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**"I Think I Have an Addiction Too": Narrative Analysis of Mothers' Experiences in
Methamphetamine-Affected Partnerships**

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Arts in Psychology

Massey University, New Zealand

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2024

Abstract

Methamphetamine, a highly addictive stimulant, has become a major global health concern. In New Zealand, methamphetamine is the second most used illicit drug, with per capita usage ranked third highest globally. Although individual impacts are well-documented, the toll on family members is less understood. Substance abuse places a substantial burden on families, impacting their physical, emotional, and financial well-being. Additionally, stigma surrounding substance abuse often discourages families from seeking help, which can worsen the issue. Despite various treatment options in New Zealand, accessing specialized services for methamphetamine addiction remains challenging. Using narrative analysis within a constructivist framework, this research delved into the lived experiences of women in New Zealand as they supported partners struggling with methamphetamine addiction. Four women participated in a semi-structured interview to share their insights into the personal, relational and societal factors influencing their experiences of supporting their partner whilst raising children. The findings underscore the significant mental, physical, emotional, and financial toll on individuals caring for partners with methamphetamine addiction. Caregivers experience anxiety, stress, trauma, and physical distress, alongside emotional turmoil, financial strain, and social isolation, while raising children. The stigma surrounding addiction exacerbates these challenges, limiting access to support services. Societal expectations, particularly gender roles, influence caregiving behaviours, with women often internalizing these roles, leading to co-dependency and difficulty setting boundaries. Emotional labour and societal pressures contribute to burnout, reinforcing unhealthy relational dynamics. The research emphasises the need for systemic solutions, including better access to mental health care, legal protections, and social support. Comprehensive support systems integrating practical resources, therapeutic interventions, and peer support groups are crucial. Legal tools like protection orders and professional support networks are vital for safety and emotional resilience. A collaborative approach involving mental health professionals, addiction specialists, and policymakers is necessary to provide holistic, long-term support for individuals and families affected by addiction.

Acknowledgements

This research would not have been possible without the invaluable contributions of the remarkable women who participated in both my honours project and the current study. Your courage in entrusting me with such intimate and vulnerable experiences is truly inspiring. I am moved by the profound insights, wisdom, and resilience you each hold in navigating such complex experiences. Your profound insights, resilience, and wisdom have not only shaped this research but have also deepened my understanding of addiction's impact on families. Your voices have illuminated this work, enriching it in ways that words cannot fully capture. I am honoured to have had the opportunity to engage with your stories and to share your perspectives, ensuring they contribute to a broader conversation. Thank you for your courage, honesty, and trust—you have been integral to this research, and I am forever grateful.

I am also deeply grateful to my supervisor Dr. Kathryn Mcguigan. Your unwavering support, patience, and understanding have been invaluable throughout this journey, which included navigating the demands of pregnancy, the challenges of early parenting, and the disruptions of the COVID-19 pandemic. Your ability to offer guidance while giving me the freedom to work at my own pace made me feel truly supported and capable. Your guidance, especially in helping me refocus when I became immersed in the finer details or took extended detours into the literature, has kept me on track and made the entire process feel both achievable and rewarding. Thank you for being a steady, insightful presence throughout this journey. I am deeply appreciative of the balance of independence and guidance you provided, as it has enabled me to grow not only as a researcher but also as a writer and critical thinker.

I would also like to express my heartfelt thanks to my mother, whose patience and support have been unwavering. Thank you for listening to countless hours of theorising, sharing insights, and spending precious mornings with Roman to give me the dedicated time to write.

Finally, to my partner, Billy – perhaps the biggest thank you goes to you. Your support has been boundless, and I am immensely grateful. Thank you for embracing full-time dad duty, for all the healthy brain food, the endless cups of coffee, and above all, for your encouragement, patience, and unconditional love. This journey would not have been possible without your steadfast support and belief in me.

Table of contents

Abstract.....	ii
Acknowledgements.....	iii
Table of contents.....	iv
Chapter One: Introduction	1
Methamphetamine: A Growing Global Threat	1
Regional Variations	3
Methamphetamine's Grip on New Zealand	4
The Physical and Psychological Impact	8
Beyond the Individual: Family Impacts of Substance Use	9
Seeking Recovery: Treatment Options in New Zealand.....	10
Research Rationale	13
Research Aims	13
Chapter Two: Literature review	14
Personal	15
The Emotional Burden of Addiction on Families.....	15
The Physical Price of Addiction.....	16
The Silence of Stigma: Family Isolation in Addiction.....	18
The Weight of Self-Blame.....	19
Interpersonal.....	20
Financial and Violent Burdens of Addiction.....	20
Grieving the Living: The Hidden Pain of Addiction.....	21
Family and Social Support Networks.....	23
Children Affected by Parental Substance Use.....	25

Societal	28
Stigma	28
The Evolving Understanding of Addiction: From Moral Failing to Chronic Disease	30
The Intersection of Addiction and Domestic Violence	33
The Burden of Care: Gender Roles and Addiction.....	35
Chapter Three: Methodology	38
Constructivism	38
Narrative Inquiry	40
Procedure.....	42
Recruitment and Participants.....	42
Interviews	44
Reflexivity	45
Ethics	47
Data Analysis.....	49
Chapter Four: Analysis	53
Personal	53
Vicious cycles: Addiction, anxiety, and physical decline in intimate relationships.....	53
Broken promises to balanced lives: Stories of transformation	56
The art of manipulation: The psychological impact on supporters	58
From shield to cage: How secrecy and isolation impact supporters.....	61
Working in Mental Health: How did I not see the flags?.....	63
Interpersonal.....	64
Intimate relationship dynamics	64
The weight of judgement: How addiction alters friendships and social life	69
Shifting blame: The complexities of family dynamics in addiction.....	70

Dual realities: Children navigating the love and pain of an addicted parent.....	73
Societal.....	76
Redefining abuse: Beyond physical violence in relationships	76
Reframing addiction: The role of education and empathy	77
Breaking the silence: Challenging the stigma of addiction	79
Beyond the individual: The urgent need for family-centric addiction support	81
Reclaiming control: How protection orders and legal support restore safety	87
Co-dependency.....	89
From survival to self-awareness: A journey of boundaries, recovery, and growth.....	90
The cost of caregiving: Gendered roles, co-dependency, and self-discovery	92
Chapter Five: Discussion	96
The Toll on the Partner.....	96
The intertwined emotional and practical costs of supporting addiction	97
"Am I crazy?": The psychological toll of gaslighting in substance-affected relationships ...	99
The Price of Addiction: The Emotional and Psychological Toll on Children	101
Navigating Isolation and Stigma.....	102
Supporting in silence: The emotional isolation of partners	102
Caught in a cycle: Internal, secondary, and societal stigma's impact on families	103
Co-dependency.....	105
The entanglement of love and addiction.....	105
Exploring the role of personality and gender in co-dependency.....	108
Chaos, Recovery and Renewal: Family Stability in the Aftermath of Addiction.....	111
Support and Practical Implications	112
Navigating addiction: The Role of practical and emotional resources for families	112
Breaking down barriers: Towards comprehensive and accessible support	115

Limitations and Future Directions.....	116
References.....	119
Appendix A – NZ P Pull Facebook Post	143
Appendix B – Information Sheet.....	144
Appendix C – Consent Form	148
Appendix D – Confidentiality	149
Appendix E – Interview Guide	150
Appendix F – Authority for the Release of Transcripts	151

List of table and figures

Figure 1: Revised Ecological Model Highlighting the Levels of Impact on Supporters.....	15
Figure 2: Participant Quotes on Support Seeking.....	116

Chapter One: Introduction

This introduction provides an overview of global methamphetamine statistics before delving into the situation in New Zealand. The introduction then moves to the general side effects and consequences of addiction, including their impact on families, before introducing the research objectives.

Methamphetamine, a powerful stimulant in the amphetamine-type category, directly impacts the central nervous system (United Nations, 2022). The National Institute on Drug Abuse (NIDA, 2013) describes methamphetamine—commonly known as meth, crystal meth, or ice—as highly addictive, producing intense pleasure and heightened energy by releasing a massive surge of dopamine in the brain. This surge delivers a level of pleasure far greater than typical experiences, but with repeated use, the brain’s dopamine receptors adapt and become less responsive. As a result, users require increasing doses to experience the same euphoria. Quitting methamphetamine proves especially difficult, as reduced dopamine levels make everyday activities less enjoyable. Withdrawal often brings anhedonia (inability to feel pleasure), irritability, fatigue, depression, impaired social interactions, and powerful cravings (Cantwell & McBride, 1998; Newton et al., 2004). In New Zealand, methamphetamine is classified as a Class A drug, with serious penalties for its possession, manufacture, and supply (Foulds & Nutt, 2020).

Methamphetamine: A growing global threat

Methamphetamine abuse is a global health concern, linked to numerous health issues. Dependence on psychostimulants, including cocaine and amphetamines, contributes significantly to the global disease burden, with varying levels of impact across different regions (Degenhardt et al., 2014). The United Nations World Drug Report (2022) estimates that in 2020, approximately 34 million people used amphetamines globally, making them among the most widely used drugs worldwide. Global seizures of amphetamines reached a record high in 2020 with over 525,000 kgs seized (United Nations, 2022). Of those seizures, 72% were methamphetamine (United Nations, 2022). North America had the highest prevalence of amphetamine use at 3.9% of the population, followed closely by Australia and New Zealand at

1.3% (United Nations, 2022). Methamphetamine use has spread rapidly worldwide, increasing from 84 countries between 2006-2010 to 117 countries between 2016-2020, as demonstrated by seizure data (United Nations, 2022). Wastewater analyses confirm methamphetamine presence in Europe and Southern Africa, in addition to its well-established concentrations in North America, East and Southeast Asia, Australia, and New Zealand (United Nations, 2022).

Criminalizing drug use complicates the collection of reliable data on usage patterns and associated harms. Illicit drug use appears to be most prevalent in high-income countries and regions close to major drug production areas, but data from low-income countries is often lacking (Degenhardt & Hall, 2012). Legal repercussions often discourage honest disclosure from research participants in regions with strict drug laws, making it difficult to estimate illicit drug use accurately. There is no universally accepted gold-standard method for estimating the true size of the population of illicit drug users, nor a single approach suitable across all drugs and countries (Degenhardt & Hall, 2012). Compounding this issue, data collection disruptions during the Covid-19 pandemic after 2019 have further complicated trend analysis. These inconsistencies and potential biases create substantial challenges for meaningful cross-national comparisons.

The most effective approach for estimating drug use combines results from multiple estimation methods (Degenhardt & Hall, 2012). Direct methods include general population or household surveys, which ask participants about their past month, year, or lifetime drug use. These surveys provide accurate estimates if representative samples are obtained, participants are truthful, and drug users are evenly distributed. However, individuals may be hesitant to participate and admit drug use, and are often concentrated in urban areas, leading to underestimations, particularly for stigmatized drugs (Degenhardt & Hall, 2012). School surveys, targeting drug use among school-aged youth, offer similar insights but exclude youth who have left school—a group more likely to have used drugs (Degenhardt & Hall, 2012). High-income countries often utilize such direct methods, yet these may underrepresent highly stigmatized drug use, which causes the most significant harm (Degenhardt & Hall, 2012). Indirect methods provide estimates by using existing data across multiple sources to estimate drug use prevalence (Hickman et al., 2002). Routinely collected mortality and morbidity data can track trends related to drug use, but even in well-resourced countries, illicit drug use may

not always be accurately recognised or recorded as a contributing factor in deaths or hospitalizations (Hickman et al., 2002). Despite challenges in obtaining precise statistics, methamphetamine use remains a critical global issue with high rates and adverse effects in many regions. Understanding these regional variations is crucial for developing effective prevention and treatment strategies due to their influence on social determinants of health.

Regional variations

Methamphetamine use has surged in the United States. In North America, amphetamine use has reached the highest regional prevalence globally, at 3.9% (United Nations, 2022), creating a significant public health burden with rising rates of addiction and overdoses (Frank, 2024). According to the 2012 National Survey on Drug Use and Health (NSDUH), 12 million Americans (4.7%) have tried methamphetamine, and 1.2 million (0.4%) used it in the past year. While Johnston et al. (2018) found a decline in methamphetamine use among youth, Radatz et al. (2015) reported stable usage rates in Nebraska, suggesting that social determinants, like after-school programmes, impact regional differences (Radatz et al., 2015). Further research is essential to uncover racial and ethnic variations and tailor public health strategies to meet the needs of diverse populations.

In Vancouver, Canada, methamphetamine use remains notably high among vulnerable youth. The 2006 Vancouver Youth Drug Survey revealed that 4.1% of youth aged 14-25 reported using crystal methamphetamine in the past year, with 2.2% reporting use within the past month (Vancouver Coastal Health, 2007). Usage disproportionately impacts marginalized groups, including LGBTQ+ youth, Indigenous youth, and homeless youth. The At-Risk Youth Study (Wood et al., 2008) found that 71% of street-involved youth had used methamphetamine, linking it to homelessness, sexual abuse, sex work, incarceration, and mental illness. These findings underscore an urgent need for targeted interventions that address the complex social and economic factors driving methamphetamine use among vulnerable youth.

Methamphetamine use, once concentrated in the Czech Republic and Slovakia, is spreading rapidly across Europe. The European Drug Report (2021) highlights its growing prevalence, with Czechia, Germany, Slovakia, and Turkey reporting the highest user concentrations (European Monitoring Centre for Drugs and Drug Addiction, 2021). In many

European regions, methamphetamine has even surpassed heroin as the second most commonly used illicit substance (Alniak et al., 2022). A 2022 study by Hartnett et al. (2022) analysed emergency department data in England revealing a surge in methamphetamine-related visits—from just four cases in 2005 to 294 in 2018. The study also revealed a significant gender disparity, with males accounting for 94.9% of the 850 presentations recorded between 2014 and 2018.

Methamphetamine has become a global public health issue, with distinct regional patterns in production, usage, and associated challenges. East and Southeast Asia have emerged as a major hub, accounting for over 70% of global methamphetamine seizures in 2019 (UNODC, 2019). This dominance is reflected in the high rates of methamphetamine use documented in countries like Thailand and the Philippines (UNODC, 2019). Africa, while still a developing market for methamphetamine, is experiencing a concerning rise in production and use, particularly in West Africa and South Africa (United Nations, 2022). Australia stands out globally, with some of the highest methamphetamine use rates, particularly since the rise of ‘ice’—the crystalline form—around 2010 (United Nations, 2022). Rural and Aboriginal communities have been disproportionately affected by this surge in methamphetamine use (United Nations, 2022), highlighting the need for targeted interventions to address these disparities.

Overall, methamphetamine is a significant problem globally with high rates of use seen across many countries. Understanding regional variations in methamphetamine use is crucial to developing effective public health responses tailored to the unique cultural, demographic, and socioeconomic needs of each area. This will require ongoing research and collaboration between governments, public health authorities, and international organizations.

Methamphetamine's grip on New Zealand

In New Zealand, methamphetamine, commonly referred to as 'P' or 'pure,' first surfaced in the late 1990s, marking the country's most significant drug issue since a surge of heroin use during the mid-1970s (Pates & Riley, 2009). The United Nations Office on Drugs and Crime (2003) ranks New Zealand as having the third-highest per capita prevalence of methamphetamine use globally, following Thailand and Australia. Initially confined to

subcultures, particularly within the dance party scene, methamphetamine use rapidly expanded, becoming the second most commonly used illegal drug by 2001, after cannabis (New Zealand Police, 2002; Zander, 2002; Wilkins et al., 2002).

Over time, the availability of methamphetamine in New Zealand has surged, as evidenced by the sharp increase in police seizures. In 1999, authorities confiscated only 1.3 kilograms; a mere three years later, that number had skyrocketed to a staggering 83.3 kilograms (Ministerial Action Group on Drugs, 2003). Notably, the location of these seizures shifted, with a growing number occurring within New Zealand rather than at international borders. This trend suggests a concerning rise in domestic methamphetamine production.

While user numbers in New Zealand and Australia appear to be on a downward trajectory since 2011 (United Nations, 2022), wastewater analysis reveals a concerning shift in consumption patterns. Those who continue to use methamphetamine are reportedly doing so with greater frequency and use is present in every community tested throughout the week (New Zealand Police, 2020; NZ Drug Foundation, 2022b). Further complicating the picture, wastewater testing indicates that methamphetamine consumption is higher in towns and regional areas compared to major cities (Price, 2021). Several factors may explain this regional disparity. Clandestine methamphetamine laboratories are often hidden in remote areas to evade law enforcement detection, and criminal gangs may target smaller towns for their operations. Additionally, these regions typically have fewer police resources and face greater socioeconomic challenges, which may make them more vulnerable to methamphetamine use (Price, 2021). This troubling pattern mirrors trends seen in rural communities across Australia and the United States (Banta et al., 2009; Lai et al., 2016).

Over the past decade, the increased supply of methamphetamine across Southeast and East Asia has made the drug more accessible and lowered prices in both Australia and New Zealand (UNODC, 2017). This concerning trend is evidenced by declining methamphetamine prices within New Zealand (Wilkins et al., 2019), raising serious public health concerns. Lower costs are linked to increased consumption and harmful use patterns, especially among vulnerable populations like youth, those with lower socioeconomic backgrounds, and individuals struggling with dependence (Babor., 2018). This concern is amplified by methamphetamine's widespread availability and highly addictive nature, which fuels a

persistent usage pattern. Unlike other drugs, which typically see spikes in use on weekends, wastewater analysis indicates that methamphetamine consumption remains steady throughout the week (Price, 2021). This steady pattern likely stems from the drug's prevalent availability, fuelled by both imports and local production. The concerning aspect of this consistent use is the high dependency rates associated with methamphetamine (Shearer et al., 2002).

Methamphetamine use in New Zealand varies significantly across different demographics. Ministry of Health data (2014; 2016; 2019) indicates that men are two to three times more likely to use methamphetamine than women, with the highest prevalence observed in the 25-44 age group. Additionally, people living in the most deprived neighbourhoods are five times more likely to use methamphetamine than those in the least deprived areas. Māori communities experience disproportionate levels of methamphetamine use and criminalization compared to non-Māori (Mercier & Jarret, 2022). This disparity is rooted in the lasting effects of colonization and systemic racism, which contribute to higher rates of mental health issues, addiction, and poorer health outcomes among Māori (Yasbeck et al., 2022). Consequently, methamphetamine use has a more severe impact on Māori, who also face greater challenges accessing adequate healthcare (Yasbeck et al., 2022). Furthermore, Māori communities grapple with the cultural repercussions of widespread methamphetamine use, and community leaders highlight it as a pressing issue (Yasbeck et al., 2022).

Methamphetamine is the second most commonly used substance in New Zealand, yet according to United Nations qualitative questionnaire reports it is associated with the highest rates of substance use disorders (SUDs), treatment admissions, and injection use (United Nations, 2022). In 2021, methamphetamine offenses accounted for nearly half (51%) of all drug charges in New Zealand (Ministry of Justice, 2021). The New Zealand Drug Foundation estimates that the government spends over four times more on drug law enforcement for all illicit substances than on treatment and support services for SUDs (NZ Drug Foundation, 2022a). Specifically, enforcement costs for police, the Department of Corrections, the Ministry of Justice, and customs range from \$365 to \$410 million per year, while drug addiction treatment services (excluding alcohol) receive about \$93 million (Yasbeck et al., 2022).

Among frequent methamphetamine users in New Zealand, injecting the drug is the most common method of consumption (Yasbeck et al., 2022). Other common ingestion methods

include oral swallowing or smoking, and intranasal consumption (Mcketin et al., 2008). In 2020-2021, methamphetamine was the most injected drug among clients of needle exchanges, accounting for 29% of injections (Yu et al., 2021). The percentage of people injecting methamphetamine increased from 28% in 2006 to 52% in 2016 (Wilkins et al., 2017). Māori clients, particularly those aged 16-24, were more likely to inject methamphetamine than other ethnic groups, with 68% of Māori clients in this age range reporting injection use compared to just 30% of clients aged 50 and older. Injection drug use carries significant health risks, including overdose, infectious diseases such as HIV and hepatitis C, and serious social and economic consequences (Wood et al., 2006).

Understanding the effects of methamphetamine use in New Zealand is essential for both public health and shaping effective policy. Media coverage plays a pivotal role in influencing public perceptions of this issue. Prior to 2002, New Zealand media focused on methamphetamine's rise as a party drug. However, in 2002, the narrative shifted dramatically to emphasise its impact on users, particularly linking methamphetamine to high-profile violent crime (Pates & Riley, 2009). Methamphetamine was identified as a factor in a triple and double homicide in 2002 where both killings were notable for their callous nature and perpetrator history of methamphetamine use (Gower, 2002). In January 2003, methamphetamine was linked to a samurai sword attack leaving two women with their hands severed and another man murdered, culminating in a home invasion and police standoff (Wall & Horwood, 2003). Later that year, in December, methamphetamine was connected to the fatal beating of a 6-year-old child after the perpetrator had been on a five-night binge of methamphetamine (Gardiner, 2003). These incidents significantly influenced public perception, leading to increased media focus on methamphetamine's link to violent crime and its mental health effects (MacLeod, 2003; Zander, 2002). This pattern of media portrayal persists in New Zealand, as seen in recent cases. In 2017, a violent teenager, under the influence of methamphetamine, assaulted a woman, stole her vehicle, and committed a ram-raid on a service station (New Zealand Herald, 2017). During her arrest, she violently resisted, inflicting a severe bite on a police officer. The teenager exhibited no remorse, instead expressing a desire to gain notoriety through imprisonment. More recently, in 2024, the pervasive influence of methamphetamine has emerged in the court proceedings of Philip Polkinghorne, who stands trial for the alleged murder of his wife (Radio New Zealand, 2024). These recurring portrayals in the media

continue to shape how the public perceives the relationship between methamphetamine use and violent crime in New Zealand.

Methamphetamine remains a significant public health challenge in New Zealand, despite a potential decline in user numbers (United Nations, 2022). The drug's easy availability, frequent use patterns, and association with injecting raise serious concerns (UNODC, 2017; United Nations, 2022; Yasbeck et al., 2022). Moreover, the aforementioned disproportionate impact on Māori communities necessitates a multifaceted approach (Mercier & Jarret, 2022; Yasbeck et al., 2022). This comprehensive approach should include culturally appropriate and community-led interventions, such as Māori-centred addiction treatment services, harm reduction strategies, and public awareness campaigns. These efforts are crucial to mitigating the negative consequences of methamphetamine use in New Zealand.

The physical and psychological impact

Consistent methamphetamine use is linked to numerous negative physical health effects. Prolonged and high-dose usage introduces more complex challenges that can lead to the development of a SUD (Haber et al., 2015). Weight loss is a common consequence, often accompanied by sleep disturbances (Darke et al., 2008; Sommers et al., 2006). These persistent sleep issues can lead to a range of health problems, further compounding the toll on an individual's overall well-being. Additionally, oral health is significantly compromised, with dry mouth (xerostomia) and rapidly progressing cavities reported as prevalent issues among methamphetamine users (Hamamoto & Rhodus, 2009; Kaye et al., 2007; Sommers et al., 2006). Cardiovascular problems, including hypertension and increased risk of heart attacks, have also been documented in association with methamphetamine use (Hamamoto & Rhodus, 2009; Sommers et al., 2006). While some physical consequences are well-documented, others are more severe and less frequently cited in the literature. Methamphetamine use has been linked to an increased risk of seizures, convulsions, and, in extreme cases, the potential for fatal overdose (Herbeck et al., 2015; Sommers et al., 2006). These serious physical health risks underscore the urgency of addressing methamphetamine use from both a public health and clinical perspective.

Beyond its impact on physical health, methamphetamine use is associated with a range of psychopathological consequences. High rates of depression, anxiety, and paranoia have been

consistently reported in individuals using methamphetamine (Darke et al., 2008; Sommers et al., 2006). Hallucinations, violent behaviour, and cognitive deficits further contribute to the complex mental health challenges faced by individuals caught in the grip of methamphetamine addiction (Hall et al., 1996; Sommers et al., 2006). Furthermore, there is a correlation between methamphetamine use and an increased incidence of underlying psychiatric disorders, as well as greater utilization of health services (Glasner et al., 2008).

The interplay between physical and psychopathological consequences creates a challenging landscape for healthcare professionals and underscores the need for integrated and multidisciplinary approaches in addressing the health impacts of methamphetamine use. Understanding the intricate connections between physical and mental health can inform targeted interventions aimed at mitigating the comprehensive toll of methamphetamine addiction on individuals and communities.

Beyond the individual: Family impacts of substance use

Substance addiction and misuse are frequently framed as individual issues in both research and treatment, yet their impact extends far beyond the individual, affecting the entire family (Orford et al., 2010; Schultz & Alpaslan, 2020). A family member's substance use significantly affects the family's physical, social, emotional, and financial well-being, often heightening the risk of family violence (Fereidouni et al., 2015; Lander, 2013; Schultz & Alpaslan, 2020). Research shows that these families often face unmet emotional and developmental needs, in addition to struggling with economic hardship (Fereidouni et al., 2015; Lander, 2013).

Estimating the number of families impacted by substance addiction and the extent of the harm is a complex challenge. One method involves considering the prevalence of substance addiction worldwide and adding an average of one impacted family member per individual, although this is likely an underestimation (United Nations, 2019). The 2019 World Drug Report estimated that around 35 million people worldwide suffer from SUDs, with only one in seven receiving treatment (United Nations, 2019). In 2020, 34 million people reported using amphetamines in the past year (United Nations, 2022). This suggests that millions of families worldwide are impacted by substance use, with an estimated 35 million individuals affected and

potentially a similar number of family members experiencing the consequences of addiction and harmful drug use.

Existing research on the impacts of addiction within families has predominantly focused on the partners of men who engage in alcohol abuse (Orford et al., 2013). Much of this research tends to portray the supportive spouse in a negative light, often attributing character defects to them, implying a role in attracting dysfunctional men and facilitating their deviant behaviours (Orford et al., 2013). Similarly, research on parents of young adults with drug problems adopts a critical perspective, holding the parents accountable for perceived inadequate parenting or dysfunction within the family (Orford et al., 2013). Although husbands of women with substance problems have received limited attention, the available research tends to view them negatively, characterizing them as unsympathetic or disinterested in their wives' issues (Orford et al., 2013). The literature review covers this research and the potential impacts on family members in more depth.

Family members of those struggling with addiction often experience significant stress due to erratic behaviour, financial strain, and the ongoing uncertainty surrounding the addiction (Fereidouni et al., 2015; Orford et al., 2010). In addition, the stigma associated with substance abuse prevents many families from seeking help or disclosing the issue, which ultimately hinders both the addict's recovery and the well-being of the family as a whole (Corrigan et al., 2006; McCann & Lubman, 2018a, 2018b, 2018c). Addressing negative perceptions and reducing the impact of stigma is critical for supporting both individuals with addiction and their families. The following literature review will delve deeper into the complexity of these factors.

Seeking recovery: Treatment options in New Zealand

Many methamphetamine users delay seeking treatment, even when they want to reduce their consumption, until they face severe consequences (Halkitis, 2009). This delay is often attributed to the enjoyment of the drug's effects and the development of addiction over time (Jenner & Lee, 2008). Various barriers, including stigma, financial limitations, privacy concerns, lack of information, limited-service accessibility, and insufficient support, can prevent users from accessing treatment (Halkitis, 2009). Additionally, the shortage of

specialized providers and appropriate services further hinders the effectiveness of treatment (Cannon, 2018).

Despite the availability of services in Aotearoa New Zealand to address drug and alcohol issues, methamphetamine users face a significant challenge due to the lack of specialized services and providers (Gordon & Stephens, 2021). The New Zealand government's 2009 action plan established treatment guidelines and created Matua Raki, the national centre for addiction workforce development (Gordon & Stephens, 2021). These guidelines promote the use of modalities used internationally, including the Matrix Model, Contingency Model, and utilising rehabilitation centres for high-dose users (Ministry of Health, 2010). While these guidelines offer a valuable foundation, there is still a need for more comprehensive services and greater public awareness. In response, grassroots initiatives, such as volunteer-run drop-in centres for people in recovery and their supporters, have emerged (Gordon & Stephens, 2021). However, these centres are often overwhelmed, with limited capacity and long waiting lists.

