Reinforcement Approach (CRA), and has been developed and researched in randomized controlled trials. CRAFT has two goals: engaging the substance user in treatment through behavioral training *for the family members* and enhancing family-member self-care. A primary strategy of CRAFT is to create a relationship environment where abstinence/change behaviors are positively and incrementally reinforced. CRAFT enlists family members as powerful *collaborators* in effecting change without the use of detachment or confrontation.

In several clinical trials CRAFT engaged the substance user into treatment with rates of 74% Meyers et al. [37], 64% Miller, Meyers and Tonigan [40], 67% Meyers et al. [38], 64% Kirby et al. [25], and 71% Waldron et al. [62]. Families reported significant improvements in happiness and sense of family cohesion, as well as reduced anxiety, depression, and anger [53]. The individuals with SUDs significantly reduced substance use, regardless of whether they entered treatment.

The key here is collaboration instead of detachment. The CRAFT approach encourages families to remain engaged, seeing their loved ones as multi-faceted persons who happen to be struggling with substance abuse. CRAFT teaches families to reward positive change and to create respectful, empathic environments that invite change instead of demanding it. Families are considered sources of strength and understanding, and they are valued as key motivators of change. This is the antithesis of a judgmental, stigmatizing stance. By teaching family members functional and behavioral strategies rather than moralistic approaches, CRAFT effectively deconstructs stigma.

Utilizing platforms that go beyond formal treatment systems also offer hope. A recent, grassroots example is instructive. In collaboration with other nonprofit organizations, we have developed a nationwide training program for peer-to-peer dissemination of research-supported, clinically tested approaches at the community level (https://cmcffc.org/). A primary goal is to make concepts and practices from empirically supported treatments (ESTs) available to families outside the formal treatment system. This peer-to-peer coaching

model (in many ways a family “self-help” model) allows families to learn and share new perspectives and effective strategies otherwise unavailable to them.

The coaching program utilizes the Invitation to Change Approach, a composite of several ESTs for substance use problems, including CRAFT, Motivational Interviewing (MI), and Acceptance and Commitment Therapy (ACT), with a particular emphasis on self-empowerment [51], a sense of agency, self-control, and goal directedness [18, 27]. This national network of skilled, volunteer parent coaches providing free evidence-based support to other parents who have children with substance use disorders taps into the largest of all untapped resources for fighting the rising toll of substance use in this country: the families of people using. We are encouraged by the positive changes in family attitudes and practices to date, and we are testing the sustainability and scalability of this peer-to-peer network. We are hopeful that this and other nontreatment, family-based models will provide more keys to eliminating the stigma of substance use disorders.

References

1. Angermeyer MC, Matschinger H, Corrigan PW. Familiarity with mental illness and social distance from people with schizophrenia and major depression. Schizophr Res. 2004;69(2):175–82.
2. Barry C, McGinty EE, Pescosolido BA, et al. Stigma, discrimination, treatment effectiveness, and policy. 2004. https://doiorg/101176/appips201400140.
3. Beattie M. Codependent no more. Center City: Hazelden; 1992.
4. Burk JP, Sher KJ. Labeling the child of an alcoholic. J Studies Alcohol. 1990;51(2):156–63.
5. Carson AE. Prisoners in 2016 Washington, DC. US Dept of justice Bureau of Justice Statistics, NCJ251149, p 13. 2018. https://wwwbjsgov/indexcfm?.
6. Cermak TL. Diagnostic criteria for codependency. J Psychoactive Drugs. 1986;18(1):15–20.
7. Cooper AE, Corrigan PW, Watson AC. Mental illness stigma and care seeking. J Nerv Ment Dis. 2003;191:339–41.

