Experiences of family members supporting a relative with substance use problems: a qualitative study

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Background: Affected family members (AFMs) play an important role in supporting relatives with alcohol and/or other drug (AOD) misuse. However, they frequently lack support and experience considerable challenges to their own well-being.

Aim: To explore the experience of AFMs who support a close relative with AOD misuse.

Method: Thirty-one AFMs were recruited through AOD helplines and through their social media accounts in the Australian state of Victoria. A semi-structured interview guide was used to inform data collection, focusing on their general experiences, impact of support-giving and support options. Interviews were audio-recorded and conducted by telephone.

Results: One overarching theme and six related subthemes were abstracted from the data. The overarching theme was conceptualised as Feeling overwhelmed by, and struggling with, the experience. Subthemes were as follows: Emotionally draining and exhausting, Maintaining constant vigilance: curbing social activities, Grappling with the financial impact, Struggling to cope with harmful family dynamics, Avoiding and containing aggression and Fearfulness and hopelessness about the future.

Conclusion: Affected family members experienced wide-ranging harms, which affected their emotional, social and financial well-being, safety and family dynamics, and instilled a persistent sense of fearfulness and hopelessness about the future. The findings have implications for mental health nurses and other clinicians in AOD services to identify AFMs’ needs and provide them with timely, accessible and appropriate support to help sustain their important role.

Keywords: affected family members, alcohol and other drug misuse, family relations, nurses, qualitative research.

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Introduction

There is growing concern regarding the challenges faced by family members of relatives with alcohol and/or other drug (AOD) misuse (1–3). Affected family members (AFMs) (partners, children, parents, grandparents, siblings, close relatives and friends) are profoundly affected by relatives’ AOD misuse (1, 4, 5). They frequently experience harm to their emotional, physical, social and financial well-being (6, 7). In addition, persistent worry about the relative’s health, safety and future prospects is compounded by concern about overall functioning of the family (8, 9). Intimate partners (spouse, de facto partner, girlfriend, boyfriend, ex-partner) are particularly affected by AOD misuse (10). In addition to their increased risk of anxiety, stress and depression, they are more likely to experience aggression, financial stress and family conflict (10, 11). Parents, particularly mothers, experience significant burden (2), as they grapple with profound grief at the demise of their child, and the effect of the AOD misuse on grandchildren (7). Intimate partners and parents are also typically concerned with protecting the family unit, serving as a buffer between the relative and other family members, particularly children (12). For siblings, anger, resentment, neglect and isolation are common (12). AFMs’ experiences are exacerbated by frustration with the relative’s apparent lack of acknowledgement of the broad impact of their behaviour and the futility of their attempts to change the relative’s behaviour (8, 11). This, in turn, undermines their capacity and willingness to continue to support the relative (13).
Notwithstanding the significant challenges they face, AFMs play a crucial role in supporting and advocating on behalf of their relative and often influence the course and outcome of the relative’s behaviour positively (14, 15). How AFMs cope with their circumstances influence their experience and the outcomes for them and the relative (6).

Overall, there is a lack of AOD service focus into supporting AFMs (8). Even though there is a slowly growing body of research into the impact of substance misuse in families, considerably fewer qualitative studies have been undertaken to examine these experiences (e.g. in the UK (9) and Australia (16)). In Australia, a recent study of 100 transcripts of online chat from a 24-hour national counselling service for partners of people with AOD misuse indicated that partners experienced a range of harms to their interpersonal relationships, parenting responsibilities, social networking (17), and on their cognitive, behavioural and emotional well-being (10, 18). While these are important findings, it is necessary to examine the experiences of a broader range of AFMs (intimate partners, parents, siblings, offspring) recruited from settings where families have had limited support from services. Hence, the aim of this paper was to understand AFMs’ overall experience of supporting a relative with AOD misuse. The paper is abstracted from a broader mixed methods study (online survey and qualitative interviews) of the experience and support needs of AFMs of close relatives with AOD misuse, with a view to developing a specialised Internet program to assist them in their critical support-giving role. Other qualitative findings on aggression and violence (11), coping (19), help-seeking (20) and stigma (21), are reported elsewhere.