There are a few specialised units to support recovery from methamphetamine. Located in the Hutt Valley near Wellington, Red Door Recovery rehabilitation centre offers the Pipe Down Meth Recovery Programme, tailored to address the unique challenges of methamphetamine addiction (Red Door Recovery, 2018). In Auckland, Higher Ground has an eight-bed capacity and accommodates methamphetamine clients in other funded beds within its broader programme (Gordon & Stephens, 2021). The Higher Ground outcome review (2011–2014) showed promising results, with 94% of clients remaining abstinent after three months and 87% after twelve months (King, 2014). Additionally, Te Whare Oranga Ngakau, a residential alcohol and drug treatment centre in Rotorua, operates within a Kaupapa Māori framework (Māori and Addiction Treatment Services, 2012). The centre offers a 24-hour residential programme with 15 alcohol and drug treatment beds and two methamphetamine-specific beds. Their programme runs for 12 weeks, with extensions available if needed (Māori and Addiction Treatment Services, 2012).

The most used interventions for methamphetamine treatment across six agencies in Aotearoa New Zealand are Te Whare Tapa Whā and Cognitive Behavioural Therapy, followed by harm reduction, motivational interviewing, relapse prevention, behaviour therapy, brief therapy, as well as group and person-centred (Cobzaru, 2010, as cited in Gordon & Stephens,

2021). Increasingly widespread use of Te Whare Tapa Whā highlights its cultural relevance for Māori, aligning with Māori values and cultural identity (Ministry of Health, 2010).

Narcotics Anonymous (NA) follows the 12-step programme of Alcoholics Anonymous (AA) (Welham, 2011). Established in the 1950s in response to the rising opioid crisis in the United States, NA is now the second-largest 12-step programme, with over 58,000 weekly meetings held in 131 countries as of 2010 (Welham, 2011). NA originated when some AA members recognised drug use issues among participants and sought to create dedicated meetings to address these concerns. The first NA meeting was held in California in 1953, marking the beginning of the fellowship that continues today (Budnick et al., 2011; Narcotics Anonymous World Services, 1998). NA was formally established in Aotearoa in 1982, although early efforts to create a recovery community for addicts began in the late 1960s (Welham, 2011). Today, more than 100 NA meetings are held weekly across the country, often in public venues such as libraries, maraes, or council buildings. A key component of NA is sponsorship; this is where experienced members mentor newcomers, providing support through daily, weekly, or as-needed communication (Welham, 2011).

The philosophy of NA emphasises free access to meetings, providing support for individuals seeking to overcome addiction (Narcotics Anonymous, 1986). Currently, there are around 76,000 weekly NA meetings across 143 countries (Narcotics Anonymous World Services, 2022). The only condition for membership is the desire to stop using substances. Key principles include total abstinence, regular attendance, and following the 12 steps to achieve well-being. Although NA meetings are not formal therapy, they rely on the idea that support from fellow members offers therapeutic value (Narcotics Anonymous, 2008). Members share their personal experiences and messages of strength and hope rather than responding to each other's stories (Narcotics Anonymous, 2008).

There is very little support offered routinely for family members in New Zealand. Nar-Anon is a dedicated 12-step programme designed specifically for those impacted by someone else's addiction (Nar-Anon Family Groups, 2014). Nar-Anon New Zealand is part of a global fellowship that includes parents, spouses, children, siblings, and friends of addicts. This programme offers valuable insights to help individuals improve their attitudes, behaviours, and emotions, focusing on regaining personal well-being and mental health. Nar-Anon emphasises

that addiction affects the entire family, and just as the addict needs recovery, family members can also benefit from a recovery programme, and they suggest that participants may find relief in learning more effective coping strategies and finding hope and peace of mind. The group members often share similar experiences of hurt, anger, and anxiety, offering a sense of solidarity and support. The fellowship is filled with people who understand what they are going through and are ready to offer their experiences, strength, and hope to help others. Narateen, a branch of Nar-Anon, is specifically designed for teenagers affected by the addiction of a family member or friend. In specially arranged meetings, teens share their experiences and offer support to one another as they navigate similar challenges (Nar-Anon Family Groups, 2014).

Research rationale

The stigma associated with addiction takes a toll on families, resulting in adverse mental and physical outcomes and fostering a sense of isolation (Barnard, 2006; Condry, 2007; Orford et al., 2013; Sampson et al., 2020). This impact extends not only to the substance user but also to extended family members. It is therefore imperative to conduct further research to delve into the repercussions of methamphetamine addiction on families to understand the effects of this particular drug. Recognising the significant impact of this pervasive stress on families is critical for formulating effective strategies to enhance support for relatives contending with substance use. Additionally, a thorough examination of these stressors can offer valuable insights, facilitating the development of resources that promote the overall health and well-being of family members affected by their relatives' substance use. In consideration of these insights, a sole focus on the substance-using individual in research and treatment neglects the devastating consequences that reverberate throughout the entire family system.

Thus, the primary objective of this research is to fill the gaps in the literature by exploring the impact of methamphetamine addiction on families, with the aim of developing strategies to alleviate the harm and reduce the stigma faced by these families.

Research aims

The main aim was to explore the impact of methamphetamine addiction on women who have supported an intimate male partner with methamphetamine addiction. The inclusion

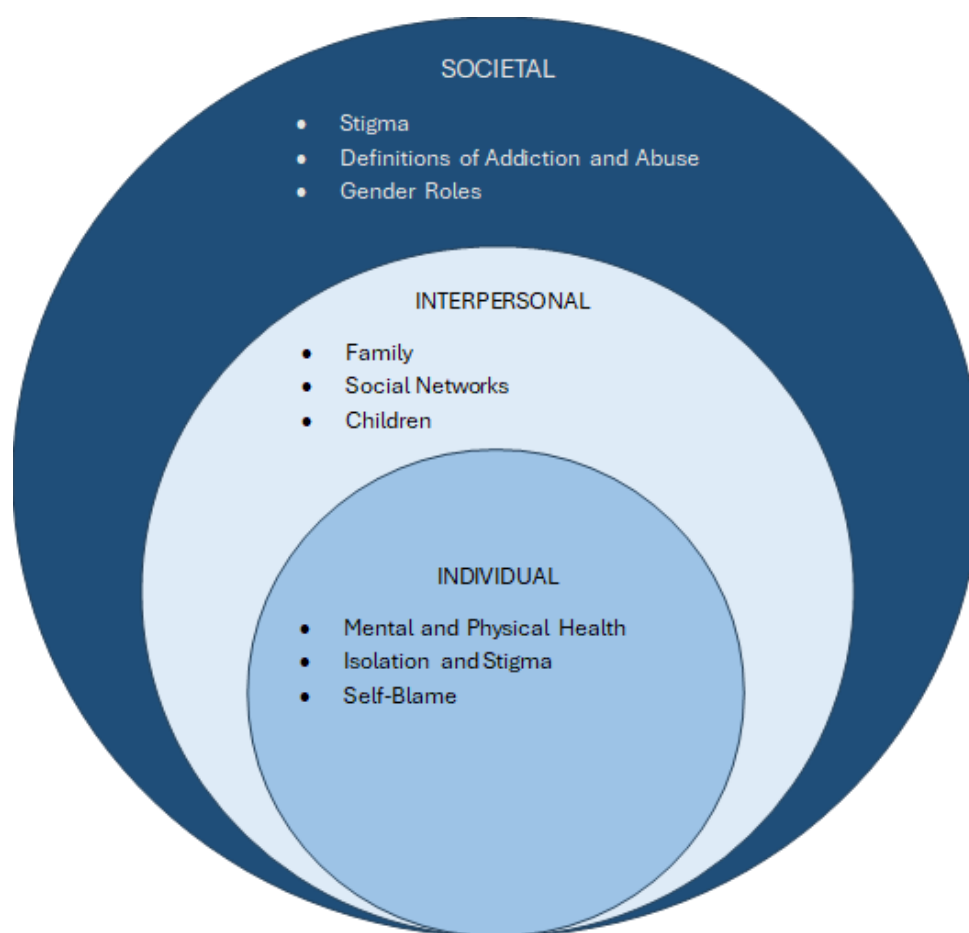
criteria for this research also stated participants had to have shared parenthood with this partner or ex-partner to one or more children.

1. Explore personal impacts including those on mental and physical health.
2. Explore interpersonal impacts including relational impacts on children, family, and friends.
3. Explore the societal factors contributing to the experience including stigma and access to support.

Chapter Two: Literature review

Although limited research specifically explores the qualitative experiences of women whose partners are addicted to methamphetamine, a substantial body of literature examines the broader psychosocial impacts of addiction on families, including partners, children, and extended family members. This review will summarize these broader findings, with a particular focus on studies directly relevant to this research. An ecological framework will guide the organisation of this section, starting at the personal level, expanding to interpersonal and relational factors, and concluding with societal influences to reflect the interconnected nature of these levels. A visual model of this framework is provided below.

Figure 1: Revised Ecological Model Highlighting the Levels of Impact on Supporters



Personal

Evidence consistently shows that family members are significantly impacted by their partner's addiction, regardless of the substance involved, and this holds true across various cultures worldwide (Rane et al., 2017). Family members commonly experience both physical and mental health issues, alongside challenges related to finances, employment, and parenting responsibilities. These impacts underscore the widespread and multifaceted nature of addiction's toll on the family unit.

The emotional burden of addiction on families

Substance use profoundly impacts families, often making them the overlooked victims of addiction. Orford (2017) argues that the closer an individual is to a loved one struggling with

substance use, the greater the emotional burden they experience. Family members frequently endure chronic stress, leading to depression, severe anxiety, and persistent fatigue (Barnard, 2006). Research conducted by Olafsdottir and colleagues (2018) on Icelandic families affected by substance use found that more than a third dealt with depression, anxiety, and stress. Similarly, Dawson et al. (2007) analysed epidemiological data involving over 10,000 married or cohabiting women and found that those with partners exhibiting problematic alcohol use were significantly more likely to develop mood and anxiety disorders. These findings paint a clear picture: substance abuse's impact extends far beyond the individual, leaving a trail of emotional distress within families.

Highlighting the emotional toll on families, Asante and Lentoer (2017) conducted a study in South Africa focusing on mothers of male adolescent methamphetamine users. The mothers reported heightened feelings of panic and anxiety due to the unpredictable behaviour, aggression, and frequent disappearances of their children. A recurring concern was the fear of receiving bad news about their sons' addiction or safety, alongside worries about protecting their other children. These persistent anxieties placed them at considerable risk for developing anxiety disorders and post-traumatic stress disorder (Asante & Lentoer, 2017).

Similarly, women living with partners struggling with substance use experience a wide range of negative effects. Persistent anxiety, loneliness, and emotional exhaustion become defining features of their daily lives, severely undermining their well-being (Dawson et al., 2007; Wells, 2021). Financial difficulties are also common, stemming from hidden spending, job loss, or the partner's neglect of financial obligations (Wells; 2021; Wilson et al., 2018). Trust becomes a battleground as partners scrutinize for signs of relapse while dealing with the emotional toll of past betrayals (Wilson et al., 2018). This cycle of suspicion, combined with a longing for honesty, fosters emotional exhaustion, despair, and even co-dependency within the relationship (Orford et al., 2010; Johannessen et al., 2022). Thus, the impact of substance abuse extends far beyond the individual, creating a complex web of emotional, financial, and relational hardship for those closely involved.

The physical and practical costs of addiction

In addition to the mental health impact, the physical well-being of family members is also significantly affected by living with someone struggling with substance use. Spouses face

numerous challenges, including heightened anxiety, financial strain, and ongoing trust issues (Dawson et al., 2007; Wilson et al., 2018). These stressors can contribute to various physical ailments, such as chronic fatigue, sleep disturbances, and, in severe cases, anorexia (Butler & Bauld, 2005; Orford et al., 1998; Salter & Clark, 2004). Families also report suffering from long-term conditions, including high blood pressure, digestive issues, and tension headaches (Salter & Clark, 2004). Additionally, disruptions in sleep patterns, changes in dietary habits, and increased reliance on substances—such as smoking or prescribed medications—are frequently reported among family members (Orford et al., 2013). Other physical symptoms include anaemia, back pain, asthma, heart palpitations, migraines, and diarrhoea (Orford et al., 2013). My honours research found that spouses experienced profound sleep disruptions, leading to extreme exhaustion (Wells, 2021), which resulted in serious health consequences, including fainting, hair loss, weight loss, and dental issues due to inadequate nutrition.

Johannessen et al. (2022) found in a qualitative study varied physical responses among participants who had lived with an affected family member for an extended period, including feelings of exhaustion, fatigue, self-harm, eating disorders, and post-traumatic stress disorders. Importantly, these observations resonate across diverse cultural contexts, as evidenced by consistent reports from countries such as Finland, the United States, the Czech Republic (formerly Czechoslovakia), and South Korea (Student & Matova, 1969; Wiseman, 1991; Yang, 1997). This effect has been shown in a range of addiction substances including alcohol (Caswell et al., 2011; Laslett et al., 2010). These findings highlight the far-reaching consequences of addiction, demonstrating its ability to negatively impact the physical health of not just those struggling with the addiction but also those around them, even outside the immediate family unit.

Parents are another population affected by a child's substance use, often enduring severe physical and emotional health challenges as a result (Smith & Estefan, 2014). The emotional impact extends beyond the immediate family, with mothers of addicted sons frequently reporting heightened fear and anxiety (Asante & Lentoer, 2017). Many parents develop health issues linked to the stress of raising a child with SUDs (Mathibela & Skhossana, 2019; Orford et al., 2010). Common stress-related conditions include high blood pressure, chronic headaches, and disrupted sleep patterns (Smith & Estefan, 2014). The constant worry about their child's

behaviour and lifestyle imposes considerable emotional and physical strain on parents. As Teater (2014) highlights, the effects of substance abuse permeate multiple areas—biological, psychosocial, health, and social—impacting not only individuals but also their families. In response to these challenges, many caregivers turn to support groups, therapy, or self-care practices as coping mechanisms to manage the ongoing stress.

The silence of stigma: Family isolation in addiction

Due to the stigma associated with addiction, family caregivers supporting loved ones in active substance use often find themselves isolated from their social support systems (Condry, 2007; Sampson et al., 2020). Fearing judgement and disapproval, they may withdraw and become consumed by managing the addiction, hindering their ability to establish new connections (Cornille & Boronto, 1992; Fathi et al., 2020). This social isolation can manifest in many ways within family dynamics. Hudson et al. (2014) found that women married to partners with alcohol use disorder experienced significant difficulties adjusting to social situations. Participants reported difficulties at work, including impaired performance and strained relationships with colleagues, withdrawal from social and leisure activities, and increased dysfunction within their families. The fear of gossip, embarrassment, and unpredictable behaviour from the addicted relative further exacerbated social withdrawal (Fathi et al., 2020; Joolae et al., 2014; Orford et al., 2013; Straussner & Fewell, 2011).

Parents, particularly mothers, often feel hesitant to leave their substance-using child alone, adding another layer of isolation to their lives (Orford et al., 2010; Wells, 2021). Despite being in relationships, they frequently feel solely responsible for their children due to concerns about trust, financial support, and safety (Wells, 2021). This isolation, while detrimental, becomes a coping mechanism to avoid the sting of stigma—a stark reminder that while support systems are crucial, they remain out of reach due to societal attitudes. Ironically, research shows the significant role families can play in aiding recovery (Avery & Avery, 2019).

Families grappling with substance abuse often experience a paradoxical loneliness despite being surrounded by loved ones. This contradiction arises from their conflicting desires for privacy and the urge to share their struggles (Lindeman et al., 2022). Lindeman and colleagues (2022) found that families described the daunting challenge of discussing addiction, likening it to walking a precarious tightrope. While they yearn for relief and support, the

pervasive fear of further damaging their fragile familial bonds looms large (Werner & Malterud, 2016). As one participant described, it was a catch-22 situation—speaking openly risks tearing the family apart, yet the suffocating silence feels hopeless (Lindeman et al., 2022). This fear of exacerbating family breakdown manifests as intense silence within the home, leaving members emotionally distant and grappling with their burdens in solitude (Lindeman et al., 2022). Schultz and Alpaslan (2020) and Wells (2021) found that supportive partners view secrecy as a coping mechanism, resorting to deception and fabricating excuses to maintain an illusion of normalcy, particularly to preserve the family unit. This isolation intensifies feelings of loneliness and despair, perpetuating a vicious cycle.

To cope with the stigma surrounding addiction, families often resort to secrecy (Arcidiacono et al., 2009), striving to uphold a positive public image while fearing judgement from peers and extended family (Lindeman et al., 2022). Keeping secrets becomes a survival strategy, a desperate attempt to shield themselves from shame (Wells, 2021). The repercussions of this isolation are extreme. Families lose access to the support systems they desperately need during such trying times. The silence prevents them from reaching out to friends, support groups, or therapy, perpetuating the cycle of loneliness and despair. Combating stigma is essential to ensure families receive the support they desperately need.

The weight of self-blame

One of the most insidious consequences of addiction is the profound sense of responsibility and self-blame it often fosters within family members. Studies reveal a heartbreaking pattern of loved ones internalizing guilt for the addict's behaviour (Asante & Lentoor, 2017; Peled & Sacks, 2008; Wilson et al., 2018).

Parents, for instance, may struggle with feelings of guilt, believing they are somehow responsible for their child's addiction (Asante & Lentoor, 2017). In Asante and Lentoor's study, mothers of sons addicted to methamphetamine reflected on how they might have overindulged their children, offering excessive material possessions and feeling personally responsible for the outcome. These feelings extend beyond parenting doubts, with some parents regretting past decisions and wishing they had been more positive role models for younger children (Asante & Lentoor, 2017).

This sense of responsibility extends to partners of individuals struggling with addiction, who often feel a similar burden. Many partners describe taking on caregiving roles, feeling an overwhelming duty to manage the situation, but this often leads to guilt and self-blame for making things worse (Wilson et al., 2018; Wells, 2021). Peled and Sacks (2008) found that female partners of alcoholics experienced immense self-blame for their loved one's drinking, compounded by feelings of helplessness, sadness, anger, and a diminished sense of self-worth.

These studies highlight the emotional toll addiction inflicts on families. The burden of responsibility and self-condemnation can be overwhelming, undermining self-worth and straining familial relationships. It is crucial to recognise that addiction is a multifaceted disease, and loved ones are not at fault. Rather than shouldering blame, their focus should be on prioritising their own well-being and seeking professional assistance to navigate this challenging journey.

Interpersonal

The negative impact of addiction extends beyond the individual, affecting partners, children, and extended family members. Substance abuse disrupts family cohesion, fragments communication, and reduces the ability to adapt to changing circumstances (Shamsaei et al., 2019). Research also highlights feelings of abandonment, anxiety, fear, anger, concern, embarrassment, and guilt among family members (Shamsaei et al., 2019). Additionally, significant differences have been observed in families regarding somatization, interpersonal sensitivity, depression, anxiety, and phobias, further demonstrating the broad psychological toll of addiction on the family unit (Shamsaei et al., 2019). The interpersonal costs of addiction highlight how the behaviour of an addicted family member can strain finances, breed violence, and erode trust within the household. This broad impact is explored below in terms of finances, violence, grief, family systems, and the effects on children.

Financial and violent burdens of addiction

Caring for a loved one struggling with addiction places a significant burden on family members, extending beyond emotional stress to include considerable financial strain. For

example, in a study on male adolescent methamphetamine users in South Africa, mothers reported that their sons' habitual stealing drained family resources and led to job losses (Asante & Lentoer, 2017). Furthermore, much of their sons' income was spent on methamphetamine, limiting their ability to contribute to household expenses (Asante & Lentoer, 2017). Caregivers, including mothers and grandmothers, often felt manipulated and blackmailed, unsure of how to respond to requests for money (Orford et al., 2010).

For spouses supporting an addicted partner, financial challenges, job instability, and housing insecurity are common (Fathi et al., 2020). One participant in my honours research highlighted the financial strain, sharing that they couldn't afford to meet friends for a coffee or participate in social outings due to lack of funds, deepening their isolation (Wells, 2021). Conflicts over finances and possessions often arise, including scenarios such as buying items for the addicted relative only to see them sold for quick cash, theft of household items with sentimental or monetary value, failure to pay rent or contribute to the family budget, or the addicted individual taking control of family finances, leaving the primary caregiver financially vulnerable (Orford et al., 2010).

The emotional and financial stress of living with a person prone to unpredictable mood swings stressful for family members (Fereidouni et al., 2015; Lewis, 2018; Mitchell & Burgess, 2009; Weimand et al., 2020). Research has shown a significant correlation between SUDs and an increased likelihood of domestic violence, which can affect both children and spouses (Donohue et al., 2006; Freisthler et al., 2017; Gruber & Taylor, 2006; Hartley, 2002). Johnson (2004) suggests that common couple violence often stems from relational dissatisfaction or past grievances, with severity ranging from mild to moderate. Even in the absence of physical violence, increased aggression, irritability, verbal abuse, and domineering behaviour are prevalent (Orford et al., 2010). In extreme cases, this aggression escalates to physical altercations and property damage (Orford et al., 2010). The presence of addiction fosters a toxic environment within families, jeopardizing the safety and well-being of all members.

Grieving the living: The hidden pain of addiction

Grief is a common experience for family members supporting a loved one through addiction. Much of the current research examines either the grief experienced by individuals using alcohol or other drugs, or the experiences of families grieving the death of a

person who used drugs (Field, 2014; Sampson et al., 2020). However, there is a need for further investigation into the grief that can arise while a person using drugs is still alive. Emerging concepts like ambiguous loss and disenfranchised grief offer valuable insights into the unique challenges faced by families dealing with addiction (Boss, 2010; Sampson et al., 2020). This discussion explores these concepts and examines their relevance to the experiences of those affected by addiction.

Boss (2010) defines ambiguous loss as a state where a part of a person remains present, while another part is definitively lost. This manifests in several ways. An individual might be physically absent but psychologically present, as is common with missing persons. Conversely, they might be physically present but emotionally distant due to various conditions like dementia, mental illness, or substance abuse disorders (Boss, 2010). In the context of substance use, emotional distance may emerge as a result of personality changes, cognitive decline induced by substances, or a breakdown in communication and trust (Boss, 2010). This type of loss presents a unique challenge – the loved one remains physically present in the family unit, yet their true essence seems lost or obscured by the addiction (Sampson et al., 2020).

Another important concept is disenfranchised grief (Attig, 2004; Bailey, 2018; Simpson, 2013). Disenfranchised grief arises from societal norms and perceptions that dictate the perceived legitimacy of certain losses to be openly mourned (Sampson et al., 2020). Individuals experiencing such losses may be inadvertently denied the acknowledgement or validation of their grief due to cultural expectations surrounding the significance of the loss (Sampson et al., 2020). In the context of substance use, the stigma associated with addiction can contribute to feelings of disenfranchisement, leaving family members struggling to express their grief openly for fear of judgement or dismissal (Sampson et al., 2020).

Sampson et al. (2020) explored ambiguous loss in families affected by methamphetamine use revealing a consistent theme of loss among participants. Families described a profound sense of loss for the person their loved one once was, highlighting the dramatic personality shifts and behavioural changes brought on by substance use. This grief extended to the future, encompassing shattered dreams and aspirations – both for the individual and the family unit. Participants mourned the unrealised potential of their loved one's life, fearing their ability to maintain a healthy and fulfilling future (Sampson et al.,

2020). Additionally, families noted a disconnect between the past persona of their loved one and their current addiction-driven identity, further deepening feelings of ambiguous loss.

The frameworks of ambiguous loss and disenfranchised grief illuminate the intricate and frequently unrecognised experiences of families confronting addiction. Acknowledging these distinct forms of grief is a critical first step in developing appropriate support systems and fostering open communication within families navigating the challenges of SUD.

Family and social support networks

Family Systems Theory, or the family system model, emphasises the interconnectedness between family members and the influence of external systems on family dynamics (Ólafsdóttir, 2020). He conceptualized the family as a complex system of emotional and relational subsystems, positing that symptoms—whether emotional, physical, or social—are often adaptive responses to shifts within the family dynamic (Metcalf, 2023). The addiction of one family member therefore can be viewed as a symptom that impacts the entire family unit. This perspective underscores the need to understand addiction not merely as an individual problem but as a multifaceted issue that profoundly impacts family dynamics.

The impact of addiction often radiates beyond the immediate family, disrupting extended family relationships and contributing to intergenerational stress. Studies on families dealing with methamphetamine addiction illustrate this ripple effect, showing that addiction can intensify existing conflicts and create new tensions. For example, Asante and Lentoor (2017) documented frequent disagreements among parents over how to handle their child's addiction. In some cases, the aggressive behaviour associated with substance use led to confrontations with siblings and other relatives, fracturing family unity (Asante & Lentoor, 2017). Research highlights how addiction may introduce or exacerbate violence within the family, with reports of verbal abuse, aggression, and physical violence as common challenges faced by family members (Sampson et al., 2020). These findings underscore the pervasive disruptions addiction can bring into the family environment, affecting safety, trust, and cohesion.

Beyond the immediate challenges of managing addiction-related behaviour, partners often grapple with complex dynamics within the broader family network. These dynamics may include feeling pressure from their own families to abandon the relationship with the person

struggling with addiction, as well as encountering judgement or conflicting advice on how to handle the situation (Wilson et al., 2019). Wilson and colleagues (2019) found that such partners often feel isolated, lacking support and acknowledgment from the extended family, which can further hinder their efforts to provide meaningful help. This isolation is compounded when family members do not recognise the severity of the addiction or when they show a perceived bias toward the person struggling with substance use (Wilson et al., 2019).

Many supporters' express uncertainty about managing the wide-ranging effects of addiction, citing a lack of information and resources as a significant barrier (Kane, 2020). Nebhinani et al. (2013) found that caregivers not only face emotional challenges but also bear financial burdens due to treatment costs and other addiction-related expenses. In Kane's (2020) research, caregivers frequently voiced frustration over the limited public understanding of addiction, which often prevents family and friends from providing meaningful support. Additionally, caregivers reported dissatisfaction with healthcare support, noting that many primary care providers lacked the necessary training to address addiction adequately. Over one-third of participants (Kane, 2020) encountered barriers to accessing care, including lack of information, cost, availability, privacy restrictions, and stigma. When services were available, privacy laws often limited caregivers' access to critical information about their loved one's condition, further complicating their ability to offer appropriate support.

Emotional support, which bolsters self-worth and identity, is crucial for supporters (Caplan, 1974; Toner, 2009). Kane's (2020) study found that 34% of respondents reported receiving constructive emotional support—through listening, offering advice, showing respect, and validating decisions. This type of support was valued most when provided without judgement or fear. However, slightly more respondents (35%) indicated receiving little to no emotional support, describing experiences of misunderstanding from family, friends, and healthcare providers, as well as receiving negative comments or unhelpful advice on how to manage the situation (Kane, 2020). This lack of support can negatively affect caregivers, diminishing their self-worth and eroding their sense of identity (Caplan, 1974). These findings underscore caregivers' need for increased social support, access to accurate information, and empathetic understanding (Caplan, 1974; Kane, 2020). Additionally, supporters express the importance of healthcare professionals being adequately educated about addiction, as well as

the need for affordable, reliable, and effective treatment options for their loved ones (Caplan, 1974; Kane, 2020).

Children affected by parental substance use

The devastating impact of SUDs profoundly affects families, particularly children within the household. Data from the National Surveys on Drug Use and Health paints a concerning picture, revealing that a staggering 8.7 million children aged 17 or younger in the US were exposed to substance use within their homes between 2009 and 2014 (Lipari & Van Horn, 2017).

