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ORIGINAL ARTICLE

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

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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 focussed 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.

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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 (Orford, Copello, et al. 2010; Fotopoulou and Parkes 2017). 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 et al. 2006), anxiety (Dawson et al. 2007), and stress (Orford, Copello, et al. 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 et al. 2012).

Intimate partners of individuals with problem AOD use (referred to from here as partners) are particularly affected. Rodriguez et al. (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 and 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

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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 (Rodda et al. 2013; Garde et al. 2017). 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 et al. 2017). Online transcripts have been studied to provide novel information regarding help-seeking for other addictions such as gambling (Rodda et al. 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 et al. 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 generalisable to current practices. This training related to the 5-Step Method by Copello et al. (2009), 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 years, 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+ years, 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. (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 and 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 et al. 2017). 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. 2009) 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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References

Beck AT. 2005. The current state of cognitive therapy: a 40-year retrospective. Arch Gen Psychiatry. 62:953–959.

Berends L, Ferris J, Laslett A-M. 2012. A problematic drinker in the family: variations in the level of negative impact experienced by sex, relationship and living status. Addict Res Theory. 20:300–306.

Braun V, Clarke V. 2006. Using thematic analysis in psychology. Qualitat Res Psychol. 3:77–101.

Copello A, Templeton L, Orford J, Velleman R. 2009. The 5-step method: principles and practice. Drugs. 17(Suppl 1):86–99.

Dawson DA, Grant BF, Chou SP, Stinson FS. 2007. The impact of partner alcohol problems on women's physical and mental health. J Stud Alcohol Drugs. 68:66–75.

Dowling NA, Rodda SN, Lubman DI, Jackson AC. 2014. The impacts of problem gambling on concerned significant others accessing web-based counselling. Addict Behav. 39:1253–1257.

Fotopoulou M, Parkes T. 2017. Family solidarity in the face of stress: responses to drug use problems in Greece. Addict Res Theory. 25:326–333.

Garde EL, Manning V, Lubman DI. 2017. Characteristics of clients accessing a national online alcohol and drug counselling service. Australas Psychiatry. 25:250–253.

Hofmann SG, Smits JA. 2008. Cognitive-behavioral therapy for adult anxiety disorders: a meta-analysis of randomized placebo-controlled trials. J Clin Psychiatry. 69:621–632.

Homish GG, Leonard KE, Kearns-Bodkin JN. 2006. Alcohol use, alcohol problems, and depressive symptomatology among newly married couples. Drug Alcohol Depend. 83:185–192.

Howells E, Orford J. 2006. Coping with a problem drinker: a therapeutic intervention for the partners of problem drinkers, in their own right. J Substance Use. 11:53–71.

Laslett A, Room R, Ferris J, Wilkinson C, Livingston M, Mugavin J. 2011. Surveying the range and magnitude of alcohol's harm to others in Australia. Addiction. 106:1603–1611.

Lee KMT, Manning V, Teoh HC, Winslow M, Lee A, Subramaniam M, Guo S, Wong KE. 2011. Stress-coping morbidity among family members of addiction patients in Singapore. Drug Alcohol Rev. 30:441–447.

Orford J. 2017. How does the common core to the harm experienced by affected family members vary by relationship, social and cultural factors? Drugs. 24:9–16.

Orford J, Copello A, Velleman R, Templeton L. 2010. Family members affected by a close relative's addiction: the stress-strain-coping-support model. Drugs. 17(suppl 1):36–43.

Orford J, Natera G, Copello A, Atkinson C, Mora J, Velleman R. 2005. Coping with alcohol and drug problems: The experiences of family members in three contrasting cultures. London (UK): Brunner-Routledge.

Orford J, Natera G, Davies J, Nava A, Mora J, Rigby K, Bradbury C, Bowie N, Copello A, Velleman R. 1998. Tolerate, engage or withdraw: a study of the structure of families coping with alcohol and drug problems in South West England and Mexico City. Addiction. 93:1799–1813.

Orford J, Velleman R, Copello A, Templeton L, Ibanga A. 2010. The experiences of affected family members: a summary of two decades of qualitative research. Drugs. 17(Suppl 1):44–62.

Orford J, Velleman R, Natera G, Templeton L, Copello A. 2013. Addiction in the family is a major but neglected contributor to the global burden of adult ill-health. Soc Sci Med. 78:70–77.

Peled E, Sacks I. 2008. The self-perception of women who live with an alcoholic partner: dialoging with deviance, strength, and self-fulfillment. Family Relations. 57:390–403.

Rodda SN, Dowling N, Jackson AC, Lubman DI. 2017. Improved outcomes following a single session web-based intervention for problem gambling. J Gambl Stud. 33:283–299.

Rodda SN, Lubman DI, Cheetham A, Dowling NA, Jackson AC. 2015. Single session web-based counselling: a thematic analysis of content from the perspective of the client. Br J Guidance Counsel. 43:117–130.

Rodda SN, Lubman DI, Dowling NA, McCann TV. 2013. Reasons for using web-based counselling among family and friends impacted by problem gambling. Asian J Gambl Issues Publ Health. 3:1–11.

Rodriguez LM, Neighbors C, Knee R. 2014. Problematic alcohol use and marital distress: an interdependence theory perspective. Addict Res Theory. 22:294–312.

Sandelowski MJ. 2008. Justifying qualitative research. Res Nurs Health. 31:193–195.

Wilson SR, Rodda S, Lubman DI, Manning V, Yap MBH. 2017. How online counselling can support partners of individuals with problem alcohol or other drug use. J Subst Abuse Treat. 78:56–62.

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