Method

Study design

Data collection and analysis were guided by interpretative phenomenological analysis (IPA). Researchers using IPA draw on the principles of phenomenology and hermeneutics, as they seek to understand how individuals make sense of their lived experiences (22). IPA accounts for the influence of social, contextual, situational and historical influences on participants’ perceptions and experiences. It is well-suited to new, complex or under-researched problems, and in studies where researchers seek to understand process and change (23). IPA researchers are also informed by idiography, focusing initially on the individual participant, before progressively developing broad themes from the data (22).

Earlier iterations of IPA recommended the use of small sample sizes (24); however, this severely limited the usefulness of the approach. More recently, Pietkiewicz and Smith (25) acknowledged that the approach could also be used with larger sample sizes.

Participants

Recruitment occurred through AOD helplines (Directline, Ice Advice Line and Family Drug Help) and their related social media accounts (Twitter), in the Australian state of Victoria. AFMs who accessed the helplines for support were given brief details about the study by helpline counsellors and how to access the online survey through a link on the helpline websites (At the end of the survey, respondents were asked to indicate if they would be interested in participating in a qualitative interview and, if so, to provide their telephone contact details). Social media was also used to promote the study, with interested AFMs contacting the researcher directly for information and then being referred to the online survey. Eligibility to participate was determined through purposeful sampling (26). Inclusion criteria were as follows: (1) AFMs of a close relative, aged 18-65 years old, with AOD misuse; and (2) in the support-giving role for at least 1 year. Exclusion criteria were as follows: (1) previous recipient of specialist family interventions for AOD misuse and/or (2) recent personal history of AOD misuse or severe mental illness. AFMs who had undertaken specialist family interventions were excluded. Our focus was on understanding experiences of those family members who had not received specialised family support, as we were seeking to understand what would help the majority of families who receive no specific intervention. We also excluded those with recent personal history of AOD misuse or severe mental illness due to the risk of harm associated with participation and because our focus was on AFMs coping with others, not contaminated with managing their own issues.

Data collection

Participants’ experiences were elicited through telephone interviews, which are used widely in qualitative research as an effective and convenient way of interviewing. They enable an immediate response between the researcher and participant, protect participant anonymity and overcome time and travel barriers (27). Each interview was guided by an interview schedule (Table 1) and audio-recorded, and responses were probed. The questions focused on participants’ experience of having a relative with AOD misuse, impact of support-giving and support options. In light of the method of data collection used, transcripts were not returned to participants for checking. Each interview lasted approximately 45 minutes, and at the end of each interview, participants were informed that they could request a summary of the findings (none requested). Data collection occurred January–December.
Researchers had no prior contact with participants. A graduate female researcher, who was given prior training by TMcC conducted most interviews.

Data analysis
Interviews were transcribed verbatim and read and re-read, to obtain a broad understanding of participants’ overall experience of supporting their relative. Data coding was done electronically, in NVivo (Version 11; QSR International). Participants’ actual words were captured as in vivo codes, to ensure the researcher did not superimpose pre-existing beliefs or theories on the data (27). Next, codes were sorted into provisional themes and related subthemes. As themes were refined, a more concentrated analysis then enabled a higher level of data abstraction (28). This inductive process continued until any unexplained gaps in the data were addressed and data saturation occurred. Semantic level of analysis progressed from description and summary (Results section), to interpretation (Discussion section).

Reflexivity and rigour
To minimise the risk of bias, reflexivity was undertaken. Reflexivity necessitates researchers making explicit their role as they adopt a self-critical stance throughout data collection, analysis and writing-up (27). In this way, reflexivity contributes to data reliability, as researchers’ actions and interpretations are based on the data, and not constrained by any preconceptions (27). Examples of reflexivity in the present study included use and training of a female research assistant who conducted most interviews (most participants were female), the professional perspective of the authors who believed that AFMs were underserved by AOD services and the rigorous steps the authors took to analyse the data (outlined below).

