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Coping with a loved one's substance use disorder or gambling disorder: what strategies really help?

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Abstract

Family members of people with substance use or gambling disorders (SUD/GD) struggle to cope with ongoing impacts to family life. Effective coping is critical but it is unclear which strategies are helpful for family members, as research is lacking. Female spouses/partners of people with SUD/GD (*N*=211) reported helpfulness and use of engaged, tolerant, and withdrawal coping strategies. Withdrawal coping was most helpful, and commonly used. Some engaged coping strategies were unhelpful but frequently used. Coping is complex; research is needed into effective coping for differing goals and contexts Professionals should empower family members to use strategies helpful to their well-being.

Keywords

Substance use disorder; gambling disorder; family; coping; stress; helpfulness of coping

Introduction

Dealing with a loved one's substance use disorder or gambling disorder (SUD/GD) is a process of enduring loss for family members. Families affected by a relative's SUD/GD worry about their relative's safety and future, often shoulder extra family responsibilities, and experience significant stress and family chaos (Orford, Natera, et al., 2005). They also deal with other consequences of the SUD/GD such as their relative's or their own mental or physical health issues, financial and/or legal troubles, and SUD/GD-related problems such as intimate partner violence (Cafferky, Mendez, Anderson & Stith, 2018; Dowling, Rodda, Lubman, & Jackson, 2014; Orford, Natera, et al., 2005; Weisner, Parthasarathy, Moore, & Mertens, 2010). Families typically deal with these problems over long periods of time, as less than 11% of people needing SUD/GD treatment receive it in any year (Ahrnsbrak, Bose, Hedden, Lipari, & Park-Lee, 2017).

Family members are often in dire need of effective coping strategies (McCann & Lubman, 2018). Too frequently, they are on their own to struggle on a trial and error basis with

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ongoing stress and loss related to their loved one's SUD/GD, as little help is available for families affected by SUD/GD (Kelly, Fallah-Sohy, Cristello, & Bergman, 2017). Understanding which coping strategies are more or less effective is crucially important to informing and improving supports for families affected by SUD/GD.

Stress and coping theory offers one way to understand coping in family members of people with SUD/GD. According to the Stress-Strain-Coping-Support model (SSCS, Orford, Copello, Velleman, & Templeton, 2010), the SUD/GD is a stressor on family members, who consequently experience strain. However, by use of certain coping strategies and receipt of social support, they may lessen the strain they would otherwise experience and improve their physical and mental health. There are three types of coping described in the SSCS theory: engaged (actively attempting to get the person with the SUD/GD to cut down or quit via emotional or assertive tactics), tolerant (attempting to live with the situation, i.e. putting up with it), and withdrawal (removing oneself from the effects of the SUD/GD and/or the loved one). Withdrawal is considered the most effective type of coping, as it was found to predict reduced family member distress (Orford, Templeton, Velleman, & Copello, 2005).

Another way to understand effective coping in families affected by SUD/GD is through empirical research. For instance, the SSCS model was informed by studies of family members (Orford, Natera, et al., 2005), in which researchers documented the familial effects of SUD/GD and how family members coped (e.g., engaged, tolerant, and withdrawal). Similarly, family members reported in another study that they engaged in self-care activities, took time away from the person with the SUD/GD, and got support from others (McCann and Lubman, 2018). Some studies focused on family members' goals, i.e. what they were hoping to achieve when using coping strategies. Common goals were to improve their well-being (McCann & Lubman, 2018) and to influence their loved one's alcohol or drug use and/or gambling behavior (Côte, Tremblay, & Brunelle, 2018). However, there has been little research on the helpfulness of coping strategies for family members. One such study utilized transcripts from online counseling sessions with family members to identify coping strategies they found helpful or unhelpful (Wilson, Lubman, Rodda, Manning, & Yap, 2018). Family members reported that self-care and boundary-setting were helpful, but that withdrawal from the person with the SUD/GD was not helpful.

There are some inconsistencies between family member reports about their experiences, e.g., withdrawal is not helpful (Wilson et al., 2018), and the SSCS theory, which posits that withdrawal is effective (Orford et al., 2010). Thus, it is not yet clear which coping strategies are truly helpful for people coping with a loved one's SUD/GD, and whether family members primarily use these helpful strategies. Investigation into how families may effectively cope with a loved one's SUD/GD is especially important given the current drug use crisis, which has affected unprecedented numbers of families in North America and parts of Africa (United Nations Office on Drugs and Crime, 2018). Therefore, the purpose of this study is to determine which coping strategies are more or less helpful according to family members of people with SUD/GD, and to explore associations between helpfulness and use of coping.