Research by Velleman and Templeton (2003) underscores the long-lasting effects of growing up in such households. Children exposed to addiction in the family often face emotional, behavioural, and educational challenges that can persist into adolescence and adulthood. These adolescents are more prone to early initiation of alcohol or drug use. While some may develop excessive substance use patterns as young adults, the majority do not follow the same path as their parents. Instead, they found, many become abstainers or light drinkers, although they may be more likely to engage in heavy smoking. Living with a parent struggling with addiction can lead to emotional, behavioural, and educational difficulties during childhood and adolescence. The constant turmoil and dysfunction can lead to maladaptive coping mechanisms such as avoidance, shutting down emotionally, self-blame, or feelings of guilt (Velleman & Templeton, 2003). These experiences can have long-lasting impacts on the mental and emotional well-being of the children as they navigate their formative years and beyond.

Insecure attachments and behavioural concerns are common among children living with an addicted parent. Schultz and Alpaslan (2020) found that the emotional distance between children and their parents struggling with substance use can lead to a lack of meaningful connections, as these parents may fail to fulfil the role of a warm and reliable caregiver. This lack of connection stems from the parent's failure to fulfil the crucial role of a positive role model, one who provides essential warmth, security, and care. Consequently, children of parents with SUDs are susceptible to a spectrum of adverse emotions, such as guilt, self-blame, embarrassment, helplessness, anger, and anxiety (Copello et al., 2005; Lander et al., 2013).

Parental concerns about the effects of addiction on children extend beyond the physical risks of substance use to the emotional and psychological impacts of exposure to a chaotic and hostile environment. Research by Wilson et al. (2019) highlights that supportive partners often express significant worries about their children's well-being, noting instances of verbal abuse, loss of temper, and belittling behaviours from the parent struggling with addiction. These partners feel heightened anxiety over their children's safety, especially when the parent with substance use issues is left alone with the children, creating a deeply unsettling environment that can lead to long-term distress for the young ones. Children exposed to such environments often display signs of emotional distress, either by acting out through argumentative behaviour or by concealing their true emotions to create a semblance of normalcy. In extreme situations, some children may even choose to leave home as an escape from the toxic atmosphere (Wilson et al., 2019). One significant concern among parents is the possibility that their children may adopt similar unhealthy coping mechanisms, as children often model behaviours observed from their caregivers (Catalano & Hawkins, 1996). This worry adds to the stress parents feel, as they fear that their actions may inadvertently teach their children maladaptive responses to stress.

Parental conflict exacerbates these issues, with children witnessing frequent, heated arguments filled with yelling, insults, and a hostile atmosphere (Wilson et al., 2019). Such exposure can be damaging to a child's sense of security, leading to anxiety, depression, and behavioural problems (Grych et al., 2004). In cases where abusive behaviour is directed at a partner in front of children, the psychological impact is even more profound, influencing a child's future ability to form healthy relationships and regulate their emotions (Barrett et al., 2016). This ongoing exposure to conflict and aggression can hinder a child's emotional development and leave long-lasting effects that extend into their adult relationships, underscoring the need for interventions to protect and support children in these challenging family situations.

Foster and Macchetto's (1999) study revealed a concerning trend, with children of parents who abuse alcohol and drugs three times more likely to experience abuse and over four times more likely to suffer neglect compared to their counterparts in non-substance-abusing families. These disparities extend beyond the realm of physical harm. Peleg-Oren and Teichman's (2006) research indicates that children of parents with substance disorders often

contend with lower socioeconomic status and encounter more challenges in academic, social, and family functioning compared to their peers. Furthermore, many of these children take on caretaking responsibilities for their parents and siblings, all while grappling with the profound effects of stigma associated with their home environment (Avery & Avery, 2019).

The detrimental effects of substance use extend beyond the substances themselves. The dangers faced by children in homes where methamphetamine or other drugs are manufactured are concerning. Methamphetamine production frequently occurs within private residences, exposing children to the hazardous manufacturing processes. Messina et al. (2014) observed a disturbing increase in the number of children brought to emergency rooms due to such exposures, highlighting a critical public health concern. A report by the National Drug Intelligence Centre (Horton et al., 2003) reinforces this concern, highlighting that over 2,000 children were found at locations where clandestine methamphetamine laboratories were seized. Worryingly, 35% of these children tested positive for harmful chemical levels. The report outlines the direct hazards faced by these children, including inhalation of toxic fumes and burns from chemicals, alongside indirect risks such as neglect, malnutrition, and abuse (Horton et al., 2003). Additional challenges include neglect by caregivers who are preoccupied with drug production, exposure to dangerous weapons, and the heightened risk of sexual abuse. The physical health consequences for children in such environments are equally concerning. Symptoms include respiratory distress, agitation, hyperactivity, gastrointestinal issues, chemical burns, potential brain damage, headaches, and skin and eye irritation (Irvine et al., 1997; Messina et al., 2014). Kolecki's (1998) review of paediatric patients accidentally poisoned with methamphetamine revealed common presentations such as tachycardia, agitation, inconsolable crying, irritability, and vomiting. These findings underscore the heightened vulnerability of children, particularly infants and toddlers who are heavily reliant on their caregivers for safety and well-being.

These statistics encompass a wide range of physical, emotional, social, and academic challenges. Recognising the at-risk status of children in families affected by substance use is crucial for the development of effective intervention strategies and support systems. Early

intervention may help mitigate the negative impacts of parental addiction and promote positive outcomes for vulnerable children.

Societal

Supporting a family member with addiction is further complicated by broader community and societal issues.

Stigma

Stigma significantly impacts individuals with SUDs and their families. While the term is widely used, its definition varies. Goffman (2009) describes stigma as an attribute that deeply discredits a person, reducing them to a diminished version of themselves. Building on this, Link and Phelan (2001) emphasise that stigma labels, stereotypes, socially separates, lowers status, and discriminates, often arising within unequal power structures. In addiction contexts, stigma can be categorized into several types:

1. **Public Stigma:** Negative societal attitudes and beliefs about individuals with addiction (Avery & Avery, 2019).
2. **Self-Stigma:** Internalisation of societal negativity by those with addiction, resulting in shame and reduced self-esteem (Matthews et al., 2019).
3. **Stigma by Association:** Stigma experienced by family members due to their relationship with the person struggling with addiction (Goffman, 1963; Larson & Corrigan, 2008).
4. **Structural:** Manifestation of stigma on a systemic level within systems such as housing, law or education (Hemeida & Goldberg, 2022).

Public Stigma

Public stigma, characterized by negative attitudes and beliefs towards individuals with SUDs (Avery & Avery, 2019), often stems from misconceptions that label them as selfish, lacking willpower, or dangerous (Room, 2005; Keyes et al., 2010). These misconceptions significantly impact the physical, psychological, social, and professional well-being of those

affected (Avery & Avery, 2019). Major and O'Brien (2005) emphasise the psychological toll of stigma, noting that it creates unique stressors and emotional distress, primarily due to the loss of social status experienced by individuals facing such judgement. This stigma intensifies the marginalization of individuals with addiction, surpassing the stigma faced by those with mental illnesses or physical disabilities (Corrigan et al., 2009). Alcohol dependence, in particular, attracts heightened stigma (Keyes et al., 2010), with perceptions of blame and dangerousness increasing social exclusion and creating significant barriers to seeking treatment (Corrigan et al., 2009).

Self-Stigma and the Psychological Toll

Self-stigma occurs when individuals internalize society's negative perceptions, resulting in harmful self-views and feelings of shame (Avery & Avery, 2019). Matthews et al. (2019) found that internalized stigma can perpetuate substance use, as individuals may turn to drugs or alcohol to cope with overwhelming emotions. Shame plays a pivotal role in this cycle, with research showing that guilt often exacerbates substance use (Flanagan, 2013; Lewis, 2017). This creates a vicious cycle, where substance use fuels self-blame, making recovery even more difficult.

Research underscores the disproportionate burden of addiction stigma on individuals with SUDs. Compared to those with mental illnesses or physical disabilities, individuals with addiction experience even greater social exclusion and marginalization (Corrigan et al., 2009). Alcohol dependence, in particular, carries a more intense stigma than many other mental health conditions, compounding the challenges faced by those seeking help (Keyes et al., 2010).

Stigma by Association: The Impact on Families

Families of individuals with SUDs endure stigma by association, facing societal judgement and blame for their loved one's addiction (Goffman, 1963; Larson & Corrigan, 2008). This stigma diminishes the family's social status and triggers feelings of shame, guilt, and social withdrawal (McCann & Lubman, 2018). Condry's (2007) concept of contamination illustrates how society unfairly holds family members accountable for the actions of their loved ones. Family members often lose respect and status, facing unjust blame and perceptions of perpetuating the problem (Corrigan & Miller, 2004). Additionally, they may be viewed as

contaminated or less capable, and experience deeper shame compared to families dealing with other mental health challenges (Corrigan et al., 2006; McCann & Lubman, 2018).

Social Stigma and Isolation

The interplay of public, self, and associative stigmas drives individuals with addiction and their families into social isolation. Facing judgement, families often hide their circumstances, which worsens their mental and physical well-being (Room, 2005). Orford et al. (2010) emphasise that the shame linked to addiction severely restricts family members' social lives, discouraging them from seeking help or sharing their struggles. This secrecy prolongs isolation, amplifying distress throughout the family unit.

Barriers to Help-Seeking and Long-Term Consequences

Stigma poses a significant barrier to individuals and families seeking professional support. Supporters indicate that stigma—whether experienced directly, perceived, or anticipated—discourages them from accessing assistance from healthcare professionals, social networks, and even their own families (Sampson et al., 2020; Wilson et al., 2019). Fear of judgement further complicates help-seeking, leading many supporters to avoid available resources (Sampson et al., 2020; Wilson et al., 2019). Additionally, stigmatizing laws and punitive policies prioritise punishment over rehabilitation, intensifying these challenges (Hemeida & Goldberg, 2022). For instance, San Francisco County permits employers to terminate employees based on past substance use, even when they are sober (Hemeida & Goldberg, 2022). Keyes et al. (2010) argue that the pervasive societal belief of once an addict, always an addict, reinforces stigma, prolonging social exclusion even after recovery. This enduring stigma undermines one of the most powerful motivators in recovery: support from family.

The evolving understanding of addiction: From moral failing to chronic disease

The stigma surrounding addiction, intensified by the criminalization of drug use, shapes public and institutional responses, reinforcing the belief that punitive actions, rather than medical interventions, are the primary solution to addiction (Avery & Avery, 2019). This perspective persists despite clear evidence: punitive approaches are ineffective, and the criminal justice system is not suited for addiction recovery (Duncan et al., 2014). For over 50 years,

policymakers have staunchly supported the aggressive ‘war on drugs’, allocating more funding to punitive measures than to expanding treatment options (Avery & Avery, 2019; Lopez, 2017). This emphasis on punishment is particularly concerning considering the high prevalence of addiction within prison populations, with estimates suggesting that half of all prisoners in the United States meet criteria for drug dependence (Karberg & James, 2005; Mumola & Karberg, 2007). Furthermore, despite evidence that addiction is a treatable medical condition, the vast majority of drug arrests involve possession, not sale or manufacture (Glaze & Boncar, 2002; Avery & Avery, 2019). While a sizeable portion of the prison population struggles with addiction, only a small fraction receives treatment. Estimates suggest that 80-85% of prisoners who could benefit from drug abuse treatment go without it (Karberg & James, 2005; Mumola & Karberg, 2007). This lack of access to treatment significantly hinders their chances of recovery and successful reintegration into society.

The case of Portugal offers a compelling example of the success of alternative approaches (Ford & Bressan, 2014; Hughes & Stevens, 2010). Following decriminalization in 2001, Portugal prioritised treatment and harm reduction, leading to positive outcomes. Hughes and Stevens (2010) report a decrease in drug-related deaths, lower HIV transmission rates, and an increase in individuals seeking treatment – all following decriminalization. Portugal's success is echoed in other European nations like Belgium, Germany, and Spain, which have adopted some form of decriminalization (Ford & Bressan, 2014).

The National Institute on Drug Abuse (2020) promotes a biomedical model of addiction, which conceptualizes addiction as a chronic, relapsing brain disease characterized by compulsive drug-seeking behaviour despite negative consequences. This model emerged as a counterpoint to earlier perspectives that viewed addiction as a moral failing, advocating for a shift towards treatment within the medical framework rather than punishment within the criminal justice system (Pickard et al., 2015). However, the effectiveness of the biomedical model in reducing stigma surrounding addiction remains a subject of debate. While the model aims to destigmatize addiction by framing it as a medical condition akin to diabetes or asthma (Heather et al., 2018), the terminology of disease can itself be stigmatizing (Hammer et al., 2012). Some individuals report feeling labelled as having ‘weak genes’ or battling a ‘filthy’ condition, suggesting a potential for the stigma to simply shift form. Furthermore, critics argue

that the disease model undermines personal responsibility, a crucial element for successful recovery (Davies, 1998; Walker, 2010).

Recent advancements in addiction research have introduced models that integrate both individual life experiences and broader social influences. One such model, proposed by Maté (2012), emphasises the role of stress-response mechanisms. Maté posits that adverse childhood experiences and trauma can alter the functioning of brain regions responsible for attachment, reward processing, motivation, and self-regulation, leading to maladaptive responses to stress in adulthood (2012). Building upon this foundation, Lewis (2017) offers a neuroplasticity model, portraying addiction as a learned habit reinforced by intense motivation and shaped by past experiences, particularly those rooted in childhood adversity. Lewis likens addiction to Pavlovian conditioning, where repeated drug use becomes a deeply ingrained habit due to the powerful reinforcement it provides. This pattern of learned behaviour often coincides with personality traits cemented by early negative experiences, leading individuals to seek external sources of comfort and relief (Lewis, 2017).

Neuroscience offers an alternative framework for comprehending addictive behaviour, contrasting with the perspective of moral weakness often implied by the justice system (Kosten, 1998). By uncovering the neurological underpinnings of addictive behaviour, we gain a more rational understanding because it shifts the focus from moral judgment to the biological processes that drive addiction. Neuroscience shows that addiction involves changes to brain mechanisms involved in decision-making and reward processing, explaining why individuals with SUDs may engage in compulsive behaviour despite negative consequences (Chandler et al., 2009). This does not absolve individuals with SUDs of responsibility for any illicit actions but rather illuminates how addictive substances impact brain mechanisms involved in decision-making (Chandler et al., 2009). The persistence of neurologic impairments in addiction underscores its classification as a chronic disease, emphasizing the need for ongoing care similar to the treatment approach for other chronic illnesses, such as asthma or hypertension (Baler & Volkow, 2006).

When addiction is framed as a criminal issue, the burden falls heavily on families (Avery & Avery, 2019; Duncan et al., 2014). This perspective fosters shame and secrecy, hindering open communication and delaying intervention (McCann & Lubman, 2018). Families

become isolated, fearing judgement and legal repercussions (Orford et al., 2010; Room, 2005). Instead of focusing on supporting their loved one's recovery, they grapple with the emotional and financial strain of addiction-related problems (Asante & Lentoor, 2017; Fathi et al., 2020; Orford et al., 2010). This misplaced emphasis on punishment creates a lose-lose situation, neglecting the health of the individual and inflicting significant hardship on their support system (Karberg & James, 2005; Mumola & Karberg, 2007). Newer models, such as those proposed by Lewis (2017) and Maté (2012), shift the focus by emphasizing individuals' agency and capacity for change. These approaches recognise the interplay between individual experiences and social determinants of addiction, offering a more holistic understanding. This shift in perspective is crucial for dismantling the stigma surrounding addiction and fostering a public health approach that prioritises support and evidence-based interventions over punishment.

The intersection of addiction and domestic violence

Substance abuse and intimate partner violence (IPV) often intersect, particularly in family settings, creating complex challenges for individuals struggling with addiction and their loved ones (Chermack et al., 2008; Lipsey et al., 1997). Societal perceptions of trauma and abuse, along with the nuanced ways these issues intersect, further complicate efforts to understand and address them effectively. Recognising the interplay between IPV and substance abuse is essential for developing more comprehensive approaches to intervention and support.

While substance abuse and IPV frequently co-occur (Chermack et al., 2008; Lipsey et al., 1997), their connection is not always straightforward. While severe addiction frequently leads to family conflict, it does not guarantee an escalation to domestic violence (Orford et al., 2013). Similarly, domestic violence is strongly linked to excessive alcohol, cocaine, or other substance use, but it can also occur in families where there are no such dependencies (Orford et al., 2013). This highlights the complexity of the issue, where both problems can influence each other, but neither is solely dependent on the other.

Supporting someone battling substance abuse can be incredibly challenging, often involving struggles with IPV (Petra, 2020). IPV is a pattern of controlling behaviours aimed at dominating a partner. This can manifest as physical, sexual, or psychological abuse, often accompanied by attempts to control the partner's finances, time, behaviour, and social

interactions (Pokman et al., 2014; Tanha et al., 2010). The prevalence of such violence is particularly high among drug users, possibly linked to their disproportionately high rates of past trauma (Cohen et al., 2003; Edalati & Krank, 2016). This underlying trauma can create a vicious cycle, where substance abuse fuels violence and past abuse contributes to addiction.

Research reveals a troubling trend: most individuals entering treatment for methamphetamine dependence report experiencing past or current intimate partner violence (IPV) as part of their lifestyle, including perpetrating violence themselves (Cohen et al., 2003). Problems with spouses and intimate relationships are often cited as one of the most apparent issues among drug treatment programme respondents (Sommers et al., 2006). Moreover, men in substance treatment centres show far higher rates of IPV perpetration than the general population (O'Farrell et al., 2003; Radcliffe & Gilchrist 2016). A study on IPV victims found that perpetrators were more likely to use alcohol and methamphetamine, revealing a troubling link between substance use and IPV (Ernst et al., 2008). Many children, unfortunately, witness these violent episodes, facing long-term impacts on their mental health, including increased risks of anxiety, depression, and future substance use (Ernst et al., 2006; Ernst et al., 2007; Kernic et al., 2003; McCloskey et al., 2005). This experience often perpetuates a cycle, where children raised in violent homes may develop substance abuse issues, increasing their risk of IPV in adulthood.

The impact of IPV particularly affects women. A South African study on methamphetamine users showed a gender imbalance in IPV, with women more frequently experiencing violence from male partners. While both genders reported irritability and aggression linked to methamphetamine, the study found that women often used violence in self-defence, highlighting the complexities of abuse in these relationships (Watt et al., 2017). This gender disparity is further supported by statistics from Iran (Fathi et al., 2020). Here, addiction-related issues are a leading cause of divorce, often cited by women as the primary reason for separation. These findings emphasise the devastating impact of addiction on families, particularly for women who may face violence and choose to leave the relationship.

Despite the strong link between substance abuse and IPV, current drug policies often overlook this connection. Instead, policies focus on criminal behaviour, social disorder, and label affected families as troubled or toxic (Radcliffe & Gilchrist, 2016). Treating violence and

substance use as separate issues disregards their overlap, leading to several negative outcomes. First, by viewing families solely as enablers rather than as sources of support, policy overlooks the critical role they play in recovery (Radcliffe & Gilchrist, 2016). Second, families dealing with both IPV, and addiction rarely receive adequate support. Lastly, treatment providers lack clear guidelines on handling IPV disclosures from individuals seeking help for substance abuse (Radcliffe & Gilchrist, 2016). We need a major shift in perspective, recognising individuals with addiction as vulnerable and potentially victims of abuse (Cohen et al., 2003; Edalati & Krank, 2016). This approach could challenge punitive narratives and pave the way for more comprehensive drug policies that address the complex interplay of substance abuse, domestic violence, and family dynamics.

The intertwined nature of substance abuse and IPV in family contexts calls for a unified intervention approach. Research shows their significant overlap and impact on individuals and communities, emphasizing the need for integrated support systems.

The burden of care: Gender roles and addiction

While societal attitudes towards gender roles within families have changed somewhat (Scott & Braun, 2009), traditional views persist. Men are still largely seen as the primary earners, while women are expected to handle caregiving duties (Gershuny et al, 2005; Zuo, 2004). These expectations are reflected in negative evaluations of those who deviate from these norms. Studies consistently show less favourable views toward fathers who are primary caregivers and mothers who are the primary breadwinners compared to those who conform to traditional roles (Brescoll & Uhlmann, 2005; Coleman & Franiuk, 2011; Etaugh & Folger, 1998). For instance, Brescoll and Uhlmann (2005) found that couples with employed mothers and stay-at-home fathers were judged less favourably, with fathers perceived as less competent and mothers as more selfish. Similarly, Coleman and Franiuk (2011) reported that women who continued working after childbirth were viewed with less warmth and less positivity than men in the same situation.

Some women supporting their spouse through addiction have mentioned the burden of assuming dual parental roles (Fathi et al., 2020). The mental strain of meeting the needs of their children, along with their other responsibilities, results in hardship for these women. They sometimes find themselves neglecting their children's emotional needs while filling the void left

by an absent father figure (Fathi et al., 2020). This caregiving role, while serving as a coping mechanism for the supporter, is maladaptive as it enables the using partner to continue abusing substances with no consequences for their actions (Schultz & Alpaslan, 2020). Some women report caregiving extending to the needs of not only their own children, but to the biological children of the substance using partner (Wilson et al., 2019). These struggles illustrate the broader societal cost of clinging to outdated gender norms within families.

The societal expectation of intensive mothering creates immense pressure for mothers to be omnipresent and all-knowing when caring for their children (Afflerback et al., 2013; Byrt & Dempsey, 2020). It is assumed that a mother's constant physical presence and expertise are crucial for fulfilling a child's needs (Carter & Anthony, 2015). This expectation is particularly burdensome for mothers supporting partners with addictions, who are left managing the household, caring for children, and potentially working outside the home (Fathi et al., 2020). The impossibility of meeting the ideal mother standard in such circumstances often leads to self-blame and guilt (Peled & Sacks, 2008; Wilson et al., 2018). Social norms like 'mother knows best' further cement this pressure, discouraging mothers from seeking external support or delegating tasks, hindering their ability to cope with the challenges at hand (Cowdery & Knudson-Martin, 2005).

Orford and colleagues (2010) review the pathologization of family members in professional discourse, which often portrays wives of individuals with alcohol use disorders as psychopathological or co-dependent and parents of young adults with substance use issues as inadequate or abusive. Husbands of women with drinking problems were frequently portrayed unsympathetically, often stereotyped as abandoning their spouses. Additionally, other concerned family members, such as siblings, grandparents, aunts, uncles, and cousins, were typically overlooked in professional discourse until more recent times (Orford et al., 2020). This negative portrayal continues in both academic and mainstream literature, often relying on outdated gender roles that place undue blame on wives for their husbands' addictions or mothers as solely responsible for their children's well-being (Orford et al., 2020).

Parents, particularly mothers, of children with substance use disorders (SUDs) often face harsh societal judgement (Avery & Avery, 2019). Substance abuse is commonly attributed to character flaws, leading to the assumption that parents have failed in instilling proper morals

and values in their child (Avery & Avery, 2019). This aligns with the societal expectation, particularly for mothers, to be the primary caregivers and moral compasses of the family (Gershuny et al., 2005). Research shows that many parents feel blamed for their children's addiction issues, and public attitude surveys indicate that a significant portion of people think parents are at fault for not preventing their children's substance abuse (Francis, 2012). Similarly, studies indicate that parents of children with hidden disabilities, including SUDs, feel labelled as bad parents (Francis, 2012; Struening et al., 2001). Accusatory remarks, such as being labelled an enabler when seeking support, further solidify families' belief that they are responsible for their loved one's addiction (Avery & Avery, 2019). These negative judgements further reinforce the belief that parents, especially mothers, are responsible for their children's behaviours (Francis, 2012; Struening et al., 2001).

Addiction's impact on families is profound, often resembling trauma with lasting psychological, social, and physical health consequences (McGovern et al., 2020). These effects contribute to interpersonal conflict, financial stress, caregiving burdens, and family discord. Furthermore, the strong link between substance use and IPV highlights the need to address these issues together. Intervention studies show that supporting all family members can improve outcomes, but support systems must be carefully tailored to avoid unintended negative consequences and account for the complexities of individual family dynamics (McGovern et al., 2020). Families are often the hidden victims of substance abuse, bearing significant emotional and financial burdens (Barnard, 2006; Orford, 2017). This underscores the urgent need for better support systems and resources to help families navigate these challenges (Caplan, 1974; Kane, 2020).

Chapter Three: Methodology

This chapter will begin by outlining ontological and epistemological assumptions followed by the rationale for using narrative inquiry. The data collection procedures are then outlined followed by ethical considerations, reflexivity and data analysis.

Constructivism

This study delves into the intricate world of women supporting partners battling methamphetamine addiction, employing a constructivist approach. Constructivism views 'truth' as a product shaped by socio-cultural factors and the perspectives of observers (Shaffer & Robbins, 1991) and recognises that reality is not a fixed, objective truth but a dynamic tapestry woven from individual experiences and social contexts (Crotty, 1998). Scientific truths, much like personal narratives, are constructed, maintained, and revised through the interaction between social influences and belief systems, echoing the broader scientific understanding that reality is a social and cultural production (Casti, 1989). Thus, ontologically constructivism suggests that there are multiple realities and each of these realities comes from the 'construction' of meaning and understanding. These meanings adapt based on an individual's context, knowledge, attitudes, previous experience, and beliefs (MacLeod et al., 2023). Qualitative research focuses on interpreting the meanings participants attach to their experiences (Denzin & Lincoln, 1998), while constructivism emphasises the value of knowledge for navigating a world where truth is relative, shaped by individual and social perspectives (Finlay, 2006). In the same way that therapists working within systems theory have used social constructions as both conceptual and clinical tools (Shaffer, 1991), this study treats participants' stories as windows into the complex interplay of individual experience and larger social dynamics.

Epistemologically, this approach embraces the interconnectedness between the researcher and the world being studied (Hein & Austin, 2001). The researcher, abandoning the notion of absolute objectivity, acknowledges that their worldview may shape the research process. (Hein & Austin, 2001). Instead, the study facilitates a co-construction of knowledge with the participants (Crotty, 1998), mirroring the constructivist idea that reality emerges through ongoing social interactions. Through dialogue, the research aims not merely to gather

data but to guide participants in sharing their unique stories, recognising these narratives as valuable contributions to understanding addiction and its impact. This was important for this research as reflexivity and sense making of my own position (addressed in the reflexivity section) in relation to the stories is important to acknowledge. This is important in this research project as the study recognises that the participants' realities are subjective and shaped by the stories they tell about their journeys (Sikes & Gale, 2006). These narratives—shared through in-depth interviews—illuminate the unique experiences, while also acknowledging the influence of social and experiential factors within their specific contexts (Guba & Lincoln, 1994). Just as mental health practitioners have increasingly embraced the constructivist idea that knowledge and meaning are socially constructed, this study applies these principles to better understand the personal and relational dimensions of addiction within the lives of women and their families (Efran et al., 1988).

Constructivism is well-suited for an ecological and narrative approach to understanding the effects of addiction on families and the experiences of women supporting partners with addiction. While social constructionism would offer a similar perspective to understand the same phenomenon, constructivism typically allows for the interpretation of meaning derived from both environmental objects and social interactions. In contrast, social constructionism maintains that meaning cannot be derived directly from objects (Crotty, 1998; Kim, 2001). Therefore, constructivism is a fitting choice for this research, as it is better suited to acknowledging the interactions of participants with tangible structures like the justice system and legal frameworks. This approach recognises that each participant actively constructs meaning as they navigate the complexities of supporting partners with addiction over time. Their experiences are shaped by social contexts, including the stigma surrounding addiction and the framing of addiction as a legal issue within the justice system. Additionally, all participants in this study are mothers, and the experience of mothering is influenced by societal norms and expectations, which emphasise the importance of protecting children and fulfilling parenting roles. It is crucial to understand that mothering occurs within a family system, making it essential to consider these dynamics as well. Furthermore, this approach acknowledges the tangible physical, social, and psychological impacts on women. These effects are genuine and vary among individuals, as each woman's social context is unique, leading to no singular truth across their experiences.

