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The Feasibility of a Web-Intervention for Military and Veteran Spouses Concerned about their Partner's Alcohol Misuse

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Abstract

Concerned partners (CPs) of military service members and veterans with alcohol misuse can be an important catalyst for change. We adapted the Community Reinforcement and Family Training (CRAFT) intervention into a 4-session web-based intervention (WBI) called *Partners Connect*. The program aims to help the CP increase their own well-being, teach the CP how to manage his/her behavior (e.g., communication) toward their partner, and identify ways the CP can help their partner reduce drinking and seek treatment. We recruited CPs through social media, and then tested the feasibility and acceptance of the WBI by conducting qualitative interviews and post-WBI session surveys after their WBI sessions. CPs (n=12) spontaneously reported improvements in communication and more effective management of their partner's drinking due to skills learned. They discussed how the online approach can help overcome barriers to seeking in-person help. This WBI fills an important gap in clinical services for military and veteran CPs and CPs in the general population who may not otherwise seek in-person counseling.

Keywords

military; alcohol misuse; unhealthy alcohol use; web intervention; computer-assisted intervention; motivational interviewing; CRAFT

Introduction

The number of U.S. military service members who misuse alcohol is growing along with the need for effective and accessible interventions.[1, 2] A precursor for more severe alcohol use disorders, alcohol misuse is defined as more than 3 drinks/day or 7 drinks/week for women, and more than 4 drinks/day or 14 drinks/week for men[3, 4] About 20% of U.S. service members report heavy drinking in the past month.[1, 5] For those service members, there are a number of adverse occupational and health consequences associated with heavy drinking, including military readiness, productivity, and comorbid depression and anxiety.[6–8] Furthermore, the delay in seeking or failure to seek care for alcohol misuse may escalate problem drinking behaviors and impact operational readiness of the service member and

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Conflict of Interest Statement

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their unit.[6] For the partners of service members, alcohol misuse has been linked with low levels of marital satisfaction and greater rates of infidelity, emotional and physical abuse, and divorce.[9–11] Thus, both service members and their partners can benefit from services targeting the service members' alcohol misuse. Unfortunately, existing military reporting policies make it challenging for service members and their families to seek available resources and treatment. Mandated reporting creates significant concerns that pursuing services will result in both a loss of confidentiality and negative repercussions associated with seeking care for alcohol misuse.[6, 12–14] This systemic barrier has made the delivery of treatment for alcohol misuse among service members a challenge to overcome.

Partners of service members and veterans commonly express a desire to help their significant other reduce drinking and work towards improving the relationship.[15, 16] This motivation found among concerned partners (CPs) can be leveraged to deliver resources and support to the family unit as well as initiate change at home. Furthermore, CPs are often recognized as positive rehabilitative influences on service members and veterans due to their ability to recognize risky behaviors earlier in the misuse trajectory, and provide continued support during treatment. A CP spends significant amounts of time and is usually in close proximity with the service member and veteran, and therefore has an unique advantage over health providers in identifying warning signs of problematic drinking.[17, 18] Service members with alcohol misuse cite encouragement from partners as the most common facilitator of seeking care.[12] In the broader civilian population, individuals who change their drinking patterns most often cite partner support as the most helpful mechanism in supporting change.[19] In many cases, prevention programs targeting the CP have shown to reduce mental health symptoms of partners and increase relationship satisfaction.[20–22] Thus, the CP can be a powerful catalyst to motivate service members and veterans to seek treatment and represents a critical participant in efforts to reduce alcohol misuse.

In considering potential CP-focused approaches for addressing alcohol misuse, the Community Reinforcement and Family Training (CRAFT) intervention addresses both the need to provide support and education to CPs and to increase motivation of service members and veterans to enter treatment.[21] The CRAFT model was developed for the general population with the belief that a CP has substantial information about their family member's substance abuse behavior patterns and can play a powerful role in helping their treatment-resistant family member pursue services. A CP is encouraged to first make positive changes in their own life and take care of their own needs. They then receive feedback on how their actions may be unintentionally reinforcing undesirable drinking behaviors; they establish new communication skills to more effectively interact with their family member to consider change; and they learn how to reshape the environment the family member lives in to encourage a rewarding substance-free lifestyle.[21, 23, 24] In the general population, CRAFT has consistently shown to improve depression, relationship satisfaction, and family conflict among CPs in addition to increasing engagement in alcohol treatment among treatment-resistant individuals.[20, 22]

We aimed to adapt CRAFT to better address the needs of this highly mobile population. Traditionally, CRAFT is conducted over 12 face-to-face sessions. However, military families move frequently due to re-assignment and deployment which may limit a CP's access to,

and continuity in care. Moreover, CRAFT was developed to target individuals with active alcohol use disorders who are resistant to treatment. Limited focus was placed on individuals in the early stages of alcohol misuse before long-term problems or dependence occurred. Thus, we saw an opportunity to adapt CRAFT to fill the needs of service members with alcohol misuse and their CPs.