Materials and Methods

Participants

Study participants were 24- to 65-year-old female spouses or partners of people who had problems with alcohol, drugs, and/or gambling. They were eligible if the relationship was current or recent (within the past year), and had lasted at least six months. Participants were recruited from the community via the university's research participant registry, via flyers posted in public places around the metropolitan area, and via online notices. These were posted on the state problem gambling alliance web site, on social media, and on a regional online classified ad site.

Measures

The survey was available online via Qualtrics (https://www.qualtrics.com). It included screening questions, demographics, the Depression Anxiety Stress Scale-21 (DASS-21; Lovibond & Lovibond, 1995), the Coping Questionnaire (CQ, Orford, Templeton, et al., 2005), and questions about the helpfulness of each coping strategy. DASS-21, CQ, and helpfulness questions used a past-year time frame.

The DASS-21 (Lovibond & Lovibond, 1995) has seven questions about frequency of distress symptoms in each of three domains, scored on a four-point scale (0 = never, 1 = some of the time, 2 = a good part of the time, 3 = most of the time). Published reliability scores are good for the DASS-21 (depression α = .82, anxiety α = .90, stress α = .93; Henry & Crawford, 2005), and reliability was comparable in the current study (depression α = .92, anxiety α = .89, stress α = .89). Scores are summed in each domain. Population norms are available for the United States (Sinclair et al., 2012).

The 30-item CQ (Orford, Templeton, et al., 2005) measures three types of coping used by family members of people with SUD/GD. Questions are scored on a four-point scale (0 = never, 1 = once or twice, 2 = sometimes, 3 = often), and are summed to create subscale scores. Published reliability scores are good for engaged coping (14 questions, Cronbach's α = .85) and adequate for tolerant coping (9 questions, α = .74), but marginal for withdrawal coping (8 questions, α = .60; Orford, Templeton, et al., 2005). Reliability on each subscale was higher in the current study, with good reliability for engaged (α = .91) and tolerant subscales (α = .82) and adequate reliability for the withdrawal subscale (α = .71). Some CQ phrases were changed from British to American English (e.g., "got on with your own things" became "pursued your own interests"). Participants who had used a coping strategy in the past year also rated the strategy's helpfulness (0 = not at all helpful, 1 = a little helpful, 2 = helpful, 3 = very helpful). Helpfulness scores were averaged to create subscales.

Procedures

All materials and procedures were approved by the university institutional review board. Potential participants went online to the study site, and if interested continued to the consent form. Consent was indicated by advancing to the next page, where participants could provide optional contact information before starting the survey. Participants could skip any survey question except screener questions. At the end, participants who wanted to receive

remuneration (a $10 amazon.com e-gift certificate) provided their email address and social security number.

Data management and analysis

Data underwent extensive validation to ensure that any survey included in the final analysis was the only survey completed by a participant. This became necessary when interested parties reposted the study announcement on SUD/GD-related web sites on two occasions. Both times, many surveys were completed back-to-back overnight, in a fraction of the time taken by valid participants, using devices with similar or identical IP addresses. The validation process included scrutinizing the IP address, day and time the survey was completed, participant name & contact information, remuneration email address, and write-in answers for patterns uncharacteristic of valid data, internal inconsistencies, and impossible answers. A survey was deemed invalid if it had multiple egregious problems (e.g., it was in a group of surveys completed very quickly, overnight, by devices with the same IP address; if the participant gave a male contact name but indicated on the survey that they were female, or they provided a social security number that belonged to a deceased person; if they gave a non-existent contact address; and/or indicated physically impossible substance use such as 800 drinks/day). Of 505 consents, 40 quit before starting the survey, 211 were deemed invalid, 32 were valid but ineligible (e.g., the relationship was less than six months long), and 222 were both valid and eligible.

Analyses were conducted with IBM SPSS®, version 24. Descriptive statistics were used for demographics and for DASS-21, CQ, and helpfulness of coping scores. Within-subjects ANOVAs were run for differences in use and helpfulness between the three types of coping. Pearson's r was used for associations between use and helpfulness for the three types of coping, and Spearman's rho was used for associations between use and helpfulness of specific coping strategies. The Benjamini-Hochberg p-value adjustment controlled family-wise alpha error for Spearman correlations, with the false error rate set at .05 (McDonald, 2014).

