Associative stigma and other harms in a sample of families of heavy drinkers in Lithuania

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Abbreviated title: Associative stigma and other harms for families

Journal of Substance Use (Accepted August 17, 2016)

Introduction

An introduction to the Lithuanian context and harms to families from heavy drinking

In 2010 Lithuania had nearly the world’s highest rates of alcohol use and related deaths (World Health Organization, 2014). Lithuania, like other Baltic states and Eastern Europe, has a history of heavy drinking and a culture which tolerates drinking to intoxication (Popova et al., 2007). On average 14.9 litres of pure alcohol was consumed for every resident aged 15 or older in 2014 in Lithuania (Statistikos, 2014). Almost one third (30.9%) of deaths in Lithuania were alcohol-attributable. Problem alcohol drinking was identified in 48.3% of men and 16.2% of women (Kalasauskas et al., 2012), and harmful use of alcohol (drinking till drunkenness) was self-identified by 13.5% of women, and 25.7% of men (Tamutiene, 2014). Such alcohol use is also harmful to the people drinkers know and interact with. For instance, this is confirmed by official data on domestic violence. No less than 75% of perpetrators were intoxicated when they committed domestic violence. No less than 75% of perpetrators were intoxicated when they committed domestic violence in Lithuania in 2014 (Informatikos, 2015).

Quantitative research conducted in other countries has similarly shown that the heavy drinker’s family members commonly experience harm. In Northern European countries alcohol-related problems because of a range of people, including family members’, were reported by one in four to one in two respondents (Ramstedt et al., 2015). Seventeen per cent of Australians reported being affected by the drinking of a family member in the past year (2010). In New Zealand, respondents with heavy drinkers in their lives experienced reduced personal wellbeing and poorer health status because of these drinkers (Casswell et al., 2011). In Finland there is a substantial body of work on the effects of heavy drinking family members on spouses and children, detailing additional harms, including hospitalisations, poorer mental health and removal of children (Holmila, 1987; Holmila, 1994; Holmila, 1997; Holmila et al., 2011; Raitasalo, 2011; Raitasalo et al., 2015). Harm from heavy drinking family members, including intimate partner violence is near universal, also being common in the Americas and around the world (Cahalan, 1970; Graham et al., 2008).

Qualitative analyses by Orford et al. (2005) describe how people in different cultures (commonly from studies of people in contact with the treatment system) show similarities in their core experiences, revealing stress, strain, coping and support among members of problematic drinkers’ families. Cultural differences are also apparent. For example, threats to individual autonomy were revealed more in England, gender inequalities and poverty were highlighted in Mexico City, and the public nature of excessive drinking and associated violence was noted in an Aboriginal Australian community (Orford et al., 2005). More recently in Australia, Manton et al.(2014) reported that the

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nature of harm experienced by children and families in the general population was similar to that identified previously by Orford and others in treatment systems (2005), including physical abuse, verbal abuse, emotional abuse (including emotional neglect), threat of physical abuse, fear of physical harm, sleep disruption, witnessing of conflict (fights, physical abuse, verbal abuse), witnessing of drinking and inappropriate behaviour, as well as fear of health risks their parents were taking. They noted that although a number of children were doing well, others were, for example, scared and needed to sleep with their mother, or experienced longer term behavioural effects, including behavioural problems, shame and embarrassment and schooling instability (Laslett et al., 2015). Intimate partners of men who drank heavily reported physical, verbal and emotional abuse, financial insecurity, stalking, and damage of their property, as well as the drinker controlling whom they contact and monitoring and derision of what they do (Laslett et al., 2015). The impacts on the children’s families of the harm from others’ drinking resulted in police interventions to protect partners and children, as well as loss of custody, breakdown of parents’ relationships, issues of access to children after separation, and financial insecurity. The quality of relationship with children was affected, and there was difficulty with separation if the drinker was an adult son rather than a partner (Laslett et al., 2015).

