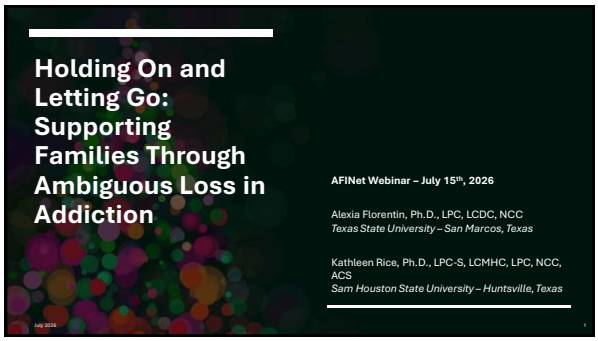

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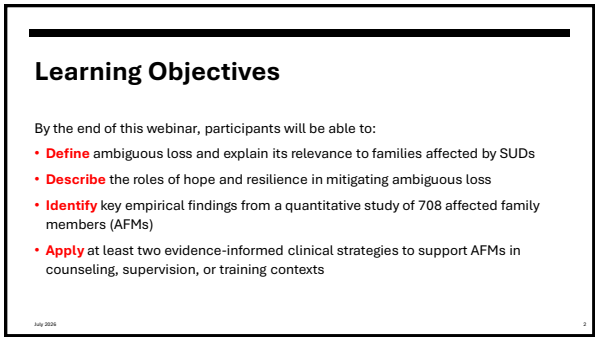

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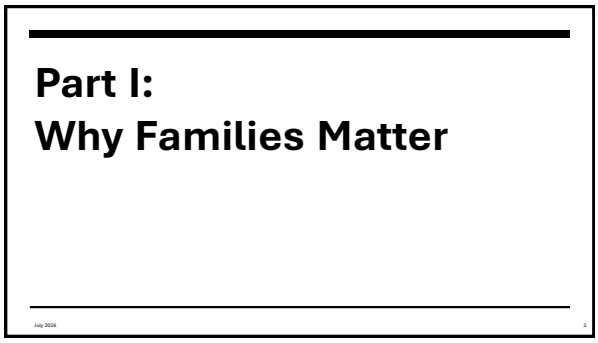

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The Scope of the Problem

- 48.4 million individuals in the U.S. met SUD criteria in the past year (SAMHSA, 2024)
- ~283 million family members globally affected by a relative's SUD (WHO, 2018)
- 14.1 million U.S. family members impacted by alcohol/substance use in the home (NIAAA, 2021)
- Addiction disrupts family systems, contributing to persistent uncertainty, grief, and relational strain

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The AFM Experience

- AFMs frequently provide practical, emotional, and financial support while coping with interpersonal strain (Orford et al., 2013)
- Documented impacts: mood/anxiety symptoms, relationship strain, economic stressors, interpersonal conflict
- Relational grief: loss of the quality of relationships prior to addiction
- NCC-AP Code of Ethics (2021) does not address providing treatment or support specifically to AFMs - a critical policy gap

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Part II: Understanding Ambiguous Loss

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What is Ambiguous Loss?

(Boss, 1999, 2006)

Loss that cannot be resolved; closure is not the goal

Two types:

- **Physical** ambiguous loss: loved one is physically absent but psychologically present (e.g., immigration, disappearance)
- **Psychological** ambiguous loss: loved one is physically present but psychologically absent (e.g., dementia, addiction)

Boss's framing: "goodbye without leaving"

Ambiguity freezes the grief process - no clear script for mourning

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Ambiguous Loss in the Context of Addiction

The ever-changing nature of addiction amplifies ambiguity (active use → relapse → recovery → relapse)

AFMs are caught in a cycle of hope and despair (Boss, 2006)

Impairs coping, decision-making, and relational clarity

Distinct from conventional grief: no social rituals, limited validation, often invisible to others

Note for our international audience today: AL experiences may be shaped by culture, collectivism, stigma, and access to services

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From Research Gap to Research Question

Limited quantitative work on AL specifically among AFMs of individuals with SUDs (Sampson et al., 2023; Mechling et al., 2018)

Prior qualitative studies highlighted hope and resilience as important - but empirical data were scarce

This study asked: *Do hope and resilience matter? And for whom?*

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Part III: The Study

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Study Overview

Cross-sectional, quantitative design; positivist paradigm

Sample: n = 708 AFMs (spouses, parents, siblings, adult children, close friends "like family")

Recruited via Qualtrics online panel with eligibility screening and bot detection

IRB-approved; Sam Houston State University

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Who Were our Participants?

Age: largest group 35–44 (20.8%); range from 18 to 85+

Gender: 51.1% female, 48.7% male

Ethnicity: 62.6% White; 37.4% from diverse backgrounds (including 18.9% Hispanic/Latinx)

Relationship to person with SUD: varied widely - spouses/partners (17.1%), siblings (13.4%), best friends (14%), multiple relationships (21.6%)

54.2% had never received any support or therapy related to their loved one's SUD

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Measures

- ALI+ (Ambiguous Loss Inventory Plus): Part 3 - psychological reactions to ambiguous loss
  - (Comtesse et al., 2023)
- AHS (Adult Hope Scale): 12 items; agency and pathways thinking
  - (Snyder et al., 1991; α = .74-.84)
- BRCS (Brief Resilient Coping Scale): 4 items; ability to rebound from stress and adversity
  - (Sinclair & Wallston, 2004; α = .69-.76)
- Data analyzed with multiple regression and moderation analyses (SPSS)

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Key Findings

- **Research Question 1 - Do hope and resilience differentially relate to AL?**
  - Both significantly and negatively associated with ambiguous loss
  - Hope: β = -0.28, $p < .001$ (stronger association)
  - Resilience: β = -0.23, $p < .001$
  - Together: $R^2 = 0.136$ → accounted for 13.6% of variance in AL
- **Research Question 2 - Do they hold up in a parsimonious model?**
  - Confirmed: $R^2 = 0.042$, $F = 15.657$, $p < .001$; both remained significant
- **Research Question 3 - Do demographics moderate these effects?**
  - Older age → lower AL (β = -0.731, $p < .001$)
  - Closer relationships (spouse, parent, child) → higher AL (β = 0.215, p = .014)
- **No significant moderation** - hope and resilience were protective *across* age, gender, and relationship type

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Part IV: What This Means in Practice

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Clinical Implications: Building Hope

Hope (agency + pathways thinking) is the stronger protective factor - intervene here first

Solution-Focused Brief Therapy (SFBT): Miracle question, exception-finding, scaling questions to help AFMs envision a positive future

Goal-setting interventions: Help AFMs identify small, achievable goals for themselves, not just in relation to their loved one's recovery

Narrative reframing: Reconnect AFMs with their own identity beyond the caregiver role

Hope-building works across demographic groups - applicable broadly!

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Clinical Implications: Building Resilience

Resilience = adaptive coping; emotional regulation; mobilizing social support

CBT strategies: Cognitive restructuring, behavioral activation, problem-solving

Mindfulness-based stress reduction (MBSR): Tolerate uncertainty without catastrophizing

Structured family sessions: Strengthen communication; reduce isolation

Psychoeducation on ambiguous loss: Naming the loss validates the experience and reduces self-blame

Consider cultural context when selecting modalities - especially for collectivist families where individual-focused coping may conflict with family obligations

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Part V: Training, Supervision, & Policy

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Implications for Counselor Training & Supervision

Integrate	Model
Counselor educators: integrate AI-informed case conceptualization into addiction counseling coursework • Use case-based learning, role-play, grief pedagogy • Train counselors-in-training to name ambiguous loss for clients	**Supervisors**: model strength-based case conceptualization in supervision • Coach supervisees to deliver psychoeducation and skills-based interventions for AFMs • Reinforce ethically responsive care for families navigating chronic uncertainty

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Policy Implications

The NCC-AP Code of Ethics (2021) mentions "family" only in contexts of dual relationships, confidentiality, and assessment limits - not in terms of family support or treatment

Findings advocate for explicit family-centered guidance in addiction treatment systems and ethical codes

AFMs need access to: psychoeducation, family counseling, and referral pathways as a standard of care

International consideration: What does family-centered addiction policy look like in your context?

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Part VI: Future Directions & Closing

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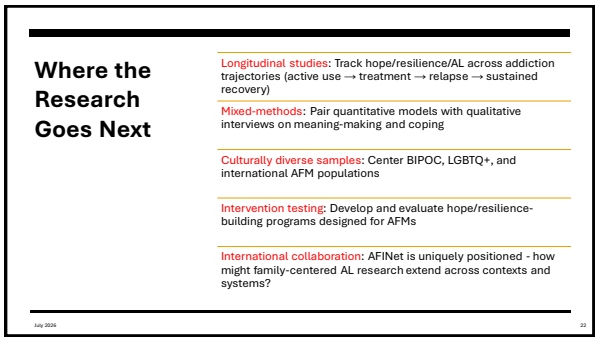

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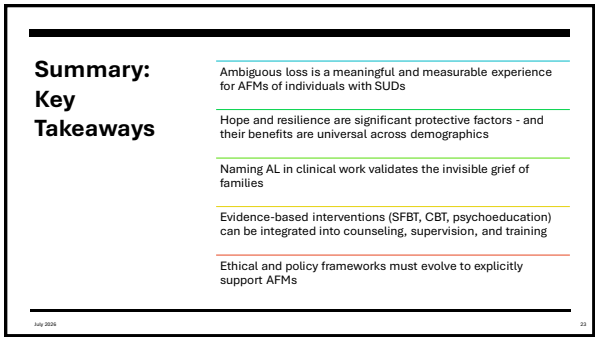

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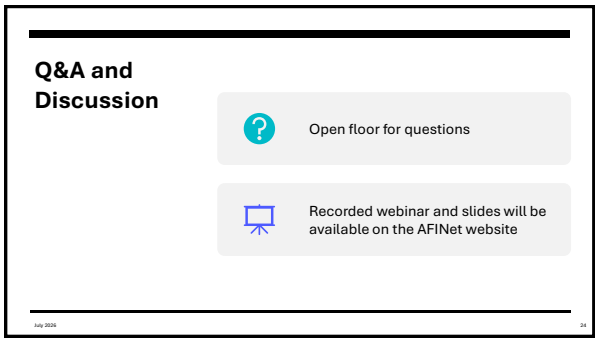

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