Supporting partners of individuals with problem alcohol and other drug (AOD) use through online counselling

Samara Ruth Wilson

B.A. (Hons)

Grad. Dip. Psych.

Dip. Mod. Lang.

Postgrad. Dip. Teach.

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School of Psychological Sciences

Monash Institute of Cognitive and Clinical Neurosciences

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Abstract

Background: Problematic alcohol and other drug (AOD) use impacts partners heavily, with an increased risk of experiencing domestic violence, financial issues, health problems, and relationship issues. However, previous research has focussed on mostly female, married partners, of problem alcohol users, or combined all family members in samples. Recruiting a broader sample can be challenging as many partners find it difficult to seek help due to barriers such as shame, stigma, and practical constraints. Online counselling may help reduce such barriers and provide us the opportunity to explore the multiple impacts from a potentially broader sample of partners, who may or may not have sought help before. The aims of this thesis were: 1) to look at the personal impacts on partners; 2) to investigate the interpersonal impacts on partners; and 3) to explore how online counselling can assist partners in help-seeking. **Method:** One hundred transcripts of partners of individuals with problem AOD use were sampled from a 24-hour national AOD synchronous online chat counselling service. Descriptive content analysis and thematic analysis were used to investigate themes related to the personal impacts, interpersonal impacts, and online help-seeking. **Results:** Personal impacts identified were reflected in partners' cognitions (depressive cognitions, responsibility beliefs, and thoughts around trust); behaviours (helpful and unhelpful coping); and affect (anger, sadness, and fear). Interpersonal impacts included included intimate relationship issues (discovery leads to communication difficulties; decisions to stay or leave), challenges in parenting (safety and well-being concerns; exposure to problem AOD use impacts; difficulty managing parenting responsibilities; pregnancy-related considerations), and impacts on and from their social network (benefits and challenges in seeking social support; extended family and social group stressors/support). Help-seeking themes related to the reason for accessing online counselling (seeking advice, wanting to talk); discussing help-seeking and coping processes (past or present help-seeking

or coping strategies, barriers and also facilitators to seeking help and change); and planning for future assistance (future planning and treatment preferences). **Conclusions:** These findings highlight the substantial burden that problematic AOD use imposes on intimate partners personally, reinforcing the need for services to engage partners as valid help-seekers in their own right. Interpersonal impacts are complex and multi-faceted, and partners should have access to targeted referrals for relationship assistance, peer support (online or face-to-face), domestic violence and welfare services. Online counselling may be a useful modality for partners seeking help to complement existing face-to-face services, through validating emotional experiences, problem-solving situations and the help-seeking process, and providing specific information and referrals.

General Declaration

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes three original papers submitted to peer reviewed journals. The core theme of the thesis is supporting partners of individuals with problem alcohol or other drug use through online counselling. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the student, working within the School of Psychological Sciences under the supervision of Dr Marie Yap, Dr Simone Rodda, Dr Victoria Manning, and Professor Dan Lubman.

The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research.

In the case of chapters 4, 5, and 6, my contribution to the work involved the following:

Thesis Chapter	Publication Title	Status	Nature and % of student contribution	Co-author name(s) Nature and % of Co-author's contribution	Co-author(s), Monash student Y/N
4	The personal impacts of having a partner with problematic alcohol or other drug use: Descriptions from online counselling sessions	Accepted for publication, 2017.	60%. Drafting and data analysis.	1) Prof Dan Lubman 10%. Drafting. 2) Dr Simone Rodda 10%. Drafting and data analysis. 3) Dr Victoria Manning 10%. Drafting. 4) Dr Marie Yap 10%. Drafting.	No for all.
5	The impact of problematic substance use on partners' interpersonal relationships: Qualitative analysis of counselling transcripts from a national online service	Returned for revision, and resubmitted August 2017.	60%. Drafting and data analysis.	1) Prof Dan Lubman 10%. Drafting. 2) Dr Simone Rodda 10%. Drafting and data analysis. 3) Dr Victoria Manning 10%. Drafting. 4) Dr Marie Yap 10%. Drafting.	No for all.

6	How online counselling can support partners of individuals with problem alcohol or other drug use	Published 2017.	50%. Drafting and data analysis.	1) Dr Simone Rodda 20%. Drafting and data analysis. 2) Prof Dan Lubman 10%. Drafting. 3) Dr Victoria Manning 10%. Drafting. 4) Dr Marie Yap 10%. Drafting.	No for all.

I have not renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

Student signature: [redacted] **Date: 16/08/2017**

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.

Main Supervisor signature: [redacted] **Date: 16/08/2017**

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1. Introduction and study overview

1.1. Background and statement of the problem

Problem alcohol and other drug (AOD) use affects not only an individual, but their family as well (Orford, Velleman, Copello, Templeton, & Ibanga, 2010b). One in three Australians experience negative effects from the problem AOD use of someone close to them, and the social cost of problem alcohol use alone exceeds $15 billion annually (Laslett et al., 2011). Partners in particular can often be quite heavily affected, as they (along with mothers) experience a greater accumulative burden from their significant other, compared to other family members (Orford, 2017). A partner can refer to a spouse, boyfriend/girlfriend relationship, de-facto partnership, heterosexual or homosexual relationships, or ex-partners who are still connected with their former significant other. Partners of individuals with problem AOD use (referred to from here as partners) can be affected in multiple ways, including impacting on their health and wellbeing, relationships, housing and finances. Such personal impacts include depression, anxiety, and stress (Dawson, Grant, Chou, & Stinson, 2007; Homish, Leonard, & Kearns-Bodkin, 2006; Orford et al., 2010b), while interpersonal impacts have been reported to include domestic violence or intimate partner violence, sexual problems, intimate relationship issues, and caring for children (Cunradi, Caetano, & Schafer, 2002; Gorin, 2004; O'Farrell, Choquette, Cutter, & Birchler, 1997). Socioeconomic impacts such as financial issues, forensic involvement for the problem AOD user, and unstable housing situations (Orford et al., 2005; Orford et al., 2010b) have also been reported.

Previous research has focussed on samples of partners of problem alcohol users (Peled & Sacks, 2008; Wiseman, 1991), mostly female samples (Dawson et al., 2007), married partners (Moos, Brennan, Schutte, & Moos, 2010), or combined all family members rather than differentiating out partners (Orford et al., 2010b). It is often difficult to recruit a broad range of partners, as barriers such as shame and stigma, or practical concerns (finances, location,

time) can prevent partners from reaching out to services for assistance. Shame can make it difficult for partners to speak to others about what they are experiencing, and even when partners can overcome this barrier, practical concerns such as being able to attend or afford services can still be challenging to overcome. Partners may therefore benefit from services which assist in overcoming such practical barriers, and personal barriers through availability, affordability, and anonymity, such as assistance provided in the online modality.

Moreover, previous research has pathologised the role partners have played in the maintenance of problem AOD use, rather than conceptualising partners as normal individuals coping as best they can with difficult life circumstances (Orford et al., 2005; Whalen, 1953). This perspective may translate into lower service utilisation for partners, as partners may feel discouraged from seeking assistance; partners have not been traditionally the primary service recipient, rather they have been viewed as an adjunct to treatment of the individual with problem AOD use (Orford et al., 2005). This overlooks the significant stress and strain partners are under which makes them valid help-seekers in and of themselves.

Partners form a large and heterogeneous population, and more research is needed to represent the variety of experiences this may encompass. To better understand the complexity of impacts on a greater range of partners, it is important for research to use sources which reach a broader sample base. One such potential source is online counselling. Online counselling is defined as online help-seeking through self-help guides, psychological assessment, email consultations, and synchronous (occurring at the same time, i.e. chat) or asynchronous (not occurring at the same time, i.e. email) support groups and counselling (Callahan & Inckle, 2012). Online counselling has the potential to reach a broader sample of partners, through being affordable, available, and anonymous (Rodda, Lubman, Dowling, & McCann, 2013b; Urbis Keys Young, 2003). These benefits may assist partners who have not previously reached out for help to access online counselling, broadening the sample base.

1.2. Research aims

This thesis aimed to better understand the complexity of personal and interpersonal impacts on partners, to assist partners for their own sake, and to support their significant others. It also aimed to investigate the type of assistance partners are seeking.

1.3. Thesis outline

This thesis comprises seven chapters, and includes three submitted papers. Chapter one is an introduction to the societal context, including a statement of the problem, the aims of the thesis, and a brief outline of the chapters in the thesis. Chapter two includes a review of the literature around partners and problem AOD use. This is not a systematic review, as a detailed overview of the experiences of family members (including partners) had been published by Orford and colleagues (2010b). Studies after this date have been included which build on the findings of Orford and colleagues in the area of impact on partners. This literature review involves defining partners and how they have been historically conceptualised, along with the current stress-coping model. It then moves on to a discussion of the multiple impacts on partners, centring on the personal, interpersonal, and socioeconomic issues they face. Next it discusses the emergence of the online counselling modality, and the role online counselling can play, both in allowing a unique sample of partners to express their needs to better our understanding, and also to increase the capacity of services to reach a broader range of partners. Finally, the current study design is presented. Chapter three includes a brief overview of methodology used, which outlines the choice of analysis and the timing. Chapter four addresses the personal impacts for partners. It begins with a preamble, and then presents a paper submitted for publication. Chapter five focuses on the interpersonal impact for partners. It starts with a brief preamble, then includes a paper submitted for publication. Chapter six covers online help-seeking for partners. It begins with

a preamble, and then has a paper submitted for publication. Chapter seven consists of an integrated discussion. It summarises the findings in the context of previous research and points to specific clinical and practical implications which flow from the results. Finally, it highlights limitations of the studies, and ends with concluding directions for future research.

2. Literature review

2.1. The impact of problem AOD use on partners

There are two main reasons to understand the impacts on partners when tackling problem AOD use. First, partners deserve help in their own right. Living with an individual with problem AOD use can be stressful and can impact upon personal and family wellbeing (Orford et al., 2010b). Secondly, involving partners in treatment can help improve the treatment outcome for the individual with problem AOD use (Copello, Velleman, & Templeton, 2005).

2.1.1. Defining partners

According to systems theory, individuals cannot be understood in isolation (Bowen, 1978). Rather, individuals are interconnected and interdependent, existing in family units, and can only be understood in their embedded context. In particular, the behaviours and problems of one family member intrinsically influence and are influenced by other family members (Kerr & Bowen, 1988). These interactions can at times be a source of strength for all involved, and at other times, serve to intensify problematic situations. In this way, it is important to investigate family systems and the key relationships of individuals with problem AOD use. Romantic relationships are a distinctive form of relationship in the family system. Individuals enter into romantic relationships, rather than being born into them as with other family relationships. There is also a symmetry to the relationship, rather than the asymmetry seen in the more dependent parent-child relationship (Collins & Sroufe, 1999). They also, generally speaking, involve love, choice, passion, and sexual activity. In most Western societies, individuals in a committed romantic relationship are called partners. There are many different types of partner relationships. These include homosexual or heterosexual relationships, spouses, girl/boyfriend and de-facto relationships. In whatever form they take, partners play

an intimate role in family systems. Ex-partners also exist within an individual's system to varying degrees, depending on the separation arrangements and/or the presence of children.

2.1.2. Problem AOD use

The global burden of disease stemming from problem AOD use accounts for 20 million disability adjusted life years annually (years of life lost to premature death or ill-health) (Degenhardt et al., 2013). AOD use is problematic when it interferes with a person's relationships, their ability to function and fulfil commitments such as work or study, or when it results in legal problems or dangerous behaviour (American Psychiatric Association, 2013). Problem AOD use can result from licit or illicit drugs, and can involve depressants (e.g., alcohol, benzodiazepines), stimulants (e.g., amphetamines, cocaine, ecstasy), hallucinogens (e.g., LSD), and opioids (e.g., codeine, heroin) (American Psychiatric Association, 2013). It can also involve single or polysubstance use. Addressing problem AOD use can be challenging as problem AOD use often results in secondary problems, which may require medical, legal, financial, vocational, or mental health services (Anderson, Rehm, & Room, 2015). This complexity makes it important to better understand the impacts on partners, to help them support both themselves and the individual with problem AOD use.

2.1.3. Historical perceptions of partners and problem AOD use

Historically partners, in particular women, have been conceptualized as co-dependent, enablers, and dispositionally pathological. Whalen (1953) proposed personality types for wives of problem alcohol users based on observations from a family service agency, such as Suffering Susan, Controlling Catherine, Wavering Winifred, and Punitive Polly. Each personality type represented pathologised stereotypes of different interactional patterns, such as playing the victim, controlling all aspects of the relationship, extreme emotional lability, or

punishing her husband as one would a child, respectively. Another theoretical model which furthered this character pathology was conceptualised by Pattison, Courlas, Patti, Mann, and Mullen (1965) who described similar presentations with different labels, such as the Masochist, the Hostile Hysteric, the Symbiotic Dependent, and the Maternal. These labels reflected negative stereotypes of women in the 1950s and 60s. This approach also lacked an understanding of the impact that problem AOD use has on an individual's partner, and the way stress and strain interact in partners' lives to produce extreme coping reactions at times.

Orford et al. (2005) have argued that since the 1980s co-dependency has become a more dominant pathologising approach. Such approaches ground the partner's distress in their own personal deficiency, in this case co-dependency. Co-dependency generally refers to an individual's preoccupation with seeking security, self-esteem, and identity through their relationship with another (Beattie, 1987). However, one major critique is that research on co-dependency lacks definitional consensus. Furthermore it has been widely critiqued as blaming, negative, and as failing to recognise the impact of stress on an individual's interactions (Harper & Capdevila, 1990; Orford et al., 2005). Co-dependency also places problem AOD use at the centre of the continuing connection between the partner and significant other, missing other aspects, such as loving the person, wanting a united family for children, or being financially dependent on the individual with problem AOD use (Troise, 1995).

2.1.4. Current conceptualisation of the stress-coping model

An alternative to pathologising models is the stress-coping approach, which views partners as normal individuals in stressful circumstances, attempting to cope the best they can. Previous research suggests there are increased stressors in partners' lives, such as mental and physical health issues, relationship issues, impacts on children, and socio-economic impacts such as

financial or employment issues (Dawson et al., 2007; Gorin, 2004; O'Farrell et al., 1997; Orford et al., 2010b). No research has directly compared the stigma experienced by partners between historical versus current conceptualisations. Still, this current de-pathologising approach seeks to reduce the shame and stigma associated with family members of individuals with problem AOD use (Orford et al., 2005). A world mental health survey found that family members of an individual with alcohol, drug, or mental health concerns felt significantly more embarrassed about the situation compared to family members of an individual with a general health condition (Ahmedani et al., 2013). This suggests that having an individual with problem alcohol or other drug use in the family could increase feelings of shame, which can be associated with the stigma family members feel. It is hoped that reducing the shame and stigma will enable more affected family members to reach out for help and receive support, to reduce the heavy burden, in particular for partners.

In line with this approach, the impact of problem AOD use on family members (including partners) has been framed by the stress-strain-coping-support model (Orford et al., 1998c). This model asserts that it can be highly stressful living with an individual with problematic substance use. This stress may then cause strain on the concerned partner or family member, strain being the manifestation of the psychological impact from stress. This strain may result in physical and psychological ill-health and contribute towards situations the partner needs to cope with or manage. Finally, the impact of the stresses and strains on the partner is mediated by both their coping style and the level and quality of social support the partner receives from others (Orford, Copello, Velleman, & Templeton, 2010a). The effectiveness of model has been examined in varied socio-cultural contexts, such as various cultural groups within the UK (Pakistani-Kashmiri and African Caribbean family members in the West Midlands, and British Sikh families) and internationally (Mexico, Italy, and an indigenous sample in Australia) (Copello, Templeton, Orford, & Velleman, 2010b; Orford et

al., 2010b). Copello et al. (2010b) summarised the evidence of gains for affected family members using both quantitative and qualitative research studies. These studies included primary care, specialist services, and community settings where the feasibility of delivering an intervention based on this model was investigated. This included looking at randomized controlled trials of different formats for delivering an intervention, such as a self-help manual versus face-to-face counselling sessions. Six out of seven feasibility studies reported significant reductions in physical and psychological symptoms following intervention using the stress-strain-coping-support framework. However, over half of these feasibility studies had small sample sizes (N=15 or less). This makes it important to conduct further research into the stress-coping approach, which uses larger sample sizes and different population groups to look at how this approach fits with the broader population. In addition, while there have been studies examining the feasibility and impact of the 5-step intervention, the aim of these was not to advance our understanding of the needs of partners, and hence this gap in knowledge persists.

2.2. Personal impacts

Partners experience an increased risk of mental health problems, such as depression, anxiety, or stress, which may arise from feelings of helplessness, self-blame, uncertainty, worry, conflict and disruption to family life (Dawson et al., 2007; Homish et al., 2006; Orford et al., 2010b). However, much of the research on personal impacts has focussed on female partners, married partners, partners of problem alcohol users, or combined samples of partners with other family members. For example, in Copello et al.'s (2010b) overview of the benefits of affected family members receiving an intervention for their stresses and strains, between 67% to 95% of the recruited samples in the seven described studies were female family members. Orford et al.'s (2010b) overview of the impact on close relatives of problem AOD use was

not specific to partners. Research from Homish et al. (2006), Peled and Sacks (2008), Velleman, Copello, and Maslin (1998), all sampled married partners. Dawson et al. (2007) did include married or cohabiting women, however this was only specific to problem alcohol use in their significant other, and did not include other drugs. This limits the generalisation of findings to casual or de-facto relationships, homosexual relationships, and partners where other drug use is problematic. Same-sex relationships may change relationship dynamics by altering the gender-specific stereotyping between partners, and this may affect the specific personal impacts that partners experience. In addition, the physiological effects and associated behaviours which result from other drug use (stimulants and hallucinogens in particular, compared to alcohol, a sedating substance) may give rise to different situations partners need to cope with, altering their impact. The illegality of some other drugs, compared to the legality of alcohol, may also create greater anxiety for partners. These different research samples are important to explore to understand the breadth of personal impacts on partners, to inform support services aimed at reducing these mental health consequences, and for the development of widely-applicable resources for partners.

2.2.1. Impact on sense of self

Peled and Sacks (2008) looked at the self-perception of ten wives of problem alcohol users. While their sample size was small, and involved married partners, and only problem alcohol use, their themes on the impact on the sense of self were rich and descriptive. Through interviews, they found that women focussed on three themes: their location on a continuum between being normal or deviant compared to other married women (referring to the extent partners differed or resembled others in their social environment); their strength when able to function while managing multiple difficulties and emotional stressors (although the women differed on how strong they felt); and feeling unfulfilled as if they had missed out on life,

with a stark difference between their ability to manage their relationship and parenting duties, and a failure to care for themselves. This demonstrates a sense of responsibility the partners feel which is at conflict with their own self-care. It also highlights the difficulty these partners have in coping, despite managing to find the strength to continue. More research is needed with a larger sample size to replicate and extend these findings.

Orford et al.'s (2010b) summary of qualitative studies reported that self-image and self-confidence of family members were often damaged. This was thought to be linked with family members either blaming themselves for the problem AOD use, or an internalisation of comments or perceived judgment from either the problem AOD user, or other social contacts. Problems with self-image and self-confidence can affect the wellbeing of partners, and limited research has explored the range of internal cognitive narratives which may be involved in such shifts in self-perception for partners. In particular, given that relationships and the feedback we receive from others can impact how we view ourselves, it is important to explore the nature of interactions between partners and their significant others, and how this may contribute to changes in partners' sense of self. Orford et al.'s (2010b) summary of qualitative studies provided a rich overview of general themes across recent research studies conducted by the authors' research group, however more research is needed from independent research groups to extend and replicate these findings. In particular, an Australian wide sample of the population is needed to expand on the richness of themes described by that research group. Currently, only an indigenous Australian sample has been investigated (Orford, Templeton, Copello, Velleman, & Bradbury, 2001), and while this was in urban and rural settings, indigenous Australians can experience greater disadvantage in the community, so it is important to see the difference in impact for partners from an Australian wide sample, to see which domains of impact are most relevant to the broader population.

2.2.2. Breakdown of trust and uncertainty

Velleman et al. (1998) presented in-depth biographies from six wives of problem alcohol users. These women described being deeply affected by deceit, which affected trust in their relationships. They felt uncertainty in their relationship, as each day had varied behaviour, and promises to change were often short lived or unmet. However, it is hard to generalise findings from such a small sample size, and the impacts of polysubstance or other drug use was not included. This theme of uncertainty was also reflected in Orford et al. (2010b), who reported that family members frequently experienced the problem AOD user coming and going, and had limited knowledge of what was going on, the extent or nature of the AOD use, and whether the situation would improve. However it is unclear how this uncertainty may vary between family members, and whether partners (as opposed to parents or children) may have a greater knowledge of the extent and nature of the use and their significant other's location, due to common friends, or more information being shared in that type of relationship.

2.2.3. Increased safety concerns

Orford et al. (2010b) reported that safety concerns were a common stressor among family members. Velleman et al. (1998) described wives as living in fear of violent behaviours from husbands with problem drinking. These fears were constantly in their minds, making them feel trapped in the relationship, impacting their sense of autonomy. This implies that even in the absence of recent physical violence, partners may feel unsafe, and experience internal distress from worry and anxiety. However, it is unclear how safety concerns may be experienced if a partner is not in a married partnership with the problem AOD user, as this research did not look at the many forms a relationship can take (de-facto, casual, polyamorous), and partners may feel differently when they are less legally intertwined with

their significant other. It is important to understand in greater detail how this internal distress manifests for a wider range of partner types, as this may contribute to the development of ongoing anxiety disorders. Experiences of intimate partner violence and the safety of children are discussed in sections 2.4.2 and 2.4.4.

2.2.4. Emotional impacts

Orford et al. (2005) summarised a range of negative emotions which were associated with being a close family member of an individual with problem AOD use, which included feeling anxious, helpless, depressed, guilty, angry, frightened and alone. This impacted their health through poor sleep, personal substance use, eating or weight changes, and physical health symptoms. However, only around one quarter of family members were partners in Orford et al.'s (2005) study, making it unclear how partners may uniquely experience these impacts. Specifically looking at partners, Velleman et al. (1998) reported partners experiencing conflicting emotions, such as anger at their significant other when they were using, yet feeling like their significant other was a different person when sober. Furthermore, one partner noted they did not always feel unhappy, but they were not greatly happy either, just getting on with the tasks of life and taking each day as it comes. Feelings of increased anger among partners were also reflected in Peled and Sacks' (2008) interviews of wives of problem alcohol users. There was a common theme of loving the individual with problem AOD use, yet feeling trapped physically, economically, and emotionally, as partners feared being alone (Velleman et al., 1998).

By combining all family members into the study sample, research such as Orford and colleagues' (2005) may miss the nuance and complexity present for partners in particular. The emotional experience of a partner may differ from that of other family members, as the interpersonal needs partners may seek to meet may be different (i.e. attachment needs for

kids; parenting evaluation for parents; intimacy needs for partners) (Barnard, 2007; Holmila, 1997). For example, in partners, the loss of intimacy may lead to feelings of low desirability, which would not be expected to present in other family relationships. In this way, while similar underlying feelings may be present for different affected family members, the cognitive appraisals which lead to or maintain those feelings, or the nature and extent of those feelings may differ. This makes it important to look at the emotional impacts for partners specifically, and to look at this impact from a broad range of partners, including those partners from the community experiencing shame or stigma which may make it harder for them to share the extent of their emotional experiences.

2.2.5. Behavioural impacts and coping

Three main behavioural styles have been described for coping with problem AOD use in the family based on Orford et al.'s (1998a) study on family coping styles for drug and alcohol problems in England and Mexico. Orford et al. conducted semi-structured interviews and administered the Coping Questionnaire to look at nine coping styles, however support was not found for this 9-factor structure. Factor analytic and textual analysis found three broad coping positions better represented the experiences of family members: engaged, tolerant (also called tolerant-inactive), and withdrawal coping. Copello, Orford, Velleman, Templeton, and Krishnan (2000) discussed possible advantages and disadvantages of each. Engaged coping involves trying to change the problem AOD use by using strategies which may be controlling, emotional, or supportive. This coping style can allow the family member to feel like they are doing something, however it can increase stress and encourage resentment towards the significant other when change does not occur. Tolerant-inactive coping puts up with and accepts the problem AOD use, and may encourage continued use or make sacrifices for it to continue. This coping style can reduce open conflict in the

relationship, however it may result in harboured resentment. Withdrawal coping involves withdrawing from the individual with problem AOD use and engaging in activities independently. Withdrawing may prevent partners from being over-involved and reduce conflict over problem AOD use, however partners may also feel they are rejecting their significant other and it may reduce intimacy in the relationship. Overall, this suggests that an awareness around ways of coping and the potential pros and cons of each coping style is needed for partners to best understand how to effectively cope in their specific situations.

