Drug and Alcohol Review 15:171-181, 1996.

PATTERNS OF FAMILY RESPONSES TO ALCOHOL AND TOBACCO PROBLEMS

Robin Room

Addiction Research Foundation
33 Russell St.
Toronto, Ontario M5S 2S1, Canada

ABSTRACT

Patterns of family response to drinking and smoking were studied in a sample of 1034 adults in Ontario in 1993. Concerning tobacco smoking, 69% of respondents reported having said something to a relative, and 82% to a friend; concerning drinking, 46% had said something to a relative and 65% to a friend. Having said something did not vary much with the respondent's age, educational level, and smoking or drinking status, except that current smokers were less likely than others to have said something to a friend or acquaintance, while heavier drinkers were more likely to have said something to a friend or acquaintance, and ex-drinkers were more likely to have said something to a relative. About half of all who had ever smoked reported a family member (57%) or a friend (47%) had said something to them about their smoking, compared with much smaller proportions of ever-drinkers who reported that a family member (14%) or a friend (8%) had ever said anything about their drinking. Both drinking and smoking are recognized by many respondents as imposing burdens on the family. Family members often comment on drinking and smoking, and make suggestions about cutting down or quitting.

It is a special honour and pleasure to have been invited to give the 1994 James Rankin Oration. The Oration primarily honours Jim's contributions over the years to the field in Australia. But I am well situated to testify that Jim has also made lasting contributions to the field in Canada. Indeed, Jim has played a truly unique role, in making such substantial contributions at both ends of the world.

I have been asked to focus on the theme of the conference, alcohol, drugs and the family. Having already given an overview earlier in the conference,[1] I concluded that the best further contribution I could make is a rather unconventional one for such an occasion: an empirical analysis of family responses to substance use in the population at large. Useful thinking and practical work on alcohol, drugs and the family must in the end be grounded on an understanding of what actually happens about substance use in the family, not only in the families of clinical cases but also in the population at large.

THE SPECIAL RELATION OF SUBSTANCE USE AND THE FAMILY

Drinking and drug use bring benefits and harms to the user. The use also potentially impacts on many others around the user. Drinking and drug use exists in a social context, and those around the user often respond in some way to the use. The social contexts of use thus both are affected by the use, and in turn influence the use.

In the social contexts of everyday life, the family holds a special place. As Robert Frost put it, "home is the place where when you have to go there, they have to take you in". Although the family is usually not the most frequent location of drinking and drug use, use does frequently occur in the family, and family members indeed may form a drinking or drug-using group. As we shall see, the family is often deeply affected by adverse impacts of drinking and drug use. While family members may eventually insulate themselves from the behaviour or the harm, the commitment to and continuity of relationship inherent in family life mean that often the adverse impacts on family members may continue for years. The commitment and continuity also mean that the family is a major source of social responses to drinking and drug use, and indeed of efforts to control behaviour seen as problematic.

This paper explores these patterns of interactions in the context of the general population. Much of our knowledge about the impact of drinking and drug use on the family, and about the family's response, has been based on clinical populations -- on families where the drinking or drug use of one or more members has been defined as problematic enough to receive clinical attention. Frequently, indeed, family links have been ruptured by the time a drinker comes to the clinic: in many samples of treated alcoholics, as few as half are still living in a family. Looking outside the clinic door gives us a chance to observe earlier stages in family processes around alcohol problems. It also includes within our field of vision many families where no treatment ever occurs, where problems may have been prevented or controlled or adapted to by the family process itself.

The focus here will be on two drugs -- alcohol and tobacco. Along with caffeine, alcohol and nicotine are by far the most commonly used psychoactive drugs in societies such as ours, so that information about effects of and responses to them in the family can be readily gathered in a conventionally-sized general population sample survey. It also seemed interesting to consider alcohol and tobacco in the context of the family in a comparable frame, using equivalent measures for each.

PREVIOUS WORK ON FAMILY RESPONSES TO DRINKING AND SMOKING

The interaction of drug use with family life has been much better explored for alcohol than for tobacco. In a general-population framework, the influence of the family on smoking has primarily been measured in the context of reasons for quitting smoking. In a 1986 U.S. national survey, 35% of current smokers with at least one serious quit attempt and 25% of former smokers agreed with a precoded item that pressure from family and friends was important in quitting or attempting to quit.[2] Another family-related reason, concern about the example they were setting for their children, was endorsed by 36% of the current smokers and 35% of the former smokers. But both current and former smokers gave much more weight to both their present health (64%, 59%) and their future health (80%, 75%) as reasons for quitting.