8. Copello A, Templeton L, Powell J. Adult family members and carers of dependent drug users. London: UK Drug Policy Commission; 2009.
9. Corrigan P. Mental health stigma as social attribution. Clin Psych-Sci and Practice. 2000;7:48–67.
10. Corrigan P, Miller F. Shame, blame, and contamination. J of Mental Health. 2004;13(6):537–48.
11. Corrigan PW, River LP, Lundin RK, et al. Predictors of participation in campaigns against mental illness stigma. J Nerv Ment Dis. 1999;187(6):378–80.
12. Corrigan P, Watson A. The paradox of self-stigma and mental illness. Clin Psych-Science and Practice. 2002;9:35–53.
13. Corrigan P, Watson A, Miller F. Blame, shame, and contamination. J Fam Psych. 2006;20(2):239–46.
14. Daley DC, Raskin M. Relapse prevention and treatment effectiveness studies. In: Daley D, Raskin M, editors. Treating the chemically dependent and their families. Newbury Park, CA: Sage; 1991. p. 128–71.
15. Dawson DA, Grant BF. Family history of alcoholism and gender. J Stud Alc. 1998;59:97–106.
16. Eaton K, Ohan J, Stritzke W, et al. Failing to meet the good parent ideal. J Child Fam Stud. 2016;25(10):3109–23.
17. Felitti V, Anda R, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. Amer J Prev Med. 1998;14(4):245–58.
18. Foote J, Wilkens C, Kosanke N, Higgs S. Beyond addiction. New York: Scribner; 2014.
19. Francis A. Stigma in an era of medicalisation and anxious parenting. Soc of Health & Illness. 2012;34(6):927.
20. Gerson R, Davidson L, Booty A, et al. Families' experience with seeking treatment for recent-onset psychosis. Psychiatr Serv. 2009;60(6):812–6.
21. Girma E, Moller-Leimkuhler AM, Muller N, et al. Public stigma against family members of people with mental illness. BMC Int Health & Human Rights. 2014;14:2.
22. Goffman E. Stigma. New York: Simon & Schuster; 1963.
23. Haskell R, Graham K, Bernards S, et al. Service user and family member perspectives on services for mental health, substance use/addiction, and violence. Int J Mental Health. 2016;10:9.
24. Johnson V. Intervention. Minneapolis: Johnson Institute Books; 1986.

25. Kirby KC, Marlowe DB, Festinger DS, et al. Community reinforcement training for family and significant others of drug abusers. Drug Alcohol Depend. 1999;56:85–96.
26. Kulik C, Bainbridge J, Cregan C. Known by the Company we Keep: Stigma-by-Association Effects in the Workplace. Acad Manag Rev. 2008;33(1):216–30.
27. Larson J, Corrigan P. The stigma of families with mental illness. Academic Psych. 2008;32(2):87–91.
28. Laslett AM, Mugavin J, Jiang H, et al. The hidden harm: Alcohol’s impact on children and families. Canberra: Foundation for Alcohol Research and Education; 2015.
29. Lefley H. Family burden and family stigma in major mental illness. Am Psychol. 1989;44(3):556–60.
30. Ligon J. Families and significant other. NAADAC News. 2005;15(4):8.
31. Lipari RN, Van Horn S. Children living with parents who have a substance use disorder. The CBHSQ Report: August 24, 2017. Center for Behavioral Health Statistics and Quality. Rockville: Substance Abuse and Mental Health Services Administration; 2017.
32. Link BG, Phelan JC. Conceptualizing stigma. Annual Rev Soc. 2001;27:363–85.
33. Marlowe D, Merikle E, Kirby K, et al. Multidimensional assessment of perceived treatment-entry pressures among substance abusers. Psych Addict Behav. 2001;15(2):97–108.
34. McCann TV, Lubman D. Stigma experience of families supporting an adult member with substance misuse. Int J Mental Health. 2018;27:693–701.
35. McCann TV, Lubman D, Boardman G, Flood M. Affected family members’ experience of, and coping with, aggression and violence within the context of problematic substance use. BioMed Central J Psychiatry. 2017;17:209.
36. Meyers R, Wolfe B. Get your loved one sober. Center City, MN: Hazelden; 2004.
37. Meyers R, Miller W, Hill D, Tonigan S. Community reinforcement and family training (CRAFT). J Sub Ab. 1999;10:291–308.
38. Meyers R, Miller W, Smith J, Tonigan S. A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. J Consult Clinical Psych. 2002;70:1182–5.
39. Miller W. Alcoholism Psych Addict Behav. 1993;7(2):129–36.