Constructivism has provided a useful lens for understanding substance use in previous research (Burrell, 1999; Eriksen et al., 2022), suggesting that people's experiences and relationships with substances are shaped by meanings they construct both personally and socially. Within this framework, substance use is interpreted as part of a person's efforts to anticipate and manage future challenges (Burrell, 1999; Eriksen et al., 2022). Although the processes involved in substance use are often implicit, substance users are regarded as active agents who, even when feeling out of control or struggling to understand their behaviour, possess a level of awareness that may exceed their ability to express it (Burrell, 1999). From an evolutionary constructivist perspective, substance-centred identities (addictions) develop as part of an individual's ongoing efforts to create meaning and adapt within perceived social environments (Burrell, 1999). In constructing meaning through narrative, people reshape past experiences and events within various social frameworks, emphasizing elements they consider significant, while also defining their role within the story and shaping specific social identities (Larsson et al., 2013a, 2013b; Riessman, 1993, 2008). Thus, this constructivist approach can similarly provide valuable insights into how female partners of individuals with addictions construct their lived experiences, uncovering the depth and complexity of their realities beyond simplistic or one-dimensional portrayals. This perspective has significant implications for theory, research, and practice. It encourages a more nuanced exploration of individuals' relationships with substances, emphasizing the subjective meanings they attach to their experiences. In research, this lens can inform methodologies that centre participants' narratives and personal insights. In practice, it highlights the need for interventions that respect individuals' agency and focus on fostering meaning-making processes, supporting healthier adaptations to life's challenges.

Narrative Inquiry

Narrative Inquiry is the ideal method to explore the lived experiences of women supporting partners through addiction. It allows them to share their stories in their own words, revealing complexities unseen in traditional research methods (Oliver, 1998). This approach also aligns well with the constructivist perspective, which emphasises the importance of subjective experiences in shaping our narratives (Shaffer & Robbins, 1991). Narrative is inherent to human existence. We construct meaning through the stories we tell ourselves and

others (Bruner, 1994). Narrative inquiry prioritises this process, offering a rich lens to explore human experience (Oliver, 1998). Stories invite multiple interpretations, creating a tapestry of potential meanings (Oliver, 1998). Narrative analysis acknowledges the researcher's positionality as a collaborator, fostering trust and encouraging participants to share their unique stories (Lincoln, 1996). This co-constructed style recognises that meaning emerges from the interplay between researcher and participant (Oliver, 1998). Narrative analysis takes an inductive approach, identifying themes from the data and allowing relationships to emerge organically (Polkinghorne, 1995). It aims to construct a holistic narrative that weaves together individual stories, illuminating the context that shapes their experiences. This approach provides not only 'what' happened but also 'when' and 'why,' revealing motivations, choices, and outcomes (Oliver, 1998).

Narrative analysis offers a compelling approach for this research as unlike quantitative methods, which often rely on standardized questionnaires, narrative analysis delves into the rich tapestry of context, illuminating the intricate web that connects each participant experience to the broader cultural and historical backdrop (Oliver, 1998). The importance of physical settings and sociocultural forces that shape each participant's life are given importance within this method. For instance, women in a geographically isolated community with limited access to support groups may face unique challenges compared to a woman in a more urban setting with readily available resources (Douthit et al., 2015). The narrative framework allows researchers to explore such contextual nuances, providing a more comprehensive understanding of the lived experience (Oliver, 1998). Furthermore, this method allows the researcher to move beyond a one-dimensional view of the woman and her family. Characters are understood as individuals with complex histories, motivations, and social roles (Oliver, 1998). Narrative analysis can therefore be used to explore the development of the addiction over time, the internal struggles of participants, and the societal pressures that may have contributed to their situations. Additionally, the woman's background can be examined. Did she witness addiction in her own family? Has she dealt with her own traumas? Understanding these facets of their identity's sheds light on their choices and interactions within the relationship. Similarly, narrative analysis places emphasis on the narrative structure or plot as a valuable tool for understanding how past experiences shape the present. The choices the woman makes, the conflicts she encounters, and

the ways she seeks support all reveal how her past has influenced her approach to supporting her partner.

By delving into these interconnected elements of setting, character, and plot, narrative analysis offers a nuanced and comprehensive understanding of the lived experiences of women supporting partners with addiction. This approach transcends the limitations of quantitative data, revealing the complexities of these women's lives, the societal and cultural factors at play, and the unique challenges and triumphs they face on this journey.

Procedure

Recruitment and participants

This research project builds upon the findings of my Honours thesis titled *Insight into the impact of methamphetamine addiction on families* (Wells, 2021). This explored the experiences of women supporting partners through addiction and used an Interpretive Phenomenological Analysis methodology. The current project sought to expand on this work by employing Narrative Inquiry to gain a deeper understanding of the lived narratives of these women.

The sensitive nature of the topic, methamphetamine addiction, necessitates a recruitment strategy that acknowledges the associated stigma (Avery & Avery, 2020). Snowball sampling, a technique where initial participants refer potential candidates who meet the study criteria, was deemed most appropriate due to its effectiveness in reaching hidden populations (Orford et al., 2005). The initial recruitment attempt involved contacting previous participants from the Honours project to inquire about potential referrals. While this yielded one initial expression of interest, the participant withdrew upon encountering the formality of the consent form.

Following this, a broader approach was adopted by reaching out to a Facebook group, *NZ P Pull*, a grassroots organisation dedicated to supporting whānau (extended family) affected by methamphetamine use. An introductory post (See Appendix A) was created outlining the research project, eligibility criteria, and participant compensation and providing a link to the information sheet (See Appendix B). The post emphasised the researcher's personal experience in supporting individuals struggling with addiction and the goal of reducing stigma through increased understanding. The inclusion criteria were as follows:

- Partner or ex-partner of an individual with a past methamphetamine substance use issue.
- Shared parenthood with this partner or ex-partner to one or more children
- Consider yourself to be in a good place to take part – i.e. in a place of well-being, no significant mental health distress.
- Have not used methamphetamine.
- Currently reside in Auckland, New Zealand or lived in New Zealand during the affected period.
- Participants of any ethnicity are invited to participate; however, the interviews will be conducted in English.

This approach generated greater interest, with numerous inquiries received through Facebook messenger. However, a recurring challenge emerged: potential participants expressed hesitance upon receiving the consent form (See Appendix C). It was hypothesised that the perceived formality of the document might act as a deterrent. In response, the research protocol was adapted to allow for verbal consent at the interview outset, with participants receiving a copy of the transcript for review and the opportunity to provide written consent for information use at that time. The initial Facebook recruitment led to two interviews, after which a snowball effect emerged. One participant referred a friend from a Nar-Anon support group, resulting in two additional participants. A combination of snowball sampling and the Facebook post yielded a total of four participants.

In total four women were interviewed from across the North Island of New Zealand.

Emily (participant alias) is a woman who became aware of her partner's methamphetamine use approximately six months after the birth of their child. Following her partner's admission, she immediately ended the relationship. Emily estimates her partner had been using for 6-7 years prior to their separation, though she acknowledges there were periods throughout their relationship where she suspected use. Emily describes multiple attempts to leave the relationship before finally ending it.

Hannah (participant alias) entered a relationship with her partner while he was in recovery from addiction. Hannah herself works in the addictions field and was aware of her partner's past struggles. Despite this knowledge, the couple married and had one

child together. Their relationship cycled through periods of sobriety and relapse for her partner. Hannah made the decision to separate, though they remain co-parents.

Sarah (participant alias) ended her relationship with her partner nine months after the birth of their child. They are no longer together.

Sophia (participant alias) remains in a relationship with her partner, who is currently sober. Her partner has a long history of methamphetamine use, characterized by extended periods of both addiction and recovery.

Interviews

Upon initial contact with participants via the Facebook post, I provided them with an information sheet (See Appendix B) detailing the project's outline, selection criteria, and potential risks. After they contacted me to express their interest in participation, to ensure their understanding, I sent a follow-up copy of the information sheet asking them to ensure eligibility. Following confirmation of eligibility, each participant was informed of the anticipated interview duration. Expressing gratitude for their interest, I provided them with ample time for deliberation to ensure informed consent, leaving them with the confidentiality agreement (See appendix D) and consent form (See Appendix C) to sign and return. Moreover, I reassured each participant of the option to address any reservations or queries, emphasizing the possibility of granting consent verbally at the outset of the interview. Of the participants, two opted to return the forms, while the remaining two provided verbal consent. To maintain a casual rapport and facilitate pre-interview rapport building, communication channels such as texting and Facebook Messenger were utilized. After receiving the forms, or a request for verbal consent, I arranged a time that would best fit each person for the interview to take place. To further enhance participant comfort, participants were offered the option to have whanau members or other support persons present during the interview, though none utilised this option. A general interview guide (See Appendix E) outlining potential topics was also provided. Considering participant safety and the need for a quiet recording environment, Zoom was chosen as the primary interview platform. While alternative options such as in-home interviews or library meeting rooms were initially considered, Zoom offered greater accessibility for geographically dispersed participants and avoided potential power imbalances associated with university settings.

The interviews commenced with introductory remarks aimed at establishing rapport and fostering a relaxed atmosphere. Prior to delving into substantive matters, I explained my personal interest in the topic and previous experiences supporting partners and loved ones through addiction to engender a sense of trust. Emphasizing confidentiality, I reassured participants that all identifiable information would be redacted. Participants were reminded of their prerogative to terminate the interview or abstain from answering any questions they found discomforting. Subsequently, consent for recording the session was obtained, with an assurance that participants would be provided with a transcript for review. Participants were granted autonomy to suggest edits as deemed necessary.

The interview guide was the same for each participant though there was flexibility around this to accommodate the natural flow of conversation. The semi-structured format permitted participants to articulate their narratives in a manner conducive to their comfort. The interview guide was designed with general opening questions that encouraged the participant to discuss their experiences of life with their partner. Questions then moved on to discussions around any support they accessed or needed. Closing questions aimed to end on a positive note by asking if there were any positives that came from the experience and what they would like other women in their situation to know.

Following each interview, participants received a copy of their transcript and the consent form for their review and signature. All interviews were transcribed verbatim. Any identifying information was removed to safeguard participant anonymity and mitigate concerns surrounding societal stigma. Once satisfied with the transcript's accuracy, participants signed and returned the transcript release authority form (See Appendix F). Notably, no participant requested transcript modifications.

Reflexivity

Qualitative research inherently relies on the researcher's interpretation of data, making reflexivity a critical tool to ensure the rigor and quality of the work (Berger, 2015; Dodgson, 2020). This introspective practice fosters trustworthiness by acknowledging the researcher's positionality and how it may influence the research process, outcomes, and participants (Berger, 2015). This process entails continual internal dialogue and critical self-evaluation of the researcher's positionality, along with an acknowledgment that this position may influence the

research process, outcomes, and participants (Berger, 2015). Furthermore, reflexivity promotes relational ethics through a collaborative approach to knowledge construction alongside participants (Crotty, 1998; Hein & Austin, 2001). Aligned with the research paradigm of constructivism, the researcher's role is collaborative, focusing on the co-construction of knowledge with participants (Crotty, 1998; Hein & Austin, 2001). Additionally, the researcher acknowledges their own background and its shaping of interpretations, prioritizing participant voices (Gadamer, 1976).

My interest in this topic stems from my insider status; rooted in my firsthand experiences as both a supportive partner and a witness to familial struggles with methamphetamine addiction. While my role as a supportive partner did not entail parenthood, it provided me with intimate insights into the complexities of addiction and the toll it takes on individuals and their relationships. I also witnessed my father struggle with methamphetamine addiction. Occupying the roles of a supportive partner and a daughter has shaped my beliefs about addiction and granted me insight into living with someone in its throes. These roles shaped my perspectives on addiction as a multifaceted issue that extends beyond the individual. These experiences have profoundly influenced my perspective, igniting a passion to challenge the stigma surrounding methamphetamine addiction and advocate for a more compassionate approach rooted in mental health support rather than punitive measures. This passion propelled me to embark on my previous Honours research project, and the desire to delve deeper led me to expand this research by interviewing more women affected by methamphetamine addiction.

In conducting my research, I was acutely aware of the need to prevent my own experiences from unduly influencing the interpretation of participants' narratives. Therefore, I conducted flexible semi-structured interviews, allowing participants to express themselves freely without my biases interjecting. Furthermore, I made a conscious effort to refrain from interrupting participants, ensuring their voices remained authentic and uninfluenced by my own opinions. Following each interview, I engaged in reflective journaling to capture any emerging thoughts or emotions. This practice of notetaking persisted throughout my research journey, serving to maintain a clear distinction between the voices of participants and my own interpretations, as recommended by Smith and Eatough (2012). Recognising the inevitable influence of my background on my interpretations, I embraced the importance of

acknowledging and navigating this influence, echoing the sentiments of Packer (1985). This process of introspection, often referred to as "turning your gaze to the self" (Shaw, 2010, p. 234), holds significant weight in qualitative narrative research. It underscores the recognition of how individual-world interactions shape and give rise to diverse realities, as highlighted by Lavery (2003).

Moreover, I remained mindful of how my background as an insider in this context inevitably shapes my interpretations. Embracing the notion of self-reflection advocated by scholars like Packer (1985) and Shaw (2010), I continuously examined my biases and preconceptions, acknowledging their potential impact on my analysis. I also remained steadily in contact with my supervisor to query any thoughts that arose while engaging in analysis. This process of introspection, integral to narrative research, allowed me to navigate the intricate interplay between individual experiences and broader social realities (Lavery, 2003). While my insider status facilitated rapport-building during interviews, it also presented challenges during analysis. Striving to maintain impartiality, I centred my analysis on the participants' narratives, recognising the nuances and unique aspects of each individual story. This approach ensured that my interpretations remained grounded in the participants' lived experiences, rather than overshadowed by my own perspectives as a supporter.

In essence, my journey as a researcher navigating the complexities of methamphetamine addiction has been guided by a commitment to ethical inquiry, reflexivity, and a steadfast dedication to amplifying the voices of those impacted by this issue.

Ethics

This research was created in line with the standards of the Massey University (2017) *Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants*. The original ethics approval for my Honours thesis (NOR20/20) was extended to my Masters research due to the similarity in research questions and the building upon previous work. Minor amendments were made to the information sheet, advertising, and interview schedule to reflect the expanded scope of the Masters project. The Masters data was collected in 2022, ensuring the continued validity of the ethics approval. To better align with the revised research focus, a minor amendment was obtained to transition from Interpretive

Phenomenological Analysis to Narrative Analysis. This methodological shift provided a more suitable framework for exploring the narrative dimensions of the research topic.

In conducting this research, ethical considerations were paramount and consistently addressed throughout the peer review process. Emphasis was placed on ensuring cultural competency, especially with regards to Māori participants. To achieve this, a dedicated meeting was convened with Dr. Pikihuia Pomare, a Massey University Kaupapa Māori lecturer, whose expertise provided invaluable guidance on navigating cultural nuances throughout the research design, data collection, and analysis. In the case of Māori participants, we would have sought out further cultural advice throughout the process. This would involve collaborating with a designated cultural advisor throughout the research process to ensure alignment with participants' values and beliefs. Finally, *the Te Ara Tika Guidelines for Māori Research Ethics* (Pūtaiora Writing Group, 2010) served as a cornerstone for the research's ethical framework. A thorough review and understanding of these guidelines ensured adherence to the principles of reciprocity, mana enhancement, whānau (family) involvement, and rangatiratanga (self-determination), thus fostering a culturally competent and ethical research approach.

An important ethical consideration throughout this study was due to the inherent vulnerability of the participant population, particularly concerning potential experiences of domestic violence and the potential for distress arising from discussions about partners' methamphetamine use. To mitigate these risks, safety plans were collaboratively developed with each participant, and they were empowered to choose the interview time, ensuring a safe and comfortable space for open communication. Interview schedules were adapted to accommodate childcare needs, and interviews were paused if children entered the room.

The anticipated benefits of the research extend beyond the participants themselves. By gaining a deeper understanding of mothers' perspectives on addiction and recovery within their families, the research aimed to shed light on a previously under-explored aspect of the issue. Furthermore, it provided a platform for women to share their experiences, giving voice to a perspective often unheard in discussions about addiction. This could contribute to a reduction in the stigma surrounding methamphetamine use and substance abuse in general, fostering greater public understanding of the broader societal impacts of addiction. Finally, the research acknowledged the potential therapeutic value of the interview process itself, allowing

participants to discuss their experiences in a safe space and potentially derive a sense of empowerment from knowing their stories could contribute to helping others.

Data analysis

The interviews were recorded using Otter software and automatically transcribed. To ensure accuracy and maintain a close connection with the data, the audio recordings were played while editing the automated transcripts for each participant. This process involved listening to the audio files, verifying the accuracy of the transcripts, and then reading and analysing the transcripts.

As I reviewed each interview, I began to engage more deeply with the stories, paying attention to their structure, function, and meaning. In narrative analysis, the focus lies on how people make sense of their experiences through storytelling (Wong & Breheny, 2018). Stories are a natural part of human cognition because we are socialized through them from childhood. However, stories do not simply chronologically list events—they are crafted to convey meaning, shaping how individuals present their identity and expect others to understand them (Riessman, 2008). The narratives people share provide insight into the unspoken rules of social interaction, as they reflect the broader narratives of the societies in which we live (Crossley, 2008). This immersion in data therefore deepened through detailed readings and re-readings, defining, refining, and elaborating on each previous analysis. Key quotes were highlighted and annotated with my ideas and opinions using Word's comment function. I initially analysed each transcript separately and then compared them, noting similarities and differences in participant experiences.

Narratives operate simultaneously across multiple levels, and separating these levels allows researchers to see how personal stories connect with broader social narratives (Wong & Breheny, 2018). In narrative psychology, the focus starts with individual stories—accounts of everyday experiences that sequence events over time and often imply causal relationships between them (Murray, 2003; Polkinghorne, 1995). However, narrative analysis also requires shifting from individual accounts to comparisons across all participants. Not every story or narrative theme will be included in the final analysis. Instead, the researcher must select the narratives that best address the research aims rather than attempt to summarize everything participants shared. Therefore, initial insights were organized in an Excel document under three

broad categories: Personal, Interpersonal, and Societal. These categories were informed by Murray's (2000) narrative analysis framework in health psychology, which outlines four interconnected levels of analysis: personal story, interpersonal, positional, and ideological. I also drew on the work of Stephens and Breheny (2013), who combined the positional and ideological levels into a public level, distinguishing between personal narratives (individual experiences) and public narratives (societal beliefs about relationships and moral positioning). This framework helped structure the analysis, revealing how personal stories are intertwined with the broader narratives available in society. By focusing on both individual and collective meanings, the narrative approach provided a deeper understanding of how participants interpret their experiences within their social contexts.

For this study, I therefore adapted Murray (2000) and Stephens and Breheny (2013) frameworks to better capture the complexities of participants' narratives. My revised framework focuses on three key levels:

- **Personal Narrative:** This level reflects the individual's personal story, encompassing their thoughts, emotions, and physical sensations at the time of the events they describe, along with their interpretation of these experiences.
- **Interpersonal Narrative:** This level delves into how participants position themselves within their narratives in relation to others, focusing on the dynamics and power structures within their relationships.
- **Societal Narrative:** This level explores the influence of public narratives on the participant's moral and social identities, examining how shared social narratives have shaped their story and understanding of their experiences.

This refined framework allowed for a nuanced analysis of the participants' stories, providing insight into how the women make sense of their experiences within personal, relational, and social contexts.

As I progressed in categorizing the data, it became apparent that an additional category was necessary—one that did not fit neatly into the existing headings. I introduced Co-dependency as a new category and grouped relevant quotes and ideas under this theme.

To explore these broad categories further, I identified subthemes within each main theme—Personal, Interpersonal, Societal, and Co-dependency—based on recurring patterns and thematic connections in the data. This iterative process helped to clarify the relationships between themes, deepening my understanding of the narratives shared by participants. The themes and subthemes are outlined below:

Personal:

1. Mental health and stress
2. Disbelief, denial, manipulation
3. Isolation, fear, judgement
4. Working in mental health

Interpersonal:

1. Relationship with partner
2. Role as mother
3. Friendships
4. Extended Family
5. Children

Societal:

1. Definitions of abuse
2. Available support and usefulness
3. Shame and stigma
4. Framing of addiction
5. Justice system and legal issues

Co-dependency:

1. Addiction and recovery
2. Carer role, gendered compassion, managing a household, learning to put self first

By breaking down these categories into subthemes, I was able to gain a more nuanced understanding of the participants' narratives and the complexities of their experiences. With these general ideas in mind, I set out to write the analysis section. Extracts were carefully

selected based on their contribution to the overall narrative. As the writing and editing process progressed, the themes were refined and honed to accurately represent the data. This inductive approach allowed for a more authentic and narrative driven analysis, ensuring that the findings were grounded in the participants' experiences.

Chapter Four: Analysis

This section maintains the structure of the literature review to ensure continuity. Accordingly, it is organized following the previously used framework of the ecological model, beginning with themes at the personal level and subsequently addressing interpersonal and societal influences. However, the final section introduces a distinct theme that emerged with particular significance, meriting focused exploration. This section examines participants' narratives of co-dependency in depth.

Personal

This theme explores the personal experiences of participants supporting their partners and the resulting consequences. The following sub-themes delve into the profound mental and physical health challenges experienced by supporters. Participants candidly shared their struggles with anxiety, stress, and trauma, highlighting the devastating emotional toll of their relationships. The interconnectedness of mental and physical well-being was evident, as participants described the manifestation of psychological distress in physical symptoms. These stories also illustrate the complexity of recovery, marked by shifts from chaos to stability, as well as the lasting emotional challenges, including loneliness and self-doubt. The accounts demonstrate how addiction erodes trust, distorts reality through manipulation, and isolates individuals socially and emotionally. Additionally, participants with mental health expertise confront the painful gap between professional knowledge and personal experience, grappling with feelings of guilt and helplessness. This chapter thus explores these themes, illuminating the nuanced realities of individuals navigating the intertwined challenges of intimate relationships and addiction.

Vicious cycles: Addiction, anxiety, and physical decline in intimate relationships

Participants revealed the intricate link between mental and physical health in intimate relationships, describing struggles with anxiety, stress, and trauma. All participants' stories highlighted the significant emotional toll of their partnerships, illustrating the extreme psychological turmoil they experienced.

Hannah candidly expressed the debilitating impact of anxiety stemming from her partner's addiction:

Hannah: The level of anxiety that I experienced, the panic, flashbacks and the level of trauma is definitely a result of his addiction.

Similar experiences of panic and anxiety were outlined by Sarah:

Sarah: Back then, I was in such a state of stress and fight/flight mode, constantly waiting for the next thing to happen.

The incessant presence of anxious thoughts, coupled with mood fluctuations, disrupted sleep, and eating patterns, underscored the extreme disruption to Hannah's mental equilibrium. She further outlined how this created a vicious cycle of overeating as a coping mechanism:

Hannah: The eating thing is kind of like a double-edged sword. It's either you don't eat at all, or you overeat because you want to compensate for how shit you feel.

Sarah's testimony echoed Hannah's sentiments, highlighting a continuous state of stress and hypervigilance precipitated by the unpredictable dynamics of their relationships. Chronic stress, pervasive anxiety, and overwhelming sadness permeated Sarah's existence, interspersed with bouts of intense rage and a deep sense of helplessness. Sarah's description of lying beside her partner, consumed by a volatile mix of emotions, poignantly illustrated the emotional turmoil festering beneath the surface:

Sarah: Chronically stressed, chronic worry. Lots of anxiety. Lots of sadness. I remember so much rage, but I couldn't expel it. I remember lying next to him and just wanting to kill him. No, but you know, just being that enraged. And that sad, yeah, just that heaving with emotion.

The intimate connection between mental and physical well-being was further underscored by accounts of physical symptoms arising from prolonged exposure to stressors within the domestic sphere. Sarah's admission of memory lapses and Sophia's harrowing depiction of physical deterioration and familial distress painted a stark picture of the toll exacted by chronic stress on overall health.

Sarah: I don't have tangible memories because I was in this state all the time. So, I didn't have any ability to retain any kind of information and the things that I remember are fucking awful.

Sophia: I lost 23 kg in two weeks. That put me in hospital. Because I was trying to eat, but I'd want to vomit because the stress was that big in me. I'm a pretty strong resilient person but this this took my feet out from underneath me.

These experiences underscore the extreme impacts of supporting a partner through addiction, drawing direct lines between stress and physical side effects. Furthermore, Sophia's narrative reveals the collateral damage inflicted on her children, who witnessed her suffering and distress.

Sophia: My children were watching me cry all the time. My children were upset all the time. Because I just didn't know how or where to get help.

Participants' inability to seek help exacerbated the sense of helplessness and isolation, compounding the trauma experienced. Additionally, the strain of addiction intensified existing stressors, such as the demands of parenthood. Emily recounts the impact of her partner's addiction on her sleep patterns, exacerbated by the stress and frustrations of early parenthood. She reflected on how ignorance of her partner's drug use during her pregnancy may have shielded her from additional stress, highlighting the delicate balance between self-preservation and the well-being of her unborn child.

Emily: I'm kind of glad that I was a little bit in ignorant bliss during my pregnancy. I feel like I had quite a good, healthy pregnancy, and if I had found out about my partner's drug use during my pregnancy, I think that would have like, really affected my baby.

Notably, Sarah illuminated the lasting impacts of trauma and how this manifested as physical symptoms. Physiological responses to trauma, such as trembling and heightened arousal when facing perceived threats emphasise how experiences from her intimate relationship influence Sarah's present reality. Despite making strides in her personal healing journey, Sarah acknowledged the persistent nature of the body's stress response, and the ongoing effort required to manage its impact long after leaving her partner.

Sarah: I'm just constantly in a state of high alert, even now, with my own recovery stuff...and my body manifests that trauma. If I think that he's starting to get a little bit crazy I start to shake or my teeth will chatter, things like that. My central nervous system remembers, still reacts in the same way. I can pull myself out and recover faster these days but it's still a lot of work.

All participants' stories underscored the multifaceted impact of supporting a partner through addiction on one's mental and physical health. From destabilizing emotional well-being to manifesting distress in physical symptoms, participants' accounts emphasised the extreme and long-lasting impact of their experiences. The participants also started to highlight how their own individual suffering was witnessed by their children, pointing to potential intergenerational consequences. This complex interplay between individual struggle, family well-being, and long-term health outcomes signals the urgent need for more holistic approaches to wellness and recovery.

Broken promises to balanced lives: Stories of transformation

This theme provides insights into participants' transformative journey from chaos to stability, marked by shifts in daily life, coping mechanisms, and emotional well-being.

Sophia reflected on the tumultuous nature of her past days, characterized by unpredictability and broken promises, contrasting sharply with her current experience of a more balanced and structured routine. She described her previous existence as fragmented and disjointed, plagued by constant turmoil and her partner's unreliability. However, she now finds solace in the semblance of normalcy and routine, emphasizing the contrast between her chaotic past and balanced present.

Sophia: A day back then? Would look like a million pieces. Come, go, come, go. Ring, say you're coming, not turn up. To now I guess, living life. Doing stuff around the house and being part of your role, whether it's father, mother, you know? Absolutely chaotic. To balanced.

Humour emerged as a coping mechanism for Sarah, who employed wit to navigate the challenges of living with her partner. By likening the situation to dealing with a tantrum-throwing toddler, Sarah injects levity into what would otherwise be overwhelming

circumstances. This use of humour serves as a tool for resilience, allowing Sarah to find moments of lightness amidst the chaos.

Sarah: Daily existence was, waking up, yelled at for not buying the right milk or the coffee being too hot or just shit. You know? It's like a toddler, exactly like a toddler, except when they kick and throw it's with force.

Sarah elaborated on the chaos of her past life, recounting a barrage of rage, outbursts, and broken promises. Financial instability, emotional strain, and physical destruction marked this period. In contrast, her current life is a serene, stable environment where her children are safe and financially secure. This transformation underscores the profound impact of recovery on the entire family.