Another analysis, of those who had quit or had tried to quit in the last five years in a 1987

U.S. national survey,[3] reported parallel findings, although with lower percentages, since the responses were to an open-ended question on reasons for trying to quit. While 63% of men and 62% of women gave some kind of health reason for quitting, only 9% of men and 12% of women gave pressure from family or friends as a reason.

The study's authors note that "in recalling the reasons that they perform a behaviour people tend to attribute the cause to their own internal decisions rather than to indicate that they were influenced by an external cause. Therefore, both the social and cost reasons may be underrepresented in this study relative to health reasons". This tendency, which may well be stronger where the behaviour succeeds, might explain why giving pressure from family and friends as an important reason was negatively associated with having succeeded in quitting in the 1986 study. Certainly, a 1990 Scottish survey[4] found the opposite result when the question was put in terms not of reasons for quitting but of how much social support the respondent received in quitting. Comparing those who had succeeded and failed in quitting for at least four months in the last five years, the study found that successful quitters were more likely to report that their partner (65% vs. 53%), other family members (62% vs. 53%), friends (46% vs. 34%) and workmates (41% vs. 28%) were very or quite helpful in their effort to quit.

With respect to alcohol consumption, also, health concerns, as well as a variety of other concerns, seem to outrank pressures from the family as reasons for quitting or cutting down among American adults. When American adults were asked in 1984 and 1990 about "reasons for abstaining from alcoholic beverages or being careful how much you drink",[5] "your family and friends get upset when you drink" ranked ninth (in 1984) or eighth (in 1990) as a "very important" reason; among ex-drinkers this reason was ninth-ranked in both years. The proportions of ex-drinkers giving different reasons as very important parallel the proportions among ex-smokers; 69% of ex-drinkers in 1990 cited "drinking is bad for your health" as a very important reason, as against 38% citing "your family and friends get upset when you drink". It should be kept in mind, however, that upsetting family and friends was given as a very important reason for quitting or being careful about drinking by fully one-quarter of the whole sample, with the proportion rising during the 1980s (27% in 1984, 32% in 1990).

To measure family influences on smoking or drinking in the context of reasons for quitting or being careful about use heavily filters our view of the situation. The answers are inevitably in terms of what Mills termed situated "vocabularies of motives"[6] -- reasons for the respondent's own behaviour which can be ascribed more or less comfortably in the respondent's particular cultural frame.[7] With respect to alcohol, the issue of family influences has also been tackled more directly, both by asking drinkers about pressures on them from family members to cut down on their drinking, and by asking respondents about their own efforts to pressure other family members. In 1990, 44% of the U.S. adult general population reported that they had at some time "said something" to a family member "about their drinking or suggested that they cut down", and 33% reported that they had said something to a friend. Figures for Ontario adults in 1993 were somewhat higher: 46% for relatives and 37% for friends. In both populations, about one-fifth had said something to a family member and about one-fifth to a friend within the last year.[8]

Viewed from the other side of the interaction, 37% of the U.S. adult general population reported in 1990 that at least one family member at some time "might have liked you to drink less or to act differently when you drank", while 9% said that a friend had given such an indication.

These numbers had risen in the course of the 1980s; the figure for family members in 1979 had been only 22%.[9]

The present paper draws on and extends this line of work, by examining pressures on and from family and friends concerning both drinking and smoking, in a 1993 Ontario adult general population survey. With this data, we are able to look in some detail at the relative prevalence of pressures in different family relationships, from the perspective of the family member who is intervening. From the perspective of the drinker or smoker who is being pressed, we are able to look at the interactions of pressure from different sources -- not only from the family and from friends, but also from the respondent's family physician.

STUDY METHODS

In the 1993 survey,[10] using random-digit dialling techniques, a total of 1,034 interviews were completed, with a response rate of 65%. Sampling weights are used to compensate for the effects of choosing one respondent per household and of multiple-telephone households, and the weighted sample size is reduced to 941 to account for an average design effect averaged over a number of variables.