Web-based interventions (WBIs) are emerging as a practical mechanism for reaching individuals in the confidentiality of their own homes. WBIs may be ideal for CPs of service members and veterans because the delivery method supports users' confidentiality and is completed at a self-directed pace,[25, 26] which is particularly attractive for service member populations concerned about mandated reporting by their superiors, and who have limited free time due to family and military work duties. Consequently, WBIs have the potential to extend the reach and impact of traditional preventative interventions. Previous work has been completed on CP-focused WBIs for gambling and posttraumatic stress disorder (PTSD)[27–29] and few studies have focused on the benefits of CP-focused WBIs for alcohol misuse[30]. Existing WBIs for alcohol misuse target the individual with misuse, not the CP.[31, 32] Conversely, WBIs targeting couples are conjoint and concentrate on relationship satisfaction, and not alcohol misuse.[33, 34] WBIs have the potential to improve communication efforts between partners, enhance family well-being, and encourage mental health service use among a traditionally treatment-resistant population.

In the current study, *Partners Connect*, we adapted the evidence-based 12-session civilian-based CRAFT intervention. Our primary purpose for adapting was to develop a shorter intervention that military and veteran partners could access online to overcome barriers to in-person care seeking. We conducted qualitative interviews and quantitative surveys with options for open-ended responses, we evaluated the acceptability and feasibility of a 4-session intervention among military partners who pilot-tested the WBI. Given there is limited WBIs available to support CPs in the prevention of alcohol misuse in the military and general population, this study fills an important gap in the alcohol misuse prevention literature. This model brings alcohol misuse services to the military community where alcohol misuse is otherwise going undetected and untreated.

Methods

Overview

We recruited 15 CPs of service members and veterans through Facebook military webpages and targeted ads. We included CPs of veterans post-9/11 to expand our inclusion criteria and also incorporate views of CPs of veterans who recently left the military. Participants were asked to complete a baseline survey, a 4-session web-intervention, 4 usability surveys (one after each session), and a phone debriefing interview. We then made revisions to the curriculum and materials after receiving all feedback as part of a larger randomized controlled trial evaluation.

Participants

We recruited military partners whose significant others were active duty service members or post-9/11 veterans. Eligibility was adapted from previous CRAFT trials.[20, 22] Participants needed to (1) be at least 18 years old; (2) be in a romantic relationship with the identified drinker; (3) be living with their partner; (4) not be in the military (i.e., active duty, reserves/guard) currently themselves; (5) have a computer, mobile, phone, or tablet with Internet access; (6) have no plans to separate from their partner in the next 60 days; (7) indicate at least a value of "3" on scale from "1 not at all" to "7 very much" for "To what extent do you think your partner has an alcohol problem? (Rodriguez, DiBello, & Neighbors, 2013), (8) indicate they believed they would be in no danger if their partner found out about their participation in the study; (9) indicate no general concerns that they would be physically hurt by their partner; and, (10) be willing to try an online program focused on communicating with their partner about his/her drinking. Though eligibility criteria did not specify that participants needed to be female, we targeted advertising to women only because 93% of active duty military spouses are female[35] and, for the purposes of this small pilot study, we only included female videotaped vignettes and stories in our intervention. In addition, ads were designed to recruit a sample of CPs who had concern about their partner's drinking. Ads stated "Concerned about your partner's drinking? Learn new skills and earn $120".

A total of 72 individuals completed the screening questionnaire in March and April 2015. Twenty-one percent (n = 15) met the screening criteria and completed an online consent form to participate in the study. Of the 15 who consented to the study, three did not complete a baseline survey and subsequently any WBI sessions, resulting in an N of 12. The remaining individuals were ineligible (n = 57). Due to a change in our programming, we only collected ineligibility reasons for 40 of the 57 CPs. The most common ineligibility reasons included not living with their partner, being in the military themselves, not in a romantic relationship with their partner, and general concerns they physically hurt by their partner. No individuals were screened eligible and then did not consent.

Procedures

CRAFT Intervention Adaptation—Study leaders attended a 3-day training in CRAFT by trainer and founder Robert J. Meyers, Ph.D. (also a U.S. veteran) and consulted with him throughout the development of the WBI. The goals of the WBI were to make the sessions relevant for a military population, using CRAFT principles and techniques to (1) help CPs increase their own well-being in various aspects of their lives, (2) teach CPs how to manage their own behavior toward their service member partner, and, (3) identify ways the CP can help the service member/veteran reduce their drinking.[24] Specific CRAFT techniques included functional analysis (the "roadmap" of substance use behavior), communication skills training with the concerned family member, positive reinforcement when not drinking, negative consequences and withdrawing rewards when drinking, allowing for natural/negative consequences when drinking, helping concerned family members enrich their own lives, and inviting the substance user to enter treatment.