Additionally, ‘associative’ stigma isolated family members and prevented them from bringing home friends or attending social occasions because of shame and embarrassment (Park & Park, 2014). Goffman defined stigma as “undesirable, ‘deeply discrediting’ attributes that ‘disqualify one from full social acceptance’ and motivate efforts by the stigmatized individual to hide their mark whenever possible” (Goffman 1963). The process by which a person is stigmatized by virtue of association with another stigmatized individual has been referred to as ‘courtesy’ (Goffman, 1963) or ‘associative’ stigma (Mehta & Farina, 1988)”. Associative stigma is directed by others (including the drinker, others, society and the affected family member themselves) away from the drinker and towards the family member. This may also occur when governments perceive family drinking problems as “personal matters” (Valstybinio, 2015).

Despite an increasing literature on harm to others, there is limited research on alcohol’s harm to others in the Baltic States and a need for greater in depth analysis of what alcohol’s harm to others means in different settings, including for those outside the treatment system. Members of Al-Anon potentially comprise an accessible sample –beyond family members in formal treatment yet involved in peer support – and have been studied in the 1960s and 1970s (Ablon, 1979), as well as more recently (Zajdow, 2002). Al-Anon is a mutual-help organisation for family members and friends of alcoholics which uses a program of recovery adapted from Alcoholics Anonymous (AA), though it is a separate organisation from AA (Humphreys, 2003). While these groups may provide perspectives of families in severe or crisis situations, there is still much to be learned from these families about the types of problems they face and how they cope.

Neither quantitative nor qualitative studies of alcohol’s harm to others have been undertaken in Lithuania, and this area of research has been largely under-researched in low and middle income countries. Drawing on the range and magnitude of alcohol’s harm to others studies (Laslett et al., 2010, Room et al., 2010) and the qualitative analyses of Manton et al. (2014), this study examines alcohol’s harm to families in a Lithuanian sample of heavy drinkers. The main aim of this study is to use qualitative interviews in order to contextualize and identify the harms families experience when they include a heavy drinker. Heavy drinkers were defined by the interviewees as “alcohol abusers” or “alcoholics”. In this paper the authors have used the term heavy drinker throughout, although the terminology of the interviewees has been retained in quotes.
**Research methodology**

This qualitative study employed a grounded theory method (Glaser and Strauss, 2009), which necessitates developing, refining, revising, and synthesising new understandings of previous studies and the interviewees’ experiences (Charmaz, 1990). Accordingly, this study was informed by the analytical framework of Room and colleagues (2010) on alcohol’s harm to others which identified the relationships and roles likely to be affected by a heavy drinker, including the spouses and partners of the heavy drinker, colleagues, friends, and society.

**Data collection procedures and tools (sampling, collecting and analysing data)**

Qualitative semi-structured individual interviews were used to understand the experiences of interviewees, including their perceptions of harm, feelings and communication with the drinker. The qualitative data was collected by the first author in May and June of 2013, and in July of 2014. Al-Anon group members (all women) and AA members were the primary informants and were the links by which other informants were reached via snowballing. Participants were purposively sought via Al-Anon and secondary contacts in order to include respondents who were: still living with, divorced, and separated from the problem drinker; living with and without children; and who were reported to be actively and passively coping. Keeping in mind that self-stories can be changed and re-conceptualized within the context of the Al-Anon group (Zajdow, 2002), respondents were asked whether they had experience of self-help group practices and more than half of the informants were selected to ensure they did not have any experience of self-help groups. One man was reached through AA, because his wife was attending AA meetings. The three other men were secondary contacts identified through the snowballing process. Six men were approached who were divorced and/or living in new families but were not willing to talk about their past experience. An additional five men were not retained in this sample, because during the interviews they were found to also be heavy drinkers. Only informants who identified themselves as current or ex intimate partners of heavy drinkers were retained in this sample.

The interview tool focussed on the harm experienced by interviewees related to their partner’s or ex-partner’s drinking. The primary research questions were about direct harms from the heavy drinker experienced in the family setting, and the ways in which the interviewees coped. The interview began with demographic and general questions and then asked: What does it mean to be a spouse or partner of a heavy drinker? What core feelings arise being the heavy drinker’s spouse or partner? What direct harms have you experienced from this drinker? How do you cope with these problems? How has being the spouse or partner of a heavy drinker and experiencing direct harm affected your family life and your relationships with other relatives, friends etc.?