Results

Participants were 24–63 years old, with a mean age of 36. Most were Caucasian (76%) or African-American (22%), and 8% were Latina. Ninety percent had some post-high school education, and 54% had a college degree. Most (69%) worked full time, with an average household income of $40,000-$49,999/year. Nearly two-thirds (65%) had children. Participants reported considerable distress. Many had elevated DASS-21 scores (in the moderate, severe, or extremely severe range for the United States; Henry & Crawford, 2005) for depression (64%), anxiety (68%), and stress (47%).

Almost all participants (96%) reported that their partner was male, and 88% were currently in the relationship when they participated in the study. Fifty-nine percent were married to their partners, and 78% lived with their partner. Relationships ranged from 1–44 years long (median 5 years). Most participants reported that their partner had a problem with alcohol (69%), with fewer indicating a drug (36%) or gambling (29%) problem. The 30% of partners with multiple problems were evenly divided between problems with alcohol plus drugs, and

problems with gambling plus alcohol and/or drugs. Median SUD/GD duration was seven years for alcohol, ten years for drugs, and five years for gambling problems.

Participants used the three types of coping at frequencies typical for family members of people with SUD/GD (Orford, Templeton, et al., 2005): engaged coping *Mean* = 23.07 (*Standard Deviation* = 9.90), tolerant coping $M = 12.78$ ($SD = 6.12$), and withdrawal coping $M = 12.86$ ($SD = 3.74$). These means are not directly comparable since each is the sum of scores for questions in its subscale. For comparison purposes, subscale use scores were transformed into the original scoring metric via dividing by the number of subscale questions. An ANOVA revealed that participants used the three types of coping at different rates, $F(2, 426) = 26.02$, $p < .0001$. Tukey's LSD showed that tolerant coping (transformed $M = 1.42$, $SD = 0.68$) was used less often than both engaged coping (transformed $M = 1.65$, $SD = 0.71$; $p < .0001$) and withdrawal coping (transformed $M = 1.59$, $SD = 0.76$; $p < .0001$). Engaged and withdrawal coping were used equally often, $p > .05$. Similarly, there were differences between the mean helpfulness of all types of coping, $F(2, 384) = 93.89$, $p < .0001$. Participants rated tolerant coping as being least helpful ($M = 0.75$, $SD = 0.05$), engaged coping as being more helpful ($M = 0.96$, $SD = 0.05$), and withdrawal coping as the most helpful ($M = 1.39$, $SD = 0.04$), all $p < .0001$.

There was no correlation between use and helpfulness of engaged coping, $r(203) = -.07$, $p = .33$ or tolerant coping, $r(201) = .10$, $p = .16$. However, there was a strong positive correlation between use and helpfulness of withdrawal coping, $r(192) = .54$, $p < .0001$. To further explore the use and helpfulness of coping, specific coping strategies within each type of coping were examined (see Table 1, questions paraphrased for brevity). [Table 1 near here.] For "typical" use and helpfulness of specific coping strategies, median responses are reported below.

Participants were very likely to use engaged coping strategies, typically using 93% of the engaged strategies in the past year. However, they tended to use engaged strategies only occasionally, with median use of "sometimes" for all but one strategy. Despite using nearly all of the engaged strategies in the past year, participants felt that most engaged strategies were only "a little helpful," with two strategies (arguing & getting emotional) typically being rated as "not at all helpful." For most engaged coping strategies, there was no association between frequency of use and helpfulness ratings (see Table 1). However, there were small negative correlations between use & helpfulness of three strategies (getting emotional, pleading, & saying SUD/GD had to change).

Participants were less likely to use tolerant coping strategies (median 74% of tolerant strategies used in the past year). In addition, they reported less frequent use of tolerant coping strategies as well, with median use of only "once or twice" for five strategies and "sometimes" for four strategies. Participants also felt that most of the tolerant strategies were "not at all helpful," with only three strategies having median ratings of "a little helpful" (put yourself out for partner, accepting situation, & trying to keep things looking normal). There was a small positive correlation between use and helpfulness for one strategy (accepting the situation; see Table 1).

Participants reported utilizing 88% of withdrawal coping strategies in the past year, typically using each of the withdrawal strategies “sometimes.” Three withdrawal strategies were typically rated as being “helpful” (putting other family members’ interests before partner’s interests, pursuing your own interests, & putting yourself first). The remaining withdrawal strategies were typically rated as being “a little helpful.” There were small positive correlations between use and helpfulness ratings for three withdrawal strategies (putting other family members’ interests before partner’s interests, going about your own business, putting yourself first; see Table 1).