WBI Content—The WBI contained a mix of audio, video, text, and exercises. To target a racial/ethnic diverse population, the WBI was narrated by a Latina female using videos and

audios. The intervention also utilized digital storytelling,[36, 37] which uses characters to convey teaching points in vignettes (e.g., an actress describing how she used positive communication with her husband) - a method currently being utilized by the military[38] to address stigma and increase treatment utilization among veterans. For example, three actresses of varying racial/ethnic backgrounds (i.e., White, Latina, African American) portrayed different experiences that the CP may be going through (e.g., a CP who has little social support due to numerous relocations and deployments). Two versions of the characters' vignettes were available based on whether the participating CP indicated prior to the WBI that they had or did not have children. CPs click on the vignette with which they most connect and follow that character across all the sessions. These characters also shared their experiences using the techniques taught in the sessions to provide examples to the CPs about how to apply the skills they learned during a session with their partner.

The WBI contained four 30–45 minute sessions that were structured with (1) an introductory video discussing the session topic (5 minutes), (2) interactive questions and personalized feedback based on the CP's baseline survey responses (in session 1), or in between session practice activities (sessions 2–4) (10 minutes), (3) session content material (10–15 minutes), and, (4) next steps (5 minutes). Each session was intended to be spaced 5 days apart to give CPs a chance to practice the skills learned in a prior session. If CPs did not finish a session, they could continue from where they left off. The main reason for scheduling sessions five days apart was to allow participants the flexibility of completing the session during the weekend if they completed their previous session on a weekday. For the purposes of this phase of the study, participants were given a maximum of six weeks to complete as many sessions as they could so that we could interview them in a timely manner and continue on with our larger randomized controlled trial.

The content of the WBI was the same for all CPs, but where possible, we tailored audios and videos based on CP's responses to specific questions to increase how interactive the intervention was. For example, the first session focused on CP self-care by identifying areas in their life that they wanted to improve upon (e.g., communication with spouse/partner, reduced depression or anxiety), provided personalized feedback on their levels of depression, anxiety, and drinking, and provided strategies and activities to help them address areas they were interested in working on. Audio recordings were therefore tailored to the areas CPs selected they wanted feedback on. During Session 1, CPs were encouraged to identify a support person to practice learned skills with during the course of the program. They were asked if they would be willing to call or visit with their support person before their next session. The next audio recording would be tailored to whether they said yes or no (e.g., If no, we normalized if they weren't ready and encouraged the CP to type any barriers that may be getting in the way). Session 2 focused on helping the CP with positive communication skills, such as through identifying old communication patterns (i.e., "broken records") that usually come up in their relationship and using positive communication to develop new patterns. The crux of this session focused on "SAID" communication skills (Stay positive, Always be understanding of your loved one, use I statements, and Demonstrate willingness to share responsibility). The third session focused on conducting a modified functional analysis of the service member's or veteran's drinking, which is an integral part of the CRAFT approach and helps the CP identify reasons why the service

member is drinking (e.g., triggers such as negative emotions), and helps to identify alternate non-drinking reinforcers to replace drinking when triggers emerge. The final session reviewed the first three sessions, encouraged further practice of communication strategies, described how to withdraw positive reinforcement when the spouse/partner drinks, and discussed next steps about how to encourage their significant other to seek help (e.g., writing down what to say and practicing, choosing the right time to talk, being flexible and trying again if it does not go well).

Each session ended with a summary and a list of practice activities, which were reviewed for completion at the beginning of subsequent sessions. The final session ended with a summary of their Sessions 1 and 2 practice material, Sessions 3 and 4 functional analysis diagram. It also included responses they endorsed throughout the sessions (e.g., drinking triggers and alternative activities they identified).

Facebook Recruitment—We recruited participants through targeted advertisements on Facebook (e.g., “Concerned about your partner’s drinking? Learn new skills and earn $120”). Ads were shown to female Facebook users between the ages of 18 and 40 who had interests related to veteran and active duty service member organizations (e.g., Iraq and Afghanistan Veterans of America, Blue Star Families, National Military Family Association) and military spouse content (e.g., “Military Spouse magazine,” “Military Spouse Central organization”).

Procedures—Participants screened into the study via an online, 10-item screening instrument they could access on the web via mobile phone, tablet, or computer. Those eligible for the study were provided an online consent form and full details about the components of the study. Once the consent form was electronically signed, participants were linked to accessing the baseline questionnaire through a secure, online website. The baseline survey took an average of 30 minutes (SD=13.3) to complete.

The first WBI session was accessible after submission of the baseline survey. The four WBI sessions were scheduled approximately five days apart and participants were encouraged to complete the sessions using email reminders and follow up phone calls, as necessary. Participants could not access future WBI sessions in advance but they could go back and review past sessions. Short, usability surveys to test the adherence to and functionality of each WBI session were administered directly after each WBI session. Each usability survey took approximately 5 minutes to complete.