Sarah: What it used to look like, was chaos. There was just constant rage, outbursts, you know, he'd be sleeping for 48 hours... if you woke him up, you'd bloody get something thrown at you, screaming in your face. If he was up, there'd be a million different jobs happening, or he'd be gone for a day or two. You know, there's always people looking for him or... broken promises. Everything was unmanageable. Never any money. Holes in walls, like everything was just awful.

Sarah: My life now is serene... I just have a normal family life, you know? Financially manageable. I can work. My kids are in a house, a healthy safe house. You know, their needs are mostly met.... emotionally sometimes not.

Emily reflects on her emotional and psychological transformation since her partner's recovery, noting improvements in her well-being such as emotional stability, reduced anxiety, and increased joy and connection. However, alongside these positive changes, she grapples with feelings of loneliness and the loss of the partnership she once relied on. This nuanced reflection highlights the complexities of recovery, acknowledging both its benefits and challenges.

Emily: I'm better emotionally, physically. I can focus on discovering myself and learning what I want out of life... How to stop my people pleasing. A lot more

faith, connection, joy. Less guilt...The one area where it's worse is that I do feel more alone, like before he was there. He helped me, I was in a partnership. I was a mother with a baby and a dad. It is hard being a single parent like I've got my parents' support but it's not the same thing.

These narratives vividly illustrate a journey from chaos to stability, showing shifts in daily life, coping strategies, and emotional well-being. Sophia reflects on past turmoil, contrasting it with a current balanced routine. Sarah humorously navigates past chaos, now enjoying serenity and stability. Emily notes emotional improvements post-partner's recovery but grapples with loneliness. This narrative shift underscores the profound and lifelong impact of living with and supporting a partner with addiction. Over time, supporters and their families undergo their own recovery process, gradually moving toward stability after enduring prolonged turmoil.

The art of manipulation: The psychological impact on supporters

Participants described their lives with their partners as a profoundly disorienting experience, filled with disbelief, denial, and manipulation. They found themselves navigating a shifting reality where personal boundaries blurred, leaving them increasingly vulnerable, betrayed, and confused. Over time, behaviours once deemed unacceptable became normalized, highlighting the insidious nature of addiction and the erosion of individuals' perceptions and judgements.

Emily illustrates how her partner's behaviour shifted so gradually that she could not distinguish "*this is actually a problem*" from what had slowly become her "*normal*." This creeping shift reveals how deeply addiction infiltrates daily life, gradually compromising one's ability to perceive clearly. Similarly, Hannah shares how her partner's actions pushed her to a breaking point, leaving her "*sucked into*" his world of chaos and prompting desperate behaviours as she struggled to understand his actions.

Emily: It all evolved so slowly, and it was hard for me to distinguish, like, this is actually a problem, versus, this is something that I've become accustomed to, or that all of a sudden felt normal, when it was never normal.

Hannah: You feel like you're going insane, because of their behaviour. And you get sucked into it. And although you're not in their world, necessarily. You start doing some crazy shit to figure out what the hell they're doing.

A pivotal moment for Sarah came when she reconnected with her cousin, experiencing her first "normal conversation" in a year. This moment jolted her back to reality, marking the beginning of her realisation that her life had drifted far from anything healthy or stable:

Sarah: I didn't realise when I was isolating, but I remember going up to visit him [cousin], having nice, normal chats. And that was the precursor to me leaving because I was like, "Oh my God." This is the first actual normal conversation I've had with another adult outside of [Sarah's partner] for like a year, you know, it was like this sort of light bulb moment.

The contrast between moments of clarity such as these, and the normalization of abuse and manipulation, highlights how harmful behaviours can become accepted over time. Sarah similarly recounts the growing confusion and doubt that came from her relationship, which left her questioning her own reality and instincts:

Sarah: I just lived in an absolute state of doubt. I still suffer from it. Now I'm constantly questioning my reality because I was... gaslit for so many years. I'm trying to learn what is instinctual versus trauma feelings when trying to make decisions, so I'm still trying to kind of unpack that.

Hannah echoes these sentiments, describing how she was made to feel responsible for her partner's relapses and was manipulated into believing she was unworthy. This gradual erosion of self-worth, rooted in psychological abuse, left her questioning her own value and sanity:

Hannah: For a long time, I was made to feel like I was crazy. I was made to feel like it was my fault, like I did something wrong, that I was the reason why he relapsed. Yeah, you know, I'm disgusting. I'm not worthy. I'm all these things.

These narratives illustrate a dangerous gradual erosion of each participants' perceptions, judgements and sense of self, leading to a normalization of their partners harmful behaviours and a disorienting loss of a grip on reality.

Denial also plays a significant role in this gradual shift of normality. Emily expresses disbelief at finding herself in such a situation, noting the contrast between her reality and the idealized portrayals of relationships often seen in popular culture. Despite gut instincts warning her of the truth, she finds herself unable to fully accept the harsh reality, grappling with feelings of shame and self-doubt as a result.

Emily: You never think that that this would happen to you, like you always think this is shit that happens in movies. This is stuff that you read about in textbooks. But never ever in my wildest dreams did I ever imagine being where I am.

These narratives reveal the survival mentality adopted by participants, where the focus on getting through each day takes precedence over any long-term aspirations. The manipulation by their partners intensifies this struggle, undermining trust and reinforcing cycles of abuse. As trust eroded within the relationship, participants also described a growing inability to trust others, leaving them increasingly isolated. Emily reveals how this shattering of trust has left a lasting impact, expressing doubt over whether she will ever regain a sense of security in others. Yet, reflecting on her journey, she also finds a sense of strength and gratitude, seeing her survival as a testament to her resilience.

Emily: Had you talked to me a year ago. I'd be like, this is the worst thing that's ever happened. I don't know if I'll ever be able to feel good about life again or trust anyone. Now I can hands down say this has saved me. This experience has given me a new opportunity to truly live my life.

Similarly, Hannah highlights the erosion of trust she experienced, describing how manipulation not only damaged her ability to rely on others but also triggered a lasting shift in her sense of self. The constant doubt and emotional turmoil left her questioning her worth, identity, and instincts, creating a deep internal struggle that persists even beyond the relationship:

Hannah: I'm a very dark person compared to what I was seven, eight years ago. Back then I had so much love for life. I had joy. I had things that I looked forward to, I had, you know, so much enjoyment, whereas now I just feel like I'm drowning in this poison and sometimes struggle to even breathe.

The personal narratives illustrate how the erosion of trust extends far beyond the immediate relationship, impairing individuals' ability to trust others and underscoring the far-reaching consequences for these women. They depict the psychological warfare inflicted by addiction, where disbelief and denial gradually give way to a distorted reality shaped by manipulation and control. Trapped in a relentless survival mode, participants struggle to regain their sense of agency and identity amidst the chaos. These stories underscore the profound emotional toll of supporting a partner through addiction, highlighting the critical need for comprehensive support systems to help individuals rebuild trust, reclaim their autonomy, and restore their well-being.

From shield to cage: How secrecy and isolation impact supporters

Participants found themselves increasingly isolated and fearful, leading to profound changes in their personal relationships and mental health. Many felt misunderstood by friends and family, as their social networks shrank due to their partners' influence and financial constraints. This isolation—both physical and social—magnified the challenges of supporting their partners.

Hannah: I isolated myself a lot from social situations. Even now. I find it uncomfortable, going out and meeting new people. Because I have a lot of anxiety and trust issues, and I don't like talking about it because I feel very judged.

The initial sense of anxiety and discomfort in social situations, as described by Hannah, became compounded with the weight of judgement and fear of being misunderstood. This led to retreating from social situations and withdrawal from the external world, deepening the sense of isolation. Furthermore, participants expressed a sense of disconnect from their friends and family, who seemed unable to comprehend their circumstances and their partners' struggles.

Stereotypes surrounding drug users and lack of awareness regarding the effects of methamphetamine fuelled this disconnect.

Hannah: You start justifying why they're doing things to make other people leave you alone. I found it was easy for me to lie on his behalf. Which goes against me as a person. I don't like lying, but there were times where I would lie to protect him.

As addiction tightened its grip, secrecy and deception became survival strategies. Hannah's reflection reveals the painful conflict between maintaining a moral compass and lying to protect her partner—a behaviour that further deepened her isolation and distanced her socially. These moments of dishonesty became a shield, enabling participants to deflect external judgement and maintain a sense of control, albeit at the cost of personal integrity.

Sarah: I isolated from most of my friends and family, so they don't really know him well. I kept us closed and I didn't want anyone to know what was going on. So, people know drips and drabs.

By deliberately keeping her partner's addiction hidden from friends and family, Sarah erects barriers that prevent others from understanding the full extent of the struggle. This selective disclosure of "drips and drabs" reflects a reluctance to confront the harsh reality and a desire to maintain a façade of normalcy.

The intertwining of social isolation with financial and practical challenges further compounded participants' mental well-being. Limited financial resources restricted participants' ability to engage in social activities, deepening their isolation and eroding any remaining support systems.

Emily: It was really, really, really hard. If it wasn't for Nar-Anon or Al-Anon, you know, I might still be there.

Emily's account highlights the critical role of support groups in breaking through the darkness of isolation. Many participants echoed this sentiment, finding solace and understanding in Nar-Anon, Al-Anon, and similar spaces where others could empathize with

their experiences. These lifelines provided participants with hope and community, offering essential relief from the emotional burdens they carried.

These stories reveal that isolation was both a symptom of societal misunderstanding and a strategy for coping with the harsh realities of addiction. Participants isolated themselves to shield their families from judgement and to protect their partners, but this withdrawal also intensified their own emotional struggles. The overlapping effects of social isolation, secrecy, financial strain, and the stigma surrounding addiction created a feedback loop, where each factor worsened the others, leading to a significant decline in mental health.

Working in mental health: How did I not see the flags?

The narratives of three out of the four participants reveal a profound sense of shame and guilt stemming from their inability to recognise the signs of methamphetamine addiction in their intimate partners, despite their professional backgrounds in mental health.

Emily, a psychologist herself, expresses deep shame over her failure to recognise the warning signs and prevent her partner's descent into addiction. This internal conflict highlights the discrepancy between her professional knowledge and personal experience, leading to a sense of bewilderment and self-blame.

Emily: I feel so ashamed and I know it's just like a human thing, but I'm a psychologist myself. And I was like, how did I end up in this situation, how did I not see the flags?

Similarly, Hannah, acknowledges being aware of the risks associated with substance abuse but finds herself unprepared for the emotional toll when it becomes personal. Despite her familiarity with addiction, she emphasises the difference between theoretical knowledge and the lived experience of supporting a loved one through addiction.

Hannah: I've worked in the addictions field before, so I was aware, there was always a risk of relapse. I first met him at high school, then we reconnected as adults. So, when we first got together, he was clean. ...It's definitely a whole other ballgame when it affects you personally. Like there is no book in the world that describes how painful that is.

Sophia, despite working in mental health and suicide prevention, confesses to experiencing anxiety and stress due to her partner's addiction. Despite professional expertise and access to coping tools, she finds herself unable to apply these strategies effectively in life, underscoring the profound impact of personal involvement in addiction dynamics.

Sophia: I work in mental health and suicide prevention work...I still couldn't stop it from happening. I don't even use my own tools that I teach other people to use. Even though I know all the tools as well. It's just too hard.

The convergence of professional expertise and personal turmoil underscores the complexity of addiction and its impact on mental health professionals. Despite their training and knowledge, they grapple with feelings of inadequacy and helplessness when faced with the challenges of addiction within their own relationships. The gap between theory and practice becomes painfully apparent, highlighting the need for greater support and any individual navigating personal crises.

Interpersonal

This section shifts to explore how the burden of supporting a partner through addiction extends beyond the relationship itself, affecting connections with friends, family, and children.

Intimate relationship dynamics

To grasp the dynamics of the relationship with the partner, it is essential to recognise the symptoms associated with their addiction, along with the emotions that accompany these challenges. While the relationship often presents significant problems, it is not devoid of nuance; moments of connection, joy, and love still exist amidst the difficulties. Understanding this complexity helps paint a fuller picture of the emotional landscape shared between partners.

Beyond the surface: Understanding the emotional and financial toll of addiction

The following accounts outline the realities of addiction's toll on intimate partnerships as the women describe their partner's behaviour. The descriptions paint a vivid picture of escalating mood swings, aggression, financial ruin, and unrealistic expectations.

Emily: His moods were getting worse, started getting aggressive verbally and started drinking more and his behaviour started becoming more erratic.

Emily: Worrying when he didn't come home when he was out on benders, and then the benders stopped and I'd think, okay, he's making changes, but then he just started using alone which was worse.

Emily describes her partner's deteriorating behaviour, noting a concerning escalation in mood swings, and erratic actions. This behaviour creates a sense of fear and uncertainty, as Emily worries for his well-being and safety. The shift to solitary use exacerbates her concerns, highlighting the isolating nature of addiction and the increased risk of harm when individuals use alone.

Additionally, Hannah recounts how the financial strain her partner's actions imposed, adds to the emotional burden:

Hannah: He cleared out my bank account. He maxed out three of my credit cards that I'm still having to pay off now. He sold pretty much everything that was of value to us as a family but also to himself. He wrote off our car that I hadn't paid off, so I had to pay off a car that was crushed.

Emily similarly reflects on her partner's manic energy and unrealistic expectations, which contribute to the strain on their relationship. Despite experiencing a serious health issue, Emily finds herself pressured to meet her partner's demands, highlighting the distorted priorities and self-centred characteristic of addiction.

Emily: He did things at like crazy speed, we bought a house and fully renovated that within a year. He had really crazy demanding expectations of me, like I was sick with a really bad chest infection, and he was expecting me to be out there cementing a fence.

These narratives provide valuable insights into the complexities of addiction and the challenges faced by supporters in their daily lives. The shared experiences underscore the interplay between a partner's erratic behaviour, financial devastation, and unrealistic expectations, all contributing to the emotional burden on women. Understanding these dynamics is crucial for grasping the full scope of challenges faced by supporters. By recognising the multifaceted nature of these relationships—marked by fear, pressure, and a

struggle for stability—one can better appreciate the emotional toll and resilience needed to navigate such difficult circumstances.

Deception and denial: The struggle for truth in the face of addiction

In addition to observing changes in their partners' outward behaviour, participants expressed feelings of betrayal, disbelief, and fear as they confronted the complexities of their partners' secrecy and lies.

Emily's account epitomizes the profound sense of betrayal and disbelief that accompanies the revelation of a loved one's addiction. Despite spending years in proximity, she remains oblivious to the extent of her partner's substance abuse, shrouded in a veil of secrecy and denial.

Emily: I still don't even know the full truth, but I feel like he was using daily. I think he's been using meth throughout our whole relationship, and I had no idea, seven or six years of having no idea.

Emily: All his friends were addicts and he made me believe that he was helping them. There was one who was in and out of rehab and I hated him, I had this gut feeling every time he came over to my house, I just felt sick and wanted to vomit. But I didn't know what my instincts were. I had no idea, and I ignored them. So, this guy had a heart attack, he nearly died. And then my partner was still using with him even after that, like it blows my mind.

Emily's narrative exposes the depths of manipulation inherent within addiction. Her partner's ability to maintain the facade of altruism while engaging in self-destructive behaviour not only deceived Emily but also eroded her trust in herself. This erosion of self-trust, coupled with the manipulation orchestrated by her partner, illustrates the extreme psychological burden of addiction on both the individual and their loved ones.

Similarly, Hannah's story underscores the corrosive impact of lies and deception on trust within a relationship. Despite pleading for honesty and transparency, Hannah is repeatedly deceived by her partner's actions. The betrayal reaches its pinnacle when her partner exploits her vulnerability in the aftermath of childbirth, abandoning her to fulfil his own needs.

Hannah: The morning after I gave birth, he stole my credit card and went off on a binge and left me by myself. And then he just, you know all the lies, the money going missing, property going missing.

Hannah: I remember quite vividly having a counselling session around trust and lying, and how I'd prefer him to be honest with me than lie. I don't care what you've done. Just tell me and we can work through it but stop lying. And then we walked out of the session, and he had sold a whole lot of my stuff and had lied about it. And then continued to lie about it.

The unpredictable nature of addiction, as highlighted by Hannah's experience, fosters a constant state of apprehension. For supportive partners, such experiences create a climate of anxiety where each interaction is coloured by doubt and uncertainty, leaving them to question whether promises of change are merely another form of manipulation. Sarah expands on this confusion, candidly admitting to living in fear:

Sarah: The unpredictable nature of his behaviour as being an addict, you know, it means that a lot of our time, I still walk on eggshells constantly with him. I'm still afraid of him to be quite honest.

This fear stems from the constant uncertainty surrounding the addicted partner's behaviour, leaving the non-addicted partner feeling perpetually on edge. Despite attempts to rationalize her partner's behaviour, Sarah is perpetually ensnared in a web of deceit, unable to distinguish between moments of sobriety and relapse. As she grapples with the painful reality of her partner's addiction, Sarah is confronted with the sobering truth that recovery is contingent on his willingness to seek help.

Sarah: Basically, he said, that he was using the whole time, and when I thought that he wasn't using, he was using. So, I used to think I had an idea, but I don't think I ever did to be honest. And I still get tricked. You know, I still think, is he using, is he not using? But I'm trying to just accept the fact that he's an addict. And so, unless he's in some sort of recovery programme, whatever that looks like for him. Then he's using. No matter what you know.

These narratives encapsulate the agonizing struggle to discern truth from fiction amidst the chaos of addiction.

Holding on: The emotional tug-of-war in relationships for supporters

The impacts of addiction on intimate relationships are multifaceted and deeply nuanced. As loved ones navigate the unpredictable nature of addiction, they must maintain a delicate balance of compassion, resilience, and unwavering support amidst the constant push and pull between hope and despair. Hannah outlines this tension as she discusses moments of hope in her journey with her partner:

Hannah: He was sober. He had goals. There was hope. And then we found out that he had a blood clot at in his frontal lobe and he was having seizures. So, then he got diagnosed with epilepsy, he just didn't cope with things and started using again.

This glimmer of optimism is swiftly shattered by the revelation of health issues stemming from substance use. The diagnosis further exacerbates the strain on the family unit, as they grapple with both the physical and emotional ramifications of addiction. Hannah's narrative delves deeper, exploring the profound sense of loss and disconnection experienced by loved ones. She describes a state of "grieving for the living," where her partner's physical presence is a painful reminder of the person he once was:

Hannah: He's still breathing, but he's not there anymore. My husband doesn't exist anymore. He's just the shell of the person I married. I don't recognise the person that he is.

This deep sense of loss and disconnection underscores the devastating impact addiction can have on intimate relationships, leaving loved ones grappling with a profound sense of emptiness and longing. Emily's narrative adds another layer of complexity, illustrating the inherent tension between love and addiction. She portrays her partner as a multifaceted individual, capable of moments of support and love amidst the chaos:

Emily: He was cooking for me, cleaning and, you know, just being a responsible person.

These positive experiences create a sense of normalcy and can serve as a temporary reprieve from confronting the harsh reality of the addiction. Emily describes how distractions like home renovations further complicated the process of acknowledging the problem:

Emily: Our house was getting renovated... So, there were a lot of other distractions to distract us from the reality of what was happening.

These narratives vividly illustrate the intricate dynamics at play in relationships affected by addiction. The pervasive fear, the strain on the family unit, and the complexities of loving someone struggling with addiction are all woven throughout these accounts. Navigating such relationships requires a delicate balance of compassion, resilience, and unwavering support as loved one's grapple with the unpredictable nature of addiction and the constant push and pull between hope and despair.

The weight of judgement: How addiction alters friendships and social life

These narratives illustrate the significant impact of supporting a partner through addiction on friendships and social connections, often resulting in isolation and feelings of judgement. While friends may offer warnings or express concern, their lack of understanding can strain relationships and create a sense of isolation. Additionally, the stigma surrounding addiction can exacerbate these challenges, leading to judgement and exclusion within social circles.

Emily's story highlights the tension that arises when loved ones offer warnings. Friends, with an external perspective, often detect concerning signs ("*red flags*") before the individual directly involved. Emily recalls how her friends voiced their apprehensions; a reflection of the common role friends play as a protective support system. However, this discrepancy in perception can strain friendships, as Emily acknowledges:

Emily: Everyone was always like, Why? Why are you guys together?

Her friends not only questioned the relationship, but also attempted to convince her that her partner's behaviour would never improve. Even her partner's own friends were perplexed by the match-up and admitted that Emily was too good for such a relationship. Despite these

external influences, Emily's perspective remained unchanged. It is worth noting that the reasons behind her persistence in the relationship may be complex and multifaceted, influenced by factors such as emotional attachment, hope for change, or a sense of obligation.

Similarly, Hannah's account underscores the strain of her intimate relationship on friendships. Friends may struggle to comprehend the rationale behind staying in such a relationship or maintaining concern for the addicted partner. This lack of understanding can create discomfort and awkwardness in social interactions, prompting individuals like Hannah to withdraw from discussing their relationship challenges with friends altogether.

Hannah: There's a lot of friends that just don't understand why I stayed with him...So it makes it awkward because it's just easier not to talk.

Sophia's story reveals how judgement from friends compounds the already significant lack of understanding and support. Despite Sophia's openness about her partner's addiction, she encountered stigmatizing attitudes and judgement from peers. Sophia's friend's wedding invitation debacle exemplifies the consequences of such judgement, where Sophia felt excluded due to the association with an individual grappling with addiction. This experience underscores the alienation and isolation that can result from the judgement and stigma surrounding addiction within social circles.

Sophia: I wouldn't hide it away. But you still got people's judgement and stigma anyway. My good friend got married and the invite only came to me. So, I said if you're going to judge him...then just don't worry. I won't come either.

In summary, these narratives reveal the strain on friendships that arises from supporting a partner through addiction. From warnings and misunderstandings to fractured relationships and judgemental attitudes, they highlight the importance of fostering empathy, support, and education within social networks to cultivate greater understanding and compassion for those navigating the complexities of relationships impacted by addiction.

Shifting blame: The complexities of family dynamics in addiction

These narratives reveal the profound impact addiction can have on extended family relationships, marked by tension, betrayal, blame, and denial. Each participant experienced varying levels of support within their own and their partners families.

Emily's experience unveils the tension within her family, characterized by differing levels of understanding and support. While Emily's parents initially exhibited openness and support towards her partner, their perception shifted dramatically following a significant incident, leading to ruptures in familial relationships. Despite this, Emily acknowledges the enduring presence of her partner within their lives due to their shared parenthood, highlighting the complexities of disentangling familial ties even amidst tumultuous circumstances.

Emily: My parents were actually quite open minded and supportive of him ...until this last thing. I think that's really ruptured his relationship with my mum and she's just done. I think she's seen how much he's hurt me. That also brings new challenges, I'm like he's going to be part of our life, whether we like it or not, whether he's in recovery or not, because he's the father of my baby, I can't just extinguish him from my life.

In contrast to such familial acceptance, Hannah's narrative exposes detrimental effects marked by betrayal, financial exploitation, and profound hurt. The consequences of her partner's actions reverberate beyond their relationship, impacting Hannah's parents deeply. Her father's disassociation and her mother's emotional investment in her partner underscore the hurt inflicted upon the wider family unit.

Hannah: He's stolen from my parents. My father wants nothing to do with him. And even if you mention his name, he pretty much just shuts me down straightaway. My mum took him in like her own son and he doesn't have family at all. So yeah, my mum's been really hurt by him.

Sophia's account adds another dimension, exploring the complexities of blame and denial within the addicted individual's family, highlighting patterns of enabling behaviour and a lack of understanding about addiction. The trauma and emotional strain faced by Sophia and her loved ones underscore the profound ways addiction can disrupt and reshape familial dynamics.

Sophia: The changes destroyed the whole family mentally, physically, emotionally. Everyone in the family was affected completely.

Sophia's narrative underscores the lack of support and understanding from her partner's family, exacerbated by their denial and tendency to shift blame onto Sophia for the relationship's difficulties.

Sophia: I used to say, educate yourself, understand this. So, I didn't get the support from them like I should have. Like there was a time when he ended up attempting to take his own life after that first relapse and he got admitted, got sectioned into the ward, you know, and talking to them then. It's like they still they had no frickin idea and they're still kind of blaming me that he used. You know "You guys mustn't have been good together," you know like, No - he just chose drugs.

Furthermore, Sophia's mention of her partner's family's desire to silence discussions about addiction due to shame highlights the pervasive stigma surrounding substance abuse within familial contexts. This desire to conceal the issue further compounds the challenges faced by individuals seeking support and understanding from their wider family networks.

Sophia: They couldn't wrap their heads around it. Plus, they don't want people to know about it because it's shamed them out. We've done loads of TV and media interviews... The first thing his sibling said was "Don't fucking do any of them again." And he's going well "I'm trying to help still suffering addicts," you know, but it was a shame on them.

When seeking support from their partners' families, Emily and Sarah encountered barriers characterized by blame, denial, and a lack of assistance. Emily's attempt to involve her partner's parents in the situation was met with denial and minimization of the issue, leaving her without crucial support:

Emily: As soon as I found out, I called his parents and told them and unfortunately, they're in complete denial, and they minimize everything. And they're addicts themselves and that's the reality of it.

This underscores the challenging reality of seeking support from a family already entrenched in similar issues. Sarah's experience with her partner's family further exemplifies the detrimental effects of blame and a lack of responsibility. Instead of offering support, they

deflect accountability onto her. This pattern of scapegoating and blaming the supporter reflects a broader dynamic observed in families affected by addiction.

Sarah: No interest in any type of responsibility. Conversations when he is in full flight are, "well what have you done, M? What are you going to do about it? They're all just traumatized family really and don't know how to support him. His grandparents just throw money at the problem and blame everyone other than him.

In summary, the narratives offer insights into the impact of addiction on wider family. From ruptured relationships and blame to denial and shame, these accounts underscore the urgent need for increased education, empathy, and support within familial circles to address the complexities of addiction and its far-reaching consequences.

Dual realities: Children navigating the love and pain of an addicted parent

These accounts shed light on the profound and enduring effects on children's emotional well-being and development within participants narratives.

Sarah's depiction of her oldest daughter's experiences illustrates the lasting trauma resulting from exposure to her father's unpredictable and volatile behaviour. Chronic neglect and traumatic incidents have left enduring marks on her daughter's psyche, leading to difficulties in concentration, confidence, and a tendency to disassociate during stressful situations. Such experiences not only undermine her daughter's emotional resilience but also hinder her ability to navigate interpersonal relationships and cope with adversity.

Sarah: She's had a lifetime of neglect from him...The unpredictable nature of his behaviour and his horrific, violent, aggressive outbursts and stuff, has had a huge impact on her in terms of her concentration and confidence. She disassociates if things get hard. There's a lot of trauma there for her.

Furthermore, Sarah's portrayal of her daughter's conflicted emotions and behaviour highlights the internal struggle faced by children in such situations. Despite longing for a nurturing and stable paternal figure, her daughter grapples with the dissonance between her

father's sporadic displays of affection and the distressing reality of his addiction-fuelled behaviour. This conflict underscores the profound confusion and emotional turmoil experienced by children attempting to reconcile their perceptions of their parent with societal norms and expectations.

Sarah: She is kind of happy and anxious at the same time, just wanting to please him so nothing happens. She looks to me a lot for support if he is around. She's not really that comfortable going with him on her own. It is a confusing relationship dynamic for her because she knows he can be great fun and loves her, and she really wants a dad. But she knows that he is not like other dads you know.

The dichotomy between her father's moments of warmth and affection and the reality of his addiction-induced behaviour presents a formidable challenge for her daughter's sense making process. In a world where societal norms dictate clear-cut distinctions between good and bad fathers (Ames, 2014; Furstenberg, 1988), her daughter grapples with the complexity of reconciling her father's dual nature.

Similarly, Sophia's account sheds light on the pervasive anxiety and emotional distress experienced by her youngest daughter. Despite being characterized as “*daddy's girl*,” her daughter grapples with profound feelings of abandonment and fear, necessitating professional intervention. These experiences not only disrupt her daughter's emotional well-being but also hinder her ability to form secure attachments and trust in interpersonal relationships.