40. Miller W, Meyers RJ, Tonigan S. Engaging the unmotivated in treatment for alcohol problems. J Consult Clinical Psych. 1999;67:688–97.
41. Moyers TB, Miller WR. Therapists' conceptualizations of alcoholism. Psych Addict Behav. 1993;7:238–45.
42. Mwinituo PP, Mills JE. Stigma associated with Ghanaian caregivers of AIDS patients. Western J Nursing Research. 2006;28(4):369–82.
43. CASAColumbia. Behind bars II. Center on addiction and substance abuse (CASA). 2010. https://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america%E2%80%99s-prison-population. Accessed 19 Jul 2018.
44. Norwood R. Women who love too much. New York: Pocket; 1990.
45. Orford J, Velleman R, Copello A, et al. The experiences of affected family members: a summary of two decades of qualitative research. Drugs. 2010a;17(sup1):44–62.
46. Orford J, Copello A, Velleman R, Templeton L. Family members affected by a close relative's addiction. Drugs. 2010b;17(sup1):36–43.
47. Orford J, Velleman R, Natera G, et al. Addiction in the family is a major but neglected contributor to the global burden of adult ill-health. Soc Sci Med. 2013;78:70–7.
48. Park S, Park KS. Family stigma. Asian Nurs Res. 2014;8(2014):165–71.
49. Peleg-Oren N, Teichman M. Young children of parents with substance use disorders (SUD). J Soc Work Pract Addict. 2006;6(1–2):49–61.
50. Reid J, Macchetto P, Foster S. No safe haven. New York: National Center on Addiction and Substance Abuse at Columbia University; 1999.
51. Rogers S, Chamberlin J, Ellison M, Crean T. A Consumer-constructed Scale to Measure Empowerment among Users of Mental Health Services. Psych Services. 1997;48:1042–7.
52. Romijn C, Platt J, Schippers G, Schaap C. Family therapy for Dutch drug users: the relationship between family functioning and stress. Int J Addict. 1992;27:1–14.
53. Roozen HG, De Waart R, Van Der Kroft P. Community reinforcement and family training: an effective option to engage treatment-resistant substance-abusing individuals in treatment. Addiction. 2010;105(10):1729–38.

54. Rüsch N, Angermeyer MC, Corrigan PW. Mental illness stigma. European Psych. 2005;20(8):529–39.
55. Singleton N. Attitudes to drug dependence. London: Drug policy commission; 2010.
56. Smith J, Meyers R. Motivating substance abusers to enter treatment: working with family members: Guilford Press; 2004.
57. Song H, Shin H, Kim Y. Perceived stigma of alcohol dependency: comparative influences on patients and family members. J Subst Use. 2015;20(3):115–61.
58. Struening EL, Perlick DA, Link BG, et al. Stigma as a barrier to recovery. Psychiatr Serv. 2001;52(12):1633–8.
59. Substance Abuse and Mental Health Services Administration (SAMHSA). 2014. https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf.
60. Wahl OF. Mental health consumers’ experience of stigma. Schizophr Bull. 1999;25(3):467.
61. Wahl OF, Harman CR. Family views of stigma. Schizophr Bull. 1989;15(1):131.
62. Waldron B, Kern-Jones K, Turner W, et al. Engaging resistant adolescents in drug abuse treatment. J Sub Abuse Treat. 2007;32:133–42.
63. Walker LO, Avant KC. Strategies for theory construction in nursing. 4th ed. Upper Saddle River: Pearson; 2005.
64. Werner P, Mittelman M, Goldstein D, Heinik J. Family stigma and caregiver burden in Alzheimer’s Disease. The Gerontologist. 2012;52(1):89–97.
65. World Health Organization (WHO). Global status report on alcohol and health. 2014. http://apps.who.int/iris/bitstream/handle/10665/112736/9789240692763_eng.pdf;jsessionid=B860C72DA9FF6463A0AF4AE2C60D7128?sequence=1.