After completing the WBI sessions and usability surveys, participants were invited to participate in a 30 minute semi-structured phone interview with study leaders to assess their reaction to the program content and functionality of the online system. We asked about their overall impressions, top three likes/dislikes, any changes they would make, anything they learned, how this WBI might affect other partners, how this WBI compares to other information they may have received, and additional content to add. We were also interested in whether CRAFT could be feasibly adapted for web delivery and therefore asked questions such as how they thought people would react to getting this information on the computer, how often they clicked on videos and audios, if they experienced technical difficulties, and

their experience with each of the sessions. This conversation was held approximately 4–6 weeks from beginning the program to allow enough time for participants to complete the 4-session WBI. Each interview was facilitated by one of the researchers with another researcher taking notes. All interviews were audio-recorded.

All questionnaires and WBI sessions were administered through our website and participants could complete them at their convenience and in private. Participants were compensated for up to $120 for their time completing the baseline questionnaire ($50), usability surveys ($5 for each of the 4 surveys and $25 for completing 3 of the 4 surveys), and phone interview ($25) via an emailed Amazon gift code. All materials and procedures were approved by the Human Subjects Protection Committee at the RAND Corporation.

Measures

Demographics—Demographic information included gender, age, race/ethnicity, education, relationship status, number of years married, and number of children who live with him or her at least half of the time.

CP Measures—We asked CPs to report on their relationship satisfaction by asking, "Taking things altogether, how satisfied are you with your relationship right now?"[39] Responses ranged from 1 (Very dissatisfied), 3 (Neutral), to 5 (Very satisfied). We also asked whether or not they received any mental health counseling, therapy, or self-help for their own well-being in the past year. Finally, we asked three questions regarding alcohol consumption from the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C).[40, 41] Response options for each of the three questions were coded on a 0 to 4 scale and were summed. Consistent with previous studies, we used a cutscore of 3 or more to be considered as at-risk drinkers.[41, 42]

CP Perceptions of their Partner—We also asked CPs to report on their perceptions of their service member or veteran partner's behaviors. Demographic information about their partner included gender, age, race/ethnicity, military status, and branch affiliation. CPs were asked to report to whether they thought a doctor or other health profession has ever told their partner that s/he had a problem with alcohol (yes, no, don't know/not sure).[43] We also asked CPs to report their perceptions of their partner's drinking by asking questions from the Drinking Norms Rating Form (DNRF). CPs were asked, "Consider a typical week during the past month (30 days). How much alcohol, on average, (measured in number of drinks), do you think your partner had on each day of a typical week?"[44, 45] The reliability of collateral reports of partner drinking (including drinkers with comorbid physical and mental health issues[46]) has been documented with accuracy and used extensively in several studies.[20, 21, 47–50]

WBI Usability and Satisfaction Measures—After each WBI session, we asked questions that assessed the CP's satisfaction with each session. We assessed helpfulness by asking, "Overall, how helpful did you find the session?" Response options ranged from 0 (Not at all) to 4 (Extremely). We also asked if the CP would recommend the specific session to a friend or family member experiencing similar issues (yes, no, maybe). After Sessions 2

through 4, we asked if they told their partner or partner about their participation in the program in between sessions (yes, no).

Analyses

Qualitative Analyses—The qualitative procedures and analyses for CP interviews were adapted from previous studies with this population.[51–53] First, we audiotaped all interviews, and then two researchers (KCO, EP) independently reviewed the recordings to identify, label, and group together key points that spoke to (1) why CPs participated in the WBI, (2) how feasible it was to complete the WBI, and, (3) what was helpful and unhelpful about the WBI. Following grounded theory analyses,[54] key points with similar concepts were grouped together into a category if referenced more than one time by different participants (e.g., the WBI was engaging). The two coders then grouped quotes together that corresponded by concept. After initial coding, the two researchers reviewed each concept, identified and discussed disagreements with initial coding, and then used classic content analysis to further categorize quotes within each concept into themes (e.g., communication strategies were helpful).[55, 56]

Quantitative Analyses—We conducted descriptive analyses of the baseline survey data (N=12) to summarize demographic characteristics of the CP sample and CP's report of their partners. We also conducted descriptive analyses on the usability survey data to examine how participants rated the helpfulness and impact of each session.