Lincoln and Guba’s (29) criteria of dependability, confirmability, credibility and transferability were used to strengthen rigour. Dependability and confirmability were maintained by, for example, having one researcher conduct preliminary thematic analysis (MP), followed by an independent review of the process by TMcC and DL. Differences in coding and theme identification were addressed through discussion until consensus was achieved (26, 30). Credibility was enhanced through, for example, participant verification, by summarising participants’ narratives to ensure their experiences were understood correctly (31).

Ethical considerations
Ethics approval to undertake the study was obtained from Eastern Health Human Research Ethics Committee (LR59/1314). All participants gave verbal consent via the telephone (which was recorded) to participate. Matters discussed were dealt with in a supportive and sensitive way by the researcher. No participants seemed to experience distress as a consequence of participation, and none withdrew from the study.

Results
Socio-demographics
Thirty-one AFMs participated (Table 2). Most were female, intimate partners or parents. Their mean age was 47 years, and they had been in the support-giving role for around 8 years. Just over three-quarters lived in metropolitan settings while the remainder resided in regional/rural areas. The main substances taken by the relative were alcohol or a combination of alcohol and other drugs. Over three-quarters (76.4%, n = 90) had not received any support from AOD services.

Overarching theme: feeling overwhelmed by, and struggling with, the experience
One overarching theme and related subthemes were abstracted from the data, reflecting AFMs’ overall experience of supporting a relative with AOD misuse: Feeling overwhelmed by, and struggling with, the experience. Overall, the experience was overwhelming and isolating, with the relative’s AOD misuse having a significant deleterious effect on AFMs’ lives. Participants felt distressed, frustrated and exhausted, as they faced almost daily challenges arising from the relative’s behaviour. Most also felt resentful at being trapped in a situation over which they had little control, which frequently left them feeling powerless.

It has taken a tremendous toll in all aspects of our lives. I can’t deal with the everyday stresses of work because the stress at home overtakes that. It dominates your life. My husband wakes up during the night worrying about him. (Participant 17, mother)
Stress was exacerbated by a lack of stability or predictability in their lives, and the financial impact of the relative’s AOD misuse, as AFMs struggled to respond to the changeable nature and impact of situations in which they felt trapped. As they grappled with the prospect that their predicament may not improve, concerns about their own well-being were compounded by apprehensiveness and fear for their relative and the future.

I can encapsulate it in one word: “nightmare.” Yes, it’s really a nightmare that doesn’t end. People live through accidents, through situations that are short-lived. This is horrific. You never know what is going to happen next and it’s ongoing.

(Participant 30, mother)

Affected family members grieved for the relationship they had enjoyed previously with the relative. A sense of loss was evident, as they described unfamiliar or unexpected behaviour by the relative who had changed as a result of AOD misuse.

He’s not who I married. He’s not who I want to be with when he drinks. He just changes.

(Participant 13, female partner)

I’ve told him a million times he’s an imposter. He’s not my son. I can never relate to him when he’s on drugs. I actually feel physically sick and he’s an imposter in my son’s body. That’s the only way I can describe it.

(Participant 7, mother)

Within this overarching theme, six subthemes were abstracted from the data, reflecting the range of challenging experiences for AFMs: Emotionally draining and exhausting, Maintaining constant vigilance: curbing social activities, Grappling with the financial impact, Struggling to cope with harmful family dynamics, Avoiding and containing aggression and Fearfulness and hopelessness about the future.

Emotionally draining and exhausting

Participants were emotionally drained and exhausted by the experience of supporting their relative. Having to be constantly available to the relative was challenging, as AFMs could not plan their days without considering if or when they might be called on to provide support. This frequently led to feelings of powerlessness.

Very difficult and draining, exhausting, mentally challenging. Every day’s different, you never know which way it’s going to go before the end of the day, what to expect.