Sophia: The youngest - she's daddy's girl - but it affected her massively and she has kind of like reactive anxiety now. So, she's been through loads of psychologists and stuff like that. And it's the worry, the abandonment, all those things.

The impact of a partner's behaviour on the child is palpable, as Hannah recounts the heartbreaking reality of her daughter growing up without the presence and support of her father. Despite her efforts to shield her daughter from the harsh truth, Hannah grapples with the delicate balance of preserving her child's innocence while also acknowledging the reality of her partner's shortcomings.

Hannah: I was pretty much raising our daughter by myself while healing from an emergency C section. And then things spiralled significantly. He started offending, he went from one charge to 28 charges, over a six-month period. He provided no financial assistance. He was not there physically for our daughter. He didn't come to any doctor appointments. He didn't try to maintain contact with her. It was me constantly chasing him to try and keep him in the loop of what was going on.

Sophia's perspective provides further insight into the frustration and anguish experienced by partners as they grapple with the seemingly incomprehensible choices made by their loved ones. The conflict between love for their children and the overpowering grip of addiction creates a profound internal struggle, as supporters lament the inability of their addicted counterparts to prioritise their familial responsibilities.

Sophia: Why are you choosing drugs over your kids? Why can't you put our daughter first? But, when you're in that deep, you can only see drugs. It's not that you don't love your kids. You just can't choose them over it.

Amidst the turmoil and despair, glimpses of hope and humanity emerge, as Hannah fondly recalls the moments of joy and connection shared with her partner during periods of sobriety. The tension between his dual personas — the loving, devoted father and the distant, addicted figure — serves as a reminder of the complexity inherent within the dynamics of addiction.

Hannah: He is a really good dad when he's sober. He's the jokester. He's doesn't mind dressing up and having his nails painted or his makeup done by her and plait her hair, plays on the playground with her you know. I try and hold on to those memories for her. Those are the things that I really miss. And that's the person that I fell in love with, but he's just not there.

In framing the issue for the child's understanding, caregivers described needing to navigate the delicate balance between honesty and protection, offering age-appropriate explanations while ensuring the child feels loved and supported. Hannah's narrative highlights the importance of preserving positive memories of her partner while also acknowledging the

harsh realities of his addiction, providing her daughter with a nuanced understanding of her father's behaviour.

Hannah: I'm trying not to put my feelings onto her about what I've been through with him. But at the same time, I don't want her to grow up idolizing or thinking he is this angelic role model? When the reality is he's done nothing for her.

In summary, the narratives vividly portray the significant and lasting impact of addiction on children. They emphasise the complexities of emotional trauma, disrupted development, and conflicted relationships experienced by these children. Caregivers grapple with the delicate balance of preserving positive memories of addicted parents while acknowledging harsh realities, all while ensuring children feel supported.

Societal

The narratives shared by participants were profoundly influenced by their societal contexts. The women expressed how societal definitions of abuse shaped their perceptions of their relationships. Likewise, prevailing understandings of addiction influenced how participants viewed their circumstances. References to the stigma surrounding addiction and its enduring effects were prevalent. Discussions also highlighted the availability of support services and the barriers to accessing them, often in conjunction with the use of the justice system.

Redefining abuse: Beyond physical violence in relationships

In analysing the narratives of participants, a valuable insight was offered into the intricacies of defining and recognising abuse within societal contexts. These narratives revealed how societal norms and expectations of what constitutes abuse, profoundly influence individuals' experiences. Emily's revelation about her relationship dynamics highlights the significance of broadening societal definitions of abuse beyond physical violence. Her acknowledgment of emotional abuse signifies a crucial shift in understanding the diverse forms of harm present in interpersonal relationships. However, Emily's initial scepticism and subsequent realisation shed light on the hidden nature of abuse, often obscured by societal misconceptions and stigma.

Emily: Someone said to me there's a lot of emotional abuse going on, like abuse is not just physical, and I never thought I would be in such a cycle. And then I learned about gaslighting, and I was like, yeah, that's 100% what's happening like, I think I'm the one going crazy.

Sarah's reflection on societal attitudes towards parental roles and abuse further illuminates the complexities surrounding the classification of abusive behaviour.

Sarah: "You can't take the children away from their father" and you know, "he would never hurt them," but he is hurting them. It's that kind of thing like, unless he is beating them, then he's an okay parent.

The prevailing notion that abuse must manifest in overt physical violence to be deemed valid neglects the myriad ways in which emotional, psychological, and verbal abuse can profoundly impact individuals, particularly children. Sarah's frustration with the dismissal of her concerns underscores the limitations of societal boundaries in addressing the multifaceted nature of abuse within familial contexts.

These narratives of participants prompt critical examination of the usefulness of societal definitions of abuse and their efficacy in supporting victims. While established boundaries serve as important frameworks for identifying and addressing abuse, their rigid adherence may inadvertently perpetuate harmful misconceptions and invalidate victims' experiences. By narrowly defining abuse within the confines of physical violence, society risks overlooking the pervasive harm inflicted through emotional manipulation, and other non-physical forms of abuse.

Reframing addiction: The role of education and empathy

The accounts shared offer valuable perspectives on how society perceives addiction, providing insight into the ongoing debate between framing addiction as a mental health concern versus a moral and criminal issue.

Emily expresses her struggle with her parents' lack of understanding of addiction, noting their tendency to hold onto resentments and their failure to comprehend her perspective.

Emily: My parents were people I could always turn to for support. And they were a huge source of support when I first left him. But now that I can hold the space of compassion for him and his disease, as well as separation and doing what's right for me. Yeah, I really struggle. Because my parents are not in recovery themselves. They don't have the same understanding of addiction as I do. They hold a lot of resentments. Part of me wishes they could understand and have some compassion.

Emily's hope for societal progress reflects a growing awareness of the need to shift away from viewing addiction as a moral choice towards recognising it as a multifaceted disease. She emphasises the physical, emotional, and spiritual dimensions of addiction, challenging the notion that individuals willingly choose addiction.

Emily: Hopefully as society we're starting to learn more and not see addiction as this like, moral choice that people do. Just that it's actually you know, a disease physical, emotional, spiritual. Like no one has ever said, "hey, I want to be an addict. I want to just randomly experiment with drugs and end up under a bridge and lose my family," you know...? Noone ever wants that.

Sarah's experience with her mother further illustrates the transformative power of education and understanding. As her mother comes to recognise addiction as a manifestation of underlying health issues rather than a personal failing, she shifts from judgement to empathy.

Sarah: My mum now feels sorry for him, you know, because she realises that he is not a well person and none of this is personal. His problems were here before I came along.

Sarah's observation about the interplay between addiction and mental health underscores the complexity of addressing SUDs. The chicken-and-egg dilemma she raises emphasises the need for comprehensive approaches that consider both addiction and underlying mental health issues:

Sarah: We went into the [mental health service] because of his mental health stuff, because of course, you know. Underlying the issue, what came first the chicken or the egg, the addiction or the mental health?

Sarah's understanding of the connection between addiction and mental health emphasises the necessity of reframing addiction. By questioning the relationship between addiction and mental health, Sarah underscores the complexity of SUDs and the significance of addressing underlying mental health issues. Her emphasis on gaining coping strategies from therapy highlights the importance of viewing addiction as an illness rather than a moral failing. Recognising addiction as a sickness, Sarah aims to equip herself and her children with tools to break intergenerational patterns.

Sarah: I'm getting tools from my therapist and my support programmes that I can hopefully pass down to my children, you know, my daughter already knows slogans like "hurt people hurt people." She is learning to not take things too personally, that her dad is unwell and that when he's upset, it's not because of her, it's because he's sick.

Emily's evolving understanding of addiction reflects a shift towards viewing addiction as a disease rather than a personal failing. Her realisation that addiction stems from a serious illness underscores the importance of maintaining compassion for individuals struggling with SUDs while also prioritizing self-preservation.

Emily: I'm learning that I can have love or compassion for this person and this person didn't set out to destroy me. They have a really serious disease, and they have their own journey. And addiction is horrible and destructive. But it also has the potential for huge growth, huge opportunities and recovery.

These narratives highlight how societal perceptions of addiction influence how supporters understand their partners and their struggles, as well as the accessibility and effectiveness of support services. They emphasise the need for greater understanding, empathy, and holistic approaches to address the complex challenges associated with addiction.

Breaking the silence: Challenging the stigma of addiction

The narratives reveal the widespread shame and stigma surrounding addiction, making it difficult for individuals to seek support and share their experiences.

Emily's experience reflects the internalized shame and guilt she felt about leaving her partner, exacerbated by societal expectations of the nuclear family. The fear of judgement from

colleagues and the reluctance to disclose her situation highlights the stigma attached to single motherhood and the societal pressure to conform to traditional family structures.

Emily: I was mortified, about people at work finding out...that I had left my partner like, who leaves their partner when you've got a baby, you know? I felt so much shame and guilt and I'm like, no one will understand unless I tell them the truth, but I don't want to tell them because what impact is that gonna have?

Additionally, Emily's partner's reluctance to engage in group meetings due to stereotypes and societal narratives about addiction further perpetuates the stigma surrounding addiction, even among those directly affected by it.

Emily: After a meeting he said to me, "They're just full of addicts who have been to jail and have ankle bracelets and have been court ordered to be there, and I'm not like them and you know?"

Emily's reluctance to attend her first online meeting mirrors her partner's initial resistance, both rooted in similar fears and misconceptions about the people they expected to encounter. Like her partner, Emily harboured apprehensions about the diversity of the group, fearing that she would not fit in or relate to others based on preconceived stereotypes.

Emily: I wasn't sure what to expect I thought everyone there would be different to me. Like ethnically, socio-economically, educationally. I thought it would all be like, partners of people who have been to jail, all this crazy stuff, and I opened up rooms and there were people just like me, like normal people, just like me and that is what blew me away.

Similarly, Hannah's experience underscores the impact of societal stereotypes and judgements associated with addiction, particularly regarding methamphetamine use. The assumption of criminality and association with gang culture demonstrates the pervasive stigma attached to addiction, leading individuals like Hannah to feel unfairly judged and marginalized by society merely for her partner's actions.

Hannah: I feel that there's a lot of stereotypes attached to methamphetamine. That people just assume that I'm a crack whore, people assume that we must be

associated with the gang life. Just automatically like, you're put into this piece of shit box. There's just there's a lack of insight in society around how big of a problem it actually is.

Hannah's desire to break free from the silence imposed by societal stigma and share her story highlights the importance of challenging such societal perceptions and speaking out against stigma and shame.

Hannah: I'm not afraid to talk about how it's impacted me. And I don't want to have to wear a muzzle anymore.

Despite the pervasive stigma surrounding addiction, both Emily and Hannah express a desire to challenge societal norms and encourage others to speak out and seek support.

Emily: I felt like I was stuck in a nightmare I wanted to wake up from and I felt so alone, so ashamed. I felt like shame was probably the worst feeling that came, I felt so broken. And I would just want people to know that they're not alone in that, even though this might seem like the worst thing in their life. It actually has the potential to be the best thing that's happened to them in their life.

Hannah: It's just really really hard. I would want to encourage someone like myself to not hide anymore, you know, don't be ashamed to talk out and have a voice.

Their narratives emphasise the need to break the silence surrounding addiction, providing a supportive and non-judgemental space for individuals to share their experiences. In doing so, societal narratives that perpetuate stigma and shame can be challenged and changed. By sharing their stories, participants seek to empower others to confront stigma, seek help, and live healthier and more fulfilling lives free from shame and judgement.

Beyond the individual: The urgent need for family-centric addiction support

The narratives presented herein reveal a stark divide within addiction support systems: while a variety of resources exist to assist individuals struggling with substance abuse, formidable barriers hinder both individuals and families from accessing them. Participants

highlight how these systems, though well-intentioned, often fail to address the multifaceted realities of addiction within a family context. A glaring deficiency lies in the system's narrow focus on the individual with addiction, leaving the critical needs of families—especially women—overlooked and unsupported. Women are frequently relegated to the sidelines, expected to navigate the complexities of their partner's addiction without adequate assistance. This expectation—that women must independently source resources while simultaneously bearing the emotional and practical burdens of their partner's substance abuse—creates yet another barrier to seeking help. The systemic failure to address the whole family dynamic reveals a profound oversight, with little recognition of the cumulative challenges women face. The current framework struggles to adequately support even those with addiction, let alone extend meaningful help to their partners or families, leaving women isolated, overwhelmed, and forced to carry the weight of addiction on their own.

Emily's journey reports a mixed experience with available support services. While she encountered initial difficulties with the drug and alcohol helpline, she found solace and assistance through organizations like Shine¹ and the Northshore Women's Centre.² These institutions provided resources which played a pivotal role in her ability to cope and navigate the challenges of supporting her partner. Additionally, Emily's involvement with Nar-anon highlights the significance of peer support groups in providing non-judgemental and empathetic spaces for in similar situations.

Emily: They were so supportive, so understanding, so non-judgemental. They understood the love I had for this person and the impact on our family and so they got me free legal advice. They got me free counselling therapists, a social worker, which was amazing, just all for free and, readily available, it blew my mind. Honestly, that saved my life and then the social worker told me about Nar-anon. And that has absolutely saved my life.

However, Emily's account also highlights the potential pitfalls of seeking professional help:

¹ Shine provides safe housing and a helpline for victims of family violence. <https://2shine.org.nz/>

² North Shore Women's Centre offers low-cost counselling, legal advice and other services <https://nswomenscentre.org.nz/>

Emily: I went to therapy and the therapist convinced me that he was ready to change, that things were gonna be different, and that moderation was possible. I've now found out that she was just enabling him.

Emily's experience with therapy highlights a crucial aspect of the complexities surrounding addiction treatment: the distinction between enabling and supporting genuine recovery efforts. The term enabling refers to behaviours or actions that inadvertently facilitate or perpetuate an individual's addictive behaviours, often by shielding them from the consequences of their actions or providing false reassurance about their readiness to change (Barnett, 2016; Youvan, 2024). In Emily's case, her therapist's assertion that her partner was ready to change, and that moderation was possible reflects an approach that Emily believed inadvertently enabled his addictive behaviours. The therapist proposed a daily therapy programme "*at home*," which Emily rightly questions given the partner's ongoing addiction and the potential for relapse in a familiar environment. Emily's frustration is evident:

Emily: He found this therapist that was like, "No, you don't have to go to rehab...Do this 30-Day programme with me."

This approach, prioritizing convenience over addressing the core issues of addiction, could be seen as enabling. By promoting moderation as a viable option, the therapist may have underestimated the severity of the addiction and the difficulty of achieving sustained recovery without a more intensive programme. Emily's story also touches on a concerning aspect of the healthcare industry: potential conflicts of interest when therapists prioritise financial gain over client well-being. Emily questions the therapist's recommendation, particularly given its financial benefit to the therapist:

Emily: What professional tells someone who is very motivated to go to rehab, to not go to rehab, but instead to do this programme? With them? That gives her a lot of money?

Emily's account exposes a concerning aspect of the healthcare industry: the potential conflict of interest that arises when private therapists prioritise financial gain over the best interests of their clients. Emily rightly questions the efficacy and ethical implications of such a recommendation, particularly given her partner's significant struggles with addiction. This

narrative gives insight on the broader issue of the commercialization of healthcare, where profit-driven motives can undermine the quality and effectiveness of therapeutic interventions (Brown, 2024; Lima, 2019). Therapists who prioritise financial gain may be more inclined to recommend treatments or programmes that generate revenue, even if they are not in the best interests of their clients. This business-based model of health care creates a conflict of interest that compromises the integrity of therapeutic relationships and undermines the trust between clients and healthcare providers (Brown, 2024; Lima, 2019).

Further barriers to accessing help were described in terms of long wait times and financial constraints. Emily shared that her partner had reached out to a psychiatrist “*who can finally help,*” only to encounter a scheduling nightmare—an appointment set months into the future. This delay exemplifies the systemic inefficiencies that leave individuals and families stranded in moments of critical need. Expressing her deep frustration, Emily bluntly stated:

Emily: No wonder people in this country kill themselves.

Her words underscore the devastating impact of these barriers, where the lack of timely care exacerbates feelings of hopelessness and despair, leaving those seeking help feeling abandoned by the very systems meant to support them.

Financial constraints are another hurdle highlighted by Hannah's experience. Therapy costs, at \$120 per session, place private treatment out of reach for many individuals struggling with addiction. Hannah's statement “*I cannot financially afford \$120 an hour to talk to someone*”, underscores the harsh reality for those without the financial means to access critical mental health services. Hannah reported finding some relief through employer-sponsored mental health support. This benefit serves as a crucial example of how employer-provided resources can help mitigate financial barriers to care. However, limitations often exist with such programmes, such as a restricted number of sessions. These limitations may not adequately address the ongoing needs of individuals struggling with addiction, leaving them without sufficient support in the long term.

The narratives also highlight the vital role of peer support groups. Multiple participants' experiences with Nar-anon emphasised the importance of non-judgemental support from like-minded peers. They discussed how finding solace in a community where they could freely

express their emotions without fear of judgement was instrumental in helping focus on their own well-being.

Hannah: It truly is because of Nar-anon that I've been able to try and bring the focus back to myself. I have a few connections within that group that I can call... I don't feel judged by them. I don't feel stupid for talking to them.

However, Hannah's lament about the lack of early awareness of Nar-anon stresses a systemic failure to adequately inform individuals about available support resources, leaving many feeling isolated and unsupported.

Hannah: I wish somebody had told me or made me aware of Nar-anon early on, so I didn't have to be so alone. There's really no support for us. I don't get financial assistance as a solo mum. I don't get child support. I don't get accommodation supplements. I don't get anything. I'm ultimately just one income. Doing it all on my own.

Similarly, Sarah's journey highlights the frustrations encountered when seeking help for a loved one's addiction. Despite relentless efforts to find suitable rehabilitation options, Sarah was met with a lack of practical guidance and support from institutional and community resources. She described feeling frustrated with the suggestion that her partner needed to seek help on his own initiative, leaving her feeling helpless. Moreover, Sarah's reflections on her experience with Al-Anon underscore the diverse needs of supporters at different stages of the journey.

Sarah: I did try a couple of Al Anon groups at that time, but when I arrived, it just wasn't the right time for me. I was done with talking about it. I just wanted practical strategies to get him sober and I didn't understand the concept of it being about me and why am I insisting on getting this person clean? Like you know that there were issues in that.

While support groups offer valuable emotional support, practical strategies and guidance are equally essential, particularly for individuals seeking tangible ways to support their loved one's recovery. Sarah's experience highlights a critical gap in the support infrastructure for individuals supporting loved ones through addiction. Despite her efforts, she

encountered a startling lack of recognition and support for supporters themselves. The absence of proactive guidance from agencies and institutions reflects a systemic failure to acknowledge the impact of addiction on the broader support network.

Sarah: All those people that I called, no one ever mentioned is there anyone that you can call or talk to? I reckon those agencies need to be skilled, you know, to at least be like look, there are places that you can ring.

Recognising the vital role that supporters play in the recovery journey, agencies must prioritise providing comprehensive support that addresses the emotional, practical, and informational needs of supporters. The failure to acknowledge supporters as key stakeholders in the recovery process perpetuates a cycle of neglect and isolation, leaving supporters feeling unsupported and marginalized. Sophia's account further reinforces this idea:

Sophia: It should include the whole family. I went hunting for everything for me and my kids. There was nothing for us... Yeah, I get that there's the addict, but you're not looking holistically at all the parts of this. So, I think a lot of treatment would work better if the family, or even the friends are involved in the whole journey. Because it keeps them accountable more and healing the people that are hurt through it too.

Sophia's account emphasises the critical need for comprehensive family-centred approaches to addiction treatment. Recognising the impact of addiction on families, Sophia advocates for holistic treatment models that involve the entire family in the recovery journey. However, Sophia's frustration with the absence of family-inclusive services exposes a critical flaw in the current system—one that overlooks the broader familial dynamics essential to effective treatment and long-term recovery.

These narratives underscore the importance of accessible, comprehensive, and family-centred support services for individuals supporting loved ones through addiction. Addressing systemic barriers to access and improving awareness of available support resources are crucial steps toward ensuring that all individuals affected by addiction receive the support and assistance they need to navigate the challenges of the recovery journey.

Reclaiming control: How protection orders and legal support restore safety

A key theme in these narratives is the crucial role of protection orders in safeguarding individuals and their children. These legal tools help women establish physical and emotional boundaries from abusive partners, fostering safety and autonomy. External validation from lawyers, family, and support groups also played a transformative role, helping participants overcome denial, shame, and guilt. These stories emphasise the importance of accessible legal interventions, external support networks, and family-centred approaches in empowering supporters to reclaim safety and agency.

One recurring motif is the significance of protection orders as vital mechanisms for ensuring the safety and security of individuals and their children. Hannah, for example, reflects on how a protection order facilitated her separation from her partner, providing both physical and emotional safety for herself and children. The protective nature of such orders is similarly underscored by Sarah, who highlights how obtaining a protection order and parenting orders provided her with a semblance of autonomy and distance from her partner, enabling her to prioritise her own well-being and that of her children.

Hannah: [My daughter] was not even a year old and I applied for the parenting order, and that was a way of keeping her safe

Sarah: I finally got a protection order and parenting orders in place which has helped me keep my own distance from him. I still have contact with him, depending on how he's going, because we do share two kids. He sees them through me at the moment.

While protection orders and reliance on the justice system were instrumental, Sarah's narrative also highlights the disruptive impact of external factors such as the COVID-19 pandemic, which inadvertently impeded the efficacy of court-mandated interventions like supervised contact arrangements. Sarah's experience underscores the challenges that can arise even when legal interventions are in place.

Sarah: We were in a supervised contact centre but then COVID kind of happened and it all just fell away a bit. So, I've started supervising again, which is not a good idea. It's not working.

While legal interventions play a crucial role in safeguarding the well-being of the women and their children, they are not without their challenges. Sarah's experience with law enforcement highlights the nature of fear and apprehension associated with engaging with the justice system.

Sarah: I rung the police a lot in the early days, and never did anything with that, but I would ring them because I'd be afraid and you know, hang up, and get off the phone. And that was quite good. Because actually, later when I went to court, those things were all documented even though I hadn't pressed charges.

Despite initial hesitancy, Sarah's frequent calls served as a form of validation and laid the groundwork for future legal recourse and protection. This emphasises the need to address barriers to justice, like fear and stigma around law enforcement, which can deter people from seeking help.

Emily's reliance on legal support amid her tumultuous circumstances underscored its crucial role in helping her confront harsh realities and initiate positive change.

Emily: And they said to me, "Look, you can make a decision to not make a decision", because I was like, do I need to sell the house, there's my baby, the lawyers telling me I need a protection order. I'm like, what the hell? I can't, it was all just too much and so making the decision to not make a decision was really helpful.

Sarah's account emphasises how external validation plays a transformative role, revealing the influence of normalization and psychological manipulation on individuals' failure to recognise the severity of their situation. It underscores the crucial involvement of external figures, like her lawyer and mother, in dispelling denial and enabling her to confront the harsh realities she faced.

Sarah: You grow accustomed to your environment, and don't see how bad things actually are. When I went to my lawyer, finally got the police involved. They were like, you have to get a protection order straight away...call a lawyer right now, this is not okay... I'd never actually allowed myself to believe that my situation was as bad as it was. My mother said to me, "M, you're a battered woman, you need to sort it out." And my lawyer said the same, sorry this makes me emotional. But my lawyer said the same thing to me. And I was like, Well, what? You know, that didn't sort of occur to me. So, I got the orders within no time at all, it was a no contact slapped straight on him with no questions asked. Just having that behind me, those boundaries there, but also just the belief of the justice system behind me. That your experience is real. You know, because without that, I'd still be questioning and allowing all this behaviour.

Participants also mentioned the significance of external support via the impact of peer support groups. Sarah acknowledges how her journey toward seeking help was aided by the encouragement and insight gained from such groups.

Sarah: I fully attribute being in those spaces to actually going and getting my protection order, my parenting order. If I wasn't in Al-Anon I would never have done that, because I just thought it was all my fault or that I wasn't good enough.

This emphasises how support networks empower individuals to overcome shame and guilt, guiding them toward seeking necessary help. The narratives reveal the intricate dynamics among families, the justice system, and support networks, stressing the need to address barriers to justice. Legal intervention and external validation are shown to be transformative, enabling survivors to regain agency and safety.

Co-dependency

The narratives presented in this theme delve into the complex relationship between addiction, co-dependency, and caregiving within intimate relationships. They highlight how partners of individuals with addiction often become enmeshed in cycles of conflict avoidance, denial, and emotional dependence. Participants reflect on their tendencies to overlook early

warning signs in relationships and their struggle to separate love from enabling behaviour. The stories reveal a dynamic where partners feel addicted to the relationship itself, despite recognising its harmful effects on their well-being.

From survival to self-awareness: A journey of boundaries, recovery, and growth

The theme of co-dependency within drug-affected relationships is deeply explored through participants' experiences, illuminating the dynamics of addiction not only within the partner but also within the supporter. Participants revealed how they learned about their own patterns of conflict avoidance and their tendency to overlook "red flags" in the early stages of the relationship, akin to the way addiction often begins with a single use and then snowballs.

Emily: There were probably a couple of little red flags, that I ignored, or that he kind of reassured me about and I thought, Oh, it's fine.

Sarah: I knew what addict behaviour was like, but I couldn't see it when it came to him. I was just in such survival mode and denial.

They describe feeling almost addicted to the relationship itself, despite knowing its detrimental effects on their well-being.

Emily: I knew that there was something wrong with me for letting things get to that point. I couldn't trust myself and I've gone back so many times when I had told myself I would never go back. So, I knew I needed help staying away from that really unhealthy relationship.

One participant articulates the idea succinctly stating:

Emily: I think I have an addiction too; I think I'm addicted to my addict. I know he's bad for me, but I can't stop, I can't stay away, I have this compulsive urge to use.

This illustrates the striking similarity in thinking patterns and emotional and behavioural problems between addiction and co-dependency. Quotes from participants further illustrate the complexity of this dynamic. They describe going against their better judgement, ignoring warning signs, and feeling compelled to return to the unhealthy relationship despite knowing its

negative impact on their lives. This compulsion is likened to addiction, with participants expressing a need for help to abstain from the relationship, akin to the compulsion “to use.”

Participants also reflect on their journey towards self-awareness and recovery. Through therapy and support groups, they come to recognise their own destructive behaviours and patterns, taking responsibility for their choices and actions. They acknowledge the role of trauma bonds, denial, and low self-esteem in perpetuating their co-dependency.

Emily: [These groups] allowed me to do what I needed for myself and start getting myself well again, because I was so unwell. And they said to me, "if you just leave your addict now, you're just going to go find another addict and start over again." Through working the programme, I realised that I blamed him for destroying my life. I realised that actually, I was on a path of self-destruction long before he came into my life, and my own issues, and the relationship choices that I was making.

Similarly, Sarah reflects on her experience of feeling indispensable to her partner, driven by her low self-esteem and intense need for validation. When her partner moved on to another person, she experienced a sense of loss and turmoil, akin to withdrawal from a drug. This realisation prompted her to seek help from Al-Anon, where she confronted the distorted perception of her partner and the trauma bonds that kept her tethered to him.

Sarah: He moved in with this woman, two weeks after they met because of course, they're both addicts. And I stopped being important. Because part of the allure for me was that I was the only person that he thought would help him. I was this amazing person, and he'd never met anyone like me... and that really fed my own issues with self-esteem. I needed somebody to be that intense for me to feel lovable. And when he removed that and then moved on to somebody else, I went actually crazy. It was like I was coming down from a drug myself.

Through this process participants described gaining insight into their relationship choices. Sarah recognised that her relationship was not an isolated incident but part of a pattern in her life. She understands that life will continue to present the same lesson until she learns from it, motivating her to break the cycle of co-dependency and pursue healthier relationships.

Sarah: It taught me a lot about addiction. It's not my fault, and why I was attracted to these men. You know what I mean? He is not my first addict. Definitely my most intense but not my first.