Results

Baseline Survey Characteristics

All CPs were female, 37.5 (SD = 10.4) years old, and mostly White (n=10; see Table 1). Five had some college experience, five had a Bachelor's degree, and two had an advanced degree. CPs reported their partners were active duty (n=3), reservist/guardsman (n=1), or veteran (n=8); and affiliated with the Army (n=4), Marine Corps (n=3), Navy (n=3), Air Force (n=1), or Army National Guard (n=1) for an average of 8 years (SD = 5.8). The majority of CPs were married to their service member or veteran partner (n=11) for an average of 9.3 (SD = 6.3) years and all participants reported having children. CPs averaged 3.4 (SD = 1.4) on the 5-point relationship scale stating they were neutral to satisfied with their relationship. Three of the 12 CPs reported receiving mental health counseling in the past year for their own well-being. Based on the AUDIT-C, six CPs met criteria for at-risk or heavy drinking (score of 3 or higher).[41, 42]

CPs also reported information about their service member or veteran partners. Eleven of the 12 CPs reported that their partners were male. One CP did not report their partner's gender. Partners were reported as 38 (SD = 8.1) years old, and mostly White (n=10). In terms of CPs' reports of their partner's drinking, CPs perceived that in the past month, in a typical week, their partner drank an average of 5.53 (SD=4.34) drinks per day. Of the 12 CPs, seven thought that a doctor or health professional had expressed concerns about their partner's drinking. Ten of the 12 CPs reported that their partners had no thoughts about changing, no interest in changing, or no plans to change, and eight of the 12 thought their partners had

never sought help for their drinking. Of the 12 CPs who completed a baseline survey, eight could be contacted (the other four did not return our phone call or email request and thus could not be reached for the interview), and they agreed to be interviewed. Of these eight, five completed all four WBI sessions, one completed two sessions, and two completed no sessions. The five participants who completed all four sessions took an average of 37.3 days (SD = 21.3 days; Min = 4; Max = 58) to complete all sessions. We interviewed these participants within 1 to 13 days (X = 5.4 days; SD = 5.4). We did our best to obtain feedback as soon as possible, but some participants were more difficult to contact. We also decided to interview the non-completers to adequately explore and troubleshoot feasibility issues with completing their sessions.

Overall Satisfaction with the WBI

We analyzed available data from the 12 participants who were eligible. Across all of the sessions (n=26 total responses across sessions; n=5 to 8 for each session), the CPs overall found the sessions to be moderately to very helpful (M=2.69, SD=1.09, scale: 0–4), where Session 1 on self-care was found to be the least helpful (M=2.38, SD=1.06, n=8), and Session 2 on communication was found to be the most helpful (M=3.13, SD=0.84, n=8). Across all the sessions, 84% of responses indicated that CPs would recommend the respective session to a friend or family member experiencing similar concerns (8% Maybe, n=2, 8% No, n=2). Table 2 shows the breakdown in satisfaction by session.

In addition, the CPs were moderately confident that they could talk with their loved one about his/her drinking using the skills they learned in the respective session (M=2.19, SD=1.39, measured on a scale from 0–4, where 0 was not at all confident and 4 was extremely confident). We were interested in more information about this finding and therefore looked back at the eight qualitative interviews we conducted for more information. Three CPs spontaneously reported that they shared with their partners that they were participating in the program, three reported they did not want to disclose their participation with them, while two did not disclose. CPs reported that they did not want to disclose their participation because of concerns about confidentiality, and that their partner did not feel he had an alcohol problem and therefore might get defensive. One CP reported that when she shared her participation with her partner, he was initially upset, but calmed down after she explained confidentiality. Another reported she was going to review the content about triggers with her partner, and that doing so would likely be helpful for him. One also reported that if there was a service member version of the program, “I think he probably would [take it.] Even if it’s just, you know, to please the wife.”

Key Themes from CP Interviews

We interviewed eight CPs. Three of the eight CPs learned about the study from Facebook advertisements, while the remaining four saw our study’s information on a Facebook page they were following or through a friend’s personal Facebook page. One CP did not remember how she learned about the study. Five of the eight CPs reported that they completed their baseline survey on their PC or Mac laptop/desktop computer, while three completed the survey on their mobile phones. We summarize each theme below according to

each of the interview sections and elaborate on each theme with additional CP quotes in Table 3.

Reasons for Participating—Two main themes emerged regarding why CPs agreed to participate in the study. First, all CPs reported **participating because they needed more tools and wanted to get connected with help**. They discussed both wanting help for themselves to communicate better with their partner (e.g., "He drinks a huge amount and it worries me. I worry about his health…So I signed up, but talking with him has not affected him in the past. I was hoping for some tools to help."), as well as learning how to assist their partner in getting help (e.g., "I know that if I don't help him, he won't go seek it himself because he'll get in trouble.").