(Participant 26, female partner)

Constantly feeling emotionally drained and exhausted had adverse effects on AFMs’ mental and physical well-being. Despite their efforts to manage their emotions and fatigue, AFMs’ mental well-being was generally inextricably bound to the relative’s behaviour. Concerns were also raised about the effect the support-giving role was having on participants’ physical well-being.

It’s hard to sleep. It’s hard to enjoy things that are happening, because it’s [the relative’s AOD misuse] always in the back of my mind.

(Participant 27, sister)

I’m sure it doesn’t do your health any good to be stressed, worried, lying awake at night and being anxious all the time.

(Participant 9, father)

Maintaining constant vigilance: curbing social activities

Being the main support person also had an adverse impact on participants’ social lives. As a result of the unpredictability of the relative’s behaviour, it was difficult to engage in social activities or go on holidays. Those who attended social events or special occasions had to be constantly vigilant about their relative’s situation and of the need to be able to respond promptly to an AOD-related crisis.

My husband and I never go away, because she needs us. We need to be around. We also never drink [alcohol] at the same time. If we have a wedding or an
engagement party, one of us is always sober because there’ve been so many times when she has needed us. (Participant 27, sister)

A consequence of being constantly vigilant and being available to respond quickly to a crisis was that participants felt increasingly socially isolated as they progressively restricted their social activities.

I don’t socialise nowhere near as much as I used to. I find it difficult to actually have my own “mental space” [time away] to socialise with friends, because it took over my whole life. (Participant 23, sister)

The worst thing is being alone. There’s no-one there to support you, when you’re there for someone all the time … there’s no-one in the background to support you. (Participant 1, female partner)

While all participants experienced an adverse impact on the type or quality of their social activities, parents, in particular, felt frustrated that they could not enjoy events that should have been available to them at a later stage in lives.

It all happened since I retired and it’s kind of frustrated me that I haven’t been able to get on with my retirement as I’ve wanted to, to do the things that I want to do, you know, go on a holiday and whatever. (Participant 19, father)

**Grappling with the financial impact**

Supporting the relative also had detrimental financial consequences. Participants recalled occasions on which they had, and struggled, to cover legal and drug debts, and rehabilitation costs, while frequently taking sole responsibility for paying the relative’s debts and daily living expenses such as rent and food.

We’ve paid a lot of his fines, court solicitors, just drug debts to save his life at different times, probably to the tune of about $60,000. Here, there and everywhere. $3,000 here, $1,200 there. Just you name it, $3,000 over there. Horrific. (Participant 30, mother)

For parents, these financial expenses had had a detrimental effect on their retirement plans.

When you retire, you get X amount of money and you say, “okay, on average, I’ve got 25, 30 years left to live and this is how I balance that and all that sort of thing.” Well, that’s had to be redone. My quality of life is really just going ‘down the tubes’ [deteriorating]. (Participant 19, father)

Intimate partners also identified the stressful financial effects of the relative’s AOD misuse, having to cope alone with paying household bills and, at times, with paying for damaged caused by the person’s behaviour. This situation often left them feeling vulnerable as they sought to maintain the household or family. Several described how they had managed to take control of the household finances, and in some instance insisted that the relative contributes towards the payment of bills.

Financially, it has been hard. I have paid most of the bills, but I am getting him to start paying. But it’s hard. A few months ago, when he was particularly bad, he caused a lot of damage to the flat that I was billed for. (Participant 20, female partner)

Financial difficulties were compounded in cases where AFMs’ capacity to work was restricted because of the relative’s AOD misuse. This was most apparent for those whose re-employment prospects were compromised, or whose jobs were no longer available to them if they had taken extended time off to support their relative.

I couldn’t function in my job. I had to take a year off … when my contract ran out, my job was not there for me. (Participant 30, mother)

**Struggling to cope with harmful family dynamics**

Family dynamics were affected greatly by the relative’s AOD misuse. As the main support person, AFMs frequently took responsibility for maintaining broader family relationships. Consequently, they had to manage the relative’s and other family members’ behaviour, and deal with family breakdown. This was a major source of stress and anxiety for participants, as they struggled to maintain a sense of normality in the home and between family members.