Copello, Templeton, Orford, and Velleman (2010a) discuss the importance of understanding each family's unique situation rather than having a prescriptive approach to coping. Orford et al. (2001) examined ways of coping in English and Mexican families, and found that tolerant-inactive and engaged coping were significantly correlated with higher scores on the Symptom Rating Test, even after controlling for family conflict in both populations. However, causality could not be inferred from these correlational results. In line with this, Lee et al. (2011) looked at the three coping styles (as measured by the Coping Questionnaire) among family members of patients with addictive problems using a matched case-control design. They found tolerant-inactive to be the coping style most correlated with poor psychological well-being for family members. However, the study was conducted with an Asian population, where different cultures may account for different coping styles and experiences of strain (such as collectivist versus individualistic societies). Hence, the findings may not generalise to a Western population such as Australia. Howells and Orford (2006) also piloted an intervention for partners of problem alcohol users, and found a reduction in sacrificial coping (similar to tolerant-inactive coping) to be associated with reduced symptoms over a 12-month period. Overall, this suggests that reducing tolerant-inactive coping may reduce partner burden.

The three coping styles described above deal with interpersonal coping, rather than intrapersonal. Interpersonal coping involves managing relationships or communication with others, whereas intrapersonal coping involves dealing with personal distress felt within the self. Partners still need to learn to manage intrapersonal distress to reduce the personal impact on their lives and increase wellbeing. It is important to think about how we can incorporate techniques which assist partners personally, in tandem with their coping strategies interpersonally to reduce the progression of stresses and strain to mental health concerns such as depression or anxiety conditions. Cognitive-behavioural therapies (CBT) are currently the gold standard for assisting individuals with a range of mental health concerns, including depression, anxiety, and stress (Beck, 2011; Hofmann & Smits, 2008). CBT involves targeting the cognitions, behaviours, and affect which are unhelpfully impacting a person's life. Cognitions (thoughts and desires), behaviours (actions), and affect (emotions and feelings) are theorised to be interrelated, and shifts in one area have an effect on the others. In this way, focussing on assisting individuals to develop realistic and useful cognitive appraisals, and helpful behaviours, can help shift or manage challenging emotional states (Beck, 2011). It would therefore be useful to map the personal impacts for partners onto these therapeutic targets, to assist with the application of focussed interventions to reduce partners' intrapersonal and interpersonal distress. This has not yet been done within a CBT framework in the partner literature. This also aligns with viewing the partner as a valid help-seeker in their own right.

2.3. Health and Socioeconomic impacts

Partners experience a range of health (physical and mental) concerns and socioeconomic impacts such as financial issues, forensic involvement when police attend a domestic violence incident, and unstable housing situations (Orford et al., 2005; Orford et al., 2010b).

However, detailed qualitative research on health and socioeconomic concerns is limited, and lacks similar breadth in sampling as the personal impact literature (gender, age, type of partner, partner versus other family members). It is important to understand in depth the broad range of impacts on partners, as this affects their interactions with society around them, the stigma and shame they experience, which together may impede their ability to seek support and assistance.

2.3.1. Mental health concerns

Most research into the personal mental health concerns for partners has focussed on problematic alcohol use, rather than other drugs. In this context, it has been found that personal stressors may contribute to the development or exacerbation of mental health concerns in partners, such as an increased risk of depression (Homish et al., 2006), anxiety (Dawson et al., 2007), and stress (Orford et al., 2010b). For example, Dawson et al. (2007) analysed epidemiological data on over 10,000 married or co-habiting women, and found that women whose partner struggled with self-reported alcohol problems were significantly more likely to struggle with mood and anxiety disorders than women whose partners did not have self-reported alcohol problems. However, this study did not look at partners of other drug users.

Partners may also have their own substance use issues to deal with (Leonard & Das Eiden, 1999; Schuckit, Smith, Eng, & Kunovac, 2002). For example, Leonard and Das Eiden (1999) explored the drinking patterns of 500 newlyweds, and found that husbands and wives displayed similar patterns in alcohol use. They asserted this may be in part due to partners' inclinations to marry similar people. Schuckit et al. (2002) also compared the marriages of sons of problem alcohol users who did and did not develop problem AOD use. They found that women who married the sons with alcohol use disorders were significantly more likely to

meet criteria for alcoholism themselves. This suggests that some partners may use similar amounts of substances to their significant other, which may be impacting their lives. However, it is unclear from these findings if the partners drink more because drinkers are more likely to get together, or because they are self-medicating from the stress of having a partner with problem AOD use.

2.3.2. Physical health concerns

The majority of physical health impacts have also been researched for partners within the context of problem alcohol use. It is important to investigate the impact on partners where their significant other has other problematic drug use as well, as the physical impacts partners experience may change depending on the specific physiological effects and associated behaviours their significant other displays. Physical health concerns are an important area for partners, as they can be at an increased risk for physical health problems and illness (Okazaki et al., 1994; Ray, Mertens, & Weisner, 2007). Dawson et al. (2007) also found that partners were at an increased risk of experiencing victimization or injury, and were more likely to be in fair or poor health compared to women whose partners did not have problem AOD use. Also, Ozaki et al. (1994) compared health problems between wives of individuals with and without problem alcohol use, and found that the wives of problem alcohol users had comparatively higher instances of genital disease, cardiovascular disease, average number of past illnesses, and current illnesses. In particular, partners' physical health may suffer as they are at an increased risk of being involved in domestic violence, although the majority of this research has focussed on female partners (Alison, 2000; Chase, O'Farrell, Murphy, Fals-Stewart, & Murphy, 2003; Fals-Stewart, Golden, & Schumacher, 2003; Gorin, 2004). Gender differences would be important to explore more broadly, as male partners may be more likely to describe emotional impacts in terms of their physical manifestations, in keeping with

traditional gender stereotypes. Overall, the research on physical health impacts suggests that partners may need to address an increased number of personal health issues.

2.3.3. Financial concerns

Financially supporting the family unit can also be challenging for partners. Disagreements over money and possessions can be at times a source of conflict. For example, Orford et al. (2010b) found that relationships between family members deteriorated over events such as the individual with problem AOD use borrowing money without asking, selling gifts, and failing to pay rent or contribute to family finances. Moreover, there may be additional medical or treatment costs associated with the problem AOD use and for other family members. For example, Ray et al. (2007) examined a large health insurance fund's administrative databases, comparing those family members of a person with a diagnosed substance use disorder, to those without. They found that family members of individuals with problem AOD use had increased medical costs due to increased health problems. This financial burden may place added strain on partners.

2.3.4. Employment and education impacts

Employment can also be impacted, with family members or the individual with problem AOD use losing jobs, or the partner needing to stop work to care for their significant other (Orford et al., 2005; Velleman, Arcidiacono, Procentese, Copello, & Sarnacchiaro, 2008). For example, Orford et al. (2005) described partners worrying about their significant other being fired, dropping out of educational courses, being neglectful of family businesses, being under disciplinary action at work, or socialising rather than working. However, there is limited research which provides in-depth qualitative description of the employment and educational impacts across a range of settings and socioeconomic groups. Instability in this area may

compound financial burdens for partners and increase personal and interpersonal strain. Therefore it is important to understand how these pressures manifest in strain for partners through detailed qualitative explorations in multiple cultural and socioeconomic groups, to better inform service provision and reduce partner burden.

2.3.5. Housing issues

Housing can also be impacted. Orford et al. (2005) described how some family members attempted to cope with their significant other's problem AOD use through moving away, kicking the significant other out, or travelling extensively. This housing instability may impact the partner, their relationship with their significant other, and their ability to provide a stable home to any dependants. However, research on the qualitative impact of housing stress on partners is limited, and more understanding is needed on how it may limit their decisions around continuing or ending relationships, interactions with financial concerns, and their concerns around children and housing.

2.3.6. Forensic interactions

In Orford et al.'s (2005) qualitative interviews, family members of problem AOD users described stress and disruption in their lives from interactions with police. This included police visiting the home, the family being called in to the police station, the family calling the police, or the problem AOD user being in trouble with police. Forensic interactions may also relate to domestic violence, child protection (Chase et al., 2003; De Bortoli, Coles, & Dolan, 2013) or drug-related offences. A greater understanding is needed on the impact of disruption from forensic matters on partners' stress and coping, to better inform services on what would be beneficial to partners when services interact with partners and other family members.

2.4. Interpersonal impacts

The term interpersonal can refer to any social context where a person is in communication or relationship with another person. For the purposes of this thesis, the term interpersonal refers to social contacts, such as friends or family, and professional service contacts, such as medical or mental health services. Partners are often heavily interpersonally impacted by problem AOD use, such as in caring for children, intimate relationship issues, sexual problems, and domestic violence or intimate partner violence (Copello et al., 2005; Cunradi et al., 2002; Fals-Stewart et al., 2003; O'Farrell et al., 1997). Previous research has been limited by age groups sampled, gender, type of relationship explored, and lacks the range of aggressive behaviours experienced by partners, focussing on the severe end of the aggressive behaviours i.e. domestic violence. It is important to investigate the broad range of interpersonal impact for partners, as damaged relationships can be a source of strain, yet strengthened relationships can be a source of resilience (Horton & Wallander, 2001). Understanding nuance and complexity in the interpersonal impacts may give us greater insight into how best to support partners with the burden they experience from interpersonal stress and strain.

2.4.1. Interpersonal interactions

Interpersonal interactions within the intimate relationship are affected by problem AOD use (Orford et al., 2010b). For example, Fals-Stewart et al. (2003) described increased arguing in couples when problem AOD use was occurring. Fischer et al. (2005) found that an increase in binge drinking episodes was associated with less positive tone in the relationship, and more disagreements over general issues and drinking. While there is an association between marital discord and substance use disorders in the relationship (Whisman, 2007), marital discord is also a risk factor for the development of substance use disorders (Overbeek et al., 2006).

Whisman, Uebelacker and Bruce (2006) assessed marital satisfaction at baseline and 12-month follow-up, in a large (N = 1675) US community sample of married adults without a substance use disorder. They found that marital discord at baseline was associated with a 3.7-fold risk of developing a substance use disorder over the 12-month period (Whisman, Uebelacker, & Bruce, 2006). Based on these findings, Whisman and Baucom (2012) suggested there may be a bidirectional relationship between problem AOD use and marital discord.

Sexual difficulties in the intimate partner relationship can also be an issue. For example O'Farrell et al. (1997) compared 26 married couples with male problem alcohol use, to 26 maritally conflicted and 26 non-conflicted couples without alcohol problems. They found that husbands with problem alcohol use experienced reduced sexual interest, increased impotence, and premature ejaculation, compared to the other husbands. There was also less overall sexual satisfaction in the married couples with a husband with problem alcohol use. The sexual difficulties align with Velleman et al.'s (1998) small (N=6) qualitative study which also described sexual difficulties in couples where AOD was being used problematically. However, these studies did not include the impact of other drug use on sexual intimacy.

2.4.2. Intimate partner violence

Partners also have an increased risk of experiencing intimate partner violence (Chase et al., 2003; Fals-Stewart et al., 2003). For example, in a large, cross-sectional, multi-ethnic US sample, Cunradi et al. (2002) found that male and female alcohol use, and female drug use were significantly associated with higher intimate partner violence. In addition, Fals-Stewart et al. (2003) had partners record aggression and substance use in daily log sheets, over a 15-month period, and found that on days males used substances they were significantly more likely to engage in aggressive behaviour towards their female partners. This suggests partners

of individuals with problem AOD use may be more likely to be victims of intimate partner violence than partners of those without problem AOD use. Moreover, Chase et al. (2003) investigated intimate partner violence among female patients with problem alcohol use in outpatient couples therapy. They found that two thirds of the women were victims of partner violence over the past year, and roughly the same percentage had also perpetrated partner violence. This suggests that it may be common for partners to be involved in domestic violence, as a victim of the violence, or as a perpetrator. Research has often focussed on more complex or extreme interpersonal issues, such as intimate partner violence, and more research is needed on the impact on partners of milder forms of aggression, including psychological and verbal abuse, which may arise in everyday interactions. This is important to help services and partners recognise and learn to manage the earlier signs of interpersonal discord and aggression to help prevent later escalation into severe aggressive behaviours.

2.4.3. Staying in or ending the intimate relationship

While previous research suggests problem alcohol use is associated with divorce (Collins, Ellickson, & Klein, 2007), it may be that different levels of or attitudes towards alcohol consumption is what increases the risk of ending the relationship. For example, Ostermann, Sloan, and Taylor (2005) conducted a US national survey of 4589 married couples on marital dissolution and alcohol consumption. They found that a discrepancy between the two partners' levels of drinking (as opposed to both partners having higher or lower levels of alcohol consumption), increased the probability of separation or divorce over four follow-up periods (each two years apart). Differing substance use levels may lead to more conflict, especially if the partner was unaware of the extent of the substance use prior to starting the relationship. Peled and Sacks (2008) found that partners often reflected on the evolution of their significant other's substance use over time, and how they found themselves in their

current situation. Orford, Velleman, Natera, Templeton, and Copello (2013) also described a feeling of loss for partners at what used to be an enjoyable relationship, which now had become centred around the AOD use. Partners' decision to stay or leave was impacted by perceived or feared judgment from family and friends. However, some partners also found the idea of being single unappealing, as they found a sense of identity in being married (Velleman et al., 1998).

2.4.4. Caring for children

Children are another key interpersonal area of impact for partners. Orford et al. (2010b) reported that partners often worried about putting their children through the experience of growing up with a parent with problem AOD use. Children in families with problem AOD use may display more problem behaviours, as well as need to be protected from parental problem behaviours, such as abuse, or exposure to domestic violence or problem AOD use (Barnard, 2007; Copello et al., 2005; Gorin, 2004). This may place partners in a challenging position of needing to deal with problem behaviours from multiple family members, and be on alert for escalations which may require quick intervention to protect children. Kroll (2004) analysed themes from seven studies which interviewed children of a parent with problem AOD use. They found that children's experiences reflected challenges with denial, attachment difficulties, family conflict, violence and fear, role reversal, and chaos. Children also experience shame around having a parent with problem AOD use, as Velleman and Orford (1999) reported children being embarrassed to invite friends over to the family home. Seeing these impacts on children may raise concerns in partners over their parenting choices, and increase personal shame and stress (Orford et al., 2010b). Moreover, in families with problem AOD use, there may be legal interventions, such as child protective services, which

need to become involved (De Bortoli et al., 2013). This can upset family dynamics, and place increased strain on partners to assist themselves and their children (Harbin & Murphy, 2000).

While previous research has looked at the impact on children of having a parent with problem AOD use (Kroll, 2004; Laslett et al., 2015; Velleman & Orford, 1999), we need more research on the impact for partners when they are attempting to parent children in a family with problem AOD use. This is important to be able to support the wellbeing not only of partners, but also of the children in their care. In particular, looking at how the heavy impacts from stresses and strains on partners around having children in this situation manifests in both interpersonal and intrapersonal distress will provide more information for services to support partners and to recognise when families are in need of extra assistance to support children.

2.4.5. Bidirectional impacts on relationships with friends and family and social support

Relationships with friends and family are also impacted by problem AOD use. Orford et al. (2010b) reported that some family members experienced a restricted social life, and worried about attending social events where the individual with problem AOD use may act out or become intoxicated. Moos et al. (2010) found that spouses of problem alcohol users had less involvement in social and religious activities compared to spouses of non-alcohol users or remitted alcohol users, suggesting some partners may withdraw from their social contexts. However these patterns were present for older spouses, and an individual's social domain can change significantly over the lifespan. Therefore it is important to see how social support is being impacted across all ages for partners. Partners may also be concerned about the problem AOD user's peer group or socialising patterns influencing their significant other's substance use, as social influences have been associated with levels of substance use in epidemiological research (Galea, Nandi, & Vlahov, 2004). This suggests that peer groups are

an important influence, yet as this was a large scale research study, the nuances of the social impacts may be missed by such results, and understanding of the impact both on and of peer groups could be enriched through more in-depth qualitative studies.

Extended family and friends can also be a helpful source of practical and/or emotional support for partners (Orford et al., 1998b). For example, grandparents may be able to assist with childcare, relieving the burden on partners (Barnard, 2007). Yet research needs to explore further the personal impacts of needing to rely on grandparents for partners, including self-esteem and self-confidence in parenting. In the broader literature, social support is associated with better health outcomes, including psychological wellbeing, physical and psychosocial adjustment, adaptive coping behaviours, and reduced depression and stress (Broadhead et al., 1983; Wang, Wu, & Liu, 2003). While less has been published around the effectiveness of social support for family members of problem AOD users, social support has also been proposed as a moderator of the impact of caregiver burden on caregivers' mental health in the addiction literature (Orford et al., 2010; Soares, Ferreira, & Pereira, 2016). For example, Soares et al. (2016) looked at 120 informal caregivers (family members or close friends) of individuals with problem AOD use, and found that increased caregiver social support predicted decreased caregiver burden. However the average age of participants in this study was 51.5 years, so it is unclear how these results would generalise to younger partners.

There is often a delay between when a partner realises they may need some form of social support and when they actually seek it (Sakiyama, de Fatima Rato Padin, Canfield, Laranjeira, & Mitsuhiro, 2015). Many partners also find it hard to reach out for social support, as some partners have reached out and not felt supported, or felt judged (Orford et al., 2005; Orford et al., 2010b). Overall, research using more inclusive samples is needed, such as a broader age range of partners, along with qualitative research which can explore the complexity of the impacts partners experience both on and from their social contexts.

2.5. Help-seeking through online counselling

2.5.1. Help-seeking for partners

Despite the range of personal, interpersonal, and socioeconomic impacts, partners often find it challenging to reach out for professional assistance, due to shame, stigma, and availability of services for partners (Orford et al., 2013). Services may assist partners when they do access help by offering services that are sensitive to their needs. For example, the 5-Step Method is a key intervention designed to assist family members (including partners) as help-seekers in their own right, regardless of whether their significant other seeks help (Copello et al., 2000). Professionals delivering the model undertake 5 key steps including 1) listen, reassure and explore concerns; 2) provide relevant, specific and targeted information; 3) explore coping responses; 4) discuss social support; and 5) discuss and explore further needs (Copello et al., 2010a). This approach aims to capitalise on the resources available to partners and other family members, to empower them to support themselves and the individual with problem AOD use. The client is encouraged to seek social support in the form of emotional support, reliable information (such as psycho-educational material around drugs), and concrete help through referrals. Personal coping resources are also explored to help reduce feelings of powerlessness, and positively contribute to the mental health of partners and other family members. This intervention has shown a reduction in physical and psychological symptoms for family members when applied in primary care or AOD service settings and helped to increase coping flexibility (Copello et al., 2010b; Velleman et al., 2011). For example, results from seven studies were summarised in Copello et al.'s (2010b) summary of benefits based on this intervention for affected family members. In all the studies, baseline physical and psychological symptoms were measured pre-intervention, and follow-up was conducted approximately 12 weeks after the baseline measurement. In six out of these seven studies, there were significant reductions in physical and psychological symptoms as

measured by the Symptom Rating Test, for example in Orford et al. (2009) total symptom scores reduced significantly from 36.8 to 29.2 in a community implementation study. However, there was no control condition or treatment as usual condition to which the symptom reduction in the intervention time frame was compared to. In addition, there was a sampling bias by largely recruiting participants from support services, which may not represent the range of partners in the community who do not reach out for such support. Moreover, interview studies can create social desirability effects, whereby answers are censored, and the full impacts on partners may not be expressed.

Moreover, Copello et al. (2009) compared brief (one professional face-to-face session with a self-help manual) versus full (five professional face-to-face sessions with a self-help manual) 5-Step intervention across 136 primary care settings in England. There was no significant difference between the two intervention lengths in physical or psychological distress outcomes (as measured by the Symptom Rating Test), or behavioural coping (measured by the Coping Questionnaire). This suggests that brief interventions using the 5-Step method may be equally beneficial for family members. However, it is challenging to deliver this assistance to all those who need it due to practical (geographic location, service cost, service availability) and personal (concerns over shame and stigma) barriers. Ibanga (2010) conducted a pilot trial of a web-based 5-step method to increase the availability of the intervention to affected family members. User reports from interviews of family members who registered on the site mentioned the method was straightforward, easy to use, and helpful in its online form (Ibanga, 2010). However, only 10 family members were interviewed, so further effectiveness studies are required to look at the 5-Step intervention in the online modality. Still, the effectiveness of brief interventions reported by Copello et al. (2009) and these preliminary findings from Ibanga (2010) suggest that the online modality, along with its

greater accessibility for the broad implementation of services, may be a useful avenue to explore for the provision of assistance to partners.

2.5.2. The online context

This emergence of a digital era has seen a societal shift in the way we interact with each other (Gackenbach, 2011). Since the mid-1990s the Internet has increased connectivity, enabling near-instantaneous communication with people all over the world (Leiner et al., 2009). Online communication technologies such as email, synchronous chat, mobile applications, and web applications, are now integrated into everyday interactions in an unprecedented manner. This provides helping professions an opportunity to engage with a larger clientele through a range of media, rather than being restricted to the traditional face-to-face modality.

The online context has been increasingly used by health professionals over the past two decades (Barak, Hen, Boniel-Nissim, & Shapira, 2008). It can employ a variety of therapeutic interventions, and has been used as stand-alone treatments or as an adjunct to traditional face-to-face services (Rochlen, Zack, & Speyer, 2004). This can include online communication with a human, such as etherapy; self-help or website-based therapy which has been set up in advance using pre-defined interventions; interventions delivered in "real-time" (synchronously, such as chat) or delayed (asynchronously, such as email); various modes of communication, such as audio, text, or visual media; and many psycho-educational resources available online (Barak et al., 2008). Clearly there is a range of resources and methods of intervention now available online. What is still unclear however, is how these services are being used to assist partners.

One particular online therapeutic interaction which has been used to support partners is online counselling or etherapy. Online counselling refers to a mental health intervention between a client and a therapist which uses technology as the mode of communication (Barak

& Grohol, 2011). Online counselling extends to self-help guides, psychological assessment, email consultations, and synchronous or asynchronous support groups and counselling (Callahan & Inckle, 2012). Self-administered online assistance has been provided to partners with promising results. Rychtarik, McGillicuddy, and Barrick (2015) implemented a web-based 8-week coping skills training program for partners of problem alcohol users. This self-paced program assisted in reducing depressive symptoms and situational anger in partners, suggesting the online modality may be a useful medium to deliver services to this underserviced population. However, this did not involve live interaction with a clinician online, and did not incorporate male partners, or partners of problem other drug users. Ibanga's (2010) web-based pilot trial of the 5-step intervention was also fully-automated, rather than involving a live clinician interaction. No research has looked at help-seeking for partners of individuals with problem AOD use in synchronous online chat counselling. A systematic review on online synchronous chat by Hoermann McCabe, Milne, and Calvo (2017) looked at mental health interventions including for addiction, and found positive post-intervention gains from the modality. However, partner-specific studies were not included in the review. Online counselling using synchronous chat has widespread appeal due to the accessibility, anonymity, and immediacy of the connection and the interaction with a person on the other end (Rodda, Lubman, Dowling, Bough, & Jackson, 2013a). Synchronous online chat may have more appeal than automated approaches, as it allows the opportunity to access a real counsellor remotely, which may assist with tailoring interventions, or increasing treatment engagement with online interventions by making the service more personable (Schubart, Stuckey, Ganeshamoorthy, & Sciamanna, 2011).

2.5.3. Online counselling modality

Online counselling is a unique modality, which would be expected to share some similarities and some differences with face-to-face or telephone modalities. This implies there may be some factors specific to the online counselling modality that may affect its quality or delivery. The following factors have been suggested to affect online counselling. They are mostly based on studies from other population groups, given the limited availability of research specific to partners for online counselling.

Advantages of online counselling. There are many factors that partners of individuals with problem AOD use may view as advantages to using online counselling. It can be affordable, available anywhere with internet access, with some services operating at any time, and accords an anonymity, encouraging individuals to seek the help they need, reducing barriers such as shame, stigma, and physical, lifestyle, financial, or geographical limitations (Rodda et al., 2013a; 2013b).

Low cost. In many countries such as Australia, New Zealand, and the United Kingdom, online counselling is free. This helps reduce the financial burden of accessing services which may be preventing many from seeking help. Other countries, such as the US have different payment systems involved depending on the state. Rychtarik, McGillicuddy, and Barrick (2013) assessed partners of problem drinkers' interest in online coping skills training, and the assistance being low cost was important to partners' interest. Financial feasibility of services may be important for partners, as financial difficulties can often accompany problem AOD use (Orford et al., 2010b).

Convenience. One of the greatest benefits of online counselling is its accessibility. Geographical limitations can reduce the extent to which individuals are able to access mental health services. This extends beyond those who live in remote areas, to individuals who frequently travel and may not be able to access AOD and counselling services on a regular

basis in their first language (Rochlen et al., 2004). This is also beneficial to individuals who may have physical or lifestyle restrictions, such as physical disabilities. Importantly for partners, it may assist them if they are unable to organise childcare.