The second theme that emerged was that they **would not go to existing in-person services because of stigma and confidentiality concerns**. Six of the eight CPs discussed their desire to participate because they would not go to in-person services because of stigma and confidentiality concerns. These concerns centered on not wanting others to know about their partner's drinking (e.g., "This isn't something I want to advertise to my family"; "If you use online, you don't have to deal with the shame that's there. A lot of people don't know what's going on behind closed doors."); concerns about sharing private information in-person (e.g., "I feel like I was more likely to do [the WBI] than going in and seeing a counselor because I guess I tend to be a little bit more private;" "I'd never go in person…I've got the privacy [with the WBI], I can go in my room and lock the door."); and, fear that their partner would get in trouble if he alone or the couple sought counseling (e.g., "Especially with his security clearance, it would be a huge issue if anyone ever found out there was something wrong with him"). Less common themes included wanting to participate because of the **financial incentive** (n=3 CPs), **inability to connect with non-military providers and groups** (n=3 CPs), **wanting to help others** (n=2 CPs), and having **difficulty finding good care** near their homes (n=2 CPs).

Feasibility of the Online Approach—All eight CPs discussed how **online access made the WBI very convenient** to access. For example, CPs discussed how they could view the content while their children were at school or napping. Some discussed how they could complete the sessions while their children or partner were in the room with them. For example, one participant viewed the sessions on her phone while others were watching television on the couch. Others saw it as a time to relax or have "me-time." Six CPs also discussed how they felt the intervention was **self-paced and easy to complete**. Videos were able to be paused and returned to at a more convenient time if distractions arose. Sessions were reported as lasting between 30 and 45 minutes depending if there were other distractions present. No CPs reported major **logistical issues** due to the program not working correctly. However, factors outside the program itself served as barriers to completion for some CPs. For example, one CP mentioned that her phone's data plan expired and she was not able to finish all the sessions, and another noted that storms disconnected her Internet connection. The three CPs who failed to finish all four sessions discussed that finding time to complete the sessions were the biggest barriers (i.e., one owned her own business and was

caring for two sick parents). Two CPs suggested that, in addition to the phone calls and emails sent, we use text messages to remind participants to complete their sessions.

Acceptability of the WBI—Among the five CPs who completed the WBI sessions, several themes emerged. First, CPs addressed the **interactive nature of the program as very helpful for engagement (e.g., exercises and videos)**. One CP stated "I liked that this was interactive. Other stuff I've received doesn't have examples – just a pamphlet or something." CPs liked the exercises and the videos in the program. One CP particularly liked the narrator (e.g., "she was just extremely calming"), and others discussed how they connected with the women in the videos (e.g., "Videos are most helpful and engaging. It's like a group where you can share stories with others and benefit from them."). All but one CP specifically mentioned how they liked learning from other's experiences (i.e., from watching the women tell their stories in the videos), and seeing examples that they could use later, such as an example of a way to say something to their partner in a situation.

Second, all five of the CPs who completed all four sessions discussed **areas that were helpful**. For example, several CPs reported that the SAID strategies and learning to wait until their partner was sober before addressing important issues were very helpful communication strategies. All CPs discussed how they noticed **personal changes in communication with partner** stating they used more "I" statements, and how they saw that communicating more effectively generated their desired outcome (e.g., partner not drinking). One participant said, "The speaking one, the communication- I know I wrote that down. I'm going to make a thing to go up on my wall…that was really, really handy, because that works you know…it's about getting your spouse to quit drinking, but really your program is great for anybody that struggles with communication."

Four CPs reported **personal changes in how they manage partner's drinking using learned skills**. These skills went beyond just communication strategies, including skills like suggesting alternate activities (e.g., going for a walk instead of opening a bottle of wine), and letting go of the need to control a situation. Two CPs discussed the benefits of gaining a better understanding of why their partner drinks (focus of Session 3) such as learning about the emotional, situational, personal triggers that precede a drinking episode. Two CPs spontaneously reported how they enjoyed setting goals and completing practice activities, such as finding a support person to connect with. Two CPs reported that their **partners were making changes to their drinking** as a result of the program (e.g., seeking counseling, learned about triggers, following participant's lead and communicating better).

Unhelpful Aspects of the WBI—CPs were varied in their opinions about what parts of the intervention were unhelpful. Two CPs reported not connecting with the women in the videos (e.g., "…a lot of the things that the spouses were saying in the video didn't relate", "I would add more spouses on there. Give people more options to connect."), one did not like the narrator (e.g., "The narrator was terrible, that poor thing. It felt really contrived. She's saying 'good job' but you could see her reading"), and one desired more text instead of videos (e.g., "Definitely adding more text. Even something where you can scroll and read the text of the videos."). Two CPs expressed a desire to have an online forum where they could connect with fellow Partners Connect users to discuss content and share stories.

Finally, one CP discussed how she would have preferred the sessions to all be available at once in case she had a free moment to complete the next one prior to the one-week delay in session delivery.