In the course of a half-hour interview, respondents were asked about their own drinking and smoking patterns, and about harm from drinking or smoking to five different life areas, including their "home life or marriage" and their "friendships or social life". Drinkers and smokers were asked about advice in the last 12 months from family members, from friends or acquaintances, and from their family doctor about quitting (smoking) or cutting down (drinking). They were also asked whether they had in fact received treatment of several specified kinds. On the other side of the interaction, respondents were asked about whether a family member or friend had had a problem with their drinking or smoking, and how much effect it had had on the respondent. Respondents were also asked for seven specific types of relative (spouse.partner, father, brother, son, mother, sister, daughter), and for male and female friends, whether they had made a suggestion to quit (smoking) or cut down (drinking).

Almost all of the questions used in this analysis were asked in comparable form for drinking and smoking. But it should be recognized that even formally equivalent questions about alcohol and tobacco may have a different connotation for the survey respondent. A response about a "problem with drinking", for instance, may be a reference to family violence, to work role failure, to drunk driving convictions, to a chronic health problem like liver cirrhosis, or to a perceived inability to control drinking. A "problem with smoking" is likely to refer only to parallel categories to the last two in the alcohol list -- that is, to chronic health problems like lung cancer, or to a perceived inability to control or stop smoking. Likewise, the repertoire of treatment modalities differ for tobacco and alcohol, as do the means by which treatment is delivered. Indeed, there is a specialized system of community treatment agencies for alcohol problems but not for tobacco problems. Despite these differences, we have found it instructive and illuminating to examine problems with and responses to the two drugs as far as possible in parallel.

RESULTS

THE IMPACT OF DRINKING AND SMOKING ON FAMILY MEMBERS

Let us begin with the impact of others' drinking and smoking on our respondents. Each respondent was asked whether a family member or friend had ever had a problem with their smoking, and separately about a problem with their drinking. Table 1 shows that better than half of all respondents reply "yes" concerning someone with alcohol problems, and likewise about half say "yes" concerning someone with smoking problems. Although some respondents saying "yes" will be talking only about a friend's problem, we know from data from other alcohol studies that in most cases respondents are including a family member with a problem in their responses. About one-quarter of all respondents report that a family member or friend had a problem in the last 12 months (this question was not asked for tobacco). Men and women are roughly equally likely to report having had a family member or friend with a problem.

The question was followed up by asking how much effect the problems had had on the respondent. While this question was asked concerning alcohol only for those reporting a problem in the last 12 months, the results were very similar to those for the same question asked on a lifetime basis in the 1992 Ontario adult survey.[11] Respondents are somewhat more likely to report that the problem had a major effect on them for alcohol problems than for tobacco problems. Women were twice as likely as men to report that a family member's or friend's alcohol problem had a major effect on them. This offers support to the idea that gender and family roles impose a special burden on women in coping with drinking problems in the family.

RESPONDING TO OTHERS' DRINKING AND SMOKING

Family members do a good deal of commenting on each others' behaviour, whether the behaviour is seen as problematic or not. These comments may be made with a variety of intentions and effects -- they may be instructional, or humorous, or devastating, or all three at once -- but many of them can be seen as efforts at social control, that is, efforts to influence future behaviour in particular directions.[12] In particular, comments in the family about drinking or smoking are often intended to steer behaviour away from the problematic.

For a variety of family and friendship relationships, we asked respondents whether they had ever said anything about the smoking of a person in the category, or suggested that they quit. A parallel series of questions was asked concerning drinking (substituting "cut down" for "quit"). Table 2 shows the patterns of responses for male and female respondents separately, and for the sample as a whole. Looking first at the row for "any of these relatives", about two-thirds of respondents at some time had said something to a relative about their smoking, while a little less than half had said something about drinking. Smoking is somewhat more widely commented on than drinking. Smokers are rarer than drinkers -- 95% of the sample reported having been a drinker at some time in their life, while only 78% reported having been a smoker -- but, on the other hand, a smoker is more likely to be a heavy smoker than a drinker is to be a heavy drinker.

Particularly for alcohol, women are more likely than men to have made a comment to another family member. Conversely, men are more likely than women to have made a comment on drinking to a friend or acquaintance, particularly to a male friend or acquaintance.