Moreover, online counselling reduces time constraints, as many online counselling services operate outside of working hours, with some providing 24/7 assistance. It allows clients to access the service when they feel they need it. For example, Rodda, Lubman, Dowling, and McCann (2013) investigated the motivations behind family and friends accessing an online counselling service for problem gambling. They found that family and friends were particularly interested in accessing help late at night when they were struggling with how to manage some of the problems stemming from the gambling. A similar process may be at work for partners of individuals with problem AOD use, as reduced time constraints offered by online counselling may provide them a service available when they are most motivated to receive help.

Anonymity. Some have suggested that online counselling may be attractive due to an increased perceived anonymity and confidentiality by the client (Glasheen & Campbell, 2009; Leibert, Archer, Munson, & York, 2006). Swan and Tyssen (2009) evaluated an Australian AOD online counselling service (Counselling Online), and found clients reported a desire for privacy as a reason for using online counselling. Moreover, Liebert et al. (2006) performed an exploratory study around perceptions of online counselling, based on 81 clients who had previously accessed online counselling for mental health issues (ranging from depression to substance abuse). They found that online clients appreciated the anonymity and convenience of the service, as this enabled them to share information they perceived to be shameful. Shame and stigma can be massive barriers to help-seeking (Clement et al., 2015). For example, Naughton, Alexandrou, Dryden, Bath, and Giles (2012) found that shame and stigma were common factors for problem alcohol users to avoid seeking help for many years.

These fears are also present in family members of individuals with problem AOD use (Orford et al., 2005). Therefore the perceived anonymity of online counselling may enable some partners to overcome barriers around shame and stigma, and reach out for help.

Moreover, online counselling may provide a means of seeking support if there is a concern about being overheard when making a telephone call (Callahan & Inckle, 2012; Rodda et al. 2013b). Providing partners the space and privacy to seek help may lower their anxiety, and help them be more open with the online counsellors when discussing their problems.

Enhancing therapeutic action. Some have suggested that writing may be in and of itself therapeutic (Murphy & Mitchell, 1998). This may enable the clients to reflect on their experiences as they write them, which can help clients to reframe the experience and make links they otherwise may not have made (Pennebaker, 1997). It also allows clients to externalise their problems in a concrete manner, seeing it written down in front of them (Rochlen et al., 2004). This may be important for partners feeling overwhelmed, to help bring some order and expression to complex stressors in their lives.

Moreover, online counselling enables counsellors to send clients links to multimedia and other therapeutic tools which the client can access immediately. This increases the amount of resources a counsellor is likely to use, as the counsellor is not limited to the resources present in their office (Rochlen et al., 2004). This may be helpful for encouraging partners to use support provided, as the partners may be more likely to use resources and access materials or referrals if they have them immediately available to them.

Challenges of online counselling. However, there are also challenges to online counselling which may affect the delivery of the service to partners. These include the lack of non-verbal cues for counsellors, time lags in chat or being unable to access a counsellor, and

a limited time for counsellors to use the full range of therapeutic techniques (Dowling & Rickwood, 2013; Shandley & Moore, 2008).

Lack of non-verbal cues. Non-verbal cues can be used to convey interpersonal warmth (Bayes, 1972). The challenge of textually based synchronous online counselling is the lack of non-verbal communication conveyed by both the therapist and the client (Anthony & Nagel, 2010). Non-verbals can help a therapist navigate the therapeutic interaction to provide a warm and empathic experience for the client. They can also inform a therapist when they may need to pull back or come at an issue from a different angle (Feltham & Horton, 2006). Lacking non-verbals may create difficulties in the therapist expressing empathy to the partners, and get in the way of a trusting and open interaction.

This challenge has led practitioners to focus on how they express themselves to create an atmosphere of warmth and acceptance in order to engender trust (Callahan & Inckle, 2012). For example, Callahan and Inckle (2012) interviewed online counselling practitioners and found that they focussed on using emoticons, abbreviations or internet short-hands, and pacing (speed and flow) in their interactions in an attempt to be perceived as warm. Examining the processes behind the establishment of trust in online counselling is beyond the scope of this study, but its application to partners is worth investigating in future research.

Time lags in chat. Delays in response have been flagged as a hindrance to online counselling (Urbis Keys Young, 2003). It takes time to type, especially with practitioners thinking about what they write in an effort to maintain professionalism and communicate warmth and empathy (Callahan & Inckle, 2012). Also, without a visual impression of the other person, it may be challenging to understand the reason behind time lags. For example, silence could mean a poor internet connection, being distracted by other people in the room, or being really frustrated with the content being discussed. This may lead to

misunderstandings which could interfere with the pace and process of the therapy (Dowling & Rickwood, 2013).

Unable to access a counsellor. While online counselling has the potential to increase the immediacy of help provided to clients, often these services can be in high demand. This may result in significant wait times for partners of individuals with problem AOD use, and subsequent frustration. King et al. (2006) explored the experiences of clients of a children's online helpline, and found that the clients felt there was insufficient time for the counselling sessions, a long wait time in the queue compared to their experiences with telephone helplines, and insufficient hours of availability on this particular online counselling service. This is problematic given the marketing of online counselling as a service aiming to increase the accessibility of therapeutic interventions to clients. Fortunately, some online counselling services for partners are open 24/7, which may counter the frustrations around insufficient availability hours. However, frustration from wait times may make it challenging for online counsellors to establish a positive relationship with the client at the start of the interaction.

Therapeutic alliance. It is important to consider the relationship between the partner and the counsellor. Challenges to conveying empathy and building a therapeutic alliance can interfere with the ability to work therapeutically and build a working alliance with clients as they can undermine trust (Feltham & Horton, 2006). Building a therapeutic or working alliance involves collaboration between individuals in the therapeutic interaction in order to facilitate healing (Bachelor & Horvath, 1999). Concern over the importance of establishing a therapeutic alliance may see online counsellors spending more time initially clarifying the problem and validating the partner, in line with Chardon, Bagraith, and King's (2011) finding of online counselling sessions having an emphasis on information gathering from the client. Stigma may also play a role here, where clients may perceive that online therapies are not real therapy, and they may express concerns around trust and privacy (Rodda et al., 2013a).

In addition, services may provide one-off interactions (Rodda, Lubman, Cheetham, Dowling, & Jackson, 2015) which may make it challenging to build the therapeutic alliance and engage in longer support programs with clients.

Overcoming these challenges. However, online counselling may have different mechanisms for establishing this therapeutic alliance, enabling therapeutic work to still take place. In fact, some of the perceived challenges to establishing a therapeutic alliance—such as a lack of non-verbal cues—may make online counselling more attractive to clients (Callahan & Inckle, 2012). McKenna and Bargh (1998) asserted that perceived anonymity may foster intimacy where there is a lower fear of rejection. This has been referred to as a 'disinhibition effect' by Suler (2004), who asserted that this may enable clients to open up more readily and engage in deeper conversations without as much of the prior rapport building which would be necessary in face-to-face therapy. This would be consistent with the findings from Cook and Doyle's (2002) study, which compared working alliance scores between online therapy clients and face-to-face clients. They found no significant difference in the level of working alliance achieved. This suggests that a therapeutic alliance is still being established online, making online counselling a viable modality for therapeutic work. Clients may find online support less intimidating, and feel more in control and less vulnerable during the session (Cook & Doyle, 2002; King et al., 2006). It may help them to feel more empowered and be more directive concerning their needs and what they hope to achieve with the therapeutic interaction. Potentially, this may also may make a single session model of online counselling beneficial as clients may be able to get to the heart of what they are talking about sooner, thus maximising the help they can receive.

Overall, partners are interested in seeking assistance through the online modality (Rychtarik et al., 2013). However, the nature of the help partners seek and receive through online synchronous chat counselling is still unclear. The online modality brings with it unique

factors described here that may influence the help-seeking experience for partners. Services have begun providing online assistance due to the immediacy of needs of partners, and research is needed to understand how we can support partners in this modality. Moreover, this modality provides us with a rich data source for uncovering greater depth in personal, interpersonal, and help-seeking needs for partners, to inform both online and face-to-face services.

2.6. Summary of limitations of previous research

2.6.1. Strengths of previous research and overall gaps in the literature

Previous research has looked at a range of impacts which affect partners, such as increased risks of experiencing domestic violence, financial issues, health problems, and relationship issues (Cunradi et al., 2002; O'Farrell et al., 1997; Orford et al., 2005). However, studies to date have sample-related limitations, focussing primarily on female partners, married partners, partners of problem alcohol users, or combining all family members in samples (Dawson et al., 2007; Moos et al., 2010; Orford et al., 2010b; Peled & Sacks, 2008). This makes it challenging to generalise results to a broader range of partners. Moreover, traditionally partners have been researched through a pathologising lense (Whalen, 1953), which limits the applicability of such research to informing services aimed at supporting partners. More research needs to research partners using de-pathologising models, such as the stress-coping approach, to assist partners to feel comfortable to access services which view them as valid help-seekers in and of themselves. However, the majority of current research using de-pathologising models for partners and family members stems from a group of key researchers in the field (Orford et al.; 2005; Orford et al., 2010b). Much more research is needed from independent groups to replicate and build the findings of this growing research base. In addition, given the limited amount of studies, more qualitative studies (as opposed to

quantitative studies) are needed to understand concepts from a bottom-up (data driven) approach for partner impacts. Qualitative research will better capture the complexity of partners' experiences, to enable theory building from data driven findings (Braun & Clarke, 2006).

2.6.2. Impact on cognitions, behaviours, and affect

Previous research has looked at interpersonal rather than intrapersonal coping for partners. Partners are valid help-seekers in their own right, and therefore looking at how to assist them intrapersonally in addition to interpersonally is highly relevant. Research mapping the impact of being a partner on cognitions, behaviours, and affect is the first step to designing interventions which incorporate this aspect of support for partners.

2.6.3. Range and prominence of intimate relationship issues

Previous research has often documented severe or complex representations of the impact on partner relationships, such as intimate partner violence which has required medical treatment, or not differentiated between mild versus severe aggression associated with problem AOD use in their analyses (Foran & O'Leary, 2008). More research is needed which seeks to understand the impact that the everyday stresses and strains have on partners' intimate relationships, such as mild arguments or violence, which do not come to the attention of hospitals, clinics, or potential research recruiters. As such, we need to understand the range of interpersonal experiences and impacts on intimate relationships from partners who may find it challenging to speak up about their situation and seek assistance.

Given the impact on relationships, prior treatment initiatives have sought to include partners in therapy. However, significant others are not always willing to engage in services with partners. It is important to understand which impacts are prompting partners to seek help

in the absence of their significant other, to be able to target assistance to the impacts partners view as most pressing in their context. Therefore, more research is needed to uncover intimate partner issues which come up while a partner is seeking help.

2.6.4. Partners versus other family members

Previous research using the stress-coping approach has often not differentiated partners from family members more broadly (Orford et al., 2010b). This neglects the different stresses and responsibilities which may fall on family members based on the closeness of their relationship to the problem AOD user. For example, Orford (2017) asserted that the two types of family members most likely to carry the heaviest burdens were partners and mothers, due to greater accumulated burdens. This makes it important to further investigate the impacts on partners specifically.

2.6.5. Types of partners

Moreover, partner research has a heavy emphasis of looking at spouses, in particular wives of problem alcohol users (Iqbal, Ahmad, & Rani, 2015; Schuckit et al., 2002; Wiseman, 1991). However, de-facto, girl/boyfriend, or ex-partners are also impacted by their partners, along with both males and females, and research which includes a broader definition of partners is needed to represent the range of impacts experienced. Moreover, less research has focussed on the impacts and stressors for partners of problem drug users. Given problem drug use is estimated to impact 29 million individuals (United Nations Office on Drugs and Crime, 2016), and only one in six individuals with drug use disorders are estimated to be in treatment, a heavy burden is placed on family members who support these individuals. Therefore it is important to explore the impacts on partners of both problem alcohol and/or other drug use.

2.6.6. Recruitment methods

Previous research on partner impacts has also sampled partners who were formally recruited to studies. A further sampling bias may be that those with the greatest impacts are the ones who choose to participate in research. Studies are therefore needed that sample from a broader range of concerned partners, who may or may not have presented to formal services in the past. One potential recruitment source that attracts a large population of concerned family members are online counselling services (such as Counselling Online in Australia), which are frequently the first point of access for partners seeking help as they allow family members to remain anonymous while accessing confidential and immediate support (Garde, Manning, & Lubman, 2017; Rodda et al., 2013b). Online counselling using synchronous chat has been found to be effective in delivering psychosocial interventions, and has not looked specifically at partners in this context (Hoermann et al., 2017). This makes recruiting from online counselling a useful extension to previous research, to uncover what impacts partners are experiencing and how we might be able to support partners in the online modality, with a view to informing future online interventions.

2.7. Current study

2.7.1. Rationale

Problematic alcohol and other drug (AOD) use impacts partners heavily, with an increased risk of experiencing mental health concerns, stress, relationship issues, and socioeconomic disadvantage (Cunradi et al., 2002; Dawson et al., 2007; Orford et al., 2010b). Partners (along with mothers) experience a greater accumulative burden from their significant other, compared to other family members (Orford, 2017), making it important to understand how best to assist them. Previous research has looked at assisting partners through building interpersonal coping skills. Further research is needed on how we can assist partners to cope

with these impacts intrapersonally, such as looking at how the stresses and strains for partners manifest in their cognitions, behaviours, and affect. This will assist us to complement existing interventions (such as the 5-Step Method by Copello et al., 2010a) with support targeting unhelpful cognitions, behaviours and affect for partners.

Moreover, previous research has often focussed on more severe impacts on relationships, such as domestic violence, or focussed on the impact on children from the child's perspective, rather than from the partner's perspective. More research is needed looking at the range of impacts which includes everyday stresses and strains, and how this impacts the intimate relationship, caring for children, and the partners' social world. In particular, the impacts on the social context are important to further understand, as social support can assist partners, yet partners still find it challenging to reach out for support due to shame and stigma. Research which seeks to understand and normalise the experience for these partners (though conceptualising partners' experiences as related to stress and coping with their situation), aims to contribute to the de-pathologising of partners, to assist them to reach out for help. This research is important to inform peer support forums and psycho-educational material for partners and the general public.

Partners also find it challenging to reach out for professional assistance, due to personal and practical barriers (shame, stigma, finding time, organising childcare, and geographical limitations) (Rodda et al., 2013b). Online counselling may assist a broader range of partners to seek help by overcoming some of these barriers. Despite the implementation of online services for partners, no research to date has looked at how to support these partners in synchronous online chat counselling, or how their help-seeking needs translate to this online modality. One such service is Counselling Online, a service for problem AOD users and concerned family members. Launched in 2005, Counselling Online provides free self-help resources, information, synchronous and asynchronous online chat counselling services, 24/7,

without an appointment. Each year over 2000 synchronous chat counselling sessions are provided across Australia. Nearly 10% of these sessions are contacts by partners, which includes spouses, boyfriend/girlfriend, de-facto partnerships, heterosexual or homosexual relationships, or ex-partners who still connected with their former significant other (Garde et al., 2017). Examining online transcripts of these interactions allows us to investigate the experiences and needs of partners of individuals with alcohol and/or other drug use, including partners of both genders, and a broad age range. Examining such online counselling transcripts provides us not only with access to a broader community sample, but also the opportunity to understand real-world descriptions of partner issues that prompt a specific call for help. It allows us to understand the actual personal and interpersonal impacts partners spontaneously describe in session, which are not biased or limited by the prompts inherent in research designs with interview or survey questions. Such findings will assist in developing appropriately targeted support resources as well training online counsellors in online service provision that addresses partner needs.

Also, as many partners may not have sought professional help before, applying a qualitative approach allows for the emergence of themes which reflect the lived experience and help-seeking needs of these individuals, and enables theory to be supported and built from a bottom-up approach. Qualitative research enables the complexity and nuance of experiences to be understood in greater detail than quantitative research, as the breadth and depth of impacts can be limited by established questionnaires. In particular, as it is expected that a broader range of partners may be accessing online counselling, compared with face-to-face services, a qualitative approach will assist with uncovering any new themes or sub-themes which may be pertinent to partners, yet have been overlooked due to sampling biases. Qualitative research also provides rich descriptions which can inform educational campaigns

through rich descriptive stories, which are well suited to assist in validating and normalising issues such as addiction in the community through shame and stigma reduction.

2.7.2. Aims

Specifically, this thesis has three core aims:

1) To examine the personal impact for partners of being in an intimate relationship with an individual with problem AOD use, under the headings of cognitions, behaviours, and affect, through a qualitative thematic analysis of online counselling transcripts from a national online AOD counselling service;
2) To examine the interpersonal impacts for partners through a qualitative thematic analysis of online counselling transcripts from a national online AOD counselling service;
3) To conduct a qualitative analysis of help-seeking in online counselling transcripts of partners contacting a national online AOD service.

3. Brief overview of Methods

3.1. Choice of analysis

This thesis contains three papers, which used two different qualitative analysis techniques, to enable an in-depth analysis of transcripts (and the meaning contained within) from different angles". Paper one (personal impacts) and paper two (interpersonal impacts) were analysed using Braun and Clarke's (2006) rigorous method of thematic analysis. This method views coding as flexible and allows themes to evolve while coding. As thematic analysis encourages the researcher to identify common themes as well as diverse experiences, it was considered a suitable analytical approach to address research questions one and two, which was about identifying both common personal and interpersonal impacts, as well as the range of impacts noted. Thematic analysis was also chosen as it allows a combination of deductive and inductive analyses to take place, as was needed in paper one. This stems from paper one's rationale to look at the cognitions, behaviours, and emotions for partners (deductive) that have been previously identified in the literature to uncover the specific new themes within these categories (inductive). Further details of this are expanded upon in the paper. Papers one and two were investigated separately based on the substantially different literature for each area (in particular for domestic violence issues), and the need to go into greater depth in each aspect of the impact on partners, given the quality of the novel online sample.

For paper three (online help-seeking), descriptive content analysis was chosen (for an example see Rodda, Lubman, Cheetham, Dowling, & Jackson, 2015). This method combines the thematic analytic process described above, for the creation of themes, with a content analysis, for a view of the spread of those themes (Neuendorf, 2002). This combined method was chosen as the paper is a critical step that builds on the contribution of the impacts described in papers one and two. Specifically, this paper focuses on how we can support partners online, which is targeted towards improving service provision in the online

environment for partners. This makes it important to both understand what themes are important to partners to discuss in relation to help-seeking (thematic analysis), and what percentage of transcripts discuss those themes (content analysis).

For all papers, an *a priori* decision was made to analyse the data from the client script, rather than the counsellor script. We chose to exclusively analyse the data from the client script, rather than the counsellor script, because our research questions and aims are exclusively about partner experiences and perceptions – not counsellors' perceptions. While recognising the interaction with counsellors may have influenced client responses, a structured assessment format with the counselling session encouraged client disclosure of key issues and concerns. This focus on the client script aims to provide a more accurate representation of what the partner experiences, as it focusses on what the partner is expressing, rather than a counsellor's perception of what the partner is conveying (Rodda et al., 2015). However, it is likely that influence from the counsellor will still be present in the transcripts, and this limitation is discussed in more detail in the integrated discussion section 7.5.3.

3.2. Timing of data analysis

The same 100 online counselling transcripts were used in all three papers. The transcripts were initially coded at the same time and codes were generated in relation to each of the research questions. Each paper focussed on one research question only so that there was no overlap in data extracts used. Further analysis on the data, including the creation of any themes, as described in the papers, was then conducted separately.

4. Paper one: Personal impacts for partners

4.1. Preamble to paper one

Results pertaining to the personal impacts on partners are presented in the form of a paper titled "The personal impacts of having a partner with problematic alcohol or other drug use: Descriptions from online counselling sessions" (Wilson, Lubman, Rodda, Manning, & Yap, 2017). This paper has been accepted for publication by the journal "Addiction Research and Theory". The aim of the paper was to examine the personal impact for partners regarding their cognitions, behaviours, and affect, through a qualitative thematic analysis of 100 online counselling transcripts from a national online AOD counselling service. The 100 transcripts analysed as part of this paper are part of the same sample used for papers two and three. Initially, transcripts were coded at the same time, and codes were generated in relation to each of the research questions. There was no overlap in data extracts used, as each paper focussed on a different research question. Further data analysis on the data, including theme creation which is described in the paper, was then conducted separately. Themes from this paper relevant to the cognitions, behaviours, and affect of partners were explored in the results. The results are followed by a discussion of the findings, which is elaborated on in the integrated discussion (sections 7.1 and 7.2).

4.2. Paper one

The personal impacts of having a partner with problematic alcohol or other drug use: Descriptions from online counselling sessions

Samara R. Wilson[1], Dan I. Lubman[2, 3], Simone Rodda[3, 4], Victoria Manning[2, 3], Marie B. H. Yap[1, 5]

[1]School of Psychological Sciences, Monash Institute of Cognitive and Clinical Neurosciences, Monash University, Clayton, Australia; [2] Eastern Health Clinical School, Monash University, Box Hill, Victoria, Australia; [3]Turning Point, Eastern Health, Fitzroy, Australia; [4]School of Population Health, University of Auckland, New Zealand; [5] School of Population and Global Health, University of Melbourne

Correspondence: please address to Prof Dan Lubman [redacted]

Biographical notes:

Samara Wilson is a Doctor of Psychology (Clinical) candidate at the School of Psychological Sciences, Monash University. Her doctoral thesis focusses on the impact of problem alcohol or other drug use on partners. [redacted]

Dan Lubman is a psychiatrist and addiction medicine specialist. He is the director of Turning Point and is a Professor of Addiction Studies at Monash University. Phone: [redacted]

Simone Rodda is a Senior Lecturer at the University of Auckland, New Zealand and an honorary senior research fellow at Turning Point, Australia. [redacted]

Victoria Manning is a Senior Research Fellow at Turning Point and a lecturer at the Eastern Health Clinical School, Monash University. [redacted]

Marie Yap is a National Health and Medical Research Council (NHMRC) Career Development Fellow, Senior Research Fellow and psychologist at Monash University. She is

the primary supervisor of Ms Wilson's doctoral research project. Phone: [redacted]

Email: [redacted]

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The personal impacts of having a partner with problematic alcohol or other drug use: Descriptions from online counselling sessions

Abstract

Background: Previous studies have identified that problematic alcohol and other drug (AOD) use has major impacts on family members. Work with partners suggests they experience mental health problems, such as depression, anxiety, or stress, which arise from feelings of helplessness, self-blame, uncertainty, worry, conflict and disruption to family life. However, most studies have focused on interviews with participants purposively recruited from face-to-face settings. Whether these issues are common to a broader range of partners seeking help and advice from online services requires further study. **Method:** One hundred synchronous online chat counselling transcripts of partners of individuals with problem AOD use were sampled from a 24-hour national online counselling service in Australia. Thematic analysis was used to look at the personal impacts reported by these partners. **Results:** The personal impacts identified were reflected in partners' cognitions (depressive cognitions, responsibility beliefs, and thoughts around trust), behaviours (helpful and unhelpful coping) and emotions (anger, sadness, and fear). **Conclusions:** These findings highlight the substantial burden that problematic AOD use imposes on intimate partners personally, reinforcing the need for services to engage partners as valid help-seekers in their own right.

Keywords

Significant other; substance misuse; illicit drugs; internet interventions; family; qualitative.

Background

Problematic alcohol and other drug (AOD) use affects not only individuals, but their families as well (Fotopoulou & Parkes, 2017; Orford, Velleman, Copello, Templeton, & Ibanga, 2010). One in three Australians experience negative effects from the problematic use of alcohol by someone close to them (Laslett et al., 2011). These negative effects include an increased risk for mental health problems, such as depression (Homish, Leonard, & Kearns-Bodkin, 2006), anxiety (Dawson, Grant, Chou, & Stinson, 2007), and stress (Orford, Copello, Velleman, & Templeton, 2010). Stress and strain (strain being the manifestation of the psychological impact from stress) arise from experiencing aggressive behaviour, conflict over finances, uncertainty, worry, and disruption to family life (Orford, Velleman, et al., 2010). The closer the family member is to the relative who has problematic AOD use, the greater the strain experienced (Orford, 2017). Strains on partners are important to investigate, as they are the most prevalent type of family member impacted; a national Australian survey on harms experienced by family members found that around one third (33.7%) of affected family members were partners or ex-partners (Berends, Ferris, & Laslett, 2012).

Intimate partners of individuals with problem AOD use (referred to from here as partners) are particularly affected. Rodriguez, Neighbors, and Knee (2014) performed a literature review which highlighted links between marital distress and problem alcohol use, with problems in either area exacerbating the other. Peled and Sacks (2008) also identified that female partners of problem drinkers reported feeling a sense of responsibility and blame for the problem drinking, along with feelings of helplessness, sadness, anger, and low self-confidence. Indeed, the stressors inherent in having a partner with problematic AOD use may contribute to the development of mental health problems. For example, Dawson et al. (2007) analysed epidemiological data on over 10,000 married or co-habiting women, and found that

women whose partners had problematic alcohol use were significantly more likely to have mood and anxiety disorders.

Mental health concerns and life stresses typically impact on an individual's cognitions, behaviours, and emotions (Beck, 2005; Hofmann & Smits, 2008). Previous research has looked at interpersonal impacts and coping styles partners display under stressful situations, such as engaged coping (trying to change the problem AOD use), withdrawal coping (withdrawing from the significant other and engaging in independent activities), and tolerant-inactive coping (putting up with the problem AOD use) (Orford et al., 1998). However, to help inform interventions to reduce stress and increase adaptive coping, such as that proposed by Howells and Orford (2006), more detail is needed on situationally specific manifestations of these coping approaches. In addition, limited research has looked at intrapersonal coping, such as impacts on the self (cognitions, behaviours, emotions). This is an important step towards gaining a richer understanding of the specific personal impacts partners experience, to inform the development of a broader range of targeted interventions and resources. As such, the current study sought to understand how the stress and strain of being a partner of an individual with problem AOD use, impacts cognitions, behaviours, and emotions.

Research investigating the personal impacts of partners to date has typically sampled partners who were formally recruited to studies from accessing high intensity supports (face-to-face counselling, groups, psychologist, psychiatrist) rather than low-intensity supports (helpline, online including chat, email, forums). We are interested in those accessing low-intensity supports because they are frequently accessed anonymously and as needed. A further sampling issue may be that partners with the greatest impacts are the ones who choose to participate in research. Studies are therefore needed that sample from a broader range of concerned partners, who may or may not have presented to high intensity treatment services in the past.

One potential recruitment source that attracts a large population of concerned family members are online counselling services, which are frequently the first point of access for partners seeking help as they allow family members to remain anonymous while accessing confidential and immediate support (Garde, Manning, & Lubman, 2017; Rodda, Lubman, Dowling, & McCann, 2013). Online counselling services (such as Counselling Online in Australia) provide free 24/7 real-time chat (i.e., synchronous) to users and concerned family members, without an appointment. Analysing online transcripts of such interactions provides a unique opportunity to understand real-world descriptions of partner issues that prompt a specific call for help (Wilson, Rodda, Lubman, Manning, & Yap, 2017). Online transcripts have been studied to provide novel information regarding help-seeking for other addictions such as gambling (Rodda, Lubman, Cheetham, Dowling, & Jackson, 2015), including contact by family members (Rodda et al., 2013). Furthermore, research involving family members of gamblers accessing online counselling reports that almost all experience personal impacts associated with emotional relational distress (Dowling, Rodda, Lubman & Jackson, 2014). Accessing online counselling transcripts also allows us to understand the actual personal impacts partners spontaneously describe in session, which is not limited by the prompts inherent in research designs with interview or survey questions. As many partners may not have sought professional help before, applying a qualitative approach allows for the emergence of themes that reflect the lived experience of these individuals, and enables theory to be supported and elaborated through deductive and inductive approaches. In this study, we aimed to examine the personal impact for partners regarding their cognitions, behaviours and emotions, through a qualitative thematic analysis of online counselling transcripts from a national online AOD counselling service.

Method

Counselling Online

Counselling Online was launched in 2005, and currently attracts roughly 40,000 visitors per annum (Garde et al., 2017). The service offers self-help resources, information, and a synchronous online chat counselling service for individuals with problem AOD use, their families and friends. Counselling Online operates 24/7, and provides over 2000 one-to-one online chat based counselling sessions per year. Roughly 10% of all online sessions are accessed by partners of individuals with problem AOD use. The service operates in all states and territories of Australia. The average session duration is 29 minutes (Garde et al., 2017). Most clients access Counselling Online anonymously, however there is an option to register with an email to have transcripts on file for repeat access to the service. Clients are advised in the terms and conditions of accessing the service that de-identified data and demographic information may be used for research or training purposes. Demographic information is collected on sex, age, cultural identity, and primary drug of concern. This information is provided directly by the client at the pre-session stage. The concept of partner was used inclusively, referring to homosexual or heterosexual relationships, spouses, girlfriend/boyfriend, de-facto, or ex-partners.

Counselling Online transcripts from 2013 to 2014 were accessed. De-identified transcripts were exported to Microsoft Excel. The most recent 100 partner transcripts were extracted to form the study's sample, as counsellors at the service had undergone training in 2013 in working with partners, and we wanted to ensure that the results were generalizable to current practices. This training related to the 5-Step Method by Copello, Templeton, Orford, and Velleman (2010), which is an approach designed to support family members of those with problem AOD use. While 100 transcripts is a relatively large sample for qualitative analysis, previous research using counselling transcripts suggest a larger number of transcripts are required to reach data saturation (Rodda et al., 2015). The sample's breakdown

of drug type and gender was then explored to enable purposeful oversampling of male partners (an under-represented group in the literature), and to ensure the sample reflected an even split between alcohol (50%) and other drugs. This involved re-sampling an extra 9 alcohol transcripts to replace 9 other drug transcripts, and replacing 4 female transcripts with male transcripts. This re-sampling was also done chronologically from the most recent transcripts in the 2013-2014 period. Ethics approval was granted by the Monash University Human Research Ethics Committee (Project number: CF14/1929 – 2014000980) and the Eastern Health Human Research Ethics Committee (Reference number: LR101/1314).

Sample Characteristics

Eighty-five percent of partners were female, and 15% were male. Participants' ages ranged from 15 to over 65 years, with 58% between 20 and 34 years old. Seventy-three per cent of partners expressed their cultural identity as Australian, with 14 different cultural identities comprising the remaining 27%. As there was no qualifier when selecting Australian, or option to select a second culture, it is unclear whether those who endorsed "Australian" included partners of mixed heritage and culture. Alcohol was the most frequently identified main drug of concern (50%; purposefully sampled), followed by amphetamines (10%) and cannabis (8%). Other main drugs of concern included sedatives (benzodiazepines, gamma-hydroxybutyrate (GHB)), stimulants (e.g. cocaine, ecstasy), hallucinogens, opioids (heroin, methadone, buprenorphine, opioid analgesics), and other drugs. Polysubstance use was mentioned in 27% of transcripts coded. Sixteen percent of transcripts also reported previously accessing Counselling Online.

Design and Rigour

Qualitative analysis was used to enable a detailed understanding of the personal impact, which may not be captured through the administration of established questionnaires. Braun and Clarke's (2006) thematic analysis was applied, which adds rigour through a step-by-step process to analyse the data. While common themes were sought, the large sample size assisted in exploring the nuances and complexity within each theme and also the heterogeneity of cognitive, behavioural and emotional impacts reported by partners. This sample size was sufficient as detailed, and deep descriptions were uncovered in each theme, as no new themes emerged towards the end of the sample, meaning data saturation was reached (Sandelowski, 2008). Discussing themes with a second rater assisted with the formation of themes that captured the personal impact for these partners, to ensure the content being coded was linked to the research question being studied.

Data analysis

The Microsoft Excel file containing the de-identified online counselling transcripts was imported into NVivo version 10 for analysis. An inductive and deductive approach was taken to data analysis. Firstly transcripts were first read and re-read (by the first author) to obtain a broad understanding of the content. An inductive approach was taken where transcripts were coded into data extracts (individual coded chunks of data) ranging from one word to full sentences, at the semantic (explicit) level. This inductive approach resulted in 836 data extracts from the 100 transcripts. Themes were coded from the partners' written content rather than the counsellors', akin to Rodda and colleagues' (2015) transcript analysis of the content of online counselling sessions. Based on Rodda and colleagues this approach was expected to provide a truer representation of the partner's experiences, as it focuses on what the partner expresses rather than the counsellor's perception of the partner's experience. A large number of initial groupings emerged from the data, which were discussed by authors

one and three. Initial groupings were then merged into themes (e.g., helpful coping behaviours) using NVivo. To ensure themes reflected the experiences of partners, authors one and three discussed 10% of the coded content. This involved reviewing data extracts from counselling transcripts to ensure the broader context was consistent with the coding and that the themes reflected the coded content. Using a deductive approach, themes were then coded by the first author into the broader categories of cognitions, behaviours and emotions. Again this coding was discussed between authors one and three and where there was a disagreement in coding, the wider research team was consulted. Some data was unable to be coded in the broad themes of cognitions, behaviours or emotions and was not included in the current study, such as descriptions of a partner's personal history. Content from these themes were then summarised and quotes extracted to reflect and further illustrate the experiences of partners. Quotes were retained in their original form except where to do so would potentially provide identifying information. Furthermore, quotes were adjusted for readability to correct errors in grammar, punctuation and spelling. To illustrate the density of coding, we have also reported the number and proportion of transcripts that include each of the following themes.

Results

The results from the thematic analysis of the online counselling transcripts are discussed in relation to the cognitions, behaviours and emotions of partners. Illustrative quotes are followed in brackets by the gender and age range of the partner, and the main problematic substance of their significant other.

Cognitions

Three cognitive sub-themes were present in the transcripts: (i) depressive cognitions, (ii) responsibility beliefs, and (iii) thoughts around trust.

Depressive cognitions

Almost half the partners (45/100 transcripts) described finding themselves overwhelmed, and ruminating on their situation. This was often combined with thoughts of uncertainty about the future. Multiple partners mentioned being very worn down, and finding it hard to have hope, as they could not see an end to their distress. *It is getting harder and harder to cope with everything* (female, 30-34 years, amphetamines). *It's just really hitting home to me that everything is so uncertain and hard* (female, 20-24 years, alcohol).

Responsibility beliefs

Just over one third of partners (37/100 transcripts) discussed varying beliefs around responsibility for the problem AOD use and recovery. Some partners viewed their responsibility as extending to taking on a caretaking role where they focussed on their significant other. *I'm focussed on her needs* (male, 40-44 years, other stimulants). Other partners reported thoughts of failure, or blamed themselves for problem behaviours displayed by the individual with problem AOD use, thinking that they were at fault for making situations worse. *But it kind of is my fault though.. like I guess I shouldn't get in the way* (female, 15-19 years, alcohol). Some partners were clearer in their mind that the individual with problem AOD use was responsible for their own actions. *I would never try and force him [to stop using], I understand. He needs to make the decision on his own* (female, 20-24 years, cannabis).

Thoughts around trust

Some partners (15/100 transcripts) described experiencing difficulty in re-establishing trust, after it had been broken multiple times. Their thoughts were often centred around their suspicion of their partner's veracity, which undermined their relationship. *I can not help feeling suspicious at times and questioning every move or phone call or message* (female, 35-39 years, alcohol). Partners found it hard to believe what the individual with problem AOD use would tell them, and monitored the environment for signs of deception. Their thoughts oscillated from thinking their suspicions were well-founded based on past experiences, to wanting to believe their significant other was being truthful. *He has said the same again this time so I am sceptical, but I also want to support him so I want to believe him* (female, 25-29 years, alcohol).

Behaviours

Specific behaviours partners used in an attempt to cope with their stressful situations were described by partners. These were sometimes described as helpful, unhelpful, or without a value judgment attached.

Helpful coping behaviours

Seventeen percent of partners (17/100 transcripts) reported helpful outcomes from their coping attempts in their specific situations. These included setting clear boundaries around the AOD use, or contingency plans for higher risk situations. Contingency plans were also needed when the individual with problem AOD use reported suicidal ideation. For example, one partner undertook suicide prevention training as a way of responding to this issue. Other partners described the ways they attempted to interact with the individual with problem AOD use, such as choosing to affirm, encourage, or be patient with them. *He didn't buy any and my response was to congratulate him for being strong and not giving in* (female, 30-34, cocaine).

Partners also mentioned prioritising self-care and their family, along with re-engaging with hobbies, in an attempt to bring balance to their lives and alleviate some distress, although sometimes the helpfulness of their strategy was short lived. *I've tried to keep my mind off it, like exercising, reading, or sleeping, but somehow the thoughts just come back* (female, 15-19 years, alcohol).

Unhelpful coping behaviours

Fourty-six percent of partners (46/100 transcripts) described unhelpful outcomes from their coping attempts, either for themselves or the person with the AOD problem. Some partners mentioned they had been withdrawing from friends and family, which was sometimes linked with an increased focus on their relationship with the problem AOD user. *She has in a sense isolated me from my friends and family and I guess I have become somewhat co-dependent on her* (female, 35-39 years, heroin). For other partners, social withdrawal extended to their relationship with the individual with AOD use, as they isolated themselves, often becoming more secretive. *We're on completely different wavelengths and I find myself closing off from him* (male, 50-54 years, alcohol). Some partners found they had come to tolerate or accept the problem AOD use, as their significant other was not changing, yet this was not the outcome they had hoped for. *I used to ask him to quit. He promised me he would when I was pregnant with our first child but when he didn't I tried to accept it* (female, 35-39 years, cannabis).

Other partners reported an increase in impulsive behaviours such as sexual infidelity, problematic eating, physical or verbal conflicts, self-harm behaviours, and personal substance use. *I didn't mean to lose control but I did. I went upstairs and broke down - I hate it when I can't handle these situations. I keep a bottle of Scotch hidden in my computer room (had it for about 6 months). I made a very strong scotch, drank it in temper and then had another and another until it was all gone. It's not like me* (female, 65+, alcohol).

Suicidal ideation and attempts were not just restricted to the person with AOD problems. Two partners also mentioned suicide attempts. *Tried to hang myself but the rope snapped so that did not work. I cut myself but yet again that did not work* (female, 15-19 years, cannabis).

A further 18% of transcripts described coping behaviours they had attempted, without reference to the helpful or unhelpfulness of the behaviour for them. These included similar strategies to those raised above, such as tolerating the problem AOD use, *I don't end up pushing the issue* (female, 25-29 years, alcohol), or asking the individual with problem AOD use to get help, *I told him he needs to go to rehab* (female, 35-39 years, methadone).

Emotions

The three main emotions expressed in the transcripts were anger, sadness, and fear.

Anger

Over one third of partners (37/100 transcripts) expressed anger towards their life situation, the individual with the problem AOD use, and themselves. Some partners felt hurt and betrayed by the individual with problem AOD use, when promises were not kept or the individual with problem AOD use lied or was deceptive. *God knows how long he has been doing this, I feel so hurt and betrayed* (female, 35-39 years, alcohol). They also felt angry at their responses in situations, such as giving money when they did not wish to, or resuming their relationship when not ready. *I always give in … this makes me angry++[sic]* (female, 35-39 years, amphetamines). Some partners also reported that feeling angry led to strong feelings of resentment and exasperation. *I'm at the end of my tether with it* (female, 30-34 years, benzodiazepines).

Sadness

Just under half of partners (44/100 transcripts) described some form of sadness linked to their situation. Some partners noticed a pervasive sadness linked to problem AOD use, which had an all-encompassing impact on their lives. *His drinking has a big impact on my energy, my mood, and my work can suffer* (female, 30-34 years, alcohol). Others noticed small changes in mood and behaviour that seemed to creep up on them. *[I] forgot how to smile lately* (female, 25-29 years, alcohol). Some partners reported a pervasive lack of feeling or feelings of apathy, which were described as feeling numb. Others however, reported sadness that was at times quite intense. This sadness was intensified when partners were isolated or alone. *When I'm alone like now I just feel these waves of despair and utter helplessness* (female, 20-24 years, alcohol). Low self-esteem was reflected in some partners' descriptions of themselves, exemplified by the use of derogatory self-description. *I also find myself believing some of his abusive names such as 'idiot' and 'useless'* (female, 40-44 years, alcohol). The online counselling setting was valued by one partner, who did not feel they would be able to verbally express themselves at the moment due to their sadness. *I don't think I could talk because I would cry too much* (female, 35-39 years, amphetamines).

Fear

Almost half of partners (46/100 transcripts) described feeling anxious or afraid. Partners described feeling concerned for the welfare of themselves and the individual with problem AOD use. They worried about the individual with problem AOD use being physically injured, for example from drink driving. Some partners described feeling unsafe around the individual with problem AOD use, particularly when they were engaging in AOD use. While some partners were adamant that the individual with problem AOD use would never physically hurt them, others minimised violent behaviour, or blamed themselves stating that

they deserved it. Safety concerns were also raised around associates of the individual with problem AOD use, with partners fearing reprisals from other individuals involved with the AOD use. *I don't feel safe sometimes because my partner is out with weird people…they all know where I live. A couple of times my partner has said baby just stay home and don't go anywhere* (female, 15-19 years, amphetamines).

Partners also worried about inadvertently enabling AOD use. They also feared they would never recover from the impacts of AOD use and that it would have a longer-term impact on their children. Some partners felt afraid to confront or leave the individual with problem AOD use, for fear of the consequences, such as a repeat suicide attempt. *I don't want to ask him to leave as I am afraid he will do something serious to himself. He has mentioned he doesn't want to be here anymore and that he hates his life* (female, 20-24 years, cannabis).

Others felt anxious about a continued relationship with the individual with problem AOD use, yet juxtaposed that fear against their hope and love. *I know the risk of returning to him, would be huge, but there is a little bit of me that lives in hope* (female, 25-29 years, alcohol).

Discussion

This study aimed to examine the personal impact for partners of individuals with problem AOD use through a qualitative analysis of online counselling transcripts. This study reported the personal impacts as reflected in partners' cognitions (depressive cognitions, responsibility beliefs, and thoughts around trust), behaviours (helpful and unhelpful coping) and emotions (anger, sadness, and fear).

The broader theme of cognitions aligned with previous research. For example, the theme of depressive cognitions elaborated on the uncertainty experienced by partners around

whether the individual with problem AOD use was using or not. This aligns with the theme of trust in the Orford, Velleman, et al.'s (2010) review, and reflects how it can be hard to re-establish trust after it has been broken multiple times. The findings build on the work of Orford and colleagues by including a broad range of partners recruited from an online counselling service, many of whom may have been help-seeking for the first time. Moreover, the findings are from a sample of partners accessing low intensity supports, unlike much of previous research which had recruited from higher intensity supports. Low intensity supports such as online counselling may attract a broader sample of partners due to factors such as anonymity, which can help us better understand the range of personal impacts. The findings also align with the work of Peled and Sacks (2008), where partners reported a sense of self-blame and responsibility for the problem AOD use, along with a sense of failure at being in their current situation. Our findings extend these findings to online help seekers by examining online counselling transcripts including partners who may not otherwise access services or participate in research, and by examining a broader sample than many previous studies (e.g., Peled and Sacks' (2008) interviews of 10 Jewish Israeli female partners of individuals with problem alcohol use).

The theme of behaviours reflected both intrapersonal impacts (such as attempts at personal emotional regulation), and interpersonal coping behaviours reported in Orford et al.'s (1998) proposed coping styles for family members (engaged, withdrawal, and tolerant-inactive). Engaged coping was sometimes seen as helpful by partners, such as setting boundaries, contingency planning, and encouraging help-seeking. Tolerant-inactive coping was used helpfully when partners felt they just needed to be patient. However, these types of coping responses led to partner frustration when boundaries were not respected, or encouragement and patience did not reduce distress or yield the desired changes. Withdrawal coping was seen in the reported helpful self-care behaviours, such as engaging in exercise or

hobbies to reduce personal stress. Yet for some partners, withdrawal coping also had the downside of creating distance in the intimate relationship. While interpersonal strategies, such as withdrawal coping had some helpful aspects, partners sometimes found intrapersonal emotion regulation challenging when withdrawing from their partner, or when engaging in tolerant-inactive coping. These partners reported engaging in unhelpful behaviours such as personal substance use, or problematic eating. The unhelpful intrapersonal impacts of tolerant-inactive coping align with the study by Lee et al. (2011), who found that among family members of patients seeking treatment for addictive disorders, tolerant-inactive coping was most correlated with psychiatric morbidity. In our study, frustrations expressed in transcripts suggested that one coping style was not seen as superior overall for partners, rather the three coping styles had helpful or unhelpful consequences depending on the specific context and way they were used. This suggests that all three coping styles may be used in different contexts to assist with the partner's well-being, hence the skill partners need to develop is knowing when best to use what type of coping style.

The emotion themes in the results also resonated with previous research, with some interesting nuance. Themes relating to sadness, or more broadly depressive symptoms, were identified in the transcripts, such as feeling overwhelmed, low mood, guilt and self-blame, rumination, fatigue or feeling worn down. Behaviourally, social withdrawal and isolation from other supportive individuals was also a concern. This is consistent with Homish et al.'s (2006) findings of increased depression in partners of individuals with problem AOD use. Furthermore, fear or worry was one of the key emotions present, which supports Dawson et al.'s (2007) findings of increased anxiety in partners of individuals with problem AOD use. Anger was a key emotion felt by partners in our study, and is consistent with the experience previously reported by wives of problematic alcohol users (Peled & Sacks, 2008). The themes of safety concerns and increased anger align with Orford, et al.'s (2013) description

of family conflict often being an issue in families where there is problem AOD use, and the presence of unwanted individuals engaging in problem AOD use in the home environment (Orford, Velleman, et al. 2010). Interestingly, shame, while present, was not one of the three main emotions expressed in the transcripts. This is not to say partners did not experience shame, but as shame is often a secondary emotion heightened by interpersonal contexts, it may have been lessened by the anonymity of the online counselling modality. This may also have enabled a greater expression of the primary emotions being experienced by partners, such as anger or sadness, which underlie the shame.

Clinical and policy implications

These findings provide further information for the targeting of clinical interventions for partners, particularly when the intervention is based on a cognitive behavioural model. The themes from this study may be more pertinent to the distress partners want to communicate and receive support for, given the themes were uncovered from actual online counselling sessions; the partners in our sample were actively engaging in help-seeking, compared with previous interview or questionnaire-based research. Clinicians may find the cognitions, behaviour, and emotions described in this study a useful starting point when planning intervention work with partners, in combination with the idiographic distress the partners present with to their online and other services (Rodda, Dowling, Jackson, & Lubman, 2016). For example, exploring cognitive themes of trust and responsibility may be highly relevant to partners, and increasing awareness around emotion regulation strategies could assist partners with intrapersonal coping for difficult emotions (anger, fear, sadness).

Furthermore, these findings reinforce the importance of viewing partners as help-seekers in their own right, given the extensive and multiple personal impacts experienced. Given that partners in our study communicated these needs in the online context, services such as online

counselling may be well placed to identify pressing needs and assist partners with brief interventions (such as assistance for mental health problems, adaptive coping skills, or assessing safety), or to act as a referral pathway to other services. More research should follow the example of Howells and Orford (2006) who looked specifically at how to target an intervention for the partners of problem drinkers. They found that targeting partners' stress and coping increased adaptive coping and reduced stress symptoms, and these effects were maintained at 12 months post-intervention. Targeting coping strategies has also been found to reduce personal distress for family members in a primary care setting (Copello et al., 2009). Our results would also reinforce that it is important to assist partners to differentiate between helpful and unhelpful coping strategies, and that the helpfulness or unhelpfulness of each strategy needs to be assessed for the specific situation. Broader psychoeducation around type of coping could assist partners to feel they have flexibility in how they choose to respond to stressful situations. In addition, future research could target the themes identified in this study (such as allocating responsibility, establishing trust, regulating emotions, and unhelpful coping behaviours), and extend partner specific interventions being researched to include partners of individuals with other problematic drug use.

The findings also highlight the need for a stronger emphasis on the impact of AOD use on family members, particularly partners. The burden of care for those with problematic AOD use can often fall on partners (Orford, 2017), as our results showed the partners often found it challenging to detach themselves from thinking they are responsible for the problem AOD use or for changing the use. As some partners live with or need to support their significant other 24/7, more services which assist partners independently of whether or not an individual with problem AOD use is seeking help are vital to help reduce the social burden and cost of problematic AOD use. In this regard, the 5-step method (Copello et al., 2010)

offers a useful intervention for services given it focusses on the stress-strain-coping-support model and can assist partners as the primary help-seeker (Orford et al., 2005).

Limitations

Comparisons were not made between types of substances due to highly variable transcript numbers for partners of problem drug use. This was the case, as we accessed pre-existing transcripts, rather than recruiting partners to create equal partner numbers for each type of problematic substance. Future research should investigate whether the impact on partners varies by type of problematic substance. In addition, the analysis was performed on the client transcript, rather than the counsellor transcript, and counsellors may have steered the conversation in a certain direction. Also, although there was a large number of transcripts, there was a lack of depth in some accounts of personal impact. There was also a limited context for many quotes, as there was not the opportunity to ask follow-up questions. Future research which asks specifically about personal impact may achieve more depth in some themes, in particular, comparing the themes with those collected through another low intensity support option, such as telephone counselling. Also, shame, embarrassment, or fears of reprisal, may mean some issues were not spoken of (e.g., domestic violence). This barrier may have been overcome by the anonymity of the service, but may still be an issue for some partners.

Furthermore, in line with qualitative research limitations, the sample's experiences may differ from other partners. Moreover, the current sample comprised partners presenting to an online counselling service, whose needs may differ from those presenting to face-to-face services; hence care should be taken when interpreting these results. The transcripts were also sampled from those engaging in help-seeking through the online counselling context, and as such partners may report different needs when not actively seeking help. In addition, as

partners were aware their transcripts could be used for research they may have censored their conversations in the counselling interaction. However this is unlikely given the depth of personal information provided in the transcripts.

Conclusion

This study reported the personal impact on partners related to their cognitions (depressive cognitions, responsibility beliefs, and thoughts around trust), behaviours (helpful and unhelpful coping) and emotions (anger, sadness, and fear). These findings extend the literature by using online counselling transcripts to provide a description of partners' real-world problems prompting help-seeking, enabling a richer understanding of the personal impact for partners, and the impact across partners of individuals with either problem alcohol or other drug use. In addition, clinical implications from the study include highlighting the prominent cognitions, behaviours and emotions that could form pertinent starting points for interventions targeting distress in partners. In particular, it would be useful to assist partners with understanding their coping responses, and how different situations may call for differing interpersonal coping strategies to be employed. Additional psychoeducation around intrapersonal coping would also assist partners in working on their own distress (anger, fear, sadness, depressive ruminations), for example by increasing emotion regulation strategies. Services should focus on supporting partners as valid help-seekers in their own right, in line with current online counselling and online forum resources. These should be extended with a greater range of self-help options for partners in the online space. Future national strategies should also continue to emphasise the support needed for these partners to reduce the burden of problematic AOD use on society.

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Declaration of interest statement

The authors declare no conflict of interest.

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5. Paper two: Interpersonal impacts on partners

5.1. Preamble to paper two

Results pertaining to the interpersonal impacts on partners are presented in the form of a paper titled "The impact of problematic substance use on partners' interpersonal relationships: Qualitative analysis of counselling transcripts from a national online service". This paper has been re-submitted to the journal "Drugs: Education, Prevention, and Policy", following revision based on reviewer feedback. The aim of the paper was to examine the broad range of interpersonal impacts described by partners through a qualitative thematic analysis of online counselling transcripts sourced from a national online AOD counselling service. One hundred online counselling transcripts were analysed using thematic analysis. The same 100 online counselling transcripts were used in paper two as for papers one and three. The transcripts were initially coded at the same time, and codes were generated in relation to each research question. Each paper focussed on one research question, so there was no overlap in the data extracts which were used. Further analyses were conducted separately, including theme creation, as described in the paper. The results section of this paper discussed themes around intimate relationship issues, challenges in parenting, and impacts on and from partners' social networks. A discussion of the findings follows the results, and this discussion is further elaborated on in the integrated discussion (sections 7.1 and 7.2).

5.2. Paper two

The impact of problematic substance use on partners' interpersonal relationships: Qualitative analysis of counselling transcripts from a national online service

Samara R. Wilson[1], Dan I. Lubman[2, 3], Simone Rodda[3, 4], Victoria Manning[2, 3], Marie B. H. Yap[1, 5]

[1] School of Psychological Sciences, Monash Institute of Cognitive and Clinical Neurosciences, Monash University, Clayton, Australia; [2] Eastern Health Clinical School, Monash University, Box Hill, Victoria, Australia; [3] Turning Point, Eastern Health, Fitzroy, Australia; [4] Auckland University of Technology, New Zealand; [5] School of Population and Global Health, University of Melbourne.

Contact details for corresponding author:

Prof Dan Lubman

Director, Turning Point

Professor of Addiction Studies and Services at Monash University

54-62 Gertrude Street, Fitzroy, 3065, Victoria, Australia

[redacted]

[redacted]

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Biographical notes

Samara Wilson is a Doctor of Psychology (Clinical) candidate at the School of Psychological Sciences, Monash University. Her doctoral thesis focuses on the impact of problem alcohol or other drug use on partners. [redacted]

Dan Lubman is a psychiatrist and addiction medicine specialist. He is the Director of Turning Point and Professor of Addiction Studies at Monash University. [redacted]

Simone Rodda is a Senior Lecturer at University of Auckland, New Zealand and an Honorary Senior Research Fellow at Turning Point, Australia. [redacted]

Victoria Manning is a Senior Research Fellow at Turning Point and the Eastern Health Clinical School, Monash University. [redacted]

Marie Yap is a National Health and Medical Research Council (NHMRC) Career Development Fellow, Senior Research Fellow and psychologist at Monash University. She is the primary supervisor of Ms Wilson's doctoral research project. [redacted]

The impact of problematic substance use on partners' interpersonal relationships: Qualitative analysis of counselling transcripts from a national online service

Abstract

Problem alcohol or other drug (AOD) use can have severe impacts on partners interpersonally, including both their intimate relationship, as well as their interactions with friends and family. Previous research has predominantly focussed on female spouses of problem drinkers, and recruited individuals who have experienced significant harm requiring medical or legal services. This paper sought to explore the breadth of interpersonal impacts on a broader range of partners, to better inform service provision. Method: One hundred synchronous online counselling transcripts of partners (85% female, aged 15 to over 65 years) of individuals with problem AOD use were sampled from a 24-hour national online AOD counselling service. A thematic analysis was conducted, exploring the interpersonal impact on partners. Findings: Interpersonal impacts included intimate relationship issues (discovery leads to communication difficulties; decisions to stay or leave), challenges in parenting (safety and well-being concerns; exposure to problem AOD use impacts; difficulty managing parenting responsibilities; pregnancy-related considerations), and impacts on and from their social network (benefits and challenges in seeking social support; extended family and social group stressors/support). Conclusions: Interpersonal impacts are multi-faceted, and partners should have access to targeted referrals for relationship assistance, peer support (online or face-to-face), domestic violence and welfare services.

Keywords

Significant other; substance misuse; relationship; e-therapy; family; burden.

The impact of problematic substance use on partners' interpersonal relationships: Qualitative analysis of counselling transcripts from a national online service

Problematic alcohol or other drug (AOD) use significantly impacts family members, with partners of individuals with problem AOD use (referred to from here as partners) particularly affected. These impacts refer to effects on both physical and mental health, as well as socioeconomic concerns (Orford, Velleman, Copello, Templeton, & Ibanga, 2010). The impact on partners' interpersonal relationships are also significant. The term 'interpersonal' refers to any situation where a person is in a relationship or communication with another person, and for the purposes of this paper includes social contacts, such as friends and family. The way in which these interpersonal relationships can be affected or impacted varies. For intimate relationships, partners may experience poor communication, reduced intimacy and sexual satisfaction, physical violence, and conflict (Cunradi, Caetano, & Schafer, 2002; Fals-Stewart, Golden, & Schumacher, 2003; O'Farrell, Choquette, Cutter, & Birchler, 1997). Interpersonal impacts also extend beyond the intimate partner dyad, and include both impacts on and from the broader social world around a partner. Partners and other family members often experience a restricted social life, worrying about attending social events where the individual with problem AOD use may act out or become intoxicated (Moos, Brennan, Schutte, & Moos, 2010; Orford, Velleman, et al., 2010). In this paper, the term 'family member' is used when referring to previous research, which has often involved broad samples of family members rather than just partners. Partners include spouses, but also other less-researched partners such as boyfriend-girlfriend, de-facto, and homosexual and heterosexual relationships. The individual with problem AOD use is also referred to as the partner's significant other. Lastly, a partner's social network refers to their friends, family, and acquaintances.

This study approaches the impact on partners with the theoretical basis of the stress-strain-coping-support model (Orford, Copello, Velleman, & Templeton, 2010). This model asserts that it is highly stressful living with an individual with problem AOD use, which psychologically manifests as strain for family members. The amount of physical and psychological ill health which is linked with this strain depends on the support family members receive, and their coping style. Studies of family members (including partners) have identified that they often cope with such interpersonal strain by enduring the problematic use, trying to change their substance use, or withdrawing from the individual with problem AOD use (Orford, Velleman, et al., 2010). The social world of partners is therefore key, with social support proposed as a moderator between caregiver burden and mental health (Orford, Velleman, et al., 2010; Soares, Ferreira, & Pereira, 2016). Indeed, social support has been found to be associated with improved health outcomes, including better psychological wellbeing, physical and psychosocial adjustment, adaptive coping behaviours, and reduced depression and stress (Broadhead et al., 1983; Wang, Wu, & Liu, 2003). Despite this, there is often a delay between when a partner realises they may need additional support (either informal or formal help) and when they actually seek it. This is particularly true in regard to formal help-seeking, with a recent study identifying that over half of affected family members took on average 2.6 years to seek professional help following the discovery of problem AOD use in a relative (Sakiyama, de Fatima Rato Padin, Canfield, Laranjeira, and Mitsuhiro, 2015).

Even when partners are concerned over the potential impacts of exposing children to problem AOD use or domestic violence (Barnard, 2007; Copello, Velleman, & Templeton, 2005; Kroll, 2004), partners are often reluctant to seek support, due to concerns of shame and stigma (Orford, Velleman, et al., 2010). This is despite research demonstrating that they do struggle to mitigate the impacts on children of exposure to problem AOD use or violence

(Copello et al., 2005; Gorin, 2004). However, social support when available, helpful (non-judgmental) and utilised, has been found to assist partners by providing emotional and practical help (Orford, Velleman, et al., 2010), such as from grandparents, who may be able to assist with childcare (Barnard, 2007).

While the available literature identifies that the interpersonal impact of having a family member with problem AOD use can be considerable, most research (which has predominantly been conducted in the UK, Mexico, Italy, and USA) has tended to focus on all family members, or female spouses of problem drinkers, rather than other partner types, such as defacto, dating couples, males, and homosexual relationships. Further, most research specific to partners has focussed on the more extreme intimate partner strains or consequences, such as violence requiring medical assistance. In contrast, less research has examined behaviours before they escalate into physical violence, such as arguing (Fals-Stewart et al., 2003) or a reduction in positive tone in the relationship (Fischer et al., 2005). As such, there is a need to understand the breadth of potential interpersonal impacts (from mild to severe) on a broader sample of partners.

One potential recruitment source for a broader sample of affected partners is through utilising online counselling services, which are often a first point of access to professional help, due to the accessibility, availability and anonymity of the service (Garde, Manning, & Lubman, 2017; Rodda, Lubman, Dowling, Bough, & Jackson, 2013). Analysing the real-world interpersonal impacts spontaneously described in such transcripts provides a unique opportunity to further understand which issues prompt a call for help, to better inform service provision that addresses partner needs (Wilson, Rodda, Lubman, Manning, & Yap, 2017). Adopting a qualitative approach to interrogate such transcripts also enables a bottom-up approach to build theory in this under-researched area. As such, the aim of the current study was to examine the broad range of interpersonal impacts described by partners through a

qualitative thematic analysis of online counselling transcripts sourced from a national online AOD counselling service.

Method

Counselling Online

Launched in 2005, the Counselling Online website attracts over 40,000 visitors each year (Garde et al., 2017). It offers individuals with problem AOD use, and their families and friends, access to self-help resources, information, and both synchronous and asynchronous online chat counselling services. Available 24/7, Counselling Online provides over 2000 online counselling sessions each year to all states and territories of Australia, with roughly one in ten service users being partners (Garde et al., 2017). The majority of Counselling Online clients access the service anonymously, however around one-quarter of clients choose to register to have their transcripts on file for repeat access. In the terms and conditions of the service, clients are advised that demographic information and de-identified data may be used in research or for training purposes. The average duration of a session is 29 minutes (Garde et al., 2017). Demographic information on age, sex, cultural identity, and primary drug of concern is provided directly by the client prior to the session.

Partner transcripts from November 2013 to November 2014 were accessed. De-identified transcripts were exported to Microsoft Excel. The most recent 100 transcripts were extracted to form the study's sample, to generalize the results to current practice, as the service had undergone training in 2013 in working with family members. A relatively large sample size (for qualitative analysis) was important to ensure the analysis covered the diversity of partners accessing the service. The sample was then explored by gender and drug to enable purposeful oversampling of male partners (an under-represented group in the literature), and

to reach a 50% alcohol sample for comparisons between alcohol and other drugs as part of the broader research project. To achieve this, an extra 9 alcohol transcripts were re-sampled to replace 9 other drug transcripts, and 4 female transcripts were replaced with male transcripts. Ethics approval was received from the Monash University Human Research Ethics Committee (Project number: CF14/1929 – 2014000980) and the Eastern Health Human Research Ethics Committee (Reference number: LR101/1314).

Sample Characteristics

One hundred transcripts of partners of individuals with problem AOD use were sampled from those accessing Counselling Online. The term partner was used inclusively, referring to heterosexual or homosexual relationships, spouses, de-facto, boyfriend/girlfriend, or ex-partners. Females accounted for 85% of partners, and 15% were male. Partners' ages ranged from 15 to over 65 years, with over half being between 20 and 34 years old. While there were 14 different cultural identities reported, 73% reported their primary cultural identity as Australian. The most frequently identified main drug of concern was alcohol (50%; purposefully sampled, see above), followed by amphetamines (10%) and cannabis (8%). The other main drugs of concern were stimulants (cocaine, ecstasy, other stimulants), sedatives (benzodiazepines, gamma-hydroxybutyrate or GHB), opioids (heroin, methadone, buprenorphine, opioid analgesics), hallucinogens, and other drugs. Polysubstance use was mentioned in 27% of transcripts. Sixteen percent of transcripts reported previous access to Counselling Online.

Design and Rigour

Qualitative analysis was chosen to enable a detailed representation of the interpersonal impact of AOD use, which may not be captured by the administration of existing

questionnaires. Braun and Clarke's (2006) thematic analysis was used which adds rigour through applying a step-by-step data analysis process. This method of thematic analysis asserts that coding is flexible and organic and that themes evolve while coding. One hundred transcripts enabled sufficient data to reach saturation, and to allow for nuance and complexity to emerge within the broader themes. As no new themes emerged towards the end of the sample, this sample size sufficiently produced rich, detailed, and deep descriptions in each theme (Sandelowski, 2008). Themes were discussed between two raters to assist in the delineation of themes, and to ensure the research question linked to the coded content.

Data analysis

The Microsoft Excel file with the de-identified transcripts was imported into NVivo version 10, which was used to analyse online counselling transcripts. To achieve a broader content understanding, the transcripts were read and re-read (by the first author). The transcripts were coded in chunks (data extracts). These ranged from one-word chunks to full sentences, and they were coded at the explicit or semantic level. This resulted in 707 data extracts from the 100 transcripts. Akin to Rodda, Lubman, Cheetham, Dowling, and Jackson's (2015) transcript analysis of the content of online counselling sessions for problem gambling, themes were coded from the partner transcript rather than the counsellor transcript. This aimed to provide a truer representation of the partner's experiences, by focussing on what the partner expresses, rather than the counsellor's perception of the partner's experience. Initial grouping which emerged from the data were discussed by authors one and three. These groupings were then merged into themes using NVivo. Ten percent of the coded content were discussed by authors one and three to ensure the themes reflected the partners' experiences. This involved reviewing the transcript data extracts to ensure the themes reflected coded content. Then, extracts were coded by the first author into the themes of intimate partner issues; challenges

in parenting; and impacts on and from the social context, including the sub-themes. Where there was a disagreement in coding between authors one and three, this was discussed with the wider research team (authors two, four and five). Summaries of content from these themes were then written and representative quotes extracted to illustrate partners' experiences. With the exception of removing identifying information, quotes were retained in their original forms. Readability adjustments were also made (e.g. correcting errors in spelling, punctuation and grammar).

Results

The thematic analysis of the partner AOD online counselling transcripts revealed three main areas of interpersonal impact. The first theme was intimate partner relationship issues, which is discussed in relation to two sub-themes; how discovery of the problem AOD use leads to communication difficulties; and how partners struggle with decisions to stay in the relationship or leave. The second theme was challenges in parenting. This included the sub-themes of safety and well-being concerns; exposure to problem AOD use and its impacts; difficulty managing parenting responsibilities; and pregnancy-related considerations. The third theme was impacts on and from partners' social network. This is discussed in the sub-themes of benefits and challenges in seeking social support; the influence and role of the extended family; and social group stress and support. Each quote presented below is followed by the gender and age range of the partner, and their significant other's main problematic substance.

Intimate partner relationship issues

Partners spoke about the impact on their intimate relationship with the individual with problem AOD use, around the sub-themes of (a) discovery leads to communication difficulties; and (b) decisions regarding staying in or leaving the relationship.

Discovery leads to communication difficulties

Partners expressed changes that had occurred in their relationship since discovering the problem AOD use. While some partners knew about the problem AOD use before starting the relationship, others were unaware of the presence or extent of the problem AOD use. '*I did know he was a binger when younger, but I did not know how much he could drink before I moved here'* (female, 35-39 years, alcohol). Some partners described an improvement of the AOD use since being in the relationship. '*The drinking has improved a lot … since we started being together'* (female, 35-39 years, alcohol). However for many, the use had become increasingly problematic over the course of the relationship. These partners often described a feeling of loss at what used to be an enjoyable relationship before the AOD use became problematic.

The discovery and evolution of the problem AOD use contributed to current communication changes and difficulties. However, communication varied between partners. Some partners reported open communication between themselves and the individual with problem AOD use, where they talked about their concerns together, and negotiated the substance use. For these partners, their communication had improved since finding out about the extent of the AOD use, or since the individual with problem AOD use had made a decision to change. '*It was bad before I found out but since then we talk a lot'* (male, 40-44 years, other party drug). Other partners reported strained communication such as continual arguing, limited or abrupt interactions, or not talking altogether. Arguments often centred around the problem AOD use, such as a recent family or social event where substance use

had been problematic. Sometimes the arguments were exacerbated by intoxication and escalated into verbal or physical confrontations. '*His drinking impacts me because we argue a lot about it and if he drinks spirits like he did last night, we argue even more (it makes him very argumentative)'* (female, 25-29 years, alcohol).

Some partners mentioned how the problem AOD use impacted quality time they spent together, as a lot of the individual with problem AOD use's time was spent either using substances, or recovering the following morning. '*It takes up time to do stuff with each other but he can't because he had a big night and feels seedy the next day'* (female, 25-29 years, alcohol). Intimate interactions were also impacted, with suspicions of infidelity creating conflict and mistrust, or sexual problems, such as lacking interest or enjoyment. '*He told me I don't make love to him. I just go through the motions'* (female, 35-39 years, cannabis).

To stay or to leave

The current status of the relationship differed considerably between partners. Partners were either currently in a relationship with the individual with problem AOD use, or separated. For those in the relationship, there was an uncertainty about the future. Some partners wanted to stay and work on the relationship. They felt invested in the relationship, or a sense of obligation to stay and help the individual with problem AOD use. '*I would've walked away by now if he still had family support but everybody has given up on him already'* (female, 20-24 years, cannabis). Some partners wanted to leave the relationship, but worried about the complications as their lives were quite intertwined practically and emotionally. They were concerned that the individual with problem AOD use would not change, or they worried about relapse in the future. This was particularly relevant to those thinking about marriage or starting a family. Often partners had both desires to stay and leave simultaneously, due to

positive and negative experiences in the relationship. '*We have super times and horrid times and that's what I struggle with'* (female, 35-39 years, heroin).

For partners who had separated or were separating from the individual with problem AOD use, some were quite content and did not wish to re-engage romantically. Other partners were unsure about whether to reconcile, as they saw potential for a future if the individual with problem AOD use would change. Most were wary about getting back together, as they had tried multiple times to end the relationship. '*I really am not sure what I want anymore. I love her but there are so many complications'* (female, 35-39 years, heroin). Relationship counselling was sometimes mentioned by partners wanting to improve their relationship.

Challenges in parenting

Three main sub-themes concerned the interpersonal impact for partners around parenting and children: (a) safety and well-being concerns, (b) exposure to problem AOD use and its impacts, (c) difficulty managing parenting responsibilities, and (d) pregnancy-related considerations.

Safety and well-being concerns

Some partners expressed safety concerns for their children. They described the individual with problem AOD use as verbally abusive to children, losing their temper, or putting them down. They also described mood swings which made the individual with problem AOD user's behaviour unpredictable. At times, they described it as the family walking on eggshells, not wanting to set the individual off. The individual with problem AOD use also

used when taking care of children in the partner's absence, heightening the partner's safety concerns.

Partners also described a concern for the emotional wellbeing of their children. Some children became argumentative towards the partner and/or the individual with problem AOD use. Other children did not express their anger, trying to be the perfect child, or left home to avoid being around the individual with problem AOD use, which was concerning to partners. '*Our son is 17 and I am worried about him…he is a good boy, straight A student...but I am afraid that he has a lot of anger in himself about this situation and his father…he would not open up to me...and is also pretending that everything is ok...'* (female, 35-39 years, amphetamines).

Exposure to problem AOD use and its impacts

Partners were concerned about their children's exposure to problem AOD use, conflict between the parents, and partner abuse. They were concerned about the negative role modelling that occurs when problem AOD use was undertaken in the presence of children. Partners sometimes had discussions with the individual with problem AOD use about limiting substance use to after the children had gone to bed. Some children would retreat to their rooms when problem AOD use was occurring. '*The kids get upset by how much he drinks and when he does they either find things in their rooms to do or I take them out somewhere'* (female, 30-34 years, alcohol). Partners also expressed their concern over children being present when heated arguments were taking place between the partner and the individual with problem AOD use. Children were also exposed to abusive behaviours towards the partner. '*He choked me about 2 weeks ago in front of our baby'* (female, 20-24 years, cannabis).

Difficulty managing parenting responsibilities

Partners described difficulty with parenting arrangements. Some felt they were a single parent, as the individual with problem AOD use was not heavily involved. They described feeling like the only responsible adult around, and sometimes had to assume responsibility for not only their children, but also for any biological children of the individual with problem AOD use. '*I look after the kids on my own 7 days a week, no break…his days off he doesn't help he just goes out, gets drunk'* (female, 30-34 years, alcohol). Some were able to involve grandparents to assist with caring for the children.

This was not the case for all partners however, as some partners described the individual with problem AOD use as being good to the children. In particular, some individuals with problem AOD use were described as better parents when using. '*When he is smoking and on weed he is a completely different person and is so nice and loving and great with the kids'* (female, 20-24 years, cannabis). Some partners also had been separated from their children through family court proceedings. While the reasons for this separation was often not elaborated on in the counselling transcripts, the separation created some distress as these partners wanted to be more involved in their children's lives.

Pregnancy-related considerations

Partners described concerns about pregnancy. Some were planning to become pregnant, but concerned about how ready their partner would be, and if the problem AOD use may have affected fertility. '*We were hoping to have a baby in the next year or so but now I am so worried that one, he is not ready/will never be, and two his sperm/fertility has been affected*' (female, 25-29 years, ecstasy). Some partners found they were less willing to put up with their significant other's AOD use since finding out they were pregnant. '*I was tired of being broke, tired of it all. As soon as I found out I was expecting I said no more, it was as simple as that*' (female, 25-29 years, amphetamines). However, other partners found that their

relationship with their significant other had improved since becoming pregnant. '*He's been great since I conceived.*' (female, 40-44 years, alcohol).

Impacts on and from the social network

Three main sub-themes concerned the interpersonal impact for partners around the impacts on their social network: (a) benefits and challenges in seeking social support, (b) the influence and role of the extended family, and (c) social group stress and support.

Benefits and challenges in seeking social support

Partners described a desire for social support, yet they had differing experiences. Some had told friends and family about their situation, and found it helpful to have this support. This was not always the case, and some partners had experienced judgment or misunderstanding from those around them when they told them about the problem AOD use. Others had not told any family or friends, and held back from doing so due to concerns of being a burden, being judged, feeling ashamed, or not believing that telling others would help their situation. '*I find it embarrassing to talk about as they think we have a perfect life. No one knows'* (female, 20-24 years, cannabis).

The influence and role of the extended family

Partners spoke of mixed relationships with their families of origin. Some partners were geographically separated from family, or found interacting with them hard due to dysfunctional relationships. Other partners spoke of pressure from their family to leave the individual with problem AOD use. Some partners also described past or present problem AOD use in their family members. '*My family want me to go home to them but my family are very dysfunctional and there's a lot of issues'* (female, 30-34 years, alcohol).

Partners also described some challenges when interacting with the family members of the individual with problem AOD use. Partners felt at times criticised by them in the way they attempted to deal with the problem AOD use, and sometimes the partners felt that these families sided with the individual with problem AOD use in arguments. Some partners described these families as not recognising the problem AOD use, and found that this made it harder to address the issue. '*I can't believe her parents don't recognise her drug use'* (male, 40-44 years, amphetamines).

Social group stress and support

Stress was created through social influences. Some partners described being concerned about the social group of the individual with problem AOD use. They worried that this social group pressured their significant other to use, or that their friends socialised at locations which encourage substance use (e.g. local bars or hotels). They worried that these social influences would hinder the individual with problem AOD use from cutting back or stopping the use. '*I know over the past year, he has had boys over every night and they sit and smoke together'* (female, 20-24 years, cannabis).

Other partners had friends who used substances recreationally, and were happy to socialise with those using moderately or responsibly. Partners also found that some of these friends were helpful in getting their significant other to use less in social settings when they all gathered together, and some actively encouraged their significant other to seek help. '*People asked him to slow down and stop drinking so much'* (female, 25-29 years, alcohol).

Discussion

This study aimed to examine the interpersonal impact for partners of individuals with problem AOD use through a qualitative thematic analysis of online counselling transcripts. The results showed that the impact extended to: intimate partner relationship issues (discovery leads to communication difficulties, and decisions to stay or leave); challenges in parenting (safety and well-being concerns, exposure to problem AOD use and its impacts, difficulty managing parenting responsibilities, pregnancy-related considerations); and impacts on and from their social network (benefits and challenges in seeking social support, the influence and role of the extended family, and social group stressors and support).

Impact on the intimate partner relationship

Our findings regarding the feelings of loss at what used to be an enjoyable relationship are consistent with Orford et al.'s (2013) summary of the experience of being a family member of a problem AOD user. The theme of whether to stay or leave was also reflected in Peled and Sacks' (2008) interviews with wives of problem drinkers. Similarly, Orford, Velleman, et al. (2010) identified that partners feared judgment from friends and family around their relationship, and methods for dealing with the problem AOD use. This suggests it could be useful for clinicians to explore how the relationship has changed, and what options partners currently have in moving forward.

Our findings of strained interactions aligns with the work of Fals-Stewart et al. (2003), who described increased arguing in couples when problem AOD use was occurring. Interactional patterns described also reflected the three coping responses described by Orford et al. (1998) of engaged coping (standing up to the AOD use), tolerant-inactive coping (putting up with it) or withdrawal coping (withdrawing from the significant other). This suggests assisting partners with situation-specific adaptive coping skills could be useful. The importance of coping style aligns with the stress-strain-coping-support theoretical model

(Orford, Copello, et al., 2010). Such assistance could be provided using the 5-Step Method (Copello, Templeton, Orford, & Velleman, 2010), which is based on this theoretical model, and assists family members to identify and understand different coping styles.

The presence of sexual problems was consistent with O'Farrell et al. (1997), however the results of our study focuses on the lack of interest in sex for the partner, whereas the individual with problem AOD use had reduced interest or performance in O'Farrell's study. Still, this highlights that sexual intimacy in the relationship is impacted by problem AOD use, and our findings extend on O'Farrell's study by including other drugs as the problematic substance, rather than just alcohol.

Impact on parenting and children

Our results concur with findings from Orford, Velleman, et al.'s review (2010), which found the safety of children and exposure to the problem AOD use were major concerns among family members of an individual with problem AOD use. This suggests that dealing with partners' anxiety over their children is an important aspect of assisting partners. The two main responses from children noted in the results (arguing or withdrawing), and the exposure to domestic violence, support the themes which Kroll (2004) identified in children of parents with problem AOD use, such as family conflict, denial, and violence and fear. This suggests it is also important to investigate risk and safety for the partner and their children, and make referrals to local family services, as there may be problematic interactional patterns or abusive behaviours present in the home environment. The results on parenting arrangements are also consistent with Barnard's (2007) qualitative study of family members, with extended family or grandparents sometimes heavily involved in the care of children, and partners did not always have full access to children due to legal issues.

Impacts on and from the social network

The difficulty in seeking and receiving social support aligns with Orford, Velleman, et al. (2010), who reported that some family members experienced a restricted social life or were concerned to disclose their situation due to shame and stigma around the AOD use. This suggests it is important to explore the impact the problem AOD use has had on available social support for partners, whether in the form of limiting social interactions or socialising, or if shame and stigma are preventing partners from reaching out with specific support needs to those around them. This reinforces the importance of social support as an important factor in mitigating or reducing the strain partners experience, in line with the stress-strain-coping-support model (Orford, Copello, et al., 2010). Our results also provide a useful insight into the mixed relationships partners experience with extended families which may either hinder or assist them with coping or dealing with the problem AOD use. The partners' concerns over the individual with problem AOD user's peer group or socialising patterns influencing their substance use also align with the results of Galea, Nandi and Vlahov's (2004) research on the social epidemiology of substance use, which highlight the importance of social influences on the level of substance use. This suggests it would be useful to explore the social stresses and strains partners may be experiencing, to understand any extra support they may be potentially able to receive from their social networks.

Our findings build on the previous research, in particular that conducted by Orford, Velleman, et al. (2010), through describing the impacts from a sample recruited through online counselling, which may include many partners seeking help for the first time. In addition, online counselling represents a form of low intensity support (which includes helplines, online chat, forums, email-based services), and differs from much of the previous research which involved partners accessing high intensity supports (e.g. face-to-face counselling, psychiatrists, psychologists, support groups). Low intensity supports, including

online counselling, provide us with access to a broader range of partners, as factors such as anonymity may assist in overcoming the stigma of help-seeking. This assists us in better understanding the nuances present in the interpersonal impact for partners.

Clinical and policy implications

These findings highlight the importance of strengthening partners' social networks, assisting them to establish flexible interpersonal coping skills and working on their interactional patterns in their intimate relationship. Online services can play a key role in assisting these partners to take the first steps towards seeking help, by reducing the shame and stigma often associated with seeking help in a face-to-face context (Rodda, Lubman, Dowling, & McCann, 2013). Online services may be able to provide a platform for greater peer support through online community forums, to assist with social support and connection for partners.

The findings also highlight the challenge of parenting responsibilities for partners. Policy initiatives which involve accessible and affordable childcare would reduce the burden on partners, in addition to programs which support partners to set boundaries with their significant other around the exposure of their children to problem AOD use and associated consequences. The provision of support to partners with programs such as the 5-Step Method could be beneficial (Orford, Velleman, et al., 2010). Furthermore, training online counsellors in risk assessment for the safety of partners and their children is highly pertinent.

Awareness campaigns aimed at reducing stigma in the community are also recommended, such as the website 'Lives of Substance' in Australia (National Drug Research Institute, 2016), which provides resources and describes personal stories of individuals with problem AOD use. Websites such as this which instead focus on partner stories may assist community members to understand that there is more to a relationship between partners and their significant other than the problem AOD use, and emphasise the multi-faceted and

complex nature of human ties. This would aim to reduce judgment around a partner's decision to stay with their significant other, or leave the relationship, by communicating a richer story of the experiences of partners.

Limitations

For gender, we attempted to oversample to increase the number of male transcripts, as this is an under-researched area. Unfortunately, there were only 15 male transcripts we could sample, thus it was not meaningful to perform gender comparisons. Future research should sample from a longer time period to increase the number of male transcripts for direct gender comparisons. While our sample represents greater breadth in partners than previous research, e.g., by including partners with varying sexual orientations, this information was not collected at the pre-session stage, and was only ascertained if it featured in the transcripts. This meant we did not have sufficient data within our sample to conduct meaningful comparisons based on this sexual orientation which would be a useful direction for future research.

Furthermore, the data was sourced from online counselling transcripts, therefore the findings may not be representative of the interpersonal impacts partners would seek help for in a face-to-face context. In addition, the impacts described may have been impacted by the counsellor's prompts or feedback during the session. Given the information here was analysed using qualitative methodology, the generalisability of the results need to be treated with caution.

Conclusion

In summary, this study found that the interpersonal impact for partners extended to intimate relationship issues; challenges in parenting; and impacts on and from their social network.

Clinical implications included the importance of implementing more online services as a platform for peer support. This could include awareness raising websites which describe partner experiences, in order to reduce stigma in the community around partners, making it easier for partners to reach out for support. This is important as social support is a key aspect in reducing partner strain within the stress-strain-coping-support model (Orford, Copello, et al., 2010). Furthermore, policies and training initiatives for professionals and partners could be useful which support partners in their parenting, in particular risk assessments for child and partner safety. Lastly, the study examined a unique sample of partners to illustrate the broad interpersonal impacts that problem AOD use can have on partners' lives, as well as highlighting the importance of viewing partners as valid help-seekers in their own right.

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Declaration of Interest

The authors report no conflicts of interest.

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6. Paper three: Online help-seeking for partners

6.1. Preamble to paper three

Results which explore help-seeking in online counselling transcripts of partners are presented in the form of a published paper titled “How online counselling can support partners of individuals with problem alcohol or other drug use” (Wilson, Rodda, Lubman, Manning, & Yap, 2017). This paper has been published by the journal “Journal of Substance Abuse Treatment”. The aim of the paper was to conduct a qualitative analysis of help-seeking in online counselling transcripts of partners contacting a national online AOD service, to identify common themes related to this modality of help. Specifically the study aimed to explore motivations for help-seeking and how counselling online can support partners in sessions. Descriptive content analysis was used to analyse 100 online counselling transcripts. Inter-rater reliability was analysed using a function in the program NVivo, which uses all coded data between two raters to calculate Kappa values. This is based on the full 1303 data extracts included in the analysis. The second coder was a masters level graduate who double coded all of the data extracts following training. Data extracts are coded into themes within the NVivo program, so that all data extracts are allocated to one of the themes separately by the two coders. The two NVivo files are then merged, and the interrater reliability test within NVivo is run. This analyses which coded extracts occur under each theme for each of the raters, and then provides the Kappa value of how much alignment there were between the two raters in placing the same extracts in the same themes. The results are presented around three core themes, relating to the reason for accessing online counselling, discussing help-seeking and coping processes, and planning for future assistance. This is followed by a discussion of the results, which is further expanded upon in the integrated discussion (section 7.3). This published paper provides a novel contribution to the literature by investigating a low intensity support option, online counselling, which not only allows us access to a group of individuals

whom might otherwise find it challenging to seek help face-to-face, but also provides a clearer understanding of how partners specifically can be supported using this modality. This paper also includes the coding dictionary used in the qualitative analysis (Table 2).

6.2. Paper three

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How online counselling can support partners of individuals with problem alcohol or other drug use

Samara R. Wilson [a], Simone Rodda [c,d], Dan I. Lubman [b,c,*], Victoria Manning [b,c], Marie B.H. Yap [a,e]

[a] School of Psychological Sciences, Monash Institute of Cognitive and Clinical Neurosciences, Monash University, Clayton, Australia
[b] Eastern Health Clinical School, Monash University, Box Hill, Victoria, Australia
[c] Turning Point, Eastern Health, Fitzroy, Australia
[d] School of Population Health, University of Auckland, New Zealand
[e] School of Population and Global Health, University of Melbourne, Australia

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ABSTRACT

Background: Problematic alcohol and other drug (AOD) use impacts partners heavily, with an increased risk of experiencing domestic violence, financial stressors, health problems and relationship challenges. However, partners often do not seek help or support due to a range of barriers (e.g., shame, stigma, practical constraints). Online counselling may facilitate help-seeking by overcoming many of these barriers, however research is needed to explore what motivates partners to contact online counselling services, their experiences and needs, and how partners can be best supported online.
Method: One hundred transcripts of partners of individuals with problem AOD use were sampled from a 24-hour national AOD synchronous online chat counselling service. Descriptive content analysis was used to investigate themes related to help-seeking.
Results: Three broad themes, with seven sub-themes, were identified: (i) the reason for accessing online counselling (seeking advice, wanting to talk), (ii) discussing help-seeking and coping processes (past/present help-seeking or coping strategies, barriers and facilitators to seeking help and change), and (iii) planning for future assistance (future planning, treatment preferences).
Conclusions: Partners wanted to talk about their concerns with a non-judgemental professional. However, the majority of help-seekers wanted advice and assistance in problem-solving, coping and the process of seeking further help. Future studies need to examine the impact of online help-seeking by partners.

1. Introduction

Problematic alcohol or other drug (AOD) use impacts the whole family unit. One in three Australians experience negative impacts from the effect of someone close to them misusing substances (Laslett et al., 2011). Research suggests that partners (i.e., a spouse, de-facto, boyfriend/girlfriend, or ex-partner) are particularly impacted, as they, along with mothers, have a greater accumulated burden compared to children, siblings, or extended male family members (Orford, 2017). Partners are a distinct family member, as there is generally a symmetry to the relationship, rather than the asymmetry seen in more dependent parent-child relationships. This may impact on the strain and stresses partners experience, making it important to focus on partners' experiences and needs specifically. In particular, partners are at increased risk of experiencing domestic violence, depression, stress, anxiety, financial stress, physical health problems and relationship challenges (Cunradi, Caetano, & Schafer, 2002; Dawson, Grant, Chou, & Stinson, 2007; Homish, Leonard, & Kearns-Bodkin, 2006). Despite this, there are low rates of help-seeking by partners for their own needs (Orford, Velleman, Natera, Templeton, & Copello, 2013).

Key barriers to help-seeking for family members, including partners, include shame, guilt, and stigma, along with practical constraints such as available time, child-care, geographical accessibility or financial costs (King et al., 2006; Rodda, Lubman, Dowling & McCann, 2013). Shame and stigma around seeking social support has been found to be a particular issue among wives of problem alcohol users (Peled & Sacks, 2008; Wiseman, 1991), with many family members concerned about being judged by others for the way they handle the person with problematic AOD use (Orford et al., 2005). Moreover, previous research has found that family members perceive professionals as lacking knowledge and awareness (and the ability to offer sympathetic understanding) about the needs of family members (Orford et al., 2013). Such

* Corresponding author at: Eastern Health Clinical School, Monash University, Box Hill, Victoria, Australia.
E-mail addresses: samara.wilson@monash.edu (S.R. Wilson), s.rodda@auckland.ac.nz (S. Rodda), dan.lubman@monash.edu (D.I. Lubman), victoriam@turningpoint.org.au (V. Manning), marie.yap@monash.edu (M.B.H. Yap).

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perceptions and barriers may be hindering many partners from reaching out for help.

Distance-based services, such as telephone and online services, are well placed to overcome many of the help-seeking barriers faced by partners (Urbis Keys Young, 2003). They enable access to professional assistance anytime, anywhere, are affordable or freely available, and provide anonymity, hence reducing shame and stigma concerns over seeking help (Barak, Hen, Boniel-Nissim, & Shapira, 2008; King et al., 2006; Rodda, Lubman, Dowling, Bough & Jackson, 2013). Indeed, family members impacted by problem gambling report being motivated to access online counselling (online synchronous chat support) for its confidentiality and accessibility (Rodda, Lubman, Dowling & McCann, 2013). In particular, online counselling has been found to cover a greater variety of topics, and more sensitive content, when compared with verbally sought assistance (Callahan & Inckle, 2012). This may make online counselling especially relevant to partners, who present with a range of needs. However, there is limited research into partners' experiences and needs within this online modality. This is despite their common presentation to online counselling services, with partners representing approximately one in ten contacts to an Australian online counselling service for problem AOD use (Garde, Manning & Lubman, 2017).

Research is also needed into the help-seeking needs of partners more broadly, as support for partners has been traditionally conceptualised as an adjunct treatment for individuals with problematic AOD use (Orford et al., 2005). More recently, the stress-strain-coping-support model has sought to de-pathologise partner strain, and reconceptualise the impact on partners as being from the stresses and strain of living with an individual with problem AOD use (Orford et al., 2005). The model also asserts the importance of partners as help-seekers in their own right (Orford et al., 2013), although much of the research in this area has focussed on all family members. Given the greater accumulated burden for partners (Orford, 2017), more research specific to partners and their help-seeking needs is required.

One approach to this issue is to examine transcripts of past online counselling interactions. Such research provides a unique opportunity to understand what needs partners are seeking help for, as well as what they receive in an online context. Due to the anonymity and accessibility of the service, such online counselling interactions are likely to encompass a broader group of partners than those examined in previous research, as it is not limited to recruiting only those willing to participate in formal interviews. Themes analysed in such transcripts also provide a clear depiction of what experiences and needs prompted access to the service, increasing the relevance of such research for informing real-world service provision. Using a qualitative approach also enables the identification of any themes that may be missed through the use of standardised questionnaires, and allows a richer description of the help-seeking process, given the paucity of research in this space. As such, the aim of the current study was to conduct a qualitative analysis of help-seeking in online counselling transcripts of partners contacting a national online AOD service, to identify common themes related to this modality of help. Specifically, the aim of the study was to explore motivations for help-seeking and how counselling online can support partners in sessions. This study is part of a broader investigation into the needs and experiences of partners accessing online counselling.

2. Method

2.1. Counselling online

Launched in 2005, Counselling Online offers free self-help resources, information, synchronous and asynchronous online chat counselling services for individuals with problem AOD use, their families and friends. Operating 24/7, Counselling Online provides over 2000 online counselling sessions per year across Australia. Approximately 9.4% of these sessions are contacts by partners, with sessions lasting an average of 29 min (Garde et al., 2017; www.counsellingonline.org.au). Accessing the service anonymously is the most common interaction (69% of clients), however there is an option to provide an email address to register with the service (31% of clients), so that transcripts are on file for subsequent counselling sessions. Demographic information is provided by the client before the session begins, and includes variables such as sex, age, cultural identity, and primary drug of concern. Counsellors have a range of qualifications and training backgrounds, including psychologists, social workers, and a variety of endorsed counselling disciplines. The primary role of counsellors is to provide assessment, brief interventions, and referral information and support, including referrals to specialty AOD services. The service is delivered within a brief intervention framework with motivational interviewing being the most predominant counselling style.

2.2. Sample characteristics

Transcripts were accessed over a 12-month period (November 2013 to November 2014), to ensure that the themes identified represented the most current issues and needs. De-identified partner transcripts were exported to Microsoft Excel. These transcripts typically began with an opening question from the counsellor such as "Hello, you are talking to an online drug and alcohol counsellor, how may I be of assistance?" Counsellors at the service had undergone training in working with partners in 2013, and therefore we wanted to ensure that the findings were generalizable to current practice by selecting the most recent 100 transcripts from the 12-month period. One hundred was chosen to ensure a broad range of clients accessing the service would be represented. Gender and drug type were then explored to allow the purposeful oversampling of male partners (an under-researched group), and a 50% alcohol sample to allow comparisons between alcohol and other drugs as part of the broader research project. This process involved 9 extra alcohol transcripts being re-sampled to replace 9 other-drug transcripts, and replacing 4 female transcripts with male transcripts.

The term partner was used inclusively, referring to spouse, girlfriend/boyfriend, de-facto, or ex-partner, and reflected partners in either homosexual or heterosexual relationships. Eighty-five percent of partners were female, and 15% were male. Over half of the partners (58%) were between 20 and 34 years old, with ages ranging between 15 to over 65 years old. Seven percent were under 20 years old, 28% were between 35 and 44 years old, and 7% were 45 or older. Seventy-three percent reported Australian as their primary cultural identity, with 14 different cultural identities comprising the other 27%. The most frequently identified main drug of concern was alcohol (50%; purposefully sampled), followed by amphetamines (10%) and cannabis (8%). Other main drugs of concern included hallucinogens, opioids (heroin, methadone, buprenorphine, opioid analgesics), sedatives (benzodiazepines, gamma-hydroxybutyrate or GHB), stimulants (cocaine, ecstasy, other stimulants), and other party drugs. Twenty-seven percent of coded transcripts mentioned polysubstance use. Sixteen percent of transcripts were identified as clients who accessed the service previously.

Ethics approval was granted by the Eastern Health Human Research Ethics Committee (Reference number: LR101/1314) and the Monash University Human Research Ethics Committee (Project number: CF14/1929 – 2014000980).

2.3. Data analysis

Demographics were analysed using the statistical package SPSS version 22. Qualitative data from transcripts was analysed using the qualitative data analysis program NVivo version 10. To provide a more realistic representation of partners' experiences, it was decided to focus on what the partner expressed, rather than the counsellor's perception or reframing of the partner's experience. Therefore, themes were coded from the partner's text in transcripts rather than the

counsellor text, akin to Rodda, Lubman, Cheetham, Dowling, and Jackson's (2015) analysis of the actual content of web-based counselling sessions.

A descriptive content analysis was conducted. This combined a thematic analysis using Braun and Clarke's (2006) guidelines, with a content analysis of data in those themes following Neuendorf's (2002) method, using a deductive approach. This method allows the combination of forming themes from the data with the richness of thematic review, along with a comparison of the amount of data present in those themes as per content analysis, to provide a comprehensive analysis of partner needs.

Transcripts were read (by SW), and initial themes were noted down and discussed by the project researchers to begin the process of familiarisation with the data. Transcripts were then coded (by SW) to capture all aspects of the counselling transcripts. Data extracts (individual coded chunks of data) ranged from one word to full sentences. Themes were coded at the semantic level (themes identified from explicit meanings) rather than the latent level (themes identifying underlying ideas and assumptions) to better represent the perspective of the client, and reduce subjectivity. This resulted in 1303 data extracts from the 100 transcripts. The research team then discussed potential themes and sub-themes related to help-seeking within the data. Three broad themes and seven sub-themes were agreed upon by two raters (SR and SW), which sufficiently represented the content from the data extracts. These themes were then refined by consulting the literature and using the data to generate clear definitions and names, in the form of a coding dictionary (see Table 2).

To assess for interrater reliability of these themes, a second coder was involved (a masters-level graduate with experience in qualitative methods). Training was conducted by SW with the second coder. This involved familiarisation with the coding dictionary; coding and correcting 20 sample items in print form, followed by 50 items in the NVivo program; and finally checking in for questions about the themes based on the next 100 items. After completing approximately one third of the coding, a preliminary interrater reliability was conducted to examine the feasibility of the themes, before coding the remaining two thirds of the extracts. All 1303 data extracts were coded into the themes by the two raters and the final interrater reliability was assessed using Cohen's kappa (κ) (see Table 1). As shown in Table 1, all kappas were above 0.8, indicating very good reliability (Cohen, 1960), with the average kappa being 0.89. In the final step of the data analysis process, representative extracts were selected from the themes to relate back to the research questions and literature.

3. Results

Descriptive content analysis of partner online counselling transcripts revealed three broad themes, with seven sub-themes. These themes related to the reason for accessing online counselling, discussing help-seeking and coping processes, and planning for future assistance.

Table 1
Interrater reliability statistics for the 7 help-seeking themes.

Themes	Cohen's kappa (κ)
3.1. The reason for accessing online counselling	
3.1.1 Seeking advice	0.97
3.1.2 Wanting to talk	0.90
3.2. Discussing help-seeking and coping processes	
3.2.1 Past/Present help-seeking or coping strategies	0.88
3.2.2 Barriers to seeking help and change	0.90
3.2.3 Facilitators to seeking help and change	0.88
3.3. Planning for future assistance	
3.3.1 Future planning	0.88
3.3.2 Treatment preferences	0.90
Average kappa	0.89

Following each quote is the gender and age range of the partner, and the main problematic substance used by their significant other.

3.1. Reasons for accessing online counselling

Most transcripts (89/100) explicitly mentioned a reason for accessing online counselling. This included seeking advice for how to promote change in their significant other or how to cope with the AOD use, a specific prompt to access the service, or a desire to be listened to.

3.1.1. Seeking advice

3.1.1.1. How to prompt change or encourage help-seeking in the individual with problem AOD use. The majority of partners (79/100) were seeking specific advice on how to address their situation and the problem AOD use. This included expressions of uncertainty, for example, "*[I] don't know what to do*" (female, 25–29 years, alcohol) and requests for the counsellor's direction in how to move forward, for example, "*what advice do you have for approaching the situation with him?*" (female, 20–24 years, alcohol). Partners also asked how to act in a specific situation, how to promote change in the individual with problem AOD use, how to talk to or confront the individual with problem AOD use, and how to identify if the individual with problem AOD use was currently using or if the use was problematic. For example, a partner asked whether it was reasonable to look for evidence of intravenous drug use, by writing "*Is it reasonable for me to ask to look at her to look for these spots?*" (female, 30–34 years, other drugs).

3.1.1.2. How to cope with the AOD use. Partners also sought advice on how to cope with the AOD use, regardless of whether or not the individual with problem AOD use was ready to change. This included differentiating the problems of the partner and the individual with problem AOD use (e.g., "*please tell me if the problem is mine as I am too anxious*"; female, 35–39 years, alcohol), brainstorming who the partner should tell about the problem, exploring self-care or advice for managing their own emotions (e.g., "*how can I protect myself and my weakness*"; other drugs), boundary setting (e.g., "*do you think I should just go home when he's had too much*"; female, 25–29 years, alcohol), and clarifying expectations (e.g., "*am I expecting too much*"; female, 40–44 years, alcohol). For partners that no longer wanted to cope with the AOD use, information was requested on how to terminate the relationship, for example, "*Should I give him a time frame and monitor his behaviour before letting go of him?*" (male, 30–34 years, other drugs).

3.1.2. Wanting to talk

Ten transcripts contained an explicitly stated prompting event for contacting the service. This was the focus of the discussion and often the stated reason for contact, for example, "*This is why I am here. Last night was the last straw when he came over drunk and high and lied about it*" (female, 20–24 years, alcohol). The characteristics of online counselling was viewed as attractive because it offered a place to talk at any time of the day or night, for example, "*The local health office is closed so I was hoping I'd find something online*" (female, 20–24 years, other drugs). Eleven transcripts suggested partners wanted to talk through their issues, and did not want external advice. One partner wrote "*[I] really just need support, not advice or solutions*" (female, 30–34 years, alcohol). However, most transcripts indicated that partners wanted to discuss their situation more broadly with the counsellor in addition to wanting specific advice. Partners described their situations to the counsellor, including their personal impact, their experience of the individual with problem AOD use, the impact on their relationships, and the interaction of the AOD use with other life domains, such as education, employment, health, finances, forensic issues, and housing. Partners appreciated having someone external to their situation to talk to, for example, "*Just been finding it hard lately and I guess [I] thought*

it might be useful having someone with no connection to the situation to talk to" (female, 20–24 years, alcohol).

3.2. Discussing help-seeking and coping processes

Following an exploration of the reason for seeking help, over 85% of transcripts engaged in a discussion around experiences of help-seeking by the partner and the individual with problem AOD use. This involved either discussing past or present help-seeking experiences or coping responses related to the AOD use, barriers and facilitators to help-seeking and change, or treatment preferences.

3.2.1. Past or present help-seeking or coping strategies

Forty-one transcripts described previous or current help-seeking experiences with formal services for the AOD problem. These included seeing a counsellor or psychologist, GP, medication, hospital care, detoxification, rehabilitation, support groups, 12-step meetings, helplines, and online services. The majority of discussions reflected frustrations that the effects of previous treatments and strategies did not last. Informal help-seeking or coping strategies were also described in over half of the transcripts. These included strategies such as talking with the individual with problem AOD use (confronting, negotiating cutting back, setting boundaries), distraction (movies, outings, keeping busy), research (online forums, brochures), self-care (fitness, nutrition, hobbies), seeking social support (friends and family for emotional support), being supportive, and withdrawing or ending the relationship. One partner discussed planning an intervention along with the family, for example, "*His family is aware and concerned so we are planning a type of intervention*" (female, 30–34 years, other drugs). Another partner discussed the timing of talking with the individual with problem AOD use, by writing "*I tried to talk to him about it while he is sober*" (female, 25–29 years, alcohol).

The transcripts also discussed help-seeking actions for both the partners and/or the individual with problem AOD use. However, the majority of transcripts focussed on help-seeking for the individual with problem AOD use. Some transcripts described how challenging it was for a partner to seek help for themselves, feeling out of place or ashamed. This was especially the case when help seeking was in a group setting, for example one partner wrote "*I did go to a meeting once…I felt very out of place in a group. Ladies with black eyes from abusive husbands – me just feeling sorry for myself*" (female, 65 + years, alcohol).

3.2.2. Barriers to seeking help and change

While discussing the help-seeking process, most transcripts (84/100) discussed barriers to seeking help and change. The main structural barriers mentioned were the lack of availability and also the affordability of treatment. Spending a lot of time at places that serve alcohol (e.g., hotel), socialising with friends while using substances, or peer pressure (e.g., to consume or use AOD), were additional barriers to recognising the need to seek help because these social contexts reinforced the problematic behaviours. Barriers also included a lack of social support, such as lacking family support, being isolated geographically or withdrawing from friends/family, or not sharing concerns with friends/family about the problem AOD use due to shame or stigma. For example, "*I can't talk to anyone because his side of friends do drugs and my side don't but I'd be ashamed*" (female, 25–29 years, other drugs).

Cognitive and attitudinal barriers were also frequently mentioned. This included attitudes (the individual with problem AOD use's lack of motivation, willingness, or readiness to change), and a lack of knowledge about problem AOD use, treatment or change. It also involved partner anxiety or unhelpful beliefs around the change process or seeking help, or concerns around confronting the individual with problem AOD use. In one transcript, a partner reflected on the balancing act between being sensitive to the mental state of the individual with problem AOD use, and still wanting to set boundaries, by writing "*Scared of him attempting suicide again if I push too hard – but also don't want to let him get away with things because of my fears*" (female, 30–34 years, other drugs). Behavioural barriers also included the problematic AOD user's avoidance or deceit regarding their AOD use, and abusive or aggressive behaviour which often coincided with times the partner had confronted the user about their use, for example "*He is mean and abusive when I try to ask him to get help*" (female, 30–34 years, alcohol).

3.2.3. Facilitators to seeking help and change

Over two-thirds of transcripts (68/100) contained discussion on facilitators to seeking help and change. Behavioural facilitators included the individual with problem AOD use taking steps toward change, such as contacting services, cutting back or stopping problem AOD use, or putting into place practical harm reduction strategies (e.g., changing phone number to avoid dealers). Social facilitators included a social environment which encourages reducing problem AOD use and provides social support, such as family or friends being aware of the problem AOD use and providing practical and emotional support in an understanding, and non-judgmental manner. For example, one partner wrote "*I have such an amazing support network and they understand the drinking side of the situation better than most – they don't judge and they are so loving*" (female, 20–24 years, alcohol).

Cognitive facilitators involved the individual with problem AOD use being motivated, willing or ready to change (e.g., wanting to seek help, feeling ready to reduce problem AOD use, the individual with problem AOD use agreeing they have a problem) or the partner being knowledgeable about problem AOD use, treatment, or change (e.g., having had other family members with problem AOD use, having experienced problem AOD use themselves, having been with the individual with problem AOD use over the course of previous attempts to change). It also involved the partner having helpful beliefs around treatment, help-seeking, and change (e.g., recognising where responsibility for change lies, believing that treatment or change is helpful or possible), and having insight into their own emotional reaction to the change process, for example "*I totally know it's her choice but I also feel guilt and responsibility*" (female, 35–39 years, other drugs).

3.3. Planning for future assistance

3.3.1. Future planning

In half of the transcripts (50/100), partners were seeking information on problem AOD use, help-seeking, or treatment. This included requesting drug-specific information, information on the course and likely prognosis of addiction, as well as future formal (20 transcripts) and informal (12 transcripts) help-seeking plans. Discussions focussed on how to get help, which types of professionals to approach, and planning specific informal strategies to implement, for example "*What would be the next step if he is serious about quitting?*" (female, 30–34 years, other drugs). Treatment information sought included the location, availability and affordability of services, referral details, treatment methods (e.g., detoxification, rehabilitation), and the role of different services (e.g., relationship or family services, helplines, university counselling, AOD specific services). This included treatment requests for the individual with problem AOD use and for the partners themselves, for example "*Are there any counsellors that you can recommend in our area also for him to see? Where can I get this sort of support for myself?*" (female, 25–29 years, alcohol).

3.3.2. Treatment preferences

Treatment preferences were often important aspects of future assistance being discussed. One quarter of transcripts (25/100) discussed treatment preferences. This included attitudes and desires toward specific types of treatment or help-seeking. Desired treatment covered type of treatment (e.g., support groups), the location of treatment (e.g., local), with an emphasis on the confidentiality and anonymity of treatment, for example "*I don't want my partner to know I'm on here talking to you*" (female, 15–19 years, other drug). Comments made

about the undesirable types or features of treatment included the inconvenience of accessing services (e.g., childcare needs, unable to drive to the service), doubt over the efficacy of treatment or negative past experiences (e.g., previous therapy being unhelpful) or a dislike for accessing specific treatment options (e.g., disliking medication, rehabilitation, detoxification, or support groups).

In some transcripts, partners also expressed a specific preference for accessing services for themselves and/or the individual with problem AOD use, or including the whole family in the treatment process, for example "*I felt I should get some "me" support to be as strong and balanced as I can*" (female, 30–34 years, other drugs). This sometimes involved a mismatch, where the partner wanted to seek help with the individual with problem AOD use, yet they did not believe the individual with problem AOD use would do so.

4. Discussion

The aim of the study was to conduct a qualitative analysis of help-seeking in online counselling transcripts of partners contacting a national online AOD service, to identify common themes related to this modality of help. We found three broad themes, with seven sub-themes – (i) reason for accessing online counselling (seeking advice, wanting to talk), (ii) discussing help-seeking and coping processes (past/present help-seeking or coping strategies, barriers and also facilitators to seeking help and change), and (iii) planning for future assistance (future planning, treatment preferences).

These findings are consistent with Orford, Copello, Velleman, and Templeton's (2010) model, as general support, advice, and information or referrals were frequent reasons to seek help. Many partners expressed a desire for their significant other to change, feeling stuck when there was a mismatch between their desire for change and the willingness of their significant other. The findings were also consistent with previous research examining why family members access online counselling (Rodda, Lubman, Dowling, Bough et al., 2013), with the availability of the service a key reason for contact. While not explicitly raised as reasons for contacting the service, affordability, accessibility, and confidentiality were raised as general treatment preferences for partners, which aligns with previous findings (Rodda, Lubman, Dowling, Bough et al., 2013).

These results suggest that online counselling services can play a key role in being a first port of contact for partners, providing a brief intervention before referring on to other services. Around half of the partners were seeking specific referral details or information they did not have to support them after the online counselling session. Others already had the service information, and were looking for assistance with problem-solving, with informal strategies to support themselves or their significant other. A small proportion of partners contacting the service had a preference to talk through their issues. These participants were not seeking immediate solutions to problems rather someone to listen non-judgementally. This suggests that for partners experiencing social isolation, online counselling could provide the means to reduce social isolation and at the same time offer support.

The findings also suggest that partners tend not to focus on themselves as the primary help-seeker, as most of the transcripts were focussed on helping the significant other, rather than the partner themselves. However, some partners did specify that they were seeking help for themselves. This suggests that while partners do need support, they also are seeking specific assistance to address the stress in their lives which results from their significant other's problematic AOD use. This is aligned with the stress-strain-coping-support theoretical model for conceptualising partners as coping with stressful life circumstances, rather than pathologising the role partners play in AOD family systems (Orford et al., 2005). The 5-Step Method is based on the stress-strain-coping-support model, which involves listening, providing information, exploring coping, exploring social support, and considering further needs for family members of those with problematic AOD use (Copello, Templeton, Orford, & Velleman, 2010).

4.1. Clinical implications

The findings from this study fit broadly within the 5-step categories identified by Copello et al. (2010), albeit with a greater emphasis on discussing or problem-solving around help-seeking processes (i.e., past experiences, barriers, facilitators, and treatment preferences). Problem-solving in this context was not generally guided by an established model of problem-solving, but rather a discussion on the costs and benefits and preferences toward different treatment options. Compared with Copello et al.'s model, the greater focus on problem-solving may be due to the broader role (e.g. problem identification, information and referral provision) of the online counselling context, whereas the 5-Step Method is usually applied in face-to-face settings where the partner may be already linked in with a service. When used in training for online counsellors, this problem-solving and referral emphasis should be noted within the 5-Step Method. Furthermore, partners (and indeed online help-seekers more broadly) may benefit from a structured problem-solving approach to determine the best fit between preference, expectations and service options.

As advice was a central part of the help-seeking process, training online counsellors in Socratic questioning (prompting using questions to think through problems) is recommended. This would assist counsellors to empower clients seeking advice, and make the solution produced more targeted to the partner's individual situation. For example, previous research has found an increase in critical thinking skills by using Socratic questioning in online discussions (Yang, Newby, & Bill, 2005), and therapist use of Socratic questions has predicted session-to-session reduction in depressive symptoms (Braun, Strunk, Sasso, & Cooper, 2015). Also, encouraging online counsellors to validate emotional experiences may assist partners when they present for counselling based on a recent prompting event, or for when the partner is just wanting to talk. This would assist in improving family members' perception that professionals do not understand their needs (Orford et al., 2013). Producing information for websites on the common experiences for partners may also help validate partners' experiences. This could include encouraging partners to access peer support services, such as online community forums. This may be particularly beneficial to partners due to the convenience of remotely accessible anonymous support, available 24/7, and allows them to interact and share experiences with people experiencing similar issues.

The results also suggest that some partners may have been through a range of formal and informal help-seeking processes, and already have specific treatment preferences. This could be useful to discuss with partners, to enable any future plans for help-seeking to be targeted to partner preferences, so as to help increase the chances of future positive and helpful experiences in help-seeking. For example it would be useful to take into account preferences for anonymity (due to shame and stigma concerns) or accessibility of the service (overcoming transport and childcare barriers) (Rodda, Lubman, Dowling, Bough et al., 2013). However, online counselling services should also note that some partners accessing the service may not have sought help before (or only experienced help-seeking for their significant other), and provide psycho-education and clear information for partners on help-seeking pathways on their websites. Online counsellors could also encourage partners to see themselves as valid help-seekers in their own right, by emphasising that partners need to attend to their own needs and psychological wellbeing, so they can continue to support the person with problem AOD use (Orford et al., 2013). Specific barriers and facilitators to help-seeking and change should be explored where possible, such as gently challenging any unhelpful cognitions, attitudes, behaviours, or social situations which may be maintaining distress, or encouraging any approaches which lessen distress. Online counsellors should also be trained to provide specific information on problem AOD use for a

range of drugs, and have an understanding of treatment services which would assist partners seeking referral information.

4.2. Limitations

This paper was unable to conduct comparisons based on gender, sexual preference, type of partner, first-time versus repeat service user, or having children versus not having children, due to a lack of available data or insufficient sample sizes for the required analyses. Future studies should target these factors to expand the findings presented here. In addition, the results draw from a sample of 100 partners, and caution needs to be used when generalising information. The results also relate to online counselling, so the generalisabiliy of these findings to non-online help-seeking settings is unclear. Furthermore, the study summarised themes present in the help-seeking transcripts, some of which were relatively brief. It did not ask partners directly what they would like in the service. Future research could conduct follow-up in-depth interviews with partners, to see if similar or additional themes emerge. Also, the data presented in the study represented partners statements made in online counselling sessions and to some degree those statements are likely to have been influenced by counsellor prompts. Future research should examine how counsellors influence the content and exchange of information in online counselling sessions so as to provide a more full description of the nature of online counselling sessions more broadly. Finally, the effectiveness of the assistance partners received was not assessed. Follow-up studies would be useful to ascertain how helpful partners found the service, and the usefulness of referrals and information provided.

4.3. Conclusion

The findings from this study were three help-seeking themes and processes present in the online counselling transcripts for partners – (i) reason for accessing the service, (ii) discussing help-seeking or coping processes, and (iii) planning for future assistance. While some partners were seeking the opportunity to talk through their concerns, the majority wanted advice, assistance with problem-solving situations around change, coping, and the help-seeking process, along with specific information or referral details. This aligns with the 5-Step Method for assisting family members, with a greater emphasis on problem-solving further help-seeking.

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Conflicts of interest

None.

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Table 2. Help-seeking coding dictionary

Theme	Definition	Example
The reason for accessing online counselling		
Seeking advice	Seeking an opinion from the counsellor on what an individual should do or how they should act in a situation.	Don't know what to do; asks counsellor for advice; unsure; partner has lots of questions.
Wanting to talk	An explicitly stated situation or emotional state which prompted access to the service. The desire to talk about their situation rather than seek specific advice.	A recent fight with their significant other; just wanting someone to talk to.
Discussing help-seeking and coping processes		
Past/present help-seeking or coping strategies	Past or present actions undertaken to change or cope which involve formal or informal assistance, oversight, strategies, or treatment.	Currently seeking help; counselling; rehabilitation; detoxification; hospital; mediation; medical services; medical trial; self-help; social support; past/present strategies on how they address problem AOD use or encourage help-seeking or treatment by self, other, friends or family.
Barriers	Structural (e.g., cost), social (e.g., support), cognitive (e.g., attitudes, knowledge) or behavioural factors that hinder or impede help-seeking, the initiation of treatment, or change. Excludes attitudes or desires relating to type of treatment.	Lack of availability or affordability of treatment or help-seeking; social context reinforcing problem AOD use; unhelpful attitudes or behaviours toward help-seeking, treatment or addressing problem AOD use; lack of motivation, willingness or readiness to change.
Facilitators	Structural (e.g., free services), social (e.g., support), cognitive (e.g., attitudes, knowledge) or behavioural factors that support help-seeking, the initiation of treatment, or change. Excludes past/present/future strategies or techniques on how they encourage treatment/help-seeking.	Social context encouraging treatment or help-seeking; knowledge of treatment or problem AOD use; helpful attitudes or behaviours toward help-seeking, treatment or addressing problem AOD use; some motivation, willingness or readiness to change.
Planning for future assistance		
Future planning	Plans for future actions to change, cope or seek help, that involve formal or informal assistance, oversight or treatment (e.g., counselling, rehabilitation, social support). Also, seeking facts on anything related to problem AOD use, treatment or help-seeking.	Discussing how to get help; discussing specific types of help they plan to access such as counselling, rehabilitation, hospital admission, or couples therapy; self-help; planning to seek social support; future strategy planning on addressing problem AOD use informally; specific referral and psycho-education information.
Treatment preferences	Attitudes (e.g., like or dislike) and desires toward (e.g., want or not want) types of treatment or help-seeking. Excludes future plans to access a type of treatment.	Preferring one type of treatment over another; liking/disliking a type of treatment; wanting/not wanting a type of treatment; preferring treatment for self, significant other, family, or couple.

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Samara R. Wilson is a Doctor of Psychology (Clinical) candidate at the School of Psychological Sciences, Monash University. Her doctoral thesis focusses on the impact of problem alcohol or other drug use on partners.

Simone Rodda is a Senior Lecturer at the University of Auckland, New Zealand and an honorary Senior Research Fellow at Turning Point, Australia.

Dan I. Lubman is a psychiatrist and addiction medicine specialist. He is the Director of Turning Point and is a Professor of Addiction Studies at Monash University.

Victoria Manning is a Senior Research Fellow at Turning Point and a lecturer at the Eastern Health Clinical School, Monash University.

Marie B. H. Yap is a National Health and Medical Research Council (NHMRC) Career Development Fellow, Senior Research Fellow and psychologist at Monash University. She is the primary supervisor of Ms Wilson's doctoral research project.

7. Integrated discussion

This thesis aimed to better understand the complexity of personal and interpersonal impacts of problem AOD use on partners. This thesis also aimed to investigate the type of assistance partners are seeking. This increased understanding can be used to inform service provision to assist partners themselves (personally and interpersonally), and to assist partners in supporting their significant others (interpersonally). The overall study was framed by the stress-coping approach of viewing partners as individuals living in a highly stressful situation (being a partner of an individual with problem AOD use), and coping the best they can. This differs from traditional approaches to partners, which views partners as pathologically involved to meet their own needs, or partly blames partners for the behaviours of their significant other (e.g. enabling, co-dependency).

The personal impacts were framed within a cognitive-behavioural model, by examining the cognitions, behaviours, and affect of partners described in online counselling transcripts. This aimed to increase the translatability of the findings to supporting partners with evidence based therapies such as cognitive-behavioural therapies. The results showed partners' cognitions focussed on depressive cognitions, responsibility beliefs, and thoughts around trust. Partners' behaviours were impacted through expressions of helpful and unhelpful coping styles. This included both behaviours relating to interpersonal and personal coping. The main affects conveyed by partners in the transcripts were anger, sadness, and fear.

The interpersonal impacts explored both the impacts on and of social contacts, such as the intimate partner relationship, friends or family, and social support through professional service contacts, such as medical or mental health services. Intimate partner relationships were impacted through communication difficulties flowing from the discovery of the problem AOD use, and uncertainty over staying in or leaving the relationship. Challenges in parenting were impacted by safety and well-being concerns, exposure of children to problem AOD use

and its impacts, difficulty managing parenting responsibilities, and pregnancy-related considerations. Benefits and challenges in seeking social support were described, along with the influence and role of the extended family, and social group stress and support.

The results also explored the type of assistance partners were seeking through help-seeking themes present in the online counselling transcripts. This aimed to inform both help-seeking in an online context for partners, and to utilise the benefits of the broader sample of partners through the online counselling sample, to better inform help-seeking in a face-to-face context. The themes related to the reason for accessing online counselling (seeking advice, wanting to talk), discussing help-seeking and coping processes (past or present help-seeking or coping strategies, barriers and also facilitators to seeking help and change), and planning for future assistance (future planning and treatment preferences).

In this discussion, the results of the personal and interpersonal impacts, and help-seeking themes summarised above, are integrated and discussed under the stress-coping framework. This discussion will also highlight how online counselling may be able to complement and assist current service provision.

7.1. How do stresses and strains impact partners personally and interpersonally?

7.1.1. Living with uncertainty

Consistent with Orford et al.'s (2010b) findings, partners experienced uncertainty about the future, finding it hard to cope as they could not see an end to their distress. Specifically, partners were uncertain how to promote change in their significant other, and how to identify and respond to problem AOD use. This translated into their relationship with their significant other; they were unsure whether to stay in the relationship or to end it, a theme also prominent in Peled and Sacks' (2008) interviews with wives of problem alcohol users.

However, some partners worried about leaving the relationship as they were practically and emotionally intertwined. This was linked at times to financial issues or employment problems, which contributed to uncertainty in financial stability, in line with Orford et al. (2010b). Our findings also highlight that uncertainty is a key theme which partners experience on a day-to-day basis (in line with Velleman et al., 1998), and learning to tolerate uncertainty is an important coping skill to develop.

7.1.2. Feeling unsafe

Consistent with Orford et al.'s (2010b) review of qualitative findings, safety concerns, or feeling threatened were key experiences for partners. This sometimes involved intimate partner violence, and often coincided with substance use, supporting Fals-Stewart et al.'s (2003) findings that substance use increases aggressive behaviour. In the current study, some partners were unwilling to leave their significant other even when experiencing intimate partner violence, as their significant other made threats, such as to attempt suicide if they left. This highlights how safety concerns can lead to partners feeling stuck. Partners were also concerned around children witnessing or experiencing domestic violence, concurring with findings from Barnard's (2007) interviews of children of problem AOD users. Home life was uneasy due to the family 'walking on eggshells', and being alert for unpredictable mood swings which may threaten safety. Some partners were also concerned about the presence of unwanted individuals in the home, engaging in problem AOD use (consistent with Orford et al., 2010b), or feared reprisals against the family from AOD-related associates of their significant other. This implies that risk assessment (assessing the risk of violence a partner or child may experience in their current situation) is highly relevant for professionals when engaging with partners and their families. Moreover, partners require assistance to learn to

assess risk for themselves, and their children, and to have a safety plan in place for periods of heightened safety concerns.

7.1.3. Increased responsibility for others

Consistent with Peled and Sacks (2008), partners reported an increased sense of responsibility for the problem AOD use, blamed themselves for being in their situation, and felt a sense of failure. Specifically from our results, partners at times felt responsible for making their significant other change, seek help, and implementing informal strategies (planning interventions, negotiating substance use with their significant other). Partners in our study reported feeling an obligation to assist the individual with problem AOD use at times, as there was no-one else left to help if they did not. Sometimes this found partners in significant caretaking roles for the significant other, especially when substance use had increased over time. In line with Barnard (2007), parenting was often affected, and extended family or grandparents were sometimes able to provide extra support to assist partners with caring for their children. However, where extended family was not available, our results found partners sometimes felt like they were single parents, with the individual with problem AOD use neglecting parenting responsibilities. This was not always the case however, as some significant others were thought by partners to be better parents while using substances. This suggests that partners need assistance and support with caregiving for their significant other and children. Increasing respite services and childcare assistance formally or informally would assist to relieve the burden on partners.

7.1.4. Strained interactions

Findings supported the association between marital discord and substance use disorders (Whisman, 2007), and extended them by expanding on the impacts for a broader range of

partners, and subclinical AOD use. Specifically this discord in our findings centred around continual arguing, limited and strained interactions, or not talking altogether. Arguments often centred around the problem AOD use, and abusive or aggressive behaviour often ensued, in line with Fischer et al. (2005). Interactions were also affected by the consequences of using substances, such as significant others being too hung over to spend quality time with the partners. Sexual difficulties were also present for partners, in line with Velleman et al. (1998). Continual strained interactions led to frustration and anger in partners, consistent with the experience reported by wives of problem alcohol users (Peled & Sacks, 2008). Partners felt angry at their responses in situations, such as giving their significant other money when they did not want to. Our findings highlight the importance of looking at interactional patterns within the couple for sources of strain, and exploring alternate communication methods. This also suggests that recommendations to explore relationship counselling may be appropriate for partners.

7.1.5. Lack of trust

Trust was a key theme also reported in Orford et al.'s (2010b) review of impacts on family members. For partners, our findings showed it was difficult to re-establish trust after it had been broken. When partners had felt deceived, they began monitoring their environment for signs of deception and felt a pervasive suspicion in the relationship. This left them feeling both hurt and betrayed, echoing the impacts described in Velleman et al.'s (1998) interviews with wives of individuals with problem alcohol use. Suspicions of infidelity also contributed to conflict and mistrust, and contributed to sexual problems in the partner. Our study supports and extends Velleman et al.'s (1998) findings through looking at partners of other drug users in addition to problem alcohol use. The potential for breakdown of trust in partners'

relationships makes it important to support partners as they explore their specific concerns and anxieties in the relationship.

7.1.6. Poorer mental health

Our findings provided a rich description of increased depressive and anxiety symptoms among partners. This is consistent with Homish et al.'s (2006) findings of increased depression among partners of problem alcohol users. In our study, some partners reported a pervasive sadness, numbness, or changes in mood and behaviour, such as withdrawing, or crying more frequently. Partners also used self-derogatory language to describe themselves at times, suggesting low self-esteem. Consistent with Orford et al. (2010b), partners described feeling overwhelmed, and were ruminating on their situation. Feeling trapped or stuck was a key rumination, where partners had the desire to stay and leave simultaneously due to a combination of positives and negatives in the relationship. Partners also felt stuck when there was a mismatch between their desire for change and the willingness of their significant other to seek help. This intensified their feelings of hopelessness. In line with Orford et al. (2013), partners also expressed a feeling of loss at what used to be an enjoyable relationship.

Our findings also support Dawson et al. (2007), who found partners had an increased risk of anxiety. Some partners experienced a pervasive anxiety, for themselves, their children, and their significant other. Worry was a common theme, consistent with family members studied by Orford et al. (2010b). In our findings, partners worried about their welfare, physical injuries (to themselves, children, or their significant other when using), longer term impacts on children, how their significant other would cope without them, inadvertently encouraging AOD use, and that their significant other would never change. These worries were constantly on their minds. This implies that partners may be assisted through an intervention specifically targeted at depression and anxiety symptoms, such as cognitive behavioural therapies (CBT;

Beck, 2011). CBT could complement assistance being provided through primary care settings, in order to better target symptoms of depression and anxiety. Primary care services currently providing support for stress and coping, such as using the 5-step method, could refer on to psychologists offering cognitive behavioural therapies, when more complex cases arise (Copello et al., 2010).

7.2. How do partners cope and seek support?

7.2.1. Coping

Coping behaviours in the transcripts reflected Orford et al.'s (1998) proposed coping styles of family members. This included three interpersonal coping styles: engaged coping (trying to change the problem AOD use); tolerant-inactive coping (putting up with the problem AOD use); and withdrawal coping (withdrawing from the significant other and engaging in independent activities). Our findings reflected the nature, benefits and challenges of these coping styles. For engaged coping, partners set boundaries, planned for contingencies, and encouraged help-seeking in their significant other. However, this led to frustrations and conflict when boundaries were not respected, or partners suspected their significant other was being deceptive in their level of change. For tolerant-inactive coping, partners tried being patient and accepting of the individual with problem AOD use. However, they became frustrated when this approach did not reduce their intrapersonal distress, or bring about any change in their significant other. For withdrawal coping, partners increased self-care activities, such as engaging in exercise or hobbies to reduce personal distress (akin to behavioural activation in cognitive behavioural therapies). However, this coping style had the downside of increasing the isolation partners felt at times. Our results suggested that there were both pros and cons for each coping style, and their appropriateness was deemed

situation-specific. This differs from Lee et al.'s (2011) findings that family members of patients seeking treatment for addictive disorders had worse psychiatric morbidity when they predominantly used tolerant-inactive coping. However, our study did not measure psychiatric morbidity, so direct comparisons cannot be made.

The results also suggested partners were struggling to cope intrapersonally, with challenging cognitions, behaviours, and affects concerning partners (see cognitive and affective themes described in the stresses and strains section above). This included avoidant coping behaviours displayed by partners, such as personal substance use, or problematic eating. It would be useful to look at ways interventions, such as CBT, could be used in adjunct to interpersonal coping training, especially when partners predominantly use withdrawal coping, to address cognitive narratives which may be maintaining or intensifying distress (Beck, 2011; Hofmann & Smits, 2008).

7.2.2. Social Support

Consistent with Orford et al. (2010b), partners experienced difficulty in seeking and receiving social support. This was linked to fears of being judged or misunderstood by those around them, akin to Orford et al. (2005). Partners often found themselves withdrawing socially from those around them, out of embarrassment for their significant other's behaviour while intoxicated, or because they felt out of place. This led to increased feelings of isolation and loneliness in partners, supporting Moos et al.'s (2010) findings of social withdrawal patterns in spouses of problem drinkers. This suggests that it is important to explore the impact shame and stigma are having on a partner's social context and whether partners are experiencing limited social interactions or support. Partners were also concerned about impacts from their significant other's social context on the problem AOD use, such as increasing the AOD use, which aligns with Galea et al.'s (2004) findings on the importance of social influences on

substance use levels. However, some partners did have access to helpful social support, which they described as non-judgmental, practical assistance (i.e., babysitting from grandparents), and emotional support. This suggests that social support, when available, can assist partners to relieve isolation, and some practical burdens they face, in line with Soares et al.'s (2016) findings of increased social support being associated with reduced burden for caregivers (friends or family members of problem AOD users). It would be useful for clinicians to explore what social support may be available for partners, barriers to accessing it, and alternate options for receiving assistance outside a partner's social context, such as available peer support. This support would align with the 5-Step method, which emphasises the importance of harnessing social support in its model (Copello et al., 2010).

7.3. How can online counselling assist partners?

7.3.1. Benefits of online counselling

Consistent with previous research (Rodda et al., 2013a), the availability of the service was a key reason for accessing online counselling. General treatment preferences raised by partners also included affordability, accessibility, and confidentiality, which align with the online counselling modality and previous research highlighting the benefits of online counselling (Rodda et al., 2013b; Rychtarik et al., 2013; Swan & Tyssen, 2009). Moreover, one partner mentioned appreciating typing in the online modality, as they were too upset to talk. This suggests that online counselling may assist clients to assemble their thoughts when in distress, highlighting the potential for written text to be used therapeutically, in line with Murphy and Mitchell's (1998) assertion of the therapeutic actions of expressing written words.

7.3.2. Seeking advice

Partners were seeking specific advice on how to prompt change or encourage help-seeking in their significant other, and how to cope with the continued problem AOD use. This is consistent with Copello et al.'s (2010) 5-Step Method steps around exploring concerns and coping. Our findings suggest that partners are wanting advice about assisting their significant other to change, and psycho-education around identifying problem AOD use. Partners are also looking for advice on differentiating their own problems from their significant other's, guidance on ending the relationship, and exploring self-care or advice for managing their own emotions. As the vast majority of partners were seeking specific advice, online counsellors would be recommended to use Socratic questioning (using prompting questions to think through issues), to empower partners and produce targeted solutions. Socratic questioning has been linked with increased critical thinking skills in online discussions (Yang et al., 2005), and has been associated with reduced depressive symptoms session-to-session (Braun et al., 2015).

7.3.3. Wanting to talk

Some partners just wanted to be heard, and talk about their experiences, consistent with Copello et al.'s (2010) step around listening and reassuring. This may be due to limited social support that partners experiences, due to shame and stigma concerns when talking about problem AOD use with family and friends (Orford et al., 2005). Partners wanted to talk about their situation, the problem AOD use, and the impacts on themselves, their relationships, and socio-economic concerns, such as finances, employment, forensic interactions, and housing. This suggests that partners seeking help online may be looking for someone to listen non-judgementally. Online counselling may be a useful point of connection for socially isolated partners, by reducing isolation, and at the same time offering support and linking partners

into services. Given this emphasis on wanting to feel understood, encouraging online counsellors to validate emotional experiences may assist partners to feel that professionals can understand their needs, a barrier previously raised by Orford et al. (2013), and may promote future help-seeking. Furthermore, encouraging access to peer support services, such as online community forums, may assist partners to feel heard and be socially connected in an ongoing manner, hence reducing social isolation beyond the online counselling session.

7.3.4. Discussing informal or formal help-seeking and change processes

Discussions which looked at help-seeking, promoting change, and coping processes formed a large part of the contact with online counselling. This aligns with the 5-Step Method's emphasis on exploring coping, social support, and concerns (Copello et al., 2010). However, there was a greater emphasis on problem-solving help-seeking processes in the online context than in the 5-Step Method, which may reflect the broader role of online counselling in identifying problems to link clients in with further relevant services. Consistent with the broader help-seeking literature, barriers to help-seeking and change included structural barriers, such as availability or affordability (Rodda et al., 2013b), social barriers, such as a social context which reinforced problem AOD use or discouraged help-seeking (Barker, Olukoya, & Aggleton, 2005; Galea et al., 2004), and cognitive and behavioural barriers, such as motivation, readiness to change, avoidance, or deceit (Tsogia, Copello, & Orford, 2001). Facilitators to help-seeking and change included helpful social support, having practical harm reduction strategies in place, knowledge about treatment and change processes, and personal insight for partners into their own coping responses, in line with Copello et al.'s areas for support in the 5-Step Method.

7.3.5. Planning for further assistance and information provision

Consistent with Copello et al. (2010), requesting specific information and referrals was a key part of contacting Counselling Online. This included contacting the service for drug-specific information, the course and prognosis of substance use disorders, and treatment information for the individual with problem AOD use and/or themselves. This suggests that online counselling may be a useful first port of call for partners seeking assistance, to better understand what help is available, and to access psycho-educational material. In particular, this highlights the benefits of online counselling for providing such information and referrals, in line with Rochlen et al.'s (2004) review of online modality benefits, as multimedia links may facilitate accessing referral information. Problem-solving regarding treatment preferences was also important. This problem-solving was not guided by an established model of problem-solving, but rather a discussion of the costs, benefits, and personal preferences and experiences around different treatment options for partners and their significant other. Future research could investigate whether structured problem-solving models may be able to assist partners to find the best fit between preferences, expectations, and service options.

7.4. What are the key findings of this thesis?

7.4.1. Partners are valid help-seekers in their own right

This thesis highlights the multiple impacts partners experience, both personally, and interpersonally, emphasising that partners are valid help-seekers in their own right. This aligns with interventions, such as Howells and Orford (2006) which targets partners, and the 5-Step Method (Copello et al., 2010) which targets all affected family members, in the aim of supporting partners to cope with their stressful life circumstances. The burden of care of

individuals with problem AOD use often falls on partners, who may need to assist their significant other 24/7. The strains described in this thesis (such as poorer mental health) require assistance, to enable partners to continue providing support to their significant other, and to reduce their personal distress.

7.4.2. Partners are mostly seeking help for their significant other

The findings highlight that partners tend not to view themselves as the primary help-seeker, with most partners contacting Counselling Online to discuss helping their significant other. However, some partners were seeking assistance for themselves, around coping, having someone to listen, or referral information for family support services. This emphasis suggests that partners are seeking help to deal with the stressors created in their lives by the individual with problem AOD use. This validates the emphasis of the stress-strain-coping-support model in conceptualising partners as coping with stressful life circumstances, as opposed to partners playing a pathological role in family dynamics (Orford et al., 2005). However, this emphasis on help-seeking for their significant other may also reflect that partners have traditionally been involved in treatments with a primary focus on assisting the individual with problem AOD use, such as behavioural couples therapy (O'Farrell, Choquette, Cutter, Brown, & McCourt, 1993), or the 'pressures to change' method in Australia (Barber & Crisp, 1995). Greater dissemination of information is needed around the heavy impacts partners face to validate that they too can and should receive support due to their stressful circumstances.

7.4.3. Online counselling may provide a useful space for partners to convey their experiences

Online contexts have been critiqued for creating challenges to establish a therapeutic alliance, due to factors such as a lack of non-verbal cues (Anthony & Nagel, 2010; Feltham & Horton,

2006). However, the overwhelming congruence between the personal and interpersonal impacts described in the online counselling transcripts, and those impacts previously reported in face-to-face contexts, highlights online counselling as a useful modality for partners to convey their experiences. This suggests that therapeutic alliance may still be established in online counselling, potentially through processes such as the 'disinhibition effect' (Suler, 2004), whereby perceived anonymity may foster intimacy (Mckenna & Bargh, 1998). Further studies are required to specifically look at the effectiveness of online counselling for partners, including perceived session effectiveness, reductions in distress and mental health symptoms, and satisfaction with referral information provided.

7.4.4. Novel contributions of this thesis

This thesis extends previous research by focussing on a sample from a low-intensity support option, online counselling, which may include individuals who have not previously been able to seek help. It also focused specifically on partners, rather than investigating the impacts on all affected family members, to see the unique impacts that partners are experiencing. In addition, it sampled from an Australian wide population of partners, whereas previous research using the stress-strain-coping-support model had only sampled from an indigenous Australian sample (Orford et al., 2001). The sample also includes broader demographics than some previous research, such as including married and un-married partners, homosexual and heterosexual partners, males and females, and different drug types. This reflects the greater diversity that exists among partners, which enabled a richer understanding of the personal and interpersonal impacts. The research also framed the personal impacts for partners in terms of partners' cognitions, behaviours, and emotions, which has not previously been analysed within the context of the stress-strain-coping-support model. This is important as it lays the foundation for building more targeted interventions for partners, which could incorporate

aspects of cognitive-behavioural interventions. It also allowed us to look specifically at how we can support partners in an online synchronous chat environment, which has not previously been researched (Hoermann et al., 2017). This has useful implications for practice, such as training recommendations for online counsellors (see section 7.6.4). It also promotes flexible thinking around how we can strengthen interpersonal coping and social support for partners (see section 7.6.3).

7.5. Overall limitations

7.5.1. Qualitative research limitations

In line with general qualitative research limitations, the findings presented here represented the impacts of 100 individual partners, and as such may not be representative of the broader population of affected partners. The findings may also only represent partners who seek help, which may differ from the experiences of partners who do not seek help. Nevertheless, this qualitative approach enabled the rich description of complex themes, from a broad sample base of 100 transcripts, which covered alcohol and other drugs, a wide age range, and partners of both genders.

Qualitative research involves subjectivity (i.e. researcher interpretation) in the creation of themes. However, the qualitative approaches taken, descriptive content analysis, and thematic analysis, both involved consultation with second raters, to decrease subjectivity (Braun & Clarke, 2006; Neuendorf, 2002).

7.5.2. Need for more demographic analyses

Our sample sizes within the different demographic groups, were not sufficient to permit meaningful comparisons between groups, e.g. 15 males to 85 females. While we attempted to oversample male transcripts, given that this is an under-researched area, the small number of

total male transcripts made it not meaningful to perform comparisons based on gender. Future research should sample transcripts over a longer time period (e.g., two years rather than one year) to increase the number of male transcripts, and enable meaningful gender comparisons. There was also insufficient data on the type of partner relationship, length of relationship, sexual preferences, having versus not having children, and first-time versus repeat service users. This is because such information was not recorded pre-session, and only uncovered if it was mentioned in session. Instead of making comparisons, our research chose to focus on using the broad sample which encompassed this variety in partner experiences, to enable a richer understanding of the personal and interpersonal impacts. These factors would be useful for future research to target and explore as potential moderators or mediators of the relationships between these factors and partner impacts.

7.5.3. Counsellor influence on partner descriptions

While this thesis chose to focus on the partner sections of the transcripts rather than the counsellor sections, to limit the influence of counsellor themes in uncovering partner impacts, it is likely that counsellor prompts and responses will have influenced the course of the conversation and the impacts described. This is akin to the influence previous research may have had from interviewer prompts and questions. Moreover, while help-seeking themes were gleaned from the transcripts, partners were not asked directly on their help-seeking needs. Future research could ask partners to describe their impacts and help-seeking needs in a written format without any prompts or questions to uncover which themes are most pertinent to partners without counsellor or interviewer interference.

7.5.4. Online modality generalisability

The findings described here relate to help-seeking in the online counselling modality, and different emphases may be present with face-to-face help-seeking, therefore care should be taken when generalising from these results to help-seeking in non-online settings.

7.5.5. Effectiveness studies needed

The effectiveness of online counselling was not assessed, and future research is required to look at the effectiveness of the modality, for supporting partners. A systematic review of online synchronous chat interventions did not include any partner specific interventions in this modality (Hoermann et al., 2017), making it highly important to see how effective supporting partners online can be. Effective online interventions would make psychosocial assistance more easily accessible to partners, a group which often finds it challenging to reach out for help. In particular, effectiveness studies of online synchronous chat counselling for partners based on the 5-Step Method are recommended.

7.6. Clinical and policy implications

7.6.1. Greater service provision for partners

The multiple impacts described in this thesis highlight the importance of providing more services for partners. In particular, the online context may be a useful modality to explore further interventions for partners, given its potential for widespread service provision. Online counselling services should note that partners accessing their websites may not have sought help previously, so having clear information on problem AOD use, how to assist significant others, and treatment pathways, would be beneficial. The findings also highlight how the multiple impacts on partners fit within the 5-Step Method (Copello et al., 2010), and how

online counselling could be a useful complement to face-to-face service provision using the 5-Step Method. Moreover, future research could explore how using the 5-Step Method as an approach in online synchronous chat counselling could be beneficial to partners, extending Ibanga's (2010) automated online 5-Step intervention.

7.6.2. Incorporating cognitive behavioural aspects into interventions for partners

The findings provide information for targeting clinical interventions to unhelpful cognitions, behaviours, and affect partners may be experiencing. This includes difficulties allocating responsibility, establishing trust, realistic appraisals of safety, regulating emotions, and maladaptive avoidant coping behaviours, such as personal substance use. Moreover, the cognitive themes described in this thesis may be more pertinent to partners seeking help, given that they were uncovered during an act of help-seeking by the partners. Future research should look at incorporating cognitive behavioural assistance (which targets unhelpful cognitions, behaviours, and affects; Beck 2011) into interventions (such as Howells & Orford, 2006) aimed at reducing personal distress for partners. This would work well in tandem with existing interventions targeting interpersonal coping strategies, such as the 5-Step Method (Copello et al., 2010).

7.6.3. The importance of strengthening interpersonal coping and social support

The findings highlight the importance of working on partners' interactional patterns, and assisting them with establishing flexible interpersonal coping skills, along with strengthening their social support networks. Online services could provide a useful context for greater provision of peer support and online community forums to assist connectivity and social support for partners. In addition, psycho-education around coping styles could be posted on the website, along with brief coping style questionnaires (such as the Coping Questionnaire

which measures engaged, tolerant-inactive, and withdrawal interpersonal coping styles; Orford, Templeton, Velleman, & Copello, 2005) to assist with awareness for partners. Moreover, the findings highlight the importance of assisting partners with parenting responsibilities, such as initiatives which involve reduced-cost or affordable childcare, and supporting partners to set boundaries with their significant other regarding child exposure to problem AOD use and its consequences.

7.6.4. Training for online counsellors

Online counsellors should be trained to provide a broad range of referral information and psycho-educational resources, to address AOD and non-AOD impacts, such as financial aid, family drug assistance, or domestic violence services. When discussing future help-seeking, it would be useful for online counsellors to encourage partners to see themselves as valid help-seekers in their own right by emphasising the need to attend to their own needs, so they will be able to continue assisting their significant other. Moreover, our findings suggest it may be pertinent to problem-solve around barriers to help-seeking and change, such as gently challenging any cognitions, behaviours or social situations which may be perpetuating distress, and harness any facilitators to change, such as helpful social support, which may reduce distress or encourage help-seeking. Along with this, online counsellors could discuss specific treatment preferences to enable targeted referrals to increase the chances of future positive and useful help-seeking experiences. Online counsellors should also be trained in risk assessment for partners and their children (i.e. assessing the risk of violence or aggressive behaviours a partner or child may be experiencing in their current situation), and understand appropriate referral options to provide partners according to current level of risk.

7.6.5. Awareness campaigns and online resources to de-stigmatise AOD use and partners

The findings of this study reinforce the conceptualisation of partners as everyday individuals, attempting to cope with highly stressful circumstances the best they can (Orford et al., 2010b). Greater awareness around this approach is needed in the community to de-stigmatise family members of problem AOD use, to assist partners to reach out for help, and validate and normalise their experience, reducing psychological distress. Websites which describe experiences of being a partner or family member affected by an individual's problem AOD use may be a useful approach in assisting to reduce stigma. These could follow the approach of websites such as 'Lives of Substance' in Australia (National Drug Research Institute, 2016), which describes personal stories from a range of individuals with problem AOD use from different socioeconomic groups, along with providing links to relevant resources and information. Sites such as this may assist the community to see that while a person can have problematic substance use, the person is not the disorder. In this way, just as it is important to emphasise that there is more to an individual than their problem AOD use, it is equally important to emphasise that there is more to a relationship between partners than the problem AOD use. Websites with personal stories on partners could communicate an awareness of the multi-faceted and complex nature of human ties and bonds, which may assist in reducing stigma and judgment around partners' choices to remain in or leave a relationship with an individual with problem AOD use, and communicate a richer story of partners' experiences.

7.7. Conclusion

This thesis highlights the multiple impacts partners experience. This includes personal, interpersonal, and socio-economic impacts. While partners experience a heavy burden, research suggests stigma can often get in the way of seeking help. Online counselling may be

a useful modality to assist partners in reaching out for assistance, and to facilitate broader service provision. This thesis reinforces the need for greater service provision to be offered to partners, as valid help-seekers in their own right. This support needs to incorporate intrapersonal and interpersonal coping skills, and methods for increasing social support, such as online peer support forums. In addition, awareness campaigns are needed which seek to de-stigmatise the experience of partners, through sharing experiences of family members, to validate and normalise the experiences of partners, and instil hope in their ability to cope and work through the challenges of being in an intimate relationship with a problem AOD user. Using the stress-coping conceptual model in educational campaigns can also assist in de-pathologising partners, to assist partners in speaking up to those around them and receive greater social support, to increase psychological wellbeing. Working on reducing the negative health and socioeconomic consequences for partners and their significant others is highly pertinent to reducing the burden of problem AOD use on society. Future investigations into the multiple roles the online context can play in supporting partners, and reducing stigma through psycho-education, are highly relevant to the current digital era of society.

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Appendices

Appendix A: Monash University Human Research Ethics Committee Approval

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

This is to certify that the project below has been approved by the Monash University Human Research Ethics Committee under the Memorandum of Agreement with Eastern Health

Project Number:	**CF14/1929 - 2014000980**
Project Title:	**Online counselling needs for partners of individuals with a problematic substance use**
Chief Investigator:	**Prof Dan Lubman**
Approved:	**From: 3 July 2014 to 3 July 2019**

Terms of approval - ***Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.***

1. Approval is only valid whilst you hold a position at Monash University and approval at the primary HREC is current.
2. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
3. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
4. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Nip Thomson
Chair, MUHREC

cc: Dr Victoria Manning; Dr Marie Yap; Ms Simone Rodda; Ms Samara Wilson

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
[redacted]

Appendix B: Eastern Health Human Research Ethics Committee Approval

easternhealth
GREAT HEALTH AND WELLBEING

5 Arnold Street, Box Hill
Victoria 3128 Australia
PO Box 94, Box Hill 3128
[redacted]
ABN 68 223 819 017

www.easternhealth.org.au

Human Research Ethics Committee - Scientific and Ethical Review

Ethical Approval – Granted

Commencement of Research at Eastern Health has been authorised

23 June 2014

Professor Dan Lubman
Director, Turning Point
54-62 Gertrude Street, Fitzroy, 3065

Eastern Health HREC
[redacted]
Website: www.easternhealth.org.au/research

Dear Professor Lubman

LR 101/1314 – Online counselling needs of partners of individuals with problematic substance use.

Principal Investigators: Professor Dan Lubman

Associate Investigators: Dr Victoria Manning, Dr Marie Yap, Ms Simone Rodda

Student Investigator: Ms Samara Wilson

Other Approved Personnel: Nil

Eastern Health Site: Turning Point

Approval Period: On-going - subject to a satisfactory progress report being submitted annually

Thank you for the submission of the above project for review. The project has been reviewed by the Eastern Health Research and Ethics Committee. The project is considered of negligible risk/low risk in accordance with definitions given in the National Statement (2007). All queries have now been addressed and the project is accordingly **APPROVED**.

Documents submitted for review:

- Low Risk & Negligible Risk Research Application Form – version 1 dated 4 April 2014
- Research Proposal Version 1 dated 17 April 2014 including:
  - Appendix A – Automated prompt for study 2 participants
  - Appendix B – CPDRI rating steps
  - Appendix C – Counselling Online Terms and Conditions
  - Appendix D – Plain language Statement (Version 2 dated 23 June 2014)
  - Appendix E – Debriefing form
  - Appendix F – Session Evaluation Questionnaire
- CVs for Dr Marie Yap & Ms Samara Wilson
- Confidentiality Agreements for Dr Marie Yap & Ms Samara Wilson

[redacted]

easternhealth
GREAT HEALTH AND WELLBEING

5 Arnold Street, Box Hill
Victoria 3128 Australia
PO Box 94, Box Hill 3128
[redacted]
ABN 68 223 819 017

www.easternhealth.org.au

IMPORTANT: A final progress report should be submitted on project completion. If the project continues beyond 12 months a progress report must be submitted at the conclusion of each calendar year (December 31) in which the research is undertaken regardless of when approval was provided. Continuing approval is subject to the submission of satisfactory progress reports. The Progress Report template can be downloaded from our web-page:

http://www.easternhealth.org.au/research/ethics/formstemplates.aspx

Please quote our reference number ***LR 101 /1314*** in all future correspondence.

Yours sincerely
[redacted]

Chris Rose'Meyer
Manager
Eastern Health Office of Research and Ethics
(Signed on behalf of the Eastern Health Human Research Ethics Committee)

Copy to:
- *Researchers*

Confidentiality, Privacy & Research

Research data stored on personal computers, USBs and other portable electronic devices must not be identifiable. No patients' names or UR numbers must be stored on these devices.

Electronic storage devices must be password protected or encrypted.

The conduct of research must be compliant with the conditions of ethics approval and Eastern Health policies.

Publications

Whilst the Eastern Health Human Research Ethics Committee is an independent committee, the committee and Eastern Health management encourage the publication of the results of research in a discipline appropriate manner. Publications provide evidence of the contribution that participants, researchers and funding sources make.

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5 Arnold Street, Box Hill
Victoria 3128 Australia
PO Box 94, Box Hill 3128
[redacted]
ABN 68 223 819 017

www.easternhealth.org.au

It is very important that the role of Eastern Health is acknowledged in publications.