It’s had an impact on every family member. My younger daughter was a lot more supportive when she was living at home, but my older daughter can’t handle it at all … and that stresses me out as well. (Participant 8, mother)

Parents and intimate partner participants sought to keep the family unit intact, despite the challenges of the relative’s AOD misuse. However, their efforts to maintain a delicate balance between meeting the relative’s and other family members’ needs were compromised by conflict regarding the provision of support. To illustrate, one participant’s children became angry when she allowed her husband to return to the family home after an unpleasant episode. Hence, further distress was caused when other family members confronted participants about their continued support of the relative.

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Sometimes, it’s one of my kids having a screaming match at me: “Why have [you] let him back into the house? Let him die on the streets. We’ve had enough!” Yeah, it’s just horrific. It’s horrible to watch your family that you nurtured. We were very close, very loving, had a lot of laughs together … this hateful, horrible thing invades every aspect. (Participant 30, mother)

All intimate partner participants were female. They reported how relationships between the children and fathers with AOD misuse had deteriorated, and that this had a paradoxical effect on their attitudes towards the children maintaining a close relationship with their father.

It’s hard because you don’t want your children to lose their dad, but then you don’t want them to be around him either. You don’t want him to have that influence on them. (Participant 13, female partner)

Detrimental effects of the relative’s AOD misuse on parents’ marriages were considerable, as AFMs attempted to maintain a close relationship with their spouse, while facing the daily challenge of supporting the relative. While strain was placed on existing relationships, their prospects of establishing new intimate relationships with others were also affected.

Certainly, myself and my wife, it’s completely changed [our relationship with each other]. I just think it’s broken us, basically; just the ongoing grief and a lot of the time in crisis. (Participant 21, father)

I’ve got a new partner who’s pretty peeved because I can’t move to live with her, because I really need to be here for [my daughter]. It’s just such a difficult set of circumstances. (Participant 6, father)

Despite the difficult circumstances in which participants found themselves, some spousal relationships remained strong.

My wife and I, our relationship’s been strong through this. It’s definitely been affected, but we work as a team. When the one’s down, the other can come in and pick that person up [provide support], and vice versa. (Participant 28, father)

Avoiding and containing aggression

Another undesirable consequence of the relative’s AOD misuse was unpredictable outbursts of aggression, which provoked anxiety and, at times, fear in AFMs. Aggression took various forms – verbal, physical, emotional – and was directed mostly at female partners. When aggression could not be avoided, AFMs attempted to cope with the relative’s behaviour. Thus, the anticipation or experience of aggression presented an additional struggle in the overall experience.

I always feel stressed and upset and uneasy about what is happening or what’s going to happen. When he’s going to explode or how he’s going to react to things. (Participant 11, female partner)

AFMs, in particular female partners, tried to prevent the relative from directing aggression to other family members or friends, most often children. Hence, they were hyper-vigilant to warning signs and triggers, as they sought to avoid or contain the risk of aggression by the relative.

I don’t like upsetting him and making him angry where the children [her grandchildren] are around, because I’m frightened that he will just take them and something will happen to them. (Participant 17, mother)

Fearfulness and hopelessness about the future

AFMs experienced a constant unease and sense of foreboding associated with their support-giving role. They were unable to foresee a future in which their circumstances would change for the better, as they experienced the constant stress of waiting for the next AOD-related incident to occur in their day-to-day family life. Most felt pessimistic about their situation improving, and a significant stressor was the sense of hopelessness they experienced because they could not see an end to their predicament.

The most difficult aspect is the ongoingness of it … I’ve come to accept that there’s no kind of solace or solution … so the hopelessness that he’s not doing anything for himself. (Participant 19, father)

AFMs’ fearfulness and hopelessness also centred on the perceived inevitability that their current circumstances would worsen if the relative hurt themselves or others.

I’m scared when he’s drinking that he will hurt himself seriously again. He was falling over, passing out outside, bashing up against brick walls. It was like watching someone bash themselves to pieces and being unable to stop it. He also used to threaten suicide when drunk. (Participant 20, female partner)

For those whose relatives had sought treatment and/or support for their AOD misuse, the risk of relapse was also a constant source of fearfulness and hopelessness.

I guess I was a driving force in getting her into all her rehabs. In the early years, I thought they’d fix [her]. But then, it only took a couple of years to
realise they really only just keep them alive . . . they don’t actually teach you how to live on the outside. So now she’s been through about five or six different ones; some several times. (Participant 4, mother)

Discussion

In this exploratory study, we gained an in-depth understanding of AFMs’ experience supporting a close relative with AOD misuse. The overarching theme was that participants felt overwhelmed by, and struggled with, their predicament. Orford (2) refers to a common core of burden experienced by AFMs, as they struggle with high levels of stress and strain, and find it difficult to enlist effective support. AFMs’ lives are permeated by stress, worry and grief, often leading to a sense of desperation (15, 32, 33). These feelings have a significant adverse effect on AFMs’ well-being and quality of life and can compromise their important influence on the relative’s recovery (34).

Receiving support from others has the potential to improve AFMs’ capacity to maintain their support-giving role (3). However, the unpredictable nature of AOD misuse (35) leaves AFMs constantly vigilant in case of another crisis, as was the case in the present study. This restricts their social activities, which, in turn, increases their sense of isolation (8, 13, 36). They are also often reluctant to share their difficulties and needs with others, typically as a result of actual or perceived stigma (6, 21).

In the present study, there was also a significant adverse financial impact on AFMs, who often had to assume responsibility for family finances. This included covering legal and drug debts, rehabilitation costs, daily living expenses and paying for damage caused by the relative’s behaviour. Unstable financial circumstances are a common experience of many AFMs, across different countries and cultures (2, 5, 34).

Impaired family functioning and increased family conflict are also significant indirect effects of AOD misuse (9, 37), as evidenced in our study. Harm caused to families includes an increase in family arguments, ruined family occasions, modelling of poor behaviours to children and higher risk of aggression (5). Thus, deteriorating family relationships place additional stress on AFMs, whose constant worry for the relative is compounded by broader concerns about overall family functioning and its future, particularly when children are involved (8, 37).

In the current study, aggression was directed mainly at female partners. However, children are also often verbally abused, physically hurt or exposed to violence (5). It was challenging for AFMs to predict, avoid or contain aggression, leaving them feeling hyper-vigilant. Relative’s unpredictable behaviour is a major stressor for AFMs (38). Consequently, AFMs frequently feel overwhelmed, confused and anxious with the relative’s changeable and inconsistent behaviour (11). Their constant unease and sense of foreboding left them with a fearfulness and hopelessness about the future. Underpinned by a general sense of pessimism about their situation, AFMs could not envisage a better future. More specifically, their fearfulness and hopelessness concerned the risk that the relative would relapse.

In summary, this study adds to existing knowledge of AFM experience in this context (the most recent study sampled online counselling transcripts of intimate partners (10, 17, 18)), whereas ours was an in-depth qualitative study with a broader sample of AFMs. The findings highlight the need for evidence-based interventions to support AFMs in similar contexts elsewhere. We recruited a hard-to-reach cohort of AFMs who experienced a range of harms resulting from their support-giving experience. The recruitment approach and telephone interviews ensured the study reach was superior to traditional recruitment methods through AOD clinics and face-to-face interviews. The findings also build on current literature by highlighting that the AFM participants experienced considerable harms from their support-giving role. Harms were wide-ranging and affected their emotional, social and financial well-being, safety and family dynamics, and instilled a pervasive sense of fearfulness and hopelessness about the future.

Limitations

As a qualitative design, the findings are context bound to the AFMs and Australian state of Victoria in which the study was conducted (39); however, the themes can be validated and may be applicable to AFMs in similar situations (40). Recruitment through state-wide AOD helplines may have produced an atypical sample. Finally, participants were predominantly females, whose experiences and responses may differ from male AFMs.

Conclusion and implications

Our findings indicate that AFMs experienced a broad range of harms affecting their emotional, social and financial well-being, safety and family dynamics. The harms contributed to a lack of stability in their lives and to a pervasive sense of fearfulness and hopelessness about the future well-being of their relative. Implications of these findings are the need for AOD services and mental health nurses and other clinicians in the field to reorient their service to ensure the provision of timely, accessible and appropriate support to help AFMs sustain their vital role. Clinicians also have a decisive role in countering AFMs’ hopelessness about the future as treatment outcomes are better than perceived (41, 42), and AFMs who access support for themselves are more likely

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to continue their support-giving role (13). Potential benefits of providing effective family support are improving AFMs’ overall support-giving experience, and, as a consequence, influencing positively the course and outcome of the relative’s AOD misuse (33, 43, 44).

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Author contributions

Terence McCann designed the study, oversaw the fieldwork and analysed the data. Dan Lubman designed the study, facilitated recruitment and analysed the data. Meg Polacsek analysed the data. All authors contributed to study, facilitated recruitment and analysed the data. Thanks also to Mollie Flood, who took part in the study and the helpline staff who assisted with recruitment. Thanks also to Mollie Flood, who took part in the study and the helpline staff who assisted with recruitment. Thanks also to Mollie Flood, who took part in the study and the helpline staff who assisted with recruitment.

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References

2 Orford J. How does the common core to the harm experienced by affected family members vary by relationship, social and cultural factors? Drugs (Abingdon Engl) 2017a; 24: 9–16. https://doi.org/10.1080/09687637.2016.1189876
15 England Kennedy ES, Horton S. “Everything that I thought that they

Ethical approval

The study was approved by Eastern Health Human Research Ethics Committee (LR59/1314).

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Competing interests

The authors declare that they have no competing interests. In the past three years, Dan Lubman has received speaking honoraria from Astra Zeneca, Janssen-Cilag, Lundbeck, Servier and Shire, and has participated on Advisory Boards for Indivior and Lundbeck. In the past three years, Terence McCann and Dan Lubman received an educational grant from Janssen-Cilag to help write a book for families of people with schizophrenia.
would be, they weren’t:” family sys-
tems as support and impediment to 
http://dx.doi.org/10.1016/j.soscimed.
2011.07.006

16 Jackson D, Usher K, O’Brien L. Frac-
tured families: parental perspectives 
of the effects of adolescent drug 
abuse on family life. Contemp Nurse
5172/conu.2006.23.2.321

17 Wilson SR, Lubman DI, Rodda S,
Manning V, Yap MBH. The impact of 
problematic substance use on part-
ners’ interpersonal relationships: 
qualitative analysis of counselling 
transcripts from a national online 
https://doi.org/10.1080/09687637.
2018.1472217 [Epub ahead of print]

18 Wilson SR, Rodda S, Lubman DI, 
Manning V, Yap MBH. How online 
counselling can support partners of 
individuals with problem alcohol or 
other drug use. J Subst Abuse Treat 
1016/j.jsat.2017.04.009

19 McCann TV, Lubman DI. Adaptive 
coping strategies of affected family 
members of a relative with substance 
org/10.1111/jan.13405

20 McCann TV, Lubman DI. Help-seeking 
barriers and facilitators for 
affected family members of a relative 
with alcohol and other drug misuse: 
A qualitative study. J Subst Abuse 
org/10.1016/j.jsat.2018.07.005

21 McCann TV, Lubman DI. The stigma 
experience of families supporting an 
adult member with substance mis-
use. Int J Ment Health Nurs 2018c; 27: 
693–701. https://doi.org/10.1111/ 
im.12355

22 Eatough V, Smith JA. Interpretative 
phenomenological analysis. In The 
SAGE Handbook of Qualitative Research 
in Psychology (Stainton-Rogers CWW 

23 Smith JA, Osborn M. Interpretative 
phenomenological analysis as a use-
ful methodology for research on the 
lived experience of pain. Br J Pain
1177/2049463714541642