The table also shows rates of having made comments to seven specific categories of family relationship. Making comments to a particular kind of relation is of course only possible if such a relative exists and is of smoking or drinking age, and this limits particularly the number of respondents who can have made comments to a son or daughter. It will be seen that both men and women are more likely to have made comments about drinking to male relations, reflecting in large part that the male relations are more likely than female relations to be heavy drinkers. Reflecting that the proportions of smokers among men and women are much closer, respondents of both genders are nearly as likely to make comments to female as to male relatives. For each kind of relationship, comments about smoking are somewhat more likely than comments about drinking.

Table 3 shows summary patterns of comments by general categories of age. Older respondents will of course have had a longer time than younger to have ever made comments. But there are rather few differences by age in the likelihood of either males or females making comments to a relative about either tobacco or alcohol. Older respondents are somewhat less likely than younger to have made comments to friends or acquaintances about their drinking or smoking.

Table 4 makes the same comparisons by general categories of educational level. Again, educational level seems to make little difference in the likelihood of saying something to a relative about smoking, but less educated respondents are the most likely to have said something to a relative about drinking. With respect to both smoking and drinking, there is a modest tendency for more educated respondents to have said something to a friend or acquaintance.

In Table 5, we examine the patterns of comments by the respondent's smoking status (for comments about smoking) and drinking status (for comments about drinking). The cut-point used

for heavier smoking is smoking 11 or more cigarettes a day; for heavier drinking, it is drinking five or more drinks on an occasion at least 12 times in the last year. Whether one is or was a smoker, and amount of smoking, do not seem to make any difference in whether one comments on a relative's smoking. On the other hand, current smokers are systematically less likely than others to have said something to a friend. Lifetime abstainers seem less likely and ex-drinkers more likely than others to have commented to relatives, although the base numbers are fairly small. Among current drinkers, heavier drinkers are no more likely than lighter to have commented to a relative, but somewhat more likely to have made a comment to a friend. Overall, the general picture is that one's own drinking or smoking status does not make a great deal of difference in the likelihood of making comments to other members of the family. Family members particularly seem to feel that they can make comments from a stance of "do as I say and not as I do".

FAMILY AND OTHER INFLUENCES ON ONE'S OWN DRINKING AND SMOKING

So far, the focus has been on the respondent's views of and influences on others' drinking and smoking. We turn now to respondents' experiences at the other end of the interaction -- questions about whether the respondent's own drinking and smoking had impacted on others, and how others had responded to it. The first two lines in Table 6 shows the proportions of smokers and of drinkers who reported their smoking or drinking had ever harmed their home life or marriage, and their friendships or social life. Tobacco smokers were slightly more likely than drinkers to report harm in both life-areas. This reflected a gender difference: men were equally likely to report harm from tobacco and from alcohol, while women, as in other surveys, were less likely to report harm from alcohol. Less than one-sixth of users of either tobacco or alcohol were willing to report harm to their home life or marriage from their tobacco or alcohol use.

For alcohol, about an equal number of respondents reported that a family member or relative ever said something about their drinking, or suggested that they cut down. Receiving comments from family members about their smoking was much more common -- over half of those who had ever smoked reported this. Comments on smoking were also more likely than comments on drinking from friends or acquaintances. Particularly for alcohol, receiving comments from family members was more common than receiving comments from friends or acquaintances.

We also asked respondents whether their family doctor had ever advised them to quit (smoking) or cut down (drinking); for both tobacco and alcohol, the doctor was a little less likely than the family and about as likely as friends and acquaintances to have done this. In other words, smokers in the general population were about five times as likely to have received advice from a doctor about their smoking as drinkers were to have received advice about their drinking.

About one-half of drinkers who have received comments from family or friends have also been advised by them to get help for their drinking problem; for smoking, the proportion is about one-third. Looked at another way, three times as many smokers as drinkers had been advised by a family member or friend to get help for their substance use.

Nearly one-third of smokers who had been advised by their family doctor to quit smoking had received help from the doctor, while this was much less likely to have happened for drinkers advised by the doctor to cut down their drinking.

Altogether, 23% of those who ever smoked have had some kind of treatment for their smoking (including self-help aids such as tapes, books or computers; going to groups like Smoke-enders, Nicotine Anonymous, etc.; and using a nicotine skin patch or nicotine gum). A much smaller proportion of those who have ever been drinkers -- 6% -- had received help for a problem related to their drinking (including going to Alcoholics Anonymous, Al-Anon, or a support group meeting; a drinking and driving program; another alcohol or drug treatment agency; a psychiatric hospital; a general hospital or emergency room; a doctor or nurse; a psychologist, psychiatrist or social worker; a minister, priest or rabbi; or any other counsellor or therapist).