Discussion

This study extended previous studies on coping in family members of people with SUD/GD, as it investigated helpfulness of coping and the association between helpfulness and use of coping strategies. Participants found withdrawal coping strategies most helpful, engaged coping strategies less helpful, and tolerant coping strategies least helpful. This finding is consistent with the SSCS theory (Orford et al., 2010). For withdrawal coping, participants’ use corresponded to their helpfulness ratings. This is desirable, since those who found withdrawal coping helpful used it more, and those who found it unhelpful used it less. The same was not true for engaged and tolerant coping: participants’ use of these types of coping was independent of (not associated with) their ratings of how helpful each type of coping was for them. An examination of the specific strategies listed under each type of coping may explain these results.

Patterns of use and helpfulness were mixed when examining specific coping strategies for each type of coping. For withdrawal coping, there were small positive correlations between use and helpfulness of three strategies: putting yourself first, putting other family members first, and going about your own business. This result is understandable given that a family member with an SUD/GD tends to become the focus of family attention, with other family members’ needs taking a back seat (Orford, Natera, et al., 2005). Refocusing attention on other family members could help bring balance to the family system, even if the SUD/GD continues.

Such positive associations between use and helpfulness were rare for the other two types of coping strategies. Among engaged strategies, associations between use and helpfulness for three communication-oriented strategies (getting emotional, pleading with the partner, or telling the partner that the SUD/GD was upsetting and had to change) were all inverse; that is, those who used them most frequently did not feel they were helpful. This is problematic, since sharing emotions and communicating are considered key ways to build relationships. Relationships are often damaged when there is an SUD/GD (Berends, Ferris, & Laslett, 2014), and many spouses/partners use coping strategies to attempt to rebuild closeness (McCann, Polacsek, & Lubman, 2019). Thus, participants may have been using these strategies in an attempt to strengthen their relationship with their partner, even though they didn’t feel that these strategies were helpful at the time. In research with partners of gamblers, Côte and colleagues (2018) noted that participants showed a similar commitment to continuing to use apparently ineffective coping strategies in hopes that they would

eventually work, with spouses/partners only discontinuing use when they were convinced the strategies would never achieve their goal.

In contrast to the significant associations found for withdrawal and engaged coping strategies, for most tolerant coping strategies there was no association between use and helpfulness of coping. This might indicate that these strategies weren't necessarily chosen because they were expected to be helpful. Instead, they may have been used in desperation – an attempt to try anything and everything in the face of a severe, long-term SUD/GD (Côte et al., 2018) – or they may not have been consciously chosen at all. That is, some of these strategies are emotional low spots that highly distressed family members might find themselves in: feeling frightened, helpless, or unable to make a decision. Other strategies in this group may represent attempts to maintain family life in the face of the SUD/GD (Côte et al., 2018): taking care of problems, trying to keep things normal, or covering up the SUD/GD. If these strategies are perceived to be important to family well-being, then they may be used regardless of whether they are helpful in addressing the SUD/GD itself. Either possibility – that these strategies were not actively chosen at all, or that they were chosen for reasons other than reducing substance use or gambling behavior – would explain the lack of association between use and helpfulness of tolerant coping. Further research is needed to explore how and why family members use each type of coping.

Implications

Dealing with a loved one's SUD/GD is extremely stressful, perhaps more so than dealing with a loved one's physical illness (Slaunwhite, Ronis, Sun, & Peters, 2017). Family members of people with SUD/GD often live under the strain of the SUD/GD for a long time (U.S. Department of Health & Human Services, 2016), and they could benefit from attention to their needs. For instance, given the high rate of anxiety and depression among participants, professionals should screen family members for mental health issues. When present, treatment for anxiety and depression is warranted.

Another way for family members to improve their mental health may be the use of effective coping strategies (Orford et al., 2010). It is critical for social service professionals to understand which ways of coping are more or less helpful for family members, so that they may best assist clients affected by a loved one's SUD/GD to cope effectively with the situation. Since participants found withdrawal to be the most helpful type of coping, professionals who work with families can advise clients that other family members have found withdrawal to be effective, and help them to plan how and when to use withdrawal strategies. However, since there was not complete agreement among participants as to the helpfulness of engaged and tolerant strategies, professionals should empower families to choose coping strategies suited to their specific situation. This could entail coping skills training and/or referrals to mutual aid organizations. One such organization is Al-Anon, which is free, widely available, and considered to be helpful by many family members who attend meetings (Al-Anon Family Group Headquarters, 2018). Finally, professionals may wish to be involved in improving existing supports for SUD/GD-affected families, and developing new and emerging interventions such as family-focused peer support groups (Kelly et al., 2017).