Discussion

Military service members, veterans and their families experience significant help-seeking barriers for their alcohol misuse. Partners of military service members and veterans are significantly affected by alcohol misuse, but no preventive interventions exist that target the CP. To address this gap in clinical services, we developed a 4-session WBI called *Partners Connect* to help the CP increase positive communication toward their partner, and identify ways the CP can help the service member or veteran reduce their alcohol misuse. Some CPs reported high satisfaction with the sessions, that they would recommend the sessions to a friend or family member experiencing similar issues, and that they were moderately confident they could tell their significant others about their participation with the program. Qualitative interviews with 8 women revealed that those who did not share their participation with their partners were worried about confidentiality, or that their partner would get defensive.

Not surprisingly, the main theme that emerged was that CPs found the WBI accessible and convenient. Due to shame, stigma, and confidentiality concerns, CPs noted that they were unlikely to access in-person counseling for their concerns about their partner, despite wanting tools to help them. Having a web-based platform was very convenient to CPs such that they could complete the sessions at any time and from anywhere. These findings support the need to develop accessible preventive interventions to help support CPs who would not otherwise seek in-person care. While the program was tailored with military-specific content, the approach transcends beyond the military culture. In 2013, only 8% of individuals in the U.S. who needed treatment for alcohol use disorders received it, and stigma has been identified as one of the largest barriers to help-seeking.[1, 3, 4] Thus, there is a great need for approaches such as *Partners Connect* outside the military community.

With regard to the content of the WBI, several CPs reported that they found the skills helpful in managing their interactions with their partners, and that the positive communication strategies were seen as the most valuable and helpful of the skills presented. This was also not surprising, as *Partners Connect* was adapted from the CRAFT intervention, which has similarly shown increased positive communication between partners after in-person CRAFT sessions.[20–22] When adapting CRAFT for web delivery, we were most curious whether CPs would be able to “digest” and learn skills without an in-person counselor. These preliminary findings suggest that several CPs found the material helpful and used these skills with their partners. Future research with larger samples should explore this finding further to evaluate whether the web-based adaptation of CRAFT increases positive communication and improves outcomes for the CP and their partner similarly to in-person trials. Given how participants rated session 2 on communication as most helpful, future research could also explore the efficacy of this session as a standalone session or as an earlier session in increasing engagement. Even if a stand-alone web session or program could have a small to medium effect on outcomes, these improvements may help facilitate readiness to change,

and eventually help-seeking if stigma can be reduced, as more acceptance is garnered for their situation. Future research could also explore how connection with women in the intervention affected how helpful the intervention was. For example, the characters in the WBI were ethnically diverse, but most of our CPs were White so exploring whether these differences were helpful or unhelpful would be valuable.

Limitations

The main limitation to this study is a small sample size making it challenging to generalize results to other military partners. The sample size is appropriate for usability testing where the goal is to collect in-depth feedback from potential users about the feasibility and acceptability of the intervention. Longitudinal data are needed to assess whether the intervention was efficacious for the CPs. Given the scope of this small study, our sample and WBI was targeted to female CPs. We are thus missing the perspectives of male CPs.

Conclusions

This preliminary work highlights the feasibility of delivering a web-based version of CRAFT to military and veteran partners, and the CPs acceptability of the program (particularly in the learning of positive communication), but more research is needed to address the program's efficacy.

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Implications for Behavioral Health

Military and veteran spouses and partners may be helpful in facilitating change by increasing engagement in help-seeking by the service member or veteran. Developing acceptable and accessible preventive interventions that CPs will use is important because alcohol use disorders are heavily stigmatized and in-person help-seeking may be particularly challenging especially for CPs in the military. We developed a WBI to fill an unmet need for CP services. This intervention attempts to address that gap in clinical services and circumvents barriers to care seeking. CPs could access the WBI anywhere and at any time, and is designed to offer support for their behavioral health concerns, help them develop skills to better manage their partner's drinking, and encourage their partner to make changes to their drinking behavior. For some, this stand-alone approach may be adequate to help alleviate the stress CPs experience. For others, it may be the catalyst that encourages their service member or veteran to change their drinking, seek help, or it may be used as an adjunctive approach to counseling. Future studies are encouraged to explore how the role of CPs may aid service members and veterans with managing alcohol misuse, and to assess the short-term and long-term outcomes for the CP and their partner.

Table 1

Sample Characteristics (N=12)

Variable	Overall
Mean age (*SD*)	37.5 (10.4)
Gender (%)	
Female	100%
Race (%)	
Black or African American	8.3%
White	83.3%
Multiracial (Checked More Than One Race)	8.3%
Education (%)	
Some college but no degree	41.7%
Bachelor's degree	41.7%
Master's, professional, or doctorate degree	16.7%
Relationship Status (%)	
Married	91.7%
Living with Partner	8.3%
Average Years if Married (*SD*)	9.3 (6.3)
Have Children (%)	100%