In Table 7 we turn to current heavier and lighter users of tobacco and alcohol, and look at pattern of harm, comments, and receiving help in the last 12 months. Drinkers who drink 5 or more drinks on an occasion at least once a month are much more likely than other drinkers to feel they have harmed their home life or friendships, and to have attracted comments on their drinking. On the other hand, lighter smokers are almost as likely to have attracted comments as heavier smokers.

That smoking is more likely to attract comment than drinking is even more true for current use (Table 7) than on a lifetime basis (Table 6). A strong majority of current smokers, whether heavy or light, have had a family member or friend suggest they quit in the last year, and a majority of heavier smokers have had a suggestion from their family doctor in that period, including actual help in quitting for almost half of those receiving advice. On the other hand, almost one-quarter of heavier drinkers had received a suggestion to get help from a family member or friend (about the same proportion as for heavier smokers), but even heavier drinkers were very unlikely to received help from a family doctor. Altogether, heavier smokers were ten times as likely as heavier drinkers to have received treatment of some sort in the previous 12 months.

In Tables 8 and 9 we return to lifetime patterns, examining the place of advice from the family in the context of advice from other sources. In Table 8, which focuses on smoking, it can be seen that smokers who attract comments from family members are somewhat more likely to attract comments, too, from friends and from a family doctor. The more sources which gave comments -- family, friends, and the doctor -- the more likely the respondent was to have had some kind of treatment for smoking. Though the family doctor's comments appear especially influential, this is partly artefactual, since popular methods of treatment (the nicotine patch, and at the time of the survey all nicotine gum) require a doctor's prescription.

Table 9 shows that, as with smokers, drinkers who attract comments from family members are somewhat more likely to attract comments also from friends and from a family doctor. In the small group which had attracted comments from all three sources, about three-quarters had been treated. At the other extreme, only 2% of those receiving no comments from any of the three sources had been in treatment. As we have previously explored in other samples,[13] it is not common to end up in alcohol treatment without a prior pattern of informal responses to drinking in the family and among friends.

CONCLUSION

Whether viewed from the perspective of the drinker or smoker, or from the perspective of another member of the family, both drinking and smoking are recognized as imposing burdens

on the family. A majority of respondents reported having a family member or friend with a drinking problem, and a like number reported having such a connection with a smoking problem. In both genders for smoking and among men for drinking, only a minority reported the problem had had a major effect on them personally, but half of the women with a connection with an alcohol problem reported it had had a major effect on them. From the perspective of the smoker or drinker, harm to home life or marriage from their drug use was by no means uncommon: about one in seven male users reported this.

Respondents' reports on their own comments to others in the family concerning drinking or smoking suggest that family members do not suffer these burdens in silence. The comments come not only from spouses, but also from parents, siblings, and eventually too from children. Comments from the family also tend to go along with comments from friends and from the family doctor. Comments from the family and from other sources are associated with receiving treatment; indeed, they are usually a precursor to it.

There is a limit to how far we can go with the present data in understanding the rich diversity of family interaction around drinking and drugs, and the sequences of events which result in successful control within the family or which lead to formal treatment. Improving our knowledge of these patterns will give us a better understanding of how we might help strengthen family processes of prevention or reduction of drinking and drug problems. Studying family interactions around drinking and drug use will also, I believe, give us important new insights on how to strengthen family life in general, while allowing for individual autonomy and growth.

TABLE 1 THE EXPERIENCE AND EFFECT OF HAVING A FAMILY MEMBER OR FRIEND WITH A PROBLEM WITH SMOKING OR DRINKING, ONTARIO 1993 (PER CENT)

	TOBACCO			ALCOH	
	TOTAL	Male	Female	TOTAL	Male
Design weighted *(N)*	(941)	(454)	(487)	(941)	(454
Family member or friend has ever had a problem with their smoking/drinking	52	47	56	58	57
Alcohol only: Problem was in last 12 months				25	24
How much effect did these problems have on you?					
Tobacco: Among those where there was ever a problem Design weighted *(N)*	(485)	(214)	(271)		
Alcohol: Among those with a problem in last 12 months Design weighted *(N)*				(238)	(108
☞ major effect	30	23	35	41	26
☞ minor effect	39	41	38	46	54
☞ not much effect at all	30	35	26	14	20