Strengths, limitations, and future research

This study has both strengths and limitations. First, one strength of this study is that participants were a non-clinical sample, so results are likely to be applicable to spouses/partners coping on their own with their loved one's SUD/GD. However, since all participants were spouses/partners, it is not clear how well these results may generalize to siblings or other types of family members, who may face different challenges in dealing with their loved one's SUD/GD (Howard et al., 2010). A second strength is that the percentage of participants who identified as members of racial or ethnic minority groups was reflective of the metropolitan area in which data were collected.

One limitation of this research is that the study used retrospective reports of coping over the past year. Participants with fluctuating situations may have found it difficult to choose one answer that was typical of the entire year. Other participants' memories of early months of the year may have blurred, making it hard for them to accurately report their coping. However, although there is variable correspondence between daily and retrospective reports of coping (Todd, Tennen, Carney, Armeli, & Affleck, 2004), stress and coping research often uses such retrospective coping reports (c.f. Orford, Natera, et al., 2005).

A second limitation is that reliability for the withdrawal coping subscale was merely adequate. Further development of this subscale may be beneficial. An additional limitation specific to cross-sectional studies is that no cause-and-effect relationship between variables can be inferred. Finally, the large number of invalid surveys is problematic in that, while an extensive validation technique used was used, it was undoubtedly less than perfect. This problem could be minimized in future research by using a different remuneration plan such as a lottery.

Future research should focus on understanding how and why people choose and use coping strategies. This will require exploring how (and if) family members actively choose strategies, what goals they are hoping to accomplish, how well the strategies worked to accomplish those goals, and any unanticipated or collateral effects. It will also be important to collect real-time coping data, in order to learn how family members of people with SUD/GD use strategies in the presence of specific stressors and/or familial contexts. This information is important to developing effective programs and practices to assist families struggling with a loved one's SUD/GD.

Conclusion

In conclusion, while most participants used most of the coping strategies in the past year, they considered withdrawal coping to be the most helpful. Social service professionals should work with families affected by SUD/GD to help them identify and implement coping strategies. Further research will be required to understand how families of people with SUD/GD may best deal with the situation, and which coping strategies are most effective in various contexts.

Declarations

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Table 1.

Past-year use and helpfulness of coping strategies.

	Past-year use (%)	At least "A little helpful" (%)	Use & Helpfulness Correlation (Rho)
Engaged Coping			
Refused to lend partner money or help with finances	72	72	−.03
Talked with partner about addiction †	90	68	−.03
Started argument with partner about addiction	82	47	−.08
Pleaded with partner about addiction	85	57	−.27 *
Said addiction upset you & had to change	90	73	−.18 *
Tried to limit addiction by making a rule about it	72	68	−.14
Encouraged partner to take oath about addiction	63	55	−.04
Got moody or emotional with partner	92	45	−.18 *
Watched or checked up on partner	85	64	.12
Refused to accept reasons for addiction or cover it up	76	75	−.06
Stated expectations re: contributions to family	85	72	−.08
Accused partner of not loving you, letting you down	85	52	−.02
Sat down with partner to deal with finances	78	69	.09
Searched for/got rid of alcohol/drugs/gambling items	62	63	−.08
Tolerant Coping			
Put yourself out for partner, took care of problems	82	58	−.16
Gave partner money	68	48	.06
Felt too frightened to do anything	63	48	.11
Felt too helpless to do anything	77	39	−.15
Made threats you didn't mean to carry out	68	49	.00
Got in a state where you couldn't make a decision	70	44	−.02
Accepted that the situation couldn't be changed	73	58	.22 *
Covered up, took blame, or made excuses for partner	62	50	.18
Tried to keep things looking normal, hid addiction evidence	84	61	−.15
Withdrawal Coping			
Put other family members' interests before partner's	84	78	.28 *
Let your partner take care of self after using	84	64	.05
Pursued your own interests, e.g. activities, job	82	89	.18
Avoided partner because of addiction	82	70	.04
Went about own business, pretended partner wasn't there	87	71	.19 *
Defended partner when others were critical	78	66	.08
Put yourself first, took care of yourself	87	90	.23 *

* Significant at $p < .05$ after Benjamini-Hochberg p-value adjustment

† Also used for withdrawal, neg. scored