Table 2

Satisfaction ratings by session

	Session 1	Session 2	Session 3	Session 4
	N=8	N=8	N=5	N=5
Overall, how helpful did you find this session? [M(SD)]	2.38 (1.06)	3.13 (0.83)	2.4 (1.52)	2.8 (1.10)
Would you recommend this session to a friend or family member experiencing similar concerns? [N (%)]				
Yes	7 (87.5%)	5 (71.4%)	4 (80%)	5 (100%)
No	0 (0%)	1 (14.3%)	1 (20%)	0 (0%)
Maybe	1 (12.5%)	1 (14.3%)	0 (0%)	0 (0%)
(Missing)	0	1	0	0

Table 3

Key Themes and Example Quotations from Participants Interviews

Key Theme	Example Quotations
Reasons for Participating	
Needed more tools and wanted to get connected with help	"It's been a real issue for me and I just wanted to do what I could do to get him to stop, but you know, but obviously I can't do everything. But what I can do I'd like to."
Would not go to existing in-person services because of stigma and confidentiality concerns	"You were willing to give me resources without me seeking help that might potentially get him in trouble in any way."
Financial incentives	"The financial incentive made it so that I did it right then instead of, oh, I'll do it when I get around to it later."
Inability to connect with non-military providers and groups	"The good intention is there, I mean, yes you can be a counselor but you have to be specialized with the veterans to understand, because it's a complete different language." "No one at Al-Anon has ever dealt with PTSD or been in the military. They didn't know how to connect."
Wanted to help others	"If there's help out there, how can I contribute and help others? I can share my experience. I was mostly motivated to help others."
Difficulty finding good care	"I feel like it would be a lot more accessible to people especially military family members who have moved to a new location and don't know how to find a counselor."
Feasibility of the Online Approach	
Online access made it very convenient	"[It] was really convenient. I could do it while the kids were at school, while my husband was away. If I chose to do it while they were with me I couldn't focus…and trying to work appointments in is very, very hard especially when I have so many appointments for my kids."
Self-paced and easy to complete	"I really loved the fact that you could just stop when you've had enough and you needed to take a break… that made it really convenient." "[It took me] about 45 minutes [per session]. It depended what I had going on."
Logistical issues	"If you guys could do text messaging, that would be even better. One would be like, 'Hey, just a reminder, your session is available today."
Acceptability of the Program	
Interactive nature was very helpful for engagement (e.g., exercises and videos)	"I liked that it was interactive. So I had options to click what related to me and what didn't. I mean, it felt like I was actually doing something. Instead of just watching something, it was something I was participating in. And it felt more tailored toward what I needed, instead, you know sometimes you just read things and walk away."
Impact on Behavior on CP and Significant Other	
Personal changes in communication with partner	"I think the communication skills is the one thing that I got from it. I have to say that it influenced my life because I've actually applied it with a husband a time or two, you know. 'We're not going to talk about this now. We'll talk about this when you're sober.' Instead of just exploding." "It's already been helpful for talking to him. If I can remember them, you know that it will be helpful down the line. You know using the "I" statements and redirecting and just not playing into the behavior. I think all those things are extremely helpful and hopefully will make a difference."
Personal changes in how they manage partner's drinking using learned skills	"I feel like it's helped give me a little bit more feeling of control not over what he does, but how I'm addressing it. How that makes me feel. Making sure my opinion is heard. Not that I'm going to change him, but making sure I've done what I can and letting the rest go." "All of it was very helpful. I could tell a difference even after the first two weeks. It helped with communication. You gave me tools to communicate better – that helped the most…He got upset at work and wanted to go to liquor store to get a drink. I asked him to wait 30 minutes and then he didn't even want to go anymore. Before we would have gotten into a fight – I would have blamed him or said you're doing something wrong. This time I said it's up to you but I was nice about it and asked him to just wait a bit."
Partner changes in drinking	"[My husband] has gotten a hold of his counselors and is working with them. He was not [seeing them before]. He saw that I was reaching out for help and he thought, 'Oh, maybe I better do something."
Additional Comments	
Recommending the program to others	"I would absolutely recommend this program to a friend. It was only 4 sessions and I can see a huge difference in our relationship."

Key Theme	Example Quotations
Sharing content with partner/ spouse	"I think maybe showing him the pathway and I think maybe asking him more of his insight why he drinks. I can't read his mind, so maybe getting his feedback on that. It might help prevent him from starting drinking again." "My husband would be pretty ticked if I let him know about this. He doesn't think he has a problem. He doesn't think it would be held completely confidential. He works in a high profile position and has security clearances."
Unhelpful aspects of the WBI	
	"Having the audio with the video was a problem because I didn't want him to hear from the other room. So, more text options as well as the video would be helpful." "I kept looking at it and feeling like they were at the extreme of everything. I know my husband has a problem and I know we need help, and it would have felt nice to see various levels and been able to relate beyond the extreme." "It would be helpful to have a network of people that can connect and share stories. It's helpful to see that others are in the same situation and knowing, you know, this can be ok…but also knowing that other people are also taking the program."