Participants expressed gratitude for the opportunity to break free from the cycle of addiction and co-dependency. They recognised that their relationships served as catalysts for personal growth and self-discovery. This journey involved a shift in personal boundaries, a recognition of repeating patterns in relationships, and a commitment to prioritizing self-care and self-responsibility.

The cost of caregiving: Gendered roles, co-dependency, and self-discovery

This subtheme highlights the intricate relationship between caregiving, compassion, and women's experiences in codependent relationships. Participants felt compelled to take on caregiving roles within their relationships and described prioritising the needs of others above themselves.

Hannah: I would be getting our daughter ready, taking her to daycare, working from home full time, managing the day-to-day stuff. And then he wouldn't come home from work, or he would sit up and not sleep. So, then it would often be me not sleeping because I was trying to figure out is he using? Where is he? Is he okay? Is he safe?

Emily: Before, I was just on autopilot burnt out mode because I was doing everything for everybody else, rather than doing things for me. Going through this has given me courage to find myself, define myself and to build a healthier relationship with myself and others. Yeah, courage to make decisions and choices unapologetically.

These accounts vividly portray the immense strain placed upon participants as they navigate their partners' addictions alongside the responsibilities of parenthood. Despite their unwavering commitment to their families, they grapple with the toll it takes on their own mental and emotional health. Emily's perspective underscores the primal instinct to protect

oneself and one's children from harm, bravely choosing to prioritise her safety and that of her baby by leaving an environment tainted by addiction:

Emily: I gave him a chance to come clean. He was completely in denial still lying about it. Until he finally said, yes. Okay, like I've done it a couple of times. As soon as he admitted, like, even if he had just done it once, that was enough for me. I knew that it was not a safe place for me and my baby.

Both Emily and Sarah described how societal expectations often dictate women's roles as caregivers, blurring the lines between nurturing and enabling behaviour. Emily reflects on excusing her partner's addiction due to his support during a vulnerable time, while Sarah acknowledges feeling more like a mother figure than a partner.

Emily: What complicated things is that my brother died a week before I moved in with him. I was totally broken and vulnerable and he was there for me emotionally. And so, then that whole year, I was just a blind mess, and I excused a lot of his drug use behaviour, being like, he chose to move in with a partner who's grieving. And, you know, he's probably stressed, he's amazing for being there for me and he could have left but he didn't. All of that also clouded up a lot of our relationship.

Sarah: I have become a mother not partner in the relationship.... So, I was a caretaker and a mother and, ... I do actually think of him almost like a third child to be quite clear.

The introspection shared by these women reveals a profound realisation: equating love with fixing others' problems only leads to neglecting one's own needs and identity. They come to understand that true empowerment lies in allowing others to take responsibility for their actions and experiencing the consequences of their choices.

Emily: Because if I'm doing everything and finding recovery for him, he's not owning it. Yeah, it's always my fault then if things work or not work. It will only be from him trying and failing and trying and failing again, that he'll surrender and be like, Okay.

This reflection reveals the tendency to equate love with fixing others' problems in a caregiving role. Participants realised this often led to neglecting their own needs and identity, prioritising peace over personal well-being. They recognised that true empowerment comes from others taking responsibility for their actions. Emily acknowledges the limitations of her role in her partner's addiction recovery, opting to let him face consequences instead of rescuing him.

Emily: Everything I thought was love, was enabling and I was completely obsessed and focused on other people. On making their lives better. I had literally lost my whole sense of identity because even in my family, I was always the peacemaker. You know, the mediator, the one that brought everyone together. I thought that gave me so much self-esteem, and I'm so good because I've kept my family together. Bullshit. I've just robbed everyone. Everyone's opportunity to take responsibility for themselves.

Emily: By not enabling or rescuing him, I can compassionately and lovingly allow him to experience the consequences of his choices and hit rock bottom. And feel that pain that he needs to, that I've been trying so hard to save him from... That's what addicts are constantly trying to get away from – pain. But actually, the pain is the key to recovery, facing that pain is the only thing that motivates people to really truly change their lives. Everyone sees pain as the enemy but actually pain is the saviour.

This understanding of pain's role in growth, challenges societal views, seeing pain as transformative rather than solely negative. The role of pain in recovery was similarly touched on by Sarah but in terms of her own experience:

Sarah: I didn't realise how uncomfortable I was feeling any type of pain. Physical or emotional pain I avoided at all costs, and so I'd constantly allow unacceptable behaviour everywhere, not just with him, because I couldn't deal with confrontation. I was so terrified of being criticized. That would then reinforce the feeling that I was a shitty, horrible person that wasn't lovable, right? So, realising I can set boundaries around what I want my environment to be has been really important, and that someone else's reaction to those

boundaries is not about me or about 'not being good enough,' and that the discomfort will pass.

The reflections shared by participants offer insights into the journey of self-discovery and empowerment after navigating codependent relationships. By embracing the mantra that *"No is a complete sentence,"* Sarah acknowledges the importance of setting boundaries and prioritising her own well-being. She recognises that avoiding discomfort and confrontation only perpetuates unhealthy patterns and reinforces feelings of unworthiness.

Sarah: I think just the three C's. Didn't cause it, can't control it, can't cure it.... And just that it's not your fault. It's not your responsibility to fix them. I tried absolutely everything, every tact I possibly could, none of it worked.

Sarah's realisation further solidifies her understanding that she is not responsible for fixing others' problems. This shift in perspective liberates her from the burden of taking on more than she can handle and allows her to release the notion that she is somehow inadequate for not being able to fix everything.

In summary, these narratives provide a compelling glimpse into how addiction deeply affects intimate relationships and family dynamics, emphasising the remarkable strength and commitment of caregivers amidst overwhelming challenges. They showcase the intricate interplay of caregiving, co-dependency, and gender roles in relationships, offering profound insights into the complexities of these dynamics. Moreover, the reflections shared offer valuable lessons on reclaiming agency, establishing boundaries, and prioritizing self-care amid societal pressures and personal evolution.

Chapter Five: Discussion

The ecological approach was utilised throughout the analysis to examine the impact of addiction on partners across personal, interpersonal and societal levels. The themes explored highlight the relational, dynamic, and enduring nature of this impact, which evolves slowly with lasting consequences. To understand these themes the discussion moves to sense-making across these dimensions. This discussion begins by outlining the emotional and practical costs of being a supporter and the effects of emotional abuse, particularly gaslighting. Consistent with previous studies, it also highlights the impact of family addiction on children. The discussion then explores the interplay between isolation and stigma for those supporting individuals with addiction. The discussion further investigates the relationship between co-dependency, gender dynamics, and caregiving behaviours in these contexts, starting with a definition of co-dependency and its relevance to participants' experiences. It examines how personality traits, such as agreeableness and neuroticism, contribute to co-dependency and the challenges faced by women supporting their partners. Parallels between participants' narratives and established stages of addiction recovery are then explored, illustrating a transition from chaos to stability as participants and family progress toward recovery. Implications of the research are then explored, highlighting the critical need for accessible, comprehensive, and family-centred support services for individuals supporting loved ones through addiction. Limitations and future directions are then summarized.

The Toll on the Partner

The research findings align with existing literature on the experiences of supportive family members in addiction, highlighting the significant personal challenges they face. These challenges include mental, physical, and financial stressors that contribute to chronic distress and declining well-being. The burden carried by partners of individuals struggling with substance use is profound, encompassing far more than emotional distress. These partners often endure a relentless combination of mental, physical, and financial challenges, leading to chronic stress and deteriorating well-being. The following discussion explores the multifaceted toll experienced by supporters, focusing on two interwoven themes: the *emotional and practical costs* of being a supporter and the impact of *emotional abuse*, particularly gaslighting. Together,

these themes highlight how supporting a partner with addiction can entrap individuals in cycles of emotional strain, financial hardship, and psychological manipulation.

The intertwined emotional and practical costs of supporting addiction

Partners of individuals with substance use issues face profound challenges that affect their well-being beyond emotional distress. This study, in line with previous research (Barnard, 2006; Dawson et al., 2007; Ólafsdóttir et al., 2018; Wells, 2021), underscores the strong interconnection between mental and physical health in close relationships, as participants' experiences of anxiety, stress, and trauma highlight the dual impact on overall well-being. Participants described a concerning progression: initial worry about their partner's substance abuse escalated into anxiety which, for some, culminated in panic attacks. This emotional strain manifested physically, leading to problems such as sleep disturbances, disordered eating, weight loss, and, in severe cases, hospitalization. Consistent with past research (Barnard, 2006; Dawson et al., 2007; Ólafsdóttir et al., 2018), many participants endured persistent stress, often leading to depression, profound anxiety, and fatigue. The prevalence of these conditions mirrored Ólafsdóttir et al.'s (2018) findings, where over a third of participants experienced depression, anxiety, and stress. Ultimately, as reported by Dawson et al. (2007), anxiety, loneliness, and emotional drain became pervasive features of their lives, significantly impacting their quality of life. These findings solidify the understanding that partners of substance abusers face a significant mental and physical health burden, highlighting the need for comprehensive support systems. This study reinforces the critical connection between mental and physical health, emphasizing the importance of addressing both aspects to improve the overall well-being of affected individuals.

The financial strain of supporting a spouse with addiction is also well-documented (Fathi et al., 2020). Participants in this study echoed these challenges, describing disputes over finances and possessions, mirroring findings by Orford et al. (2010). These conflicts encompassed a range of concerning behaviours, including selling personal belongings, unauthorized borrowing, and neglecting financial obligations. Such actions can lead to significant financial hardship for the supportive partner. These financial challenges are not limited to the direct costs of the substance abuse itself—such as depleted savings, increased

debt, or loss of income—but also involve hidden costs, including disrupted employment, housing instability, and the inability to plan for the future.

The participants' experiences aligned with research highlighting the increased risk of domestic violence associated with SUDs (Donohue et al., 2006; Freisthler et al., 2017; Gruber & Taylor, 2006; Hartley, 2002; Martin et al., 2010). Emily's account particularly exemplified this, detailing her partner's escalating mood swings, aggression, and erratic behaviour. This volatility created a climate of fear and uncertainty within the home, mirroring the anxieties documented in the literature (Orford et al., 2010).

In this study, supportive partners experienced insecurity, betrayal, and resentment—emotions stemming from both the financial consequences and the emotional erosion of trust due to their partner's addiction. The financial instability, coupled with fears of escalating violence, left these partners in a state of constant vigilance and heightened anxiety. These factors (financial strain and the threat of violence) imposed a significant burden on supporters, intensifying their emotional distress and leaving them feeling overwhelmed, isolated, and unsupported. Systemic barriers further compound these challenges (Epstein & Goodman, 2018; Kelly et al., 2014; Stoever, 2019). Many partners lacked adequate access to mental health resources, either due to high costs or overwhelming demand. Likewise, legal protections for those facing domestic violence are often limited, inaccessible, or complex, leaving victims vulnerable and with few options (Kelly et al., 2014; Stoever, 2019). Additionally, societal stigmas around addiction and domestic violence frequently isolate partners, deterring them from seeking help out of fear of judgement or disbelief (Epstein & Goodman, 2018; Page et al., 2024).

The cumulative effect of financial strain, emotional distress, and societal barriers forms a complex web of challenges that entraps partners in a state of chronic stress (Barnard, 2006; Epstein & Goodman, 2018; Fathi et al., 2020). Without adequate resources or support systems, the psychological toll can manifest as depression, anxiety, post-traumatic stress, and physical health issues, further diminishing their capacity to cope (Dawson et al., 2007; Ólafsdóttir et al., 2018; Wells, 2021). Thus, addressing these intersecting burdens requires not only individual-level interventions but also systemic changes, including improved access to mental health care,

stronger social safety nets, and more robust legal protections for victims of both substance-related violence and financial abuse.

"Am I crazy?": The psychological toll of gaslighting in substance-affected relationships

Participants all experienced emotional abuse including manipulation, lies and deception and were made to feel crazy by their partners. Encompassing a broad spectrum of manipulative tactics, emotional abuse constitutes a pervasive form of psychological aggression within relationships (Gavin, 2011). This insidious behaviour relies on overt and covert manipulation, verbal mistreatment, intimidation, and persistent criticism, all designed to erode the victim's self-esteem and exert control (Gavin, 2011; Lackhar, 2001). All of this was outlined by women in this study and my previous honours research (Wells, 2021). The long-term psychological effects of emotional abuse can be even more damaging than physical abuse (Ali et al., 1999; Geffner & Rossman, 1997; Follingstad et al., 1990).

One particularly harmful manifestation of emotional abuse within romantic relationships is termed romantic terrorism (Hayes & Jeffries, 2015). This describes the strategy of emotional and psychological manipulation used by domestic violence perpetrators to maintain control over their partners. Gaslighting is another specific subtype of emotional abuse (Hayes & Jeffries, 2016). Gaslighting is a particularly destructive tactic involving targeted manipulations that purposefully undermine the victim's mental stability and perception of reality through techniques like minimization, threats, and feigned ignorance (Barton & Whitehead, 1969; Calef & Weinshel, 1981). While the term gaslighting itself may be recent in academic literature (Hayes & Jeffries, 2016), the core concept of epistemic harms has been documented for years under various names (Eisenberg, 2011; Ferraro, 2006; Williamson, 2010) such as unreality, surreality and crazy-making. This study echoed these themes, as partners described the gradual erosion of their sense of self, leading them to question their reality.

While research suggests a gender disparity in gaslighting perpetration — with women more likely to be victims (Dorpat, 1996; Gass & Nichols, 1988) — this form of emotional abuse transcends specific relationships. It thrives in environments with power imbalances, manifesting in marriages (Abramson, 2014), workplaces (Simon, 2010), and even political spheres (Gibson, 2017). However, the most pronounced and concerning instance of gaslighting

likely occurs within IPV. Studies reveal that over 80% of IPV survivors report being called crazy by their partners (Warshaw et al., 2014), highlighting its prevalence in abusive relationships.

The core function of gaslighting in IPV becomes evident when examining its impact on the victim's sense of self. Research by Loring (1994) and Tolman (1992) suggests that inducing self-doubt and a distorted reality are central to an abuser's ability to maintain control. By eroding the victim's perception of truth, the abuser effectively manipulates and exerts dominance (Akdeniz & Cihan, 2024). Understanding why victims remain in these relationships requires acknowledging the characteristics that can make individuals more vulnerable to gaslighting. Stern (2020) highlights self-doubt, a desire for approval from the abuser, and a need to reduce conflict as vulnerabilities that can be exploited by gas lighters. Participants described themselves as individuals who seek to maintain harmony and noted their aversion to conflict, indicating the vulnerabilities that make them susceptible to gaslighting. The underhanded nature of gaslighting, often disguised as concern or affection, combined with the victim's own vulnerabilities, creates a complex situation that makes escape difficult (Akdeniz & Cihan, 2024).

Hailes and Goodman (2023) reveal the firsthand experiences of individuals subjected to gaslighting, which closely mirror the narratives of participants in this study. They emphasise that a central tactic of gaslighting involves systematically undermining the victim's self-trust. This dynamic appears both in their research and in the accounts shared here. For instance, Sarah's description of ongoing uncertainty, *"I just lived in an absolute state of doubt... constantly questioning my reality,"* vividly underscores this aspect of self-doubt induced by gaslighting. Hannah's tendency to blame herself due to her partner's manipulative tactics also underscores this phenomenon. She was made to believe she was irrational and responsible for her partner's setbacks. These strategies are designed to induce victims to doubt their own integrity and shoulder the blame for the abuser's actions (Hailes & Goodman, 2023).

Gaslighting can dismantle a victim's sense of self-worth. The sentiments of worthlessness and self-condemnation expressed in the current study, such as "I was made to feel like I was crazy... disgusting... not worthy," resonate with findings on how gas lighters manipulate their victims. As elucidated by Hailes and Goodman (2023), this self-doubt

cultivates a heightened dependence on the abuser's judgement, as evidenced by their research participants who reported defaulting to their partner's judgement and prioritizing appeasement. Further illustrating the idea of appeasement, the quote "I do kind of still catch myself placating him to an extent to avoid confrontation" reflects the learned behavioural patterns that can develop in response to gaslighting. Victims may resort to placating their abuser to sidestep further emotional abuse and manipulation, even after terminating the relationship. This aligns with the study by Hailes and Goodman (2023), which discovered that gaslighting can prompt victims to prioritise conflict avoidance with the abuser, often at their own detriment. This provides additional insight into the below discussion on agreeableness and conflict avoidance within the context of gender, caregiving and co-dependency (Hays, 1996; Panaghi et al., 2016).

Partners of individuals with SUDs endure significant emotional, practical, and psychological burdens. The stress of caregiving, financial instability, and fear of violence create cycles of chronic anxiety, depression, and exhaustion. Emotional abuse, particularly gaslighting, further deepens these challenges by eroding self-worth, fostering dependency, and reinforcing conflict avoidance. Addressing these intertwined burdens requires more than individual coping strategies—it demands systemic solutions, such as accessible mental health care, stronger legal protections, and social support. A holistic approach is essential to help partners heal, regain autonomy, and rebuild their well-being.

The price of addiction: The emotional and psychological toll on children

Research consistently highlights the detrimental effects of parental SUD on children's well-being (Copello et al., 2005; Lander et al., 2013; Schultz & Alpaslan, 2020; Velleman & Templeton, 2003; Wilson et al., 2019). Velleman and Templeton (2003) show that families affected by alcohol and drug misuse often experience recurring issues like household disharmony, placing children at risk for adopting long-lasting coping mechanisms such as avoidance, emotional withdrawal, self-blame, and guilt. These mechanisms disrupt children's mental and emotional well-being throughout their formative years and beyond (Velleman & Templeton, 2003). Schultz and Alpaslan (2020) further support these findings, as their participants expressed deep concerns about their children's inability to build meaningful relationships with an addicted parent who lacks the capacity to provide essential emotional

support crucial for healthy development. Without this connection, children often experience a range of negative emotions, including guilt, self-blame, embarrassment, helplessness, anger, and anxiety (Copello et al., 2005; Lander et al., 2013).

Participants in this study also expressed significant concern about the impact of substance use on their children's long-term well-being. Sarah, for instance, observed that her daughter struggles with concentration, confidence, and dissociation due to chronic neglect and exposure to her father's unpredictable behaviour—mirroring the emotional and psychological vulnerabilities noted in previous research (Velleman & Templeton, 2003). Similarly, Sophia's daughter's persistent anxiety and fear of abandonment, along with Hannah's daughter's experience of growing up without a supportive father, illustrate the disruption to emotional stability and secure attachment formation reported by Wilson et al. (2019). These narratives provide compelling evidence of the lasting impact of parental substance use on children's development and mental health.

Navigating isolation and stigma

This research highlighted the powerful interplay between isolation and stigma in the lives of those supporting individuals with addiction. Stigma acts as a powerful force that discourages help-seeking and weakens support systems, trapping families in a cycle of isolation (Sampson et al., 2020; Wilson et al., 2019). The fear of judgement and disapproval fuels social isolation, driving families into secrecy and withdrawal (Fathi et al., 2020; Joolae et al., 2014; Orford et al., 2013; Straussner & Fewell, 2011). This isolation intensifies feelings of shame and self-blame, deepening the cycle (Wilson et al., 2018) and obstructing positive change for both the addicted individual and their loved ones.

Supporting in silence: The emotional isolation of partners

Social isolation poses a critical barrier for families supporting individuals with addiction (Condry, 2007; Sampson et al., 2020). Supporting a partner with addiction often creates a ripple effect, straining relationships beyond the couple. Emily, for example, experienced this with friends who, instead of being a source of support, became sources of awkwardness and distance. Friends may voice concerns earlier than those directly involved, leading to strained interactions and, withdrawal by the supportive partner (Fathi et al., 2020).

As social isolation deepens, it impacts not only the well-being of supportive partners but also complicates family dynamics, introducing additional layers of pressure and judgement. Fear of judgement and disapproval traps supporters in a cycle of isolation (Fathi et al., 2020; Joolae et al., 2014; Orford et al., 2013; Straussner & Fewell, 2011). Participants in this study described feeling increasingly alone and misunderstood by their social circles, mirroring previous findings (Cornille & Boronto, 1992; Fathi et al., 2020). Ironically, to avoid this judgement, supporters often withdraw, focusing solely on managing their partner's addiction. This social withdrawal, though detrimental, often becomes a self-protective coping mechanism.

Supportive partners may also face pressure to abandon the relationship or criticism of their approach from the addict's family (Wilson et al., 2019), as felt by Emily, Hannah and Sophia. This pressure can be exacerbated by perceived biases within the family system that favour the individual with addiction, further isolating the supportive partner and hindering their ability to effectively address the situation (Wilson et al., 2019). Participants' narratives reveal a perceived need for secrecy surrounding addiction, aligning with findings by Schultz and Alpaslan (2020). Similar to Sarah's "*drips and drabs*" disclosure, participants in Schultz and Alpaslan's study resorted to deception and excuses to maintain an illusion of normalcy, particularly to preserve the family unit (Schultz & Alpaslan, 2020). However, this secrecy isolates partners further and prevents them from accessing crucial support systems, hindering positive change for both the addict and their loved ones.

Caught in a cycle: Internal, secondary, and societal stigma's impact on families

Addiction stigma fosters multi-layered isolation for families. Internally, shame and self-blame can lead to social withdrawal (Corrigan & Miller, 2004). Externally, secondary stigma, where family members are judged by association with the addiction, further isolates them (Goffman, 1963; Larson & Corrigan, 2008). This creates a complex web of isolation that hinders help-seeking behaviours and weakens support systems.

Individuals supporting those with addiction often experience a profound sense of shame and self-blame. This internalised stigma can stem from a belief that they should have been able to fix the situation or prevent their loved one from developing an addiction. Such feelings can lead to social withdrawal and a reluctance to seek help, as individuals may fear being judged by

others. The narratives of participants outline their feelings of how internalised shame coupled with fear of judgement by friends, family and colleagues functioned as significant barriers to seeking support. These anxieties intensified their feelings of isolation and withdrawal.

Emily's experience exemplifies how stigma intertwines with other societal biases. Her internalised shame and guilt about leaving her partner stemmed not only from his addiction but also from societal pressures to conform to traditional family structures (Corrigan & Miller, 2004). Her fear of judgement from colleagues regarding single motherhood highlights how stigma can exploit existing societal biases, creating a complex web of isolation.

Despite their professional backgrounds in mental health, three participants revealed a profound sense of shame and guilt, surrounding their partners addictions. Emily, a psychologist, expressed deep shame for missing the warning signs in her partner. This internal conflict between professional knowledge and personal experience suggests a self-blame that even professional training could not fully mitigate. Similarly, Hannah and Sophia, though familiar with addiction concepts from their careers in mental health, acknowledged a sense of personal failure for not being able to leverage their knowledge to "*fix*" the situation. Their stories emphasise that professional expertise does not necessarily shield individuals from the isolating effects of stigma and self-blame.

In addition to internalised stigma, supporters may also face secondary stigma. Secondary stigma, a key concept in understanding the isolation of families affected by addiction, refers to the negative attitudes directed towards family members by association (Goffman, 1963; Larson & Corrigan, 2008). This study's participants exemplify its detrimental effects. Secondary stigma operates on multiple levels. Societal stereotypes, like those associated with methamphetamine use in Hannah's case, can lead to feelings of being unfairly judged and marginalised (Corrigan & Miller, 2004). Stereotypes such as those outlined by Hannah that often depict addicts as criminals or associated with gang culture, create a pervasive stigma that extends to loved ones. This fear of judgement, as demonstrated by Hannah's initial hesitation to share her story, is a significant barrier to accessing crucial support systems (Corrigan & Miller, 2004; Keyes et al., 2010). Similarly, Emily's own and Hannah's partner's resistance to attending support groups due to preconceived notions about drug users further highlights the pervasiveness of stigma and its ability to discourage positive interventions. Secondary stigma

can also manifest within families. Emily's experience with her partner's family exemplifies this. Pressure to abandon the relationship or criticism of her approach can stem from a perceived bias within the family system towards the substance user (Wilson et al., 2019). This not only isolates the supportive partner but also hinders their efforts to address the situation effectively.

The interplay between internalised, public, and secondary stigma created significant barriers to seeking help and support for the participants in this research. This cycle of isolation and stigma was self-perpetuating as fear of judgement from friends and family (interpersonal stigma) led to social withdrawal and secrecy, further isolating the supporter (isolation). This isolation exacerbates feelings of shame and fuels internalised stigma, making it even harder to seek support from those same social circles. Societal biases regarding addiction and family structures (societal stigma) also contribute to this cycle by creating a climate where open communication is discouraged.

In summary, the interconnectedness of various levels of stigma forms a complex web that significantly obstructs help-seeking behaviours for families navigating the challenges of addiction. Breaking this cycle requires a multi-pronged approach that addresses internalised shame, fosters open communication within social circles, and challenges negative societal stereotypes about addiction and family dynamics.

Co-dependency

This section investigates the intricate relationship between co-dependency, gender dynamics, and caregiving behaviours in relationships impacted by SUDs. It begins by defining co-dependency and relating it to the experiences of participants in this research. Following this, the discussion delves into how personality traits such as agreeableness and neuroticism contribute to the development of co-dependency and the subsequent challenges faced by women supporting their partners through addiction.

The entanglement of love and addiction

A surprising finding emerged from the research as participants frequently described co-dependent behaviours, such as a compulsive need to care for or rescue the addicted individual. Co-dependency, though often discussed in literature as a stigmatizing label (Corrigan et al., 2006), was a term used willingly by participants in this research to describe their experiences.

Through their involvement in Nar-Anon, they learned that acknowledging what they could control was a crucial step in their healing. In this context, the term can be framed as helpful rather than harmful, as it allowed participants to gain clarity on their roles and behaviours, empowering them to focus on their personal growth and well-being. While support from loved ones is vital for an individual's recovery, supporters benefit greatly from recognizing and addressing their co-dependency issues as part of their healing process—a core topic in Nar-Anon Family groups (Nar-Anon Family Groups, 2014).

Co-dependency is characterized by behaviours that reflect excessive focus on another's well-being and heightened sensitivity to interpersonal dynamics, often leading to self-neglect (Ahmad-Abadi, 2017; Bortolon et al., 2017; Dear, 2002; Harkness & Cotrell, 1997; Panaghi et al., 2016; Young & Timko, 2015). The term remains debated, with some viewing it as a disease (Dear & Roberts, 2005) and others describing it as addictive love or pathological altruism (Young & Timko, 2015). Despite these definitional variations, core elements consistently emerge, such as an extreme focus on others' expectations, self-sacrificing behaviours, a belief in one's ability to fix others, and the suppression of personal emotions (Dear, 2002; Dear & Roberts, 2005). Participants in this study illustrated these traits; for instance, some believed that skills from their mental health training could help change their partners' behaviours, while Sarah shared that her self-esteem depended on the intensity of her partner's attention. Within the framework of co-dependency, these behaviours are understood as coping mechanisms, driven by the strong desire for connection and a fear of abandonment, characterised by feelings of powerlessness, paired with an over-attribution of power to others (Schultz & Alpaslan, 2020). This preoccupation may lead to self-neglect and a reliance on external validation for self-worth, often alongside low self-esteem (Dear, 2002). Caretaking behaviours may become a source of purpose, particularly in dysfunctional relationships characterized by denial, rigidity, and control attempts (Schultz & Alpaslan, 2020). Research suggests that efforts to control a loved one's behaviour can unintentionally reinforce these co-dependent dynamics within the family unit (Timko, et al., 2012).

The concept of co-dependency can also be understood as a form of love addiction (Briggie & Briggie, 2015). Briggie and Briggie (2015) suggest that childhood attachment styles play a significant role in shaping how individuals experience love in romantic relationships. In

a healthy progression, love moves naturally from attraction to a secure attachment. However, challenging childhood experiences, such as traumatic loss, separation, neglect, or a caregiver's mental health struggles, can disrupt this path. These early disruptions may alter the development of healthy love, sometimes resulting in a form of love that becomes compulsive, obsessive, and dependent—characteristics often associated with love addiction. Love addiction is marked by an intense yearning for romantic relationships to find euphoria, security, and self-worth (Briggie & Briggie, 2015). Such attachment styles often include difficulty controlling behaviours, an excessive need for intensity, and heightened distress when a relationship ends. This craving for connection reflects a need for closeness rather than a character flaw, with symptoms mirroring addiction, such as loss of control, tolerance, and emotional withdrawal (Briggie & Briggie, 2015).