24 Smith J. Reflecting on the develop-
ment of interpretative phenomenologi-
cal analysis and its contribution to 
qualitative research in psychology. 
doi.org/10.1191/147808704qp004oa

25 Pietkiewicz I, Smith JA. A practical 
guide to using interpretative phe-
nomenological analysis in qualitative 
https://doi.org/10.14691/CPPJ.201.1.7

26 Parahoo K. Nursing Research: Princi-
ples, Process and Issues, 3rd edn. 2014, 
Palgrave/Macmillan, Basingstoke.

27 Holloway I, Galvin K. Qualitative 
Research in Nursing and Healthcare,

28 Smith JA, Osborn M. Interpretative 
phenomenological analysis, In Quali-
tative Psychology: A Practical Guide to 
Research Methods (Smith JA ed.), 

29 Lincoln YS, Guba EG. Naturalistic 
Inquiry. 1985, Sage, Newbury Park, CA.

30 Mays N, Pope C. Rigour and qualita-
tive research. Br Med J 1990; 301: 
10–12.

31 Guba EG, Lincoln YS. Paradigmatic 
controversies, contradictions, and 
emerging confluences. In Sage Hand-
book of Qualitative Research (Denzin 
NK, Lincoln YS eds), 2005, Sage, 

32 Allard J, Lancaster S, Clayton S, 
Amos T, Birchwood M. Carers’ and service 
users’ experiences of early intervention 
in psychosis services: implications for 
care partnerships. Early Interv Psychiatry 
1111/eip.12309

33 Denomme WJ, Benhanoh O. Helping 
concerned family members of individ-
uals with substance use and concurrent 
disorders: an evaluation of a family 
member-oriented treatment program. J Subst Abuse Treat 2017; 79: 
2017.05.012

34 Copello A, Templeton L, Powell J. 
Adult Family Members and Carers of 
Dependent Drug Users: Prevalence, Social 
Cost, Resource Savings and Treatment 
Responses. 2009, UK Drug Policy Com-
org.uk/publication/adult-family-mem-
bers-carers/ (last accessed 27 March
2019)

35 Kelly JF, Fallah-Sohy N, Cristello J, 
Bergman B. Coping with the enduring 
unpredictability of opioid addiction: an 
investigation of a novel family-focused 
peer-support organization. J Subst 
doi.org/10.1016/j.jsat.2017.02.010

36 Copello A, Templeton L, Chohan G, 
McCarthy T. Adult Family Members 
Affected by a Relative’s Substance Mis-
use: Qualitative Interviews with Commiss-
ioners and Service Providers in England 
uk/publications/#Families_report 
(last accessed 24 February 2019).

37 Selbekk AS, Sagaavag H. Troubled 
families and individualised solutions: 
an institutional discourse analysis of 
alcohol and drug treatment practices 
involving affected others. Socol Health Illn 2016; 38: 1058–73. 
https://doi.org/10.1111/1467-9566.
12432

38 O’Brien JE, Ermentrout D, Fraga RC, 
Li W, Macy RJ, Dababnah S. “I 
ever knew which way he would swing…” exploring the roles of subst-
ances in the lives of system-
involved intimate partner violence 
survivors. J Fam Violence 2016; 31: 
61–73. https://doi.org/10.1007/ 
s10896-015-9747-1

39 Polit DF, Beck CT. Generalization in 
quantitative and qualitative research: 
myths and strategies. Int J Nurs Stud 
1016/j.ijsr.2010.06.004

40 Green J. Generalisability and validity 
in qualitative research. Br Med J 
1999; 319: 421.

41 Haskell R, Graham K, Bernards S, 
Flynn A, Wells S. Service user and 
family member perspectives on ser-
vices for mental health, substance 
use/addiction, and violence: a quali-
tative study of their goals, experi-
cences and recommendations. Int J 
https://doi.org/10.1186/s13033-016-
0040-3

42 Daley DC, Smith EG, Balogh D, 
Toscolani J. The impact of the opi-
oid epidemic and other substance 
use disorders on families and