TABLE 2 EVER MADE A SUGGESTION THAT RELATIVES OR FRIENDS CUT DOWN OR QUIT, FOR SMOKING AND FOR DRINKING, BY GENDER, ONTARIO 1993 (PER CENT)

	TOBACCO			ALCOHOL		
	TOTAL	Male	Female	TOTAL	Male	Female
Design weighted *(N)*	(941)	(454)	(487)	(941)	(454)	(487)
Spouse/partner	34	32	36	16	8	24[a]
Father	24	24	25	18	18	18
Brother	21	20	22	17	15	19
Son	13	13	13	6	6	6
Mother	19	18	20	5	4	7[b]
Sister	17	14	20[b]	5	3	7[a]
Daughter	12	10	14[b]	2	1	3
ANY OF THESE RELATIVES	69	65	72[b]	46	39	52[a]
Male friend/acquaintance	44	52	37[a]	33	42	25[a]
Female friend/acquaintance	42	41	43	13	13	13
ANY FRIEND OR ACQUAINTANCE	55	58	52	37	45	30[a]
ANY OF ABOVE	82	82	83	65	65	66

Tobacco: "... ever said something about their smoking, or suggested that they quit"
Alcohol: "... ever said something about
their drinking, or suggested that they cut down"
Note: Significance tests for gender differences within substance are based on Pearson's $\chi^2(1)$: [a]$p < .01$; [b]$p < .05$.
Significance tests for total proportion differences between substances are based
on the McNemar test ($\chi^2[1]$).

Differences were found for all items, $p < .01$.

TABLE 3 EVER MADE A SUGGESTION THAT RELATIVES OR FRIENDS CUT DOWN OR QUIT, FOR SMOKING AND FOR DRINKING, BY GENDER AND AGE, ONTARIO 1993 (PER CENT)

		18 - 34	35 - 54	55+	TOTAL
MALES	Design weighted *(N)*	(185)	(193)	(74)	(452)
TOBACCO	Any relative	69	63	64	65
	Any friend/acquaintance	62	56	52	58
	Any relative or friend	84	81	78	82
ALCOHOL	Any relative	36	42	38	39
	Any friend/acquaintance	49	47	32[b]	46
	Any relative or friend	64	69	56	65
FEMALES	Design weighted *(N)*	(185)	(183)	(114)	(483)
TOBACCO	Any relative	75	73	67	72
	Any friend/acquaintance	61	52	38[a]	52
	Any relative or friend	87	81	77[c]	83
ALCOHOL	Any relative	47	59	48[b]	52
	Any friend/acquaintance	31	32	25	30
	Any relative or friend	64	71	61	66

Note: Significance tests for differences among age subgroups within gender are based on Pearson's $\chi^2(2)$: [a] $p < .01$; [b] $p < .05$; [c] $p < .10$.

TABLE 4 EVER MADE A SUGGESTION THAT RELATIVES OR FRIENDS CUT DOWN OR QUIT, FOR SMOKING AND FOR DRINKING, BY EDUCATION, ONTARIO 1993 (PER CENT)

		LESS THAN HIGH SCHOOL GRADUATE	HIGH SCHOOL GRADUATE	SOME COLLEGE	UNIVERSITY DEGREE	TOTAL
	Design weighted *(N)*	(197)	(252)	(293)	(197)	(941)
TOBACCO	Any relative	70	70	68	66	69
	Any friend/acquaintance	48	55	52	66[a]	55
	Any relative or friend	79	81	82	87	82
ALCOHOL	Any relative	51	47	44	41	46
	Any friend/acquaintance	31	38	42	36	38
	Any relative or friend	66	67	66	62	65

Note: Significance tests for differences among education subgroups are based on Pearson's $\chi^2(3)$: [a]$p < .01$; [b]$p < .05$.

TABLE 5 EVER MADE A SUGGESTION THAT RELATIVES OR FRIENDS CUT DOWN OR QUIT, FOR SMOKING AND FOR DRINKING, BY WHETHER AND LEVEL OF USE, ONTARIO 1993 (PER CENT)

	SMOKING STATUS				
TOBACCO	NEVER SMOKED	PAST SMOKER	SMOKES NOW, UP TO 10 CIGS/DAY	SMOKES NOW, 11+ CIGS/DAY	TOTAL
Design weighted *(N)*	(378)	(300)	(103)	(160)	(941)
Any relative	67	72	66	67	69
Any friend/acquaintance	64	58	37	38[a]	55
Any relative or friend	87	84	74	72[a]	82

	DRINKING STATUS				
ALCOHOL	NEVER DRANK	PAST DRINKER	DRINKS NOW, BUT NOT 5+ DRINKS MONTHLY +	DRINKS NOW, 5+ DRINKS MONTHLY +	TOTAL
Design weighted *(N)*	(43)	(115)	(558)	(226)	(941)
Any relative	31	61	45	42[a]	46
Any friend/acquaintance	24	33	36	46[a]	37
Any relative or friend	48	70	64	69[b]	65

Note: Significance tests for differences among use subgroups within smoking status and drinking status are based on Pearson's $\chi^2(3)$: [a]$p < .01$; [b]$p < .05$.

TABLE 6 EVER PRESSURE FROM FAMILY, FRIENDS OR FAMILY DOCTOR TO QUIT (SMOKING) OR CUT DOWN (DRINKING), BY GENDER, ONTARIO 1993 (PER CENT)

	TOBACCO			ALCOHOL		
	TOTAL	Male	Female	TOTAL	Male	Female
Design weighted *(N)*: Ever smokers/drinkers	(563)	(315)	(248)	(898)	(445)	(453)
Ever harmed: home life or marriage	14	13	15	10	14	6[a]
Ever harmed: friendships and social life	17	17	16	12	17	6[a]
Family member or relative ever said anything, or suggested you quit/cut down	57	58	55	14[a]	22	5[a]
Friend or acquaintance ever said anything, or suggested you quit/cut down	47	48	45	8[a]	13	3[a]
Family/friend ever suggested getting help	15	16	15	4[a]	6	3[b]
Family doctor ever advised to quit/cut down	46	44	49	8[a]	11	4[a]
Received help from doctor to quit/cut down	14	13	15	1[a]	2	1[c]
Ever received specified treatments	23	23	22	6[a]	9	4[a]

Note: Significance tests for gender differences within substance are based on Pearson's $\chi^2(1)$: [a]$p < .01$; [b]$p < .05$; [c]$p < .10$.
Significance tests for total proportion differences between substances are based on the McNemar test ($\chi^2[1]$): [a]$p < .01$.

TABLE 7 PRESSURE IN THE LAST YEAR FROM FAMILY, FRIENDS OR FAMILY DOCTOR TO QUIT (SMOKING) OR CUT DOWN (DRINKING), BY CURRENT USE STATUS, ONTARIO 1993 (PER CENT)

	TOBACCO			ALCOHOL		
	TOTAL	≥10 cigs/day	11+ cigs/day	TOTAL	not 5+ monthly+	5+ monthly +
Design weighted *(N)*: Current users	(263)	(102)	(160)	(783)	(558)	(226)
Harmed home life or marriage in last 12 months	10	6	13[b]	4	1	12[a]
Harmed friendships and social life in last 12 months	11	8	14	5	2	14[a]
Family member or relative said anything, or suggested you quit/cut down in last 12 months	64	54	70[a]	8[a]	3	20[a]
Friend or acquaintance said anything, or suggested you quit/cut down in last 12 months	58	55	60	5[a]	2	14[a]
Family doctor advised to quit/cut down in last 12 months	47	35	54[a]	4[a]	3	6[b]
Received help from doctor to quit/cut down in last 12 months	17	7	23[a]	0[a]	0	1
Received specified treatments in last 12 months	23	10	31[a]	2[a]	1	3[c]

Note: Significance tests for differences between current use status groups within substance are based on Pearson's $\chi^2(1)$ or Fisher's exact test (two-tailed) where
expected cell frequencies were less than five: [a]$p < .01$; [b]$p < .05$; [c]$p < .10$.
Significance tests for total proportion differences between substances

were based on the McNemar test ($\chi^2[1]$): [a]$p < .01$.

TABLE 8 INTERRELATIONS OF SUGGESTIONS FROM FAMILY, FRIENDS AND FAMILY DOCTOR, AND THEIR RELATION TO RECEIVING SPECIFIED TREATMENTS: EVER SMOKERS, ONTARIO 1993

Family member said something:	YES 57%				NO 43			
Friend or acquaintance said something:	YES 38%		NO 19		YES 10		NO 34	
Family doctor said something:	YES 26%	NO 12	YES 9	NO 10	YES 5	NO 4	YES 6	NO 27
Design weighted *(N):*	(144)	(67)	(52)	(56)	(29)	(25)	(36)	(154)
Percent of category ever treated:	45%	17%	34%	11%	34%	4%	26%	5%

Treatment categories included: self-help aids such as tapes, books or computers; going to groups like Smoke-enders, Nicotine Anonymous, etc.; using a nicotine patch; nicotine gum.

TABLE 9 INTERRELATIONS OF SUGGESTIONS FROM FAMILY, FRIENDS AND FAMILY DOCTOR, AND THEIR RELATION TO RECEIVING SPECIFIED TREATMENTS: EVER DRINKERS, ONTARIO 1993

Family member said something:	YES 14%				NO 87			
Friend or acquaintance said something:	YES 7%		NO 7		YES 2		NO 85	
Family doctor said something:	YES 2%	NO 4	YES 2	NO 5	YES 0	NO 1	YES 4	NO 81
Design weighted *(N):*	(18)	(40)	(15)	(48)	(1)	(12)	(33)	(730)
Percent of category ever treated:	72%	28%	56%	7%	--	29%	3%	2%

Treatment categories included: Alcoholics Anonymous, Al-Anon, or a support group meeting; a drinking program; another alcohol or drug treatment agency; a psychiatric hospital; a general hospital or emergency room; a doctor or nurse; a psychologist, psychiatrist or social worker; a minister, priest or rabbi; or any other counsellor or therapist.

REFERENCES

1. Room R. Alcohol, drugs and the family: an overview. Presented at the annual National Conference of the Australian Professional Society on Alcohol and Drugs, "Alcohol, Drugs and the Family", 11-13 October 1994, Melbourne, Australia.

2. Halpern MT, Warner KE. Motivations for smoking cessation: A comparison of successful quitters and failures. Journal of Substance Abuse 1993;5:247-256.

3. Gilpin E, Pierce JP, Goodman J, Burns D, Shopland D. Reasons smokers give for stopping smoking: Do they relate to success in stopping? Tobacco Control 1992;1:256-263.

4. Lennox AS, Taylor RJ. Factors associated with outcome in unaided smoking cessation, and a comparison of those who have never tried to stop with those who have. British Journal of General Practice 1994;44:245-250.

5. Greenfield TK. Reasons for abstaining or limiting drinking: U.S. national trends between 1984 and 1990. Presented at the Annual Meeting of the Research Society on Alcoholism, San Antonio, Texas, June 19-24, 1993.

6. Mills CW. Situated action and the vocabularies of motives. American Sociological Review 1940;5:904-913.

7. Anonymous. [Report of a discussion session,] Meaning and measurement of motivations for drinking, Alcohol Epidemiology Meeting, Padova 1983, Drinking and Drug Practices Surveyor 1984; 19:43-45.

8. Room R, Bondy S, Ferris J. Determinants of suggestions for alcohol treatment. Presented at an international conference on Alcohol and Drug Treatment Systems Research, Toronto, October 18-22, 1993.

9. Room R, Greenfield TK, Weisner C. "People who might have liked you to drink less": changing responses to drinking by U.S. family members and friends, 1979-1990. Contemporary Drug Problems 1991;18:573-595.

10. Bondy S. Attitudes and Experiences with Treatment of Alcohol and Tobacco Problems: A Report of the Ontario Alcohol and Other Drug Opinion Survey, 1993. Toronto: Addiction Research Foundation, Internal Document No. 119, 1994.

11. Ferris J, Templeton L, Wong S. Alcohol, Tobacco and Marijuana: Use, Norms, Problems and Policy Attitudes among Ontario Adults: A Report of the Ontario Alcohol and Other Drug Opinion Survey, 1992. Toronto: Addiction Research Foundation, Internal Document No. 118, 1994.

12. Holmila M. Wives, Husbands and Alcohol: A Study of Informal Drinking Control within the Family. Helsinki: Finnish Foundation for Alcohol Studies, vol. 36, 1988.

13. Room R. The U.S. general population's experiences of responding to alcohol problems. British Journal of Addiction 1989;84:1291-1304.