Research has revealed striking parallels in the neural processes underlying various addictions (Burkett & Young, 2012; Fisher et al., 2010). Brain scans of both pathological gamblers and crack cocaine addicts exhibit similar activity patterns (Potenza, 2008). Moreover, romantic love has been found to activate brain regions akin to those implicated in substance addiction (Fisher et al., 2010). This connection is further supported by the alignment of romantic relationship addiction with the DSM-5 criteria (American Psychiatric Association, 2013) for SUDs. These criteria, applicable across different types of addiction, encompass behaviours such as continued engagement despite harm, difficulty in cessation, loss of control, tolerance, and withdrawal symptoms. Participants' experiences mirror these patterns, showing escalating desperation, shame, and a loss of control, emphasising that the essence of addiction transcends the specific object of dependence.

The findings in this study strongly support the concept of love addiction proposed by Briggie and Briggie (2015) and align with broader research on addiction. Participants' experiences mirrored the stages and struggles commonly seen in addiction, with one key similarity being their tendency to overlook early warning signs. Just as substance users might downplay the initial effects of drug use (Chang et al., 2016), participants recounted ignoring "*red flags*" during the early stages of their relationships. Even after recognising the harm inflicted, they felt a powerful urge to stay, —much like the craving that drives substance addiction (American Psychiatric Association, 2013). This aligns with a core diagnostic criterion

for addiction: continued engagement despite negative consequences (American Psychiatric Association, 2013). The parallel with addiction becomes even more evident in the cyclical pattern participants described, as they repeatedly returned to unhealthy relationships despite efforts to leave. This echoes the struggle substance users face when trying to break free, often requiring external support to succeed (American Psychiatric Association, 2013). Finally, the intense emotional distress experienced upon leaving the relationship mirrored withdrawal symptoms, a hallmark feature of addiction. These observations solidify the view of co-dependency as an unhealthy attachment style with strikingly similar dynamics to those found in substance abuse.

These findings align closely with current addiction research, indicating that various addictions share similar underlying neural processes (Burkett & Young, 2012; Fisher et al., 2010). The DSM-5 diagnostic criteria for SUDs also apply to co-dependency, with patterns of continued involvement despite harm, difficulty stopping, and withdrawal symptoms (American Psychiatric Association, 2013). This alignment underscores co-dependency as a complex response to abuse, sharing essential traits with addiction. Recognising the addictive dynamics in co-dependency can empower individuals and support systems to break these patterns, enabling healthier relationships for those in supporting roles.

Exploring the role of personality and gender in co-dependency

Co-dependency literature suggests a link between societal gender norms and the development of co-dependency in caregiving roles for those supporting loved ones with SUDs (Cermak, 1986; Panaghi et al., 2016). This exploration examines the Big Five personality traits, focusing particularly on neuroticism and agreeableness, to better understand their connection to co-dependency and gender dynamics (Bakker et al., 2006; Flory et al., 2002; Goldberg, 1992; Jensen-Campbell & Graziano, 2001; Malouff et al., 2007). A key question emerges: is agreeableness an inherent personality trait or a learned response shaped by societal expectations, particularly those emphasising women's nurturing roles? Societal narratives like the good mother ideal, which glorify self-sacrifice, undoubtedly play a role (Hays, 1996). This raises the question of whether the pressure to be agreeable drives women toward co-dependency when confronted with a partner's SUD.

The narratives presented in this study reveal the complex interplay among gender dynamics, caregiving responsibilities, and co-dependency. Central to these stories is the depiction of individuals feeling compelled to assume caregiving roles within their relationships, often at the expense of their own well-being. The good mother narrative encourages self-sacrifice and nurturing (Hays, 1996), prompting women to internalise the expectation of prioritising others' well-being over their own. For example, Emily's self-esteem was deeply tied to her ability to hold her family together and fix her partner, creating an identity solely defined by caregiving. This aligns with societal expectations of a selfless caregiver (Hays, 1996) and correlates with the personality trait of agreeableness (Bakker et al., 2006; Goldberg, 1992; Jensen-Campbell & Graziano, 2001). Agreeable individuals, known for their kindness, empathy, and cooperation, often prioritise their partner's well-being and feel responsible for their happiness. In the context of substance use, this tendency can lead to enabling behaviours, hindering rather than promoting recovery (Panaghi et al., 2016).

Participants in this study often struggled to maintain harmony and resolve conflicts within their relationships and families. This prioritisation of others' well-being, a core aspect of agreeableness, becomes particularly challenging in the context of addiction. Driven by both inherent agreeableness and societal expectations of the good mother, these women juggle the demands of parenthood while caring for their partners. Societal norms further reinforce this cycle, making it difficult for them to establish boundaries and resist enabling their partners' addictive behaviours.

Research suggests an association between agreeableness and co-dependency. Panaghi et al. (2016) found that wives of partners with SUDs scored higher in agreeableness compared to a control group. This elevated agreeableness may serve as a compensatory trait, balancing the lower agreeableness often seen in partners with SUDs and potentially fostering stability within the relationship, as proposed by the Vulnerability-Stress-Adaptation Model (Karney & Bradbury, 1995). Alternatively, societal expectations may play a role, as culturally ingrained narratives like the good mother ideal reinforce the notion that women should prioritise others' needs (Panaghi et al., 2016). Together, these pressures may hinder women's ability to prioritise their own well-being, thus fostering co-dependent behaviours.

The role of neuroticism adds further complexity to understanding co-dependency. Panaghi et al. (2016) found a notable link between co-dependency and neuroticism, a trait associated with anxiety and negative emotions. Wives of partners with SUDs showed significantly higher neuroticism levels than a control group, supporting research that highlights the chronic stress and emotional strain often faced by partners of those with substance use issues (Asante & Lentoer, 2017; Barnard, 2006; Dawson et al., 2007; Olafsdottir et al., 2018; Wells, 2021). Such stressors likely contribute to elevated neuroticism levels, potentially increasing susceptibility to codependent behaviours. While some studies do indicate higher neuroticism in partners of those with SUDs (Panaghi et al., 2016), it is essential to consider how context influences these findings. Earlier research once stereotyped such individuals as inherently neurotic, but newer studies argue that situational factors—like a partner’s substance use—can play a significant role in elevating distress and neuroticism (Corder et al., 1964). Edwards et al. (1973) further demonstrated that partners’ distress fluctuates, rising during periods of active use and decreasing with abstinence. These insights underscore the complex interaction of personality traits, societal expectations, and the emotional toll of caregiving in SUD contexts. Participant narratives in this study reveal how agreeableness, shaped by both personality and societal pressures, can lead to self-neglect and co-dependency. As these women navigate their partners' substance use challenges, the associated stress and anxiety may intensify neuroticism, further entrenching them in a cycle of co-dependency that complicates their own mental health and well-being.

Smith-Genthôs and colleagues' (2017) study on sibling dynamics in addiction-affected families brings valuable insights to the broader discussion of gender and co-dependency in caregiving. Their findings suggest a gender disparity in how siblings respond to addiction, with female siblings experiencing a potentially greater negative impact compared to males. This discrepancy likely stems from societal expectations that position women as primary caregivers. The study also highlights that women may engage in greater emotional labour, expending effort to manage emotions, aligning with traditional views that associate women with the responsibility for family emotional well-being (Hochschild, 1983). This emotional investment in supporting an addicted sibling may lead to burnout and heightened negative emotions (Smith-Genthôs et al., 2017). This sibling-focused analysis parallels discussions on co-dependency in romantic relationships, revealing how gender roles and emotional labour shape

family responses to addiction. Further research is needed to understand how these dynamics intersect across different family relationships and collectively impact co-dependency.

These narratives reveal how agreeableness can predispose women to develop codependent tendencies, particularly when coupled with societal pressures to embody the archetype of the nurturing caregiver. Recognising these dynamics marks the first step toward reclaiming agency and fostering empowerment.

Chaos, recovery and renewal: Family stability in the aftermath of addiction

Often within addiction and recovery there is a journey with marked stages from chaos to stability as substance users shift toward the phase of being in recovery (Kougiali et al., 2017). This research highlights a striking parallel between the experiences of participants and the established stages of addiction recovery (Kougiali et al., 2017). The narratives depict a journey from a chaotic existence marked by a multitude of negative consequences to a newfound sense of stability and focus on personal recovery.

Research demonstrates the detrimental impact of living with a partner struggling with addiction (Dawson et al., 2007; Wilson et al., 2018). The women in this study echoed these findings, describing pervasive anxiety, loneliness, and emotional exhaustion. Financial struggles due to hidden spending, job loss, or neglected responsibilities further compounded their burdens, as also found in literature (Wilson et al., 2018). Trust became a constant battleground, with past deceptions fuelling suspicion and scrutiny in the present. These experiences mirror the chaos and dysfunction often associated with the active phase of addiction (Kougiali et al., 2017).

The narratives also reveal a stark contrast between the chaotic past and the newfound stability achieved by the women. Participants like Sophia and Sarah describe a transformation from a fragmented existence characterised by unpredictability and broken promises to a present marked by structure, routine, and normalcy. This shift aligns with the well-documented in-recovery phase of addiction, where individuals establish healthy routines and rebuild trust (Kougiali et al., 2017). The emphasis on financial security and a safe environment for children, as highlighted by participants, further underscores the positive impact of familial recovery.

While the narratives overwhelmingly reflect a journey from chaos to stability, the case of Emily demonstrates the complexities of this process. While acknowledging emotional improvements due to her partner's recovery, Emily grapples with lingering feelings of loneliness. This highlights the individual nature of recovery, where personal challenges may persist even as the core issues are addressed.

This research offers compelling evidence that the recovery process from addiction extends far beyond the individual struggling with substance use. The narratives presented in this study illustrate how the well-being and stability of the entire family unit are significantly impacted. By drawing parallels to existing research on addiction recovery, this study emphasises the importance of acknowledging the emotional toll on partners and the potential for shared healing journeys alongside the recovering individual.

Support and practical implications

The narratives of supporters reveal a multifaceted journey characterized by a need for practical assistance, therapeutic intervention, and a supportive community.

Navigating addiction: The role of practical and emotional resources for families

The narratives emphasise the critical role of practical support in navigating the complexities of addiction. Participants consistently highlighted the value of readily available resources to assist in traversing the justice system. Protection orders emerged as a cornerstone of safety, fostering a profound sense of security – both physical and emotional – for the participants. These orders, temporary or permanent in nature, serve as legal documentation of abuse, offering victims a mechanism to secure protection without pursuing criminal charges or seeking incarceration of the perpetrator (McFarlane et al., 2004). This security empowered participants to prioritise the well-being of themselves and their children, acting as a catalyst for accessing further support services. Significantly, the ability to ensure safety without inflicting further harm or triggering criminal proceedings resonated deeply with participants, especially given the often-complex emotional bonds with the child's other parent. In essence, resources such as protection orders and free legal assistance not only served a practical purpose in safeguarding participants but also functioned as a source of external validation. This validation

proved crucial in facilitating a cognitive shift, enabling participants to grasp the true nature of their situation. Such concrete support structures empower individuals to prioritise personal safety and well-being throughout the process of supporting their partner or navigating separation. This knowledge underscores the necessity for psychologists and addiction specialists to advocate for and connect their clients with practical support resources, empowering them to navigate the complexities of addiction and prioritise their well-being.

Beyond the realm of practical assistance, the narratives illuminate the profound need for emotional support for the supporters and families. Therapeutic interventions play a crucial role in equipping supporters with effective coping mechanisms and fostering emotional resilience. However, the case of Emily underscores the critical importance of therapist awareness regarding the multifaceted nature of addiction and the potential pitfalls of generalized treatment approaches. Emily's frustration with the suggestion of in-home treatment for her actively using partner exemplifies the necessity for therapists to possess a nuanced understanding of the cyclical nature of addiction, particularly the high probability of relapse during active use. This necessitates a tailored approach that prioritises the safety of the supporter and any dependents within the home environment. Emily's case further highlights the potential drawbacks of moderation-based interventions, especially when a loved one's safety is paramount. The narratives suggest a need for a deeper exploration of individual needs and a critical evaluation of the potential risks associated with specific treatment approaches. This necessitates a shift in focus towards frameworks that prioritise the safety and well-being of families and children within the addiction treatment ecosystem.

This research also exposes limitations within existing rehabilitation addiction services. Sarah's experience exemplifies the frustration associated with extended wait times and a lack of comprehensive guidance in navigating the complexities of the system. This aligns with findings from Moriarty et al. (2011) where supportive family members in New Zealand reported services that discouraged family involvement and offered minimal support specifically for the family unit. Furthermore, lengthy waitlists and stringent eligibility criteria resulted in delays for families seeking interventions for their loved ones. These combined findings underscore the critical need for increased accessibility to treatment options for addiction sufferers as well as clear pathways for the families.

The positive impact of Hannah's employer-sponsored mental health programme highlights the potential for workplace resources to play a significant role. Such programmes can mitigate the financial burden associated with seeking professional help. However, limitations like restricted session numbers, as mentioned by Hannah, underscore the need for more comprehensive support systems that extend beyond traditional therapeutic interventions. This knowledge emphasises the importance of collaboration between mental health professionals, addiction specialists, and policymakers. By working together, they can develop a more robust and accessible network of resources for families impacted by addiction.

The narratives further illuminate the value of peer support groups as a central theme. Participants consistently reported finding solace and strength in connecting with others who shared their experiences. These groups functioned as safe spaces for non-judgemental emotional expression, fostering a profound sense of belonging and fostering emotional resilience. This sense of mutual understanding was particularly important because it contrasted sharply with the isolation and stigma they often faced in their daily lives. In peer groups, women found safe spaces for non-judgemental emotional expression, free from the fear of being criticized or misunderstood. The shared experiences of others validated their feelings, reinforcing that their challenges were not unique or insurmountable. This aligns with established research on the effectiveness of peer support groups in improving relationships, quality of life and deeper self-understanding (DeLucia et al., 2015; McGovern et al, 2021). These benefits are critical not only for the individual but also for the overall health of family dynamics, as emotionally supported individuals are better equipped to manage stress and maintain positive connections with their partners and children (Feeney & Collins, 2015). Peer groups are most effective when integrated into a broader network of services that also provide practical guidance and intervention tools (Donovan et al., 2013; Eddie et al., 2019; Mutschler et al., 2022). Strengthening collaboration between peer groups, mental health professionals, and addiction specialists ensures women are connected with the full range of resources they need for both emotional and practical support.

Breaking down barriers: Towards comprehensive and accessible support

Addiction support systems are fundamentally flawed in their narrow focus on individuals struggling with substance abuse, neglecting the needs of the family unit—particularly women. While these systems aim to address addiction, they overlook the realities of those who support their partners through the process. This leaves women to manage not only their partner’s recovery but also the emotional and practical burdens that addiction brings into their daily lives. Women are often expected to shoulder these challenges alone, forced to find resources while managing the strain of their partner’s substance use. Participants’ narratives described feeling isolated, overwhelmed, and unsupported, citing a systemic lack of awareness about the services available to families of substance users. The absence of clear information and practical guidance adds to the emotional burden, making it even harder for women to seek or receive meaningful help.

This underscores the importance of raising awareness about available resources through crisis hotlines and community outreach programmes. A multifaceted approach is crucial, as the needs of supporters vary across different stages of their journey. While peer support groups provide emotional solace, practical strategies—such as legal guidance or intervention tools—are equally necessary to help women navigate the complexities of their circumstances. Support services must be flexible and responsive, addressing both emotional needs and practical challenges.

While peer support groups are shown to be a vital resource, awareness remains critically low. Crisis services, mental health professionals, and addiction specialists must collaborate more effectively to ensure families affected by addiction are connected with the full range of available support. This means developing stronger referral networks and integrating practical support into existing services. Only through this comprehensive approach can women and families receive the assistance they need—help that goes beyond addressing addiction alone and supports the entire family system.

Figure 2 has quotes from the participants about the importance of advocating for oneself and seeking support. These powerful messages urge those struggling to support loved ones in addiction to break the silence, seek help, and prioritise their own well-being. Understanding that

they are not alone and that effective support systems exist is a crucial step on the path to healing and self-empowerment.

Figure 2: Participant Quotes on Support Seeking

Community and Connection	Breaking the silence Awareness of shared experiences Building a supportive network	I would want to encourage someone like myself to not hide anymore, don't be ashamed to talk out and have a voice. I'd want them to understand that they're not the only one that's going through this and there's multiple other people going through it. And that it doesn't just affect the low poverty, you know, all demographics I would just want people to know they are not alone.
Support Services	Utilising available systems	I wish that somebody had told me or made me aware of NAR anon early on, so that I didn't have to be so alone ...to reach out to Al Anon, or NAR Anon
Setting healthy boundaries	Understanding enabling Prioritising self-care	So, my advice to other people that were in my shoes is understand what enabling means. Don't enable them and create your own boundaries
Recognition	Understanding what is in your control Letting go of guilt and blame	I think just the three C's. Didn't Cause it, can't Control it, can't Cure it.... Yeah. And that it's not your fault. It's not your responsibility to fix them. It's above anything that you can do any way, it's up to them
Learning from the journey	Reframing difficult experiences Cultivating resilience Practicing gratitude	This might seem like the worst thing in their life. It could be the best. It has the potential to be the best thing that's happened to them in their life. Yeah, that gives them the opportunity to live a much saner, joyful, healthy, full, rich, meaningful life

Limitations and future directions

This study provides valuable groundwork for understanding the experiences of New Zealand mothers supporting a partner through methamphetamine addiction. However, to gain a more comprehensive picture, future research should address some key limitations.

The focus on female partners and a limited range of ethnicities restricts the generalisability of the findings. Including a more balanced sample in terms of gender and ethnicity would provide richer data for understanding how cultural and social factors influence family dynamics throughout the journey of addiction. Research suggests societal expectations

and gender roles can significantly impact how partners experience and navigate addiction within their relationships (Cermak, 1986; Corrigan & Miller, 2004; Panaghi et al., 2016). Exploring the experiences of partners from diverse ethnic backgrounds would provide a more nuanced understanding of how cultural contexts shape coping mechanisms and support systems.

Future research could also benefit from examining how different types of addiction (alcohol, opioids, etc.) might uniquely impact family members. The varying characteristics and trajectories of different substances may influence the dynamics within the family unit. For instance, the withdrawal symptoms and compulsive behaviours associated with certain substances might present distinct challenges for partners compared to others.

This study focused on the experiences of female partners. However, future research should explore the experiences of other family members directly affected by substance use. Investigating the specific challenges and coping mechanisms of parents whose children struggle with addiction would be invaluable for developing targeted support groups and family therapy interventions. Examining the experiences of siblings would contribute to a more holistic understanding of the family system, as siblings can often feel overlooked within the family's focus on the addict's recovery (Smith-Genthôs et al., 2017). Additionally, research on the impact on children of a parent's substance use would provide crucial insights for therapists working with families. Research including male supporting partners, and those using different substances would also offer a more balanced perspective on gender and other dynamics within these relationships. By examining the experiences of the entire family unit, future research can gain a more comprehensive understanding of the multifaceted impact of addiction.

The Biopsychosocial (BPS) model offers a valuable framework for understanding the health impacts experienced by partners of substance abusers. This model emphasises the interconnectedness of biological, psychological, and social factors influencing health outcomes (Skewes & Gonzalez, 2013). In the context of this study, the BPS model sheds light on the observed connection between mental and physical health in supportive partners. Further research can leverage the BPS model to investigate how a partner's biological makeup (e.g., genetics) and social environment (e.g., support systems) interact with the stress of their partner's addiction. This will provide a deeper understanding of the health impacts explored in this study.

Furthermore, research on trauma and secondary trauma suggests promise for understanding the mental and physical health toll on partners of substance abusers. Figley (1989) suggests that secondary traumatisation begins when close others provide emotional support to their troubled loved ones, leading to attempts to understand and empathise with their feelings. In doing so, significant others may internalise the traumatised person's emotions, experiences, and symptoms. This process can result in overidentification, causing them to develop trauma-like symptoms themselves (Catherall, 1992; Figley, 1995; Maloney, 1988; Solomon et al., 1992). Future research could explore whether prolonged exposure to a partner's addiction parallels the development of secondary traumatic stress in partners. This line of inquiry holds significant promise for understanding the mental and physical health toll on partners of substance abusers.

In conclusion, this research highlights the critical need for accessible, comprehensive, and family-centred support services for individuals supporting loved ones through addiction. By addressing systemic barriers, raising awareness of available resources, and fostering a deeper understanding of the supporter's journey, we can empower these individuals to navigate the challenges of addiction recovery alongside their loved ones.

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Appendix A – NZ P Pull Facebook Post

Kia ora everyone,

I have lived experience supporting both partners and close family members through methamphetamine addiction and this has led to me wanting to understand more about this.

I am doing a Masters research project at Massey University for my psychology degree. I am looking for New Zealand mothers who have supported a partner through methamphetamine addiction, to take part in my research.

This would be a one-hour conversation with me about your experiences and you would get a \$30 voucher for participating. Everything would be anonymous when I write my research with no names included.

I hope to use my research to share these experiences, to increase understanding of the harms addiction can have on whanau and communities, and reduce some of the stigma of addiction.

I would love it if anyone would like to take part, or knows anyone who might. Please PM me if you would like some more information!

Appendix B – Information Sheet

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745
Tel +64 9 414 0800 ext. 43116
Fax +64 9 441 8157



Narrative analysis of mother's experiences supporting a partner with methamphetamine abuse problems INFORMATION SHEET

My name is Jesse Wells and as part of my Master's Thesis in Psychology, I am doing research about the experience of New Zealand mothers who have supported a partner with substance abuse problems relating to methamphetamine.

Project Description and Invitation

Substance abuse has long been considered an individual problem, but this is an issue which affects the whole family. This research is interested in exploring your experience of supporting an intimate partner struggling with methamphetamine abuse. This Information Sheet will help you decide if you want to participate in this study. It outlines why I am doing the study, what involvement is needed from you if you wish to participate and what would happen at the completion of the study. Before you decide, you may want to discuss the study with other people such as partners, family, whānau, friends, or health providers.

Who can take part?

Inclusion Criteria

- Partner or ex-partner of an individual with a past methamphetamine substance use issue
- Shared parenthood with this partner or ex-partner to one or more children
- Consider yourself to be in a good place to take part – i.e. in a place of well-being, no significant mental health distress
- Have not used methamphetamine
- Currently reside in Auckland New Zealand or lived in New Zealand during the affected period
- Participants of any ethnicity are invited to participate however; the interviews will be conducted in English

What would you be asked to do?

If you wish to take part, you will be invited to take part in one interview at a time and place we both agree on. It is preferred these will happen face to face, but given the current Covid-19 situation there may be a possibility of Zoom, Skype, or phone call interviews. Each interview should take no longer than one hour. During the interview, I will ask about you, your partner and your family experiences and anything you think is important to share about your experiences. You will be offered a \$30 voucher in recognition of your time.

Data Management

These interviews will be voice recorded with your permission. I will transcribe these recordings and give you a copy of the transcript which you can edit or make changes to if you wish. After reading the transcript you will be given a Transcript Release Authority form which, if you sign, gives me permission to use the information in my research. I will be reading through these transcripts to look for themes and patterns which will provide the data for my analysis.

Your confidentiality and privacy is important and therefore all names or identifying information will be removed from the transcripts, data and write up of the research. All personal information and data will be stored on a password protected computer and on a Massey University hard drive until the research is complete in February 2022, and then it will be deleted. An anonymous form of your transcript and coding will be stored indefinitely in Massey H drive as the data saved to Massey University's network is backed up, maintained and managed, secure, replicated and protected against viruses.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question
- withdraw from the study at any time up to two weeks after the interview
- ask any questions about the study at any time during participation
- provide information on the understanding that your name will not be used unless you give permission to the researcher
- be given access to a summary of the project findings when it is concluded
- Ask for the recorder to be turned off at any time during the interview

Please contact the researcher or supervisor if you have any questions about the project.

Contact details below:

Researcher:

Jesse Wells

██████████@massey.ac.nz

██████████

Supervisor:

Kathryn McGuigan

K.Mcguigan@massey.ac.nz

09 414 0800, ext. 43115

SUPPORT SERVICES

If the interviews raise issues that are particularly upsetting, I encourage you to use your personal support systems to talk through them. Often reliving an experience can be distressing, but sometimes there are benefits of talking with someone about it. Furthermore, your experience may help others who are experiencing something similar.

Mental health services – Where to get help

There's a range of resources and services available to help including phone and online services and information, as well as face to face support.

Most services are free and provide information and confidential advice from trained professionals.

If you're told that there is a waiting time for a service, please still reach out and make contact. Other supports can be put in place – ask what you can try in the meantime.

Helplines

Need to talk? Free call or text 1737 any time.

Talk to a trained counsellor or call:

- The Depression helpline – 0800 111 757
- Alcohol drug helpline – 0800 787 797
- Gambling helpline – 0800 654 655
- Healthline – 0800 611 116 – to get help from a registered nurse 24/7.
- Lifeline – 0800 543 354
- Samaritans – 0800 726 666

For Domestic Violence:

Women's Refuge crisis line — free from any phone, 24 hours a day, every day.

0508 744 633 Shine Helpline — free from any phone, 9am to 11pm every day.

0800 456 450 It's Not OK info line — free from any phone, 9am to 11pm every day.

Appendix C – Consent Form

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745
Tel +64 9 414 0800 ext. 43116
Fax +64 9 441 8157



Narrative analysis of mother’s experiences supporting a partner with methamphetamine abuse problems

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read, or have had read to me in my first language, and I understand the Information Sheet attached as Appendix I. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study up to two weeks after the interview.

1. I agree/do not agree to the interview being sound recorded.
2. I wish/do not wish to have my recordings returned to me.
3. I wish/do not wish to have data placed in an official archive.
4. I agree to participate in this study under the conditions set out in the Information Sheet.
5. I understand that if during the interviews concerns are raised for my own or children's safety there is a legal requirement for police to be notified.

Declaration by Participant:

I _____ [print full name] hereby consent to take part in this study.

Signature: _____

Date: _____

Appendix D – Confidentiality

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Auckland 0745
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Narrative analysis of mother’s experiences supporting a partner with methamphetamine abuse problems

I _____ (Full Name - printed)

agree to keep confidential all information concerning the project: *Narrative analysis of mothers experiences supporting a partner with methamphetamine abuse problems.*

I will not retain or copy any information involving the project.

Signature:

Date:

Appendix E – Interview Guide

General Opening Questions:

Tell me about your experiences of sharing a life with a partner with methamphetamine struggles:

Do you recall the discovery that your partner had a substance use problem?

Are you still with this partner?

What changes did you notice in your own or families life once your partner started, or while they were using methamphetamine (MA)?

How do you think MA has affected you/your partner/your children?

How do you think this affected your wider relationships? Family, friends, community, social life etc, Or attitudes to others (friends, family, community)

How do you think MA has affected the relationships within your family? e.g. child and parents, partner and partner..

How did you feel during this time or upon reflection what were you feeling during this time?

Your roles and support you needed or received

What have your experiences been when accessing support services in New Zealand? For yourself or your partner?

Did you make a decision to access support for your partner or family? Could you describe any barriers you faced once you made this decision?

What access to support did you have or use? This could be family, friends or official services

What are your perceived successes or limitations of the services you accessed for support?

How did your life look during this period or currently? How does your personal or family life look now? A typical day? Feelings/emotions?

Closing Questions:

Were there any positive outcomes that came from this experience?

Is there anything else you would like to add about your personal or family journey, things that have helped you, or things you'd like other people to know?

Appendix F – Authority for the Release of Transcripts

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Narrative analysis of mother's experiences supporting a partner with methamphetamine abuse problems

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature:

Date:

Full Name - printed: