

**The Role of Personal Meaning for Alcoholics in Achieving  
and Successfully Maintaining Sobriety**

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## **DEDICATION**

### **GEORGE AND MARGARET WESTWELL**

My much-loved parents who are dearly missed

I remembered, I stopped at the traffic light when I saw the red light.

## ABSTRACT

The aim of this study is to gain a greater understanding of the role of personal meaning in the lives of people previously deemed as alcoholics who have now successfully achieved and continue to maintain sobriety, including longer-term sobriety.

Existing research studies have addressed the early stages of achieving sobriety but very few have discussed the issues involved in the long-term maintenance of change. This research study aims to make an original contribution by not only addressing the early stages of change but also the maintenance of these changes and maintaining them over the longer term. The study aims to add to the existing understanding of personal change, specifically in relation to alcoholism, through a focus on the role of personal meaning in change for alcoholics. The research adopted a qualitative interpretive methodology and used Personal Construct Psychology (PCP) as its theoretical framework. The constructivist approach of PCP considers behaviour as being shaped by the personal meaning that events and experiences hold for people.

Eighteen semi-structured interviews were completed. Seven women and eleven men attending an alcoholism self-help group based in the North of England were interviewed in depth about their experiences of becoming sober and maintaining sobriety. At the time of the interviews all the participants had remained sober for between two and ten years. The study examined their perceptions of becoming sober and how they had managed to maintain this change. The interviews were analysed using Template Analysis and the findings have been interpreted within a PCP theoretical framework. The key findings to emerge from the analysis include the importance of the PCP theoretical concept of validation, which is a particular form of support from others and the involvement of families and friends in both helping and hindering recovery and its maintenance. The participants reported the use of imagination in order to rehearse the anticipated changes they needed to make before the changes were made in the 'real world'. In addition, the participants spoke of imagining and anticipating a new sense of self, a sober self and what this new self meant to them. There was also evidence that the participants had reconstructed both themselves and others and now had new perceptions of both. It is hoped that the findings will inform interventions that may help more alcoholics to successfully achieve and maintain change.

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# CHAPTER ONE: INTRODUCTION

## **Aim**

This study provides original knowledge regarding ‘alcoholics’ achieving and maintaining sobriety (this refers to the participants in the study now being sober and continuing to maintain this sobriety for up to two years) and the under-researched area of achieving long-term sobriety (defined as two years and above). It is concerned with examining the subjective experiences of alcoholics and the personal meaning they have drawn from these experiences that has enabled them to successfully achieve and maintain sobriety. It is hoped the findings will inform future interventions aimed at addressing alcoholism. In order to assist the reader, a glossary of the terms used in the thesis is available in **Appendix A**.

## **Background, context and need for the study**

The word ‘alcoholic’ may be perceived by the reader as a pejorative term and there are many other alternative words to describe the same person in contemporary literature. However, in this study the participants were asked in the preliminary meetings what was their preferred term for describing themselves and the term alcoholic was stated; therefore, it is used throughout the thesis.

Although this study will outline various intervention measures which have been effective for many alcoholics in the past, there are still a considerable number of deaths and social problems as a result of alcoholism. Consideration of statistics regarding alcoholism may indicate why it is timely to carry out this piece of research. For example, in the UK the Office for National Statistics (ONS) reported that there were 7,697 deaths in 2017 specifically related to alcohol, which is the highest rate since 2008 (ONS, 2018). According to Burton et al. (2016), alcohol misuse is the biggest risk factor for death, ill-health and disability for people aged between 15–49 in the UK, and across all ages it is the fifth highest risk factor. These harmful effects are wide ranging (Bouchery et al., 2011). They include accidents and injuries as well as disease and death affecting family, friends and the rest of society. For example, in England and Wales, violent incidents which were alcohol related were more likely to be reported than those where there was no alcohol involved (ONS, 2018). In

2016/17 in England and Wales, in 35.8% of sexual assaults, the offender was under the influence of alcohol (ONS, 2018). Rehm et al. (2009) suggest that much of the financial costs for society results from a loss of productivity in the workplace in addition to the costs of health care, criminal justice involvement and motor vehicle accidents. Alcohol Change UK (2019) reports that today in England, there are approximately 589,101 dependent drinkers (some have either self-identified as such or have been defined by society as such). Lastly, as highlighted in the HM Government policy paper, *2010–2015 Government Policy: Harmful Drinking* (2015), binge drinking makes up 50% of the drinking in the UK. The government felt that alcohol related harm costs society £21 billion a year. It appears clear that despite all current intervention measures now available in Britain, alcoholism remains a major problem concerning all of us. Addressing problems with alcohol in the UK is more complicated than merely helping and encouraging people to either reduce or abstain from drink – maintaining this change is often a long-term and difficult challenge.

Issues such as the aetiology of alcoholism and the effectiveness of intervention measures have continued to be debated. There are many underlying theories attempting to explain the aetiology of alcoholism that have developed over the years. These include the medically orientated models of alcoholism (for example, Jellinek, 1960), which see alcoholism as a disease with no cure but with symptoms requiring treatments such as detoxification, aversion therapy and medication. Further, psychoanalytical approaches believe that people abuse alcohol to act as a defensive measure against anxiety (for example, Book & Randall, 2002). A key mechanism within the behaviourist approach is that of reinforcement. For example, operant conditioning (Skinner, 1989) involves the addition of a positive reinforcing stimulus following the desired behaviour to make it more likely that the person will repeat this behaviour in the future.

Methods of intervention have evolved from these theories, and it is acknowledged that many people feel they have benefited from them. Indications of this are shown by the alcoholics who have remained sober, following for example, Twelve Step Facilitation (TSF) (Yeh et al., 2009) or the use of the trans-theoretical model (TTM) of behaviour change (Prochaska & DiClemente, 1982). Nevertheless, some people fail to access help or do not seem to benefit from the help they receive (Keyes et al., 2010). It is noted that, in addition, professionals have witnessed a change in thinking

and a 'paradigmatic shift' (White, 2004) from a focus on medical disease models and pathology to much more of an emphasis on recovery.

The term 'recovery' is defined as much more than merely abstaining from drinking or taking other drugs. It is also viewed (Laudet, 2007) as a person achieving a bountiful 'new life'. Further, Laudet (2007) sees recovery as going beyond abstinence. It is an ongoing process of growth, self-change and of reclaiming the self. Many alcoholics are constantly striving to achieve a better life for themselves (Best & Laudet, 2010). Therefore, although the term 'recovery' appears to have originated as purely a medical term, there is now a broader definition and I refer to it as such throughout the thesis. This view of sobriety and recovery will be discussed further in chapter 2.

There is a need for more understanding of the process of achieving and maintaining sobriety in order to improve the existing intervention measures and therefore the plight of alcoholics in the future. It is acknowledged that there have been past empirical studies on people achieving and maintaining sobriety (Laudet et al, 2002; Margolis et al.,2000; Rychtarik et al.,1987; Vaillant,1995; Yeh et al., 2009; Yeh et al., 2008; Hill and Leeming, 2014; Dyson, 2007; Klingemann,1992 and Klingemann (2012). However, there are still relatively few studies which have explicitly studied people who have not only achieved sobriety but have also successfully continued to maintain these changes over longer periods. Limited past empirical studies have looked at the achievement and maintenance of sobriety looking through the lens of the alcoholic themselves and, as Hill and Leeming (2014, p.2) point out, "*if effective interventions are to be designed, insight is needed into how people with alcohol dependence make sense of and engage with their difficulties with drinking over a longer timeframe*". In the light of this, this study focusses on the contribution the role of personal meaning could make to a person both achieving and maintaining these changes over a longer period.

In order to complete this study, I felt I firstly needed to look reflexively at my own relevant experiences and to position myself within the research.

### **Positioning myself within the research**

As will become apparent, I have a history of personal problems with alcohol. My drinking history, where I self-identified as a 'drinking alcoholic', lasted approximately ten years, with five of those years being at a serious life-threatening level. Initially, I



did not see myself as an alcoholic but more as a person who enjoyed a drink; however, gradually I saw myself as a drinking alcoholic as opposed to a non-drinking alcoholic because for ten years I was continually drinking, causing harm to both myself and others around me.

As a young person, I considered I lived quite a 'normal' life in terms of my school, my friends, my family and my own views and perceptions of life. Looking from my own perspective, life did not present any problems to me. At the age of eighteen, my life took a slightly different turn from many of my friends in that I became a professional musician signed to a major record label. The job involved me spending my time travelling, staying in hotels, touring and making records on a professional basis. Drinking was part of the lifestyle of both myself and of fellow musicians and I wanted to fit in with those I perceived as my peers and a general musician's culture at the time. However, I was not aware of any problems with alcohol during my career as a musician. I feel this point is important because often in my later life people assumed my alcoholism was due to my earlier 'musician's lifestyle'.

Having in later years qualified as a psychiatric nurse, I worked in various establishments, including a large Victorian psychiatric hospital, working in the community and in a general hospital. Following these experiences, I also qualified as a social worker and later became a senior commissioning manager for a social services department. Throughout all this time, I considered my alcohol intake had been a very normal experience where I felt I just enjoyed a social drink.

However, in my early thirties, my job became increasingly pressurised and my drinking gradually increased. Other people began to mention that I '*liked a drink*' and others closer to me took it a stage further and suggested that it would be good for me to cut down a little. In my eyes at the time, I did not see drinking as a problem and continued drinking, relying on my perception that there were other people who were drinking far more than me. In retrospect, I feel I was becoming aware that I at least needed to cut down on my intake but was denying this to others and probably myself. In hindsight, I feel I was missing the gratification I could obtain from being on stage and was now attempting to rekindle those feelings through drink. The drink did not fill this need even though I drank increasing amounts with the hope of achieving this gratification. Further, I was developing a tolerance to alcohol and needing more and more each day. Gradually, visits to the doctor became more infrequent as I

perceived a stigma developing and worried about being labelled as an alcoholic if I was too truthful about my drinking. I was beginning to feel low in mood on a regular basis and was having problems with my stomach amongst other physical ailments, which were all related to my drinking. After eventually succumbing to seeing a doctor, I merely resorted to complaining of various physical problems without mentioning my drinking in order to be able to continue drinking. Again, I now feel I was avoiding the problem in front of me. My drinking habits and subsequent problems escalated. My physical health deteriorated, as did my work, social and family life. Further, I had now clearly moved from enjoying a social drink to needing that drink and worried about withdrawal from it. My GP was now telling me she judged me as having two years to live if I continued drinking.

After several admissions to general hospitals as a result of falls, head injuries and 'detoxing' - involving convulsions, blackouts, hallucinations and delirium tremens, I have no doubt the medical intervention at this time of severe life-threatening crisis saved my life. For this reason, I have every respect for what medical interventions can achieve for long-term alcoholics in crisis situations. Eventually, I was beginning to see that alcohol did not serve a purpose for me anymore and it began to mean a degrading, stigmatising and pointless way of living. In my mid-thirties I gradually began to make early steps towards some sort of action to sort out my problems. In many ways it was a messy, frightening and depressing time of my life, and I experienced many relapses along the way. I had experienced other people's alcoholism on many occasions, both as a psychiatric nurse and as a social worker. However, I did not think it would ever pertain to me, just to others. Looking back, my perceptions of myself as a person where alcoholism would never relate to me was probably due to my careers as a nurse and social work manager. My perceived 'role' was to help other people with their problems. I did not want others to see my own weaknesses with alcohol and I wanted to deny them to others.

The involvement of my GP and treatment in hospital I feel were crucial early intervention measures for me; however, it was only a short-lived medical intervention for the crisis I was in. For the longer term, I felt I needed an intervention to enable me to continue with the improvements I had made. These included beginning to recognise that not only did I need to stop denying my problem to others but also how other people could help me. To this end, in my mid- to late-thirties I began to attend

self-help group meetings of varying kinds for approximately eight years. After talking to other group members, many people appeared to have benefited a great deal from the groups and had attended for several years. Others, including myself, tried many different types of groups including AA twelve-step facilitated groups and groups that did not use these methods. Having moved on from a crisis intervention situation where I needed hospital admissions, I initially attended an AA twelve-step approach group recommended by my hospital consultant. I found this useful in offering a small amount of structure to my days of early sobriety. However, after attending for about three months I was beginning to find the group and its members very heavily engrossed in a rigid AA doctrine which did not work for me personally. Other members, however, found the group invaluable. This illustrates that the same intervention does not necessarily work for everyone.

Following this, I attended numerous other self-help groups not affiliated to AA. Having stopped attendance at the groups, I eventually chose to fully abstain from drinking altogether rather than just reducing my drinking because I felt I did not want the risk of further drinking and I felt empowered enough to make my own decisions, which in my eyes were not formed in any formal doctrine (even though I was aware that complete abstinence is seen as a common goal of AA). Subsequently, I was not attending any formal 'treatment' or self-help group. Looking at my sobriety now, I firmly believe it was mainly due to my good relationships with my friends and to support from my family to make my own decisions. Sobriety meant I could hold onto the good relationships with my family. This empowerment to make my own way forward meant I still felt in charge of my own achievement of sobriety. Now I identify myself as a 'non-drinking alcoholic' and have done so for the past twelve years. I have not attended a self-help group of any kind for over fifteen years. My interest now in alcoholism is less about myself and more about how other people have chosen to become sober and how they have not only achieved this sobriety but maintained it for some time.

When I embarked on this study, I was aware of the pitfalls and advantages of having first-hand experiences of alcoholism. There was a need for me to be fully aware that there could be areas where my own past experiences may unduly influence my research. Therefore, I needed to acknowledge my own values and possible biases and be aware of the effect of my personal presence in the research situation. There

was a danger that my past experiences may also influence my interpretations of the data I collected. This point will be revisited in the Methodology and Discussion chapters. An advantage of this insider knowledge could be the ability to share my own experiences to show empathy and develop trust. I was also aware that this had to be balanced with the aim of being an effective researcher striving for a type of subjective truth.

### **Alcoholism in historical perspective**

In order to set the research in context, it is necessary to acknowledge the effects and influences of ever-changing judgements, attitudes and opinions of professionals and the public over time to alcoholism. Also, it is necessary to acknowledge the social context and what alcoholism has meant to people in history up to the present day. Definitions, attitudes, perceptions and constructs of alcoholism have evolved from ancient times to the present. It is argued that these definitions, attitudes, perceptions and constructs have followed the prevailing cultural, religious and scientific ideas of the time and have affected how alcoholism is approached. It is suggested that this is important because these attitudes may influence how alcoholics have thought about themselves and the measures they have taken to both achieve and maintain sobriety both in the past, present and their futures.

#### Drunkenness up to the 1800s

Throughout history, alcohol has provided many functions; whether it be as part of religion and worship, as a source of needed nutrients or being used for its antiseptic, medicinal and analgesic properties (Hanson,1995). Its use in 'medicinal procedures' were still in existence even in the beginning of the twentieth century and the start of modern medicine. This is in addition to its more obvious use as a quencher of thirst and its important role as a social lubricant, aiding relaxation. However, history also shows the 'downside' of alcohol when it has been used inappropriately. Chafetz (1965) commented at the time of writing that a relatively small proportion of people in the community have always drunk in excess, however he felt that alcohol has also offered some benefit to others. After looking at numerous examples concerning the quite common but moderate drinking of alcohol, Darby et al. (1977, p.590) commented that, "*All these accounts are warped by the fact that moderate users were overshadowed by their more boisterous counterparts who added 'colour' to*

history". By the 1700s people's views towards alcohol were characterised by an acknowledgment of the good effects of moderate drinking and the bad effects of drunkenness. The 1700s also saw the British government introduce several acts in order to promote the utilisation of grain for distilling spirits. The government actively encouraged gin production to make use of surplus grain and to raise revenue leading to the 'gin epidemic' (Watney, 1976); so termed because of gin's popularity and cheap price at the time. Gin became a firm favourite of the poor, and soon the daily volume of gin sold was more than that of beer and ale. In 1736, the government appeared to change its attitudes towards promoting gin production and passed laws to discourage gin drinking. This was because of the level of people publicly expressing their levels of concern for what they perceived as a 'gin craze' or people having mental health problems due to drinking gin. Most of the gin was drunk by people living in London and other cities. People who lived in the rural areas continued to drink cider, beer and ale (Watney, 1976). The 1800s saw increasing industrialisation and the need for workers who turned up for work on time and were reliable (Sournia, 1990). Self-control was thought to be necessary instead of self-expression, and there was a concentration on efficient work-based tasks being performed instead of inefficient work practices. To be drunk soon equated to a threat to efficiency and growth in the workplace. There were many problems which were perceived as being linked to alcohol at the time (Sournia, 1990). For example, poverty, crime in the streets and high death rates in children. However, it could be argued that these problems could have been equally due to unemployment or overcrowding. These perceptions linking poverty and crime to alcohol consumption may have promoted the view of alcoholism being linked to immorality.

Moral views of alcoholism have historically emphasised a lack of personal responsibility and spiritual strength as the cause of drunkenness (Hester & Miller, 1989). During the 19<sup>th</sup> century, a common perception was that alcoholism was sinful and a reflection of a person who lacked any form of spirituality (Engs, 1990; Goodwin, 2000). Eventually, more and more social, personal, religious and moral problems were all thought to be due to drinking. There was an ever-increasing emphasis, particularly by temperance groups, on not only moderation but a total ban on alcohol as being the only acceptable solution. Temperance groups that began by only promoting moderation (temperance) of drinking, increasingly became

abolitionist and fought for the total prohibition of the production, distribution and drinking of alcohol.

### The development of the temperance movement

The late 1800s saw the formation of the temperance movement, promoting the moderate use of alcohol. While it is often confused with the moral issues described above, the temperance view perceived the substance of alcohol itself as being to blame for alcoholism rather than the individual person. They viewed it as a hazardous and dangerous substance that needed to be taken cautiously (Hester & Miller, 1989). Alcoholism, or inebriety as it was termed at the time, was described by Rush in 1784 (cited in White, 2007). Rush had described the progressive nature and the medical results of long-term drunkenness. He regarded alcoholism as a state where a person has an uncontrollable, overwhelming and irresistible desire to drink alcohol. Influenced by this article, a Connecticut community formed a temperance society in 1889. Their goal was to ban the making of whiskey. According to Blocker (1989), similar groups were started in Virginia in 1800 and New York State in 1808. In the following ten years, other organisations started in eight states of America. These groups encouraged temperance rather than abstinence. In 1826, The American Temperance Society began, with over one and a half million people joining. In the same period in England, various temperance societies began. The 1830s witnessed a large growth in temperance movements in England and America, as well as the Scandinavian countries. Furthermore, 1830-1900 witnessed the temperance groups becoming much more radicalised, advocating the banning of all alcohol. In 1833, a movement calling for teetotalism (practising or promoting complete abstinence from alcohol) began in Preston, England, encouraging complete abstinence. In 1847, a society called the 'Band of Hope' was started in Leeds. The society had the goal of enabling working class children to avoid the disadvantages of alcohol by making them aware and educating them about the necessity to remain both sober and teetotal. In 1855, a national organisation was formed whereby meetings took place in churches all around the United Kingdom. The organisation campaigned by organising people to march, to have rallies and to demonstrate. They persuaded individuals to sign a pledge of allegiance to the organisation and to agree to not drink any alcohol unless it was being used for medicinal purposes (Brownlee, 2002).

Regarding legislative measures, the Defence of the Realm Act was introduced in 1914 throughout the United Kingdom. This led to the licensing of the hours where public houses were permitted to open. Further, beer was watered down and a penny a pint was added in tax. In America, society's attitudes towards drinking appeared to adopt further extreme measures with the introduction of a total ban on alcohol, known as 'prohibition'. This consisted of a national prevention of people attempting to sell, bring into the country, or transport alcoholic drinks. The law which made this possible was the Volstead Act or the National Prohibition Act (1919). The act provided the terms for ensuring the prevention took place and outlined the prohibited drinks. Those in favour of the ban were referred to as 'the dries' and they called it a victory for public morals and health. Those who did not want the ban were referred to as 'the wets'. Although the ban did reduce the amount of alcohol being drunk, it also encouraged the proliferation of underground organised crime. This was at a time when it was perceived that prohibition would lead to a reduction in crime. Slowly but surely, prohibition lost its supporters and in 1933 the act was repealed.

#### The emergence of Alcoholics Anonymous (AA)

According to Rose and Cherpitel (2011), AA began in 1935 in America as a response to the alcohol problems at the time and the resources to help alcoholics being extremely limited. As a result, many alcoholics began to organise themselves into helping each other to recover. The members talked about issues concerned with alcohol and its connected problems, sharing and offering support, and became known as Alcoholics Anonymous, or AA. They began to formulate a twelve-step programme in order to develop a person spiritually and in character. These 'Twelve Traditions' were introduced in 1946. Individual members remained anonymous to the public and to the media, altruistically helping fellow alcoholics to recover. Furthermore, the groups were not to become affiliated to other groups or organisations. AA was formed as a reaction to a continuing problem with alcohol at a time when there were limited resources (Trice & Staudenmeier, 1989).

Rose and Cherpitel (2011) suggest that self-help organisations tend to internalise the broader cultural and societal themes into which they are born. Constructivism recognises that alcoholism, self-help groups, etc. will also carry these assumptions.

This idea of alcoholism always being influenced by its historical and cultural context is further reinforced by Jellinek's findings in the mid-1940s. His view of alcoholism being a disease was not out of context with society's views of scientifically 'fixing things' at the time in Britain and America. A further example of this historical and cultural specificity is indicated by AA's views relating to being powerless (over the addiction of alcohol), unmanageability (life becoming unmanageable), hope (a feeling of trust in AA) and service (helping others to recover), being seen by Kurtz (1991) as influenced by the economic and spiritual crash (loss of empathy and compassion for others) of the Great Depression of the 1930s. It could be suggested that AA's ideas of people feeling powerless, not being able to manage the situation they were in and losing hope may have mirrored other people's thoughts generally about the economic decline they were in during the Depression.

#### The development of the disease concept of alcoholism

The resurgence of the popularity of the disease model of alcoholism in the mid-twentieth century appears to have been at least partly due to the start of Alcoholics Anonymous (AA). Alcoholism was now regarded and treated as a disease rather than a moral problem. These views were spurred on by the substantial growth in AA membership (Rose & Cherpitel, 2011). These matters will be discussed further in this section.

Back in 1784, Rush suggested that alcoholism was a medical rather than a moral problem. He felt doctors had a responsibility of caring for people with this problem (White, 2004). In the United Kingdom, a Scottish doctor, Thomas Trotter, was also describing excessive drinking as a disease or a medical condition in 1788 (Porter, 1985). Both Trotter and Rush were some of the earliest people to see heavy drinking as possibly being a disease and not necessarily just wilful or sinful behaviour. They also had the view that people drank habitually, and this habit needed breaking in order to return the person to a healthy life. Porter (1985) states that Trotter referred to the 'habit of drunkenness' as 'a disease of will'. It could be reasonably suggested that Trotter's reference to alcoholism as being a 'disease of will' could be interpreted as a metaphor for meaning a social disease rather than a medical disease. However, Rush saw drunkenness as a disease in which alcohol was the prime cause and loss of control was a 'symptom'. He saw total abstinence as being the only real 'cure'.



White (2004) states that, particularly in America, the changing patterns of chronic drunkenness were also influenced by the views of a reverend, Lyman Beecher. In 1825, he described alcohol consumption or intemperance as an accelerating disease and that total abstinence was the only solution to both prevention and cure. The above-mentioned doctors and social reformers assisted in the process of redefining the drunk as a person with a medical condition. This was at the time of the change from the eighteenth to nineteenth century.

Although the term 'alcoholism' was first used in 1849 by the Swedish physician, Magnus Huss, the preferred term at this time was 'inebriety' (White, 2004).

Regarding the meaning of the word 'inebriety', similarities can be drawn with the use of the word 'addiction' today. According to Rose and Cherpitel (2011), medical textbooks at the time described cocaine inebriety, opium inebriety, tea and coffee inebriety in addition to 'alcohol inebriety'. The widespread use of the term 'alcoholism' did not actually occur until the early twentieth century (White, 2007).

Rose and Cherpitel (2011, p.23) state that, *"during the 1870s and 1880s, the disease concept of inebriety or alcoholism formed the foundation of the movement to treat the disease medically and scientifically"*.

This movement advocated specialised institutions where alcoholics could be treated. The earliest homes or institutions which were initiated on a voluntary basis for 'inebriates or alcoholics' began in Massachusetts, America in 1893. Initially, these establishments reflected the views and ideologies of the temperance groups that originally ran them (Baumohl & Room, 1987). The medical recognition gradually made the treatment move toward the medical sphere and people being treated in much larger asylums operated with less spiritual emphasis (Porter, 1985). In 1900, there were facilities available in many European countries including Germany, France, Holland, the UK and Ireland (Baumohl & Room, 1987).

However, support for the disease concept amongst medical professionals was not unanimous (Rose & Cherpitel, 2011). In 1874, Dr. Robert Harris stated that drunkenness should be viewed as a habit, sin or crime that cannot be cured in a hospital but can be reformed. The chronic drunk was also viewed as a victim of the promotion or marketing of alcoholic drinks (White, 2000). These different views, perceptions and attitudes towards alcoholism produced quite different ideas for solutions to the problem.

The concept of alcoholism as a purely medical issue began to lose favour at the end of the 1800s. By the early 1900s, specialised medical treatment for alcoholics had collapsed. This was due to the lack of scientific validation of treatment effectiveness and ideological differences within the field (Rose & Cherpitel, 2011). There was a cultural pessimism regarding whether a permanent 'recovery' from alcoholism would ever be possible (White, 2004). Eventually, much of the 'care' of alcoholics shifted to prisons, large hospitals and psychiatry. Alcoholics were given the same treatment as other mentally ill patients, including forced sterilisation, legal commitment in the early twentieth century and electroconvulsive therapy (White, 2000).

However, the disease model was back in favour by 1935, which was after the beginnings of Alcoholics Anonymous (AA) and only two years after the repeal of prohibition. The impetus for treating alcoholism as a disease rather than a moral problem grew out of the substantial growth in AA membership at the time (Cherpitel, 2011). The AA philosophy is that people are not responsible for their alcoholism because it is a disease like any other disease. The 'disease theory' shifted the idea that alcoholics were morally weak to the notion that the person had a disease (Goodwin, 2000). The disease was perceived as a progressive, incurable and irreversible condition arrested only by abstinence. In addition, alcoholics were perceived as different from non-alcoholics, constitutionally making it impossible for them to drink moderately without experiencing any drink-related problems after a short period of drinking (Hester & Miller, 1989).

This model caused a rift between the churches; on the one hand advocating moral values and the medical profession on the other seeing a person with a disease and therefore not morally responsible for their drunken behaviour (Coombs, 2004). This was because the alcoholic was now seen as not being responsible for much of their drunken action and immoral behaviour, contrary to the view of the churches. They were, in effect, "*protected from moral condemnation and judgment*" (Coombs, 2004, p.11). The perception of alcoholics being referred to as 'patients' who should be allowed medical treatment was encouraged by organisations like AA, who showed a sympathetic attitude like the temperance movement which had gone before.

However, unlike other previous groups, it focussed solely on the plight of alcoholics. It was not really interested in how much the public at large drank. AA advocated that the most appropriate agents for intervention were other alcoholics who could spot

the tell-tale signs of another alcoholic and intervene before the alcoholism got any worse.

The medical model of alcoholism reached an important point in its history when it was formally acknowledged by the American Psychiatric Association, who included it in the 1<sup>st</sup> edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (1952). In the following edition, (DSM-II, 1968), they also appeared to adhere to the views laid down by the World Health Organisation's International Classification of Diseases (ICD-8) (1965), in the sense that they incorporated three sub-categories of disorders related to alcohol, namely, alcohol addiction, episodic excessive drinking and habitual excessive drinking. The ICD and DSM classifications both incorporate alcoholism as part of the personality disorders and certain other non-psychotic disorders. This implies that they have the view that the abuse of alcohol may be a result of extreme stress or that it is secondary to an underlying personality disorder. Viewing substance abuse as a symptom of a further psychiatric disorder is occasionally termed the 'symptomatic model'. Adopting this idea would imply that alcoholism is not really an illness in and of itself.

In the 1950s, a person's dependence physically on drugs was emphasised in the definitions. Further, psychological dependence was construed as being compatible with the psychodynamic perception that these disorders were a response to psychological distress. In 1969, the WHO curtailed its attempts to see the differences between what they saw as 'habits' and what they saw as 'addictions'. The notion of drug dependence at the time included the syndromes in which drugs come to control behaviour. It was recognised that dependence on different classes of drugs, including alcohol, can vary quite considerably and may or may not have withdrawal symptoms. In the 1970s, AA wanted to promote the idea of the serious nature of the condition. It saw alcoholism as a primary or independent illness rather than a symptom of an underlying personality disorder. This is obviously a fundamental shift from the earlier views stated in the WHO's ICD-8 (1965), where alcoholism was regarded as a secondary problem underpinned by a personality disorder. In more recent times, the DSM-IV-TR (2000) recognised a person as 'alcohol dependent' if the person showed three or more of the following criteria during any twelve-month period:

- Tolerance, as defined by a need for markedly increased amounts of alcohol to achieve intoxication or desired effect, or markedly diminished effect with continued drinking of the same amount of alcohol as in the past.
- Withdrawal, as manifested by either of the following: the characteristic withdrawal syndrome for alcohol or the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
- Alcohol is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
- A great deal of time is spent in activities to obtain alcohol or recover from its effects.
- Important social, occupational or recreational activities are given up or reduced because of alcohol use.

Alcohol use continues despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

According to Winter and Viney (2006, p.5), the DSM-IV-TR (2000) manual is clearly set out according to a medical model, “behaviours are conceptualised as coherent syndromes or disorders over which those afflicted have little control – and each of these disorders requires systematic and specific treatment”.

In May 2013, a further edition of the manual was born, namely, the DSM-5. Although this was similar in many ways to the previous edition, there were some marked differences.

Firstly, the terms alcohol abuse and alcohol dependence were merged into one term namely ‘alcohol use disorder’ (AUD). This had