Textual analysis, coding and continued sampling were iterative and developed as part of the research process by the first author. After each interview audio data were transcribed into Word, reflected upon, and coded into main categories and subcategories. During the first research stage in 2013, 14 interviews were collected and core categories were extracted. The research questions were reflexive and flowed from the interviewees’ experiences of alcohol’s harm in their families and related to the physical, social and environmental harms caused by the drinker. The themes that emerged e.g., that spouses and partners took or refused responsibility for their drinking partners, as has been described as ‘courtesy’ (Goffman, 1963) or ‘associative’ stigma (Mehta & Farina, 1988), were probed more deeply in the second round of interviews. Thus, information was gathered in a further 10 interviews in 2014 via theoretical purposive sampling and reflective interviewing (Flick, 2009, Charmaz, 1990). Emergent themes were integrated into emerging theories. Sampling was finished when theoretical saturation of emergent themes had been reached and pragmatically due to financial and time constraints.
Settings which allowed private conversation were used to conduct interview sessions and included a room at the university, interviewees’ private homes, and Al-Anon meeting places in a small regional city of Lithuania. The interviewing and coding was done in Lithuanian, and only the quotes were translated into English. The average interview time was 1 hour and 35 minutes.

**Interviewees:** In total, 24 individual semi-structured qualitative interviews with heavy drinkers’ partners and ex-partners born and living in Lithuania were conducted. Twenty interviews were conducted with females who had or currently lived with male heavy drinkers and four with men who had or currently lived with female heavy drinkers. The youngest interviewee was 23 years old, the oldest was 62. They had completed either basic or university education. Five women had 15 to 25 years of experience living with a male heavy drinker; others had one to five years of experience. Twelve females still lived with a heavy drinker, six females were divorced, and four of them had formed new families, two still lived without partners. Ex-partners of the heavy drinkers were divorced or separated one up to eight years. Five females had adult children, the rest of the interviewees had from one to five children aged under 18 years living at home. Two females were unemployed, the rest of the interviewees were employed. Four women were actively engaged in Alcoholics Anonymous, and five in Al-Anon groups. While the initial contacts were from Al Anon, the majority of the interviewees were not in formal counselling or peer support organisations.

**Ethics:** All participants were informed about the research aims and their rights, and their consent was given voluntarily. Participants could withdraw from the interview at any time – one woman did so as the interview broached a traumatic incident. The ethical principles of autonomy, beneficence, and justice were ensured. The personal information of all respondents has been removed in order to ensure anonymity and confidentiality. The study protocol was approved by the Lithuanian Council of Science and the European Social Fund (VP1-3.1-SMM-07-K).

**Results**

**Direct harm from the drinker**

Speaking with the spouses and partners of the heavy drinkers, harms to others affected not only the interviewees themselves but also children, mothers, sisters, brothers, uncles, aunts, grandparents and others. Members of the heavy drinker’s family suffered various kinds of violence and abuse. Most commonly this was emotional abuse, but in a two-thirds of interviewees the violence was physical and financial or a combination of several types. The experiences of the female informants demonstrated that inebriety was a significant risk factor for experiencing violence:

‘I was hurt and beaten by men. They would just get drunk and that’s it, they didn’t attack me sober’ (Female, age 32).

All the participants of the qualitative research, without exception, experienced disrespect, humiliation, contempt and other instances of emotional abuse. All of them suffered physical violence, which ranged from a shove to serious injuries; third of the participants revealed that they experienced sexual violence. All of them without exception confirmed that there were episodes when the heavy drinker was intoxicated and the respondent had to take care of all family matters, and often of the drinker himself (after particularly heavy drinking):

From the informants’ perspective, the greatest harm in the situation of the drinker’s harm to the family was experienced by the children. The mothers who participated in the research observed how the drinker had injured the children. For example, one child was beaten because he poured out alcohol. Another child was hurt in response to crying:

‘the little one was injured because of his crying’ (Female, age 43).
In other situations, children were indirectly affected when they witnessed harm inflicted upon others. Some of the mothers described how the drinker harmed them and their unborn children even before their babies were born:

‘When I was 8 months pregnant, he punched me in the stomach’ (Female, age 48).

Alcohol’s harm in the family may influence every important aspect of family functioning. Direct harm is but one aspect of the totality of alcohol’s harm to family members.

**Associative stigma and isolation**

Our findings show that associative stigma and isolation are common to all of these women -- because of the family member's drinking. On the one hand, women suffer shame because their family members drink. On the other hand, they feel society's pressure to change the situation, and, when they fail, they feel disappointment. In this context, social isolation is the woman's (and the family's) coping strategy; chosen in order to minimize emotional pain and shame. The situation is illustrated by this typical experience:

‘I was ashamed about the divorce, because what will people say? Now, when I'm looking back from a distance, overall I had a project, when I married, to save my husband and I failed. ... And 10 years passed, I failed, but I couldn't admit on the outside that I failed, that I caved in. I didn’t even get divorced because of this. ... It's better that nobody visits me, nobody sees and knows, and I'll live isolated like this’ (Female, age 51).

The family's responsibility for the drinker's behaviour is followed by isolation, because neither the relatives nor the employers want to be involved, especially when the drinker, who is unable to take care of himself, has to be handled, or when they are confronted with the harm the drinker causes. This is illustrated by the following experience:

‘His colleague calls me and asks me to come and do something, because he is lying down drunk in the workshop. I was already going to the support group. So I said, if he is uncomfortable, and they drank together, then he should take care of him. You can't even imagine the pressure I had to go through from his colleagues and relatives, even my closest brothers, who seemed to understand, blamed me in this situation’ (Female, age 55).

These experiences of women living with heavy drinking husbands revealed that social isolation was exacerbated though continuous and repeated incidents:

‘This isolation is also because you comfort yourself once, twice, six times, 106 times, and you realize, how much longer can you cry about the same thing?’ (Female, age 55).

There are indications that men living with heavy drinking women experience the same feelings of shame, pain, frustration and worry, and have to take on all of the family responsibilities when their spouse or partner is drinking:

‘Being at work I was worried about the safety of our child. Many times I found her drunk with my son in the park, and I had to take care of them both. I felt shame, pain and pitted myself being married to an alcoholic woman’ (Male, age 41).

Our research underlines that associative stigma can be reinforced by assumed or redirected responsibility for the drinker’s behaviour.
Assumed or redirected responsibility, associative stigma and release

Assumed or re-directed responsibility and associative stigma emerged as themes in the interviews in a gender specific context. It is true that men living with heavy drinking women took on the responsibilities of the family duties when their wives and partners were drinking. But the societal attitudes to this situation seem different to when the partners of heavy drinkers are women. It seems men more often experienced pressure from relatives, friends and general society to divorce their heavy drinker wives and find other women who would take on the traditional wife and mother roles:

‘People have said openly that I am stupid enough to live with an alcoholic. They said that I’m a good man and I can find another woman who will love me and take care of my children’ (Male, age 32).

Women whose husbands drank heavily expressed opinions consistent with publicly espoused attitudes that in Lithuania the woman is responsible for the man, including his drinking habits. Interviewees reported that even before marriage they had seen their men drinking too much and too often, but they believed in romantic love, for example saying that:

‘if he loves me, he won't drink’ or ‘my love for him is too great, he will understand and won't drink’, ‘he'll stop drinking when the children are born’ etc.

This assumed responsibility (assigned by society and cultural pressure) for being able to moderate their partner’s drinking increased the perceived guilt, tension, shame and pain. This is confirmed by a typical experience of an informant:

‘It was very painful to admit that the person I love drinks. From the mother-in-law's side, I'd heard 'she doesn't handle the husband'. Well she did give me a good one, but others handle theirs, whereas you can't control yours... This attitude creates [the attitude] inside you that you are responsible and must control him, take care of him, follow, check, and make a person out of him. And then, when you fail, you end up being a victim. You try to save him, follow him, work as a detective, and when it all finally collapses you become helpless, a complete victim with inner pain and a wound’ (Female, age 55).

Every interviewee who had indicated that they had a heavy drinking family member also pointed out that when the family member drank, they had to take care of all family matters. This involved not only simple care of the children, housework and other practical things, but additional specific tasks such as managing the place of the drinking, cleaning up after broken windows and furniture, etc. This harm involved substantial time and cost, along with the worry about their own and their children's safety, and, quite often, the drinker's:

‘when he came back drunk and threatened, I had to run away from home together with the children’ (Female, age 43).

‘I had to chase him and his friends away from home numerous times so that he would stop drinking’ (Female, age 32).

‘so many times he'd returned beaten and bloody, I even had to call the paramedics’ (Female, age 51).

The drinker's family members were burdened not only by the burden of practical work and the care of the drinker, but also by the financial weight of the drinker's financial abuse and the poverty:

‘we sank into debt, we ran up debt for the apartment, no car, no anything’ (Female, age 43).
According to the interviewees, especially those older than 30, the woman assumes the main responsibility for managing the household budget, as he ‘brings money home and gives it to the woman’, who controls it (this norm was generally common in Lithuania). The typical experience of this woman shows that she tried to control the family's income by buying a large amount of food, because the rest of the money ‘was simply taken nicely or by force by the man, when he needed to drink’. Unemployment of the heavy drinker, which was quite frequent, also contributed to the financial difficulties.

Some of the women who participated in the qualitative research revealed that they had sought help from a range of public institutions. All of these interviewees reported positive features, although over half mentioned negative experiences, especially regarding the police. The range of supports and service responses available and their effectiveness should be researched further. For instance, in Lithuania, the police can act to separate violently abusive drinkers from the family for two days. However, informants reported that ‘nothing changes because of this arrest, he comes back and it gets even worse’. Another woman reported that when the police arrived, they only moralized and asked her whether she was going to submit a statement about the domestic violence. A third female informant claimed that the police officers who came accused her of not being able to handle the drunk husband:

‘why are you picking on him, if the husband is drunk, everyone drinks, then don't provoke him and you won’t have to call the police’ (Female, age 28).

In this gendered Lithuanian traditional culture the man’s drinking is normalised, even to the point where the man cannot fulfil the responsibilities of the typical masculine role because of it. The woman, meanwhile, has responsibility for ‘the family image’. This social norm implies that she ‘has to handle the man’, ‘make a person out of him’ and makes plain the societal condemnation of the heavy drinker and their wives, who are ‘unable’ to change their husbands.

The Lithuanian government is reluctant to acknowledge and address the harm caused by drinkers within the family, viewing this as a personal matter. This reinforces the notion that the responsibility is that of the family and compounds the associative stigma. The direct harm from the drinker and the associative stigma from redirected responsibility for the drinker’s behaviour promote drinker-centred coping strategies. Having a person who understands the problem, and guides the family member to relevant services (helpline, court etc.) is a crucial point in releasing the family member from the redirected responsibilities:

‘My colleague at work helped me to realize that I have my own needs. I live with him now. He is such a good man’ (Female, age 28).

‘My social worker helped me to exit an unhealthy relationship, I learnt to meet my children's and my own needs’ (Female, age 41).

‘I met very understanding women’ (Male, age 35).

**Drinker-centred coping strategies vs recognizing and realizing one’s own needs**

The majority of interviewees reported that they tried to cater to the whims of the drinker for the sake of peace. Adult family members tried various strategies to evade harm: from passive avoidance (trying not to provoke), motivating the drinker to treat their addiction, to physical violence against the drinker:

‘I tried nicely, I also beat him, just to make him stop drinking, but nothing helped’ (Female, age 23).
Others became involved in the drinking themselves:

‘I used to do all kinds of things, I also drank, just so he would have less, and I vomited. I got lost in the drinking for a while, to avoid pain and to relieve it... ’ (Female, age 51).

The heavy drinker’s family members, especially the spouses/partners, became so involved in solving the drinker’s problems and in avoiding potential harm that they overlooked their own needs. This situation is illustrated by the following quote:

‘I was pregnant with my second child. I spent all day making every effort, gathering the alcoholics, buying vodka, just to ensure that he wouldn’t go and hang himself. What would I tell his mother? How would I be? I couldn’t live. All day I put in a lot of effort. I don’t remember where my daughter was, definitely not with me. ... After that incident, the [foetal] movement disappeared, after a celebration, a couple of days later I went to the doctor and told him passingly that there was less movement, he quickly checked me with ultrasound, eyes all scared, I have to go to the local city hospital promptly. But I don’t want to go. I can’t leave him, not the children, I can’t leave my husband’ (Female, age 51).

As can be seen in this quote, the mother’s care for her husband and the fear that he would commit suicide and about what she would tell her mother-in-law is so deep, that she is unable to think about her own needs, about the unborn child, and she completely neglects her daughter, as did her partner. The most common of these strategies is the suppression of noise from the children, which shifts the responsibility to them for the father’s reactions, because his anger may be provoked:

‘kids, father has returned, everyone go to sleep, everyone be quiet, because [otherwise] discipline will begin...’ (Female, age 51).

These coping strategies are drinker-centred, characterised by neglect of the children’s and other family members’ needs, and their constant tension and worry. This context by itself is harmful to the child, and the damage is increased by explosions of uncontrolled negative emotions of the spouse:

‘It’s common to swallow an insult, neglecting yourself, a humiliation, just to ignore it, not to argue or say that I dislike this behaviour, or that I’m offended. ...And it [my temper] then explodes at the smallest child, because you can’t really shout in public. I exploded at the children and to this day it’s hard for me to deal with it’ (Female, age 48).

This honest reflection by an informant reveals not only the cumulative aspect of the harm, but also the synergic effect of the harm on the child from the father and the mother in the family (because the child, like the mother, suffers direct harm from the father, and also suffers harm inflicted by the mother due to the stress she is under). Two other examples describe further ripple effects on family members’ decisions:

‘the older one dropped out of school and got a job to contribute to the family’s budget’ (Female, age 51).

‘the older one started dealing drugs, because he saw the critical situation of the family, he felt responsible for the younger brother and sister’ (Female, age 55).

These excerpts show early assumption of familial responsibility and hint that the children not only suffer direct harm and are drawn into the parents’ coping and harm evasion strategies, but also are themselves reacting to the harm and looking for their own ways to deal with these situations.
Interviewees engaged in Al-Anon groups reported self-help as one of the major coping strategies which helped them to reconstruct their lives, and to recognize and realize one’s own needs:

‘I feel very strongly supported by the others members of our group, especially when I feel down during the periods of my husband’s heavy drinking’ (Female, age 47).

Our findings reveal that not all interviewees who were ex-partners of the drinker had assumed either responsibility for, or taken on the responsibilities of, the drinker (redirected responsibility) and instead developed a withdrawal strategy, divorcing the partner, and/or recognizing their own needs and the limits of their responsibility and made changes to their relationship. A woman with two children shared her experience on how she decided to divorce:

‘I tried really hard to take care of the family, tried to influence him to stop drinking. The crucial turning point in my decision to divorce him was the realization that I don’t want be a wife of an alcoholic, that I’m not like myself with daily negative feelings, that my children need me positive and optimistic, and healthy. I was already convinced that I can’t change my husband, that it is his responsibility. I had divorced him and therefore do not regret’ (Female, age 47).

Of course, removing oneself from the situation means that the family composition changes and there are additional redirected responsibilities, but the partner in this situation re-exerts control over his or her own situation. However, children have no such choice, and other evidence suggests that women leaving relationships are particularly vulnerable to intimate partner violence and may need additional protection and support at this time. For the interviewees very important was informal support:

‘When he injured me, I realized that this will continue. I was afraid. My self-esteem and my body was hurt. I didn’t want children to see such a situation. My mother and my sister helped a lot. I came back to my mother’s home with my children. Security was more important to me than what others said. I was surprised that there were more people who helped than condemned me’ (Female, age 46).

One ex-partner man and two ex-partner women reflected the role of informal supporters who helped them through a difficult period of life, encouraging them to divorce, and giving temporary shelter. For some of them the former life seems like a bad nightmare:

‘My friend supported me, gave me shelter. Her help was so valuable, because I was so sad and angry, and even had the thought to kill her (drinker) or myself. I remarried. The life with my ex-wife I remember like a bad nightmare now’ (Male, age 36).

Recognizing and taking responsibility for realizing one’s own needs and the needs of children, as well as resistance to the assignation of redirected responsibility for the drinker’s behaviour and ‘family image’, along with the informal support from others, were the major factors which allowed informants not to be entrapped in drinker-centred coping strategies. The experiences of the complex harms due to the heavy drinking marked all interviewees’ biographies. The harm done by an intimate partner’s heavy drinking are long lasting.

**Discussion**

While the group varied in age, educational level, employment status and family composition, the majority were employed, middle aged women born and living in Lithuania who were not engaged in formal treatment (although nine were involved in Al-anon and AA). The way individuals
experience and respond to heavy drinking situations within families may vary by gender and in different cultural groups and by a range of other factors including the level and types of support available. Yet, despite differences in cultural backgrounds the numerous years of living with a heavy drinker meant that the majority were affected, often substantially.

A number of themes emerged in the qualitative interviews with the spouses and ex-partners of heavy drinkers. Heavy drinkers directly harmed others in the family unit (more deeply when they were still living in the family, but also if they were no longer together). Drinker-centred coping strategies adopted by the interviewees often unintentionally meant children’s (and other adults’ needs) were disregarded or de-prioritised. The interviewees had no choice but to take on the responsibilities the heavy drinker was incapable of when intoxicated. Additionally, a number of spouses felt pressured to assume responsibility for their spouse’s drinking and/or their behaviours while drinking. It seems that traditional gender roles pressure women to take on the responsibility of their spouse’s or partner’s behaviour. Holmila describes a similar phenomenon of assumption of “over-responsibility” for problem drinkers by intimate partners in Finland (Holmila, 1994). Interviewees in Lithuania felt not only shame but also experienced a sense of responsibility for the situation they found themselves in and could not control. This resulted in greater isolation and associative stigma. However, other spouses rejected this "responsibility" and employed strategies to regain autonomy and control. Withdrawal from drinker-centred strategies were employed and resulted in resolution for a few, albeit with exacerbation of concerns (particularly when they were leaving the relationship). These categories of harm are interrelated. Family members suffer direct harm (ranging from passive harm when the drinker does not perform their duties to severe violence) in private, and experience associative stigma and isolation in public.

Our modest findings about the experiences of men living with heavy drinking women, show that they experience similar feelings and take on the majority of the family responsibilities for when their female partners are drinking. Orford et al (2005) noted that husbands of drinkers’ also experience signs of strain, threats to home and family, worry about their relatives, and a range of stresses. However, Orford (2005) also described previous studies which found ‘husbands of women with drinking problems, when they had been noticed at all, had been described in very unsympathetic terms, being stereotyped as men who left their wives at the earliest opportunity (p.187)’. Our findings indicate that deeper study should be undertaken in this area, because it seems that both traditional and changing gender roles may be in play in Lithuania, with men taking on caring roles yet still more likely to be pressured and encouraged (than women) to ‘to find another woman who will love and take care of them’.

It seems family members of heavy drinkers in Lithuania experience similar harms to family members in other countries (Orford et al. 2005; Arcidiacono et al., 2009). Stark (2007) underlines that the violence paradigm provides an incomplete description, and that coercive control where women are entrapped in relationships has a more profound negative impact on women than the violence itself. Our qualitative findings support Pescosolido et al.’s (2010) theory that stigma is embedded in the social and cultural norms, including prejudicial attitudes, that discredit individuals, marking them as tainted and devalued. On a societal level, stigma becomes attached to these families. Corrigan et al.’s (2005) research with adolescents about the stigma of mental illness and alcohol abuse support the notion that stigma may be passed on from stigmatized people to members of their social network. Much research has shown that the drinker experiences stigma (Room, 2005; Schomeres et al., 2011a; Schomeres et al., 2011b; Luoma et al., 2007; Schomerus et al., 2014). But associative stigma research, meanwhile, is just beginning. Research conducted in South Korea revealed that the overall level of stigma perceived by family members was significantly higher than that of their ill relatives (Song et al., 2015). The qualitative research presented in this article
provides evidence of this associative stigma and isolation of family members and should be researched further.

Our findings fit into the conceptual model of family stigma presented by Park & Park (2014), and provides the cultural context in the case of the family of a heavy alcohol user in Lithuania. Societal norms in Lithuania redirect the responsibility for family functioning, including a spouse’s behaviour within the family, to women. Assumed responsibility for drinker behaviour reinforces drinker-centred coping strategies and disregards the woman’s needs, as well as her children’s. Rejection of this assumed or redirected responsibility for the drinker's behaviour, often by separating or divorcing the man, was a strategy that enabled the woman to attend better to her own and the children’s needs. To have a confidant who does not judge but understands and supports is crucial for the release of redirected responsibility and realization of the woman’s and her children’s needs. Brief intervention coping strategies such as those developed by Velleman et al. (2006) should be evaluated for use in Lithuania and may be useful for people affected in these situations. We are in agreement with Holmila et al. (2011), who conclude that children's ways of coping can differ from those of adults and need further exploration and support.

Family members of people who drink heavily in Lithuania suffer from fundamentally similar harms to those in other countries. As Barnard (2007) in the UK found, this study’s qualitative findings revealed that direct harm from heavy drinkers to family members is only one (severe) piece of the totality of alcohol’s harm to family members. Contextualizing the harm experienced in these families, it is argued here that alcohol’s harm to others extends beyond the direct harms reported within the family unit.

New understandings about alcohol’s harm to others arise from these qualitative findings. The flexibility of the qualitative methodology, including the grounded theory approach, allowed the researcher to go beyond the direct harm from the drinker to explore an array of additional associated harms in public and private settings, including new and unanticipated themes e.g. assumed responsibility, covering for the drinker and associative stigma. A picture of complex harm to the drinker’s family development emerged. The diverse experiences of direct violence, family reactions to violence, assumed and redirected responsibility for another family member’s drinking, associative stigma and isolation, in the context of cumulative harm, create a synergistic effect -- a larger extent of harm -- which diminishes satisfaction of other family members’ needs, their personal development, quality of life, and capability building.

Grounded theory based qualitative findings add to the alcohol’s harm to others field by contextualising the experience of alcohol’s harm to others and by making clear the multiplicative (or synergetic) harm to the drinker’s family. Direct violence, family reactions to this violence, responsibility for making up for another family member’s drinking, stigma and isolation are cumulative. This expanded concept of harm to others subjugates other family members’ needs, their personal development, quality of life, and their capacity. There are substantial follow-on effects for families and support services.

Limitations: The sample was limited only to the spouses and intimate partners of heavy drinkers. Nine interviewees from twenty four were connected to Al-Anon or AA, and their views could be influenced by the material on AA and Al-Anon ideology. Finding men who identified themselves as ex or current intimate partners of heavy drinkers was difficult. In Lithuania Al-Anon is not viewed
traditionally (as a treatment option) for men, and many men approached were reluctant to talk about their past experiences. The qualitative data represents more a feminist perspective and the views of wives, female partners or mothers, because of the small number of interviewed males. Voices of more men and other relatives should be added in future studies, perhaps by approaching family support agencies or other formal organizations such as child protection agencies or social services departments (although there may be confidentiality issues that would need to be managed in doing so). Alternatively men’s support groups may be useful contacts.

Acknowledgements

The authors are grateful for the valuable comments and suggestions by Sarah MacLean and Robin Room of the Centre for Alcohol Policy Research. The interviewees gave their time and shared their often difficult stories and we acknowledge their substantial contribution. The study was supported by the Lithuanian Council of Science and the European Social Fund (VP1-3.1-SMM-07-K). Laslett’s salary was supported by a National Health and Medical Research Council of Australia Early Career Fellowship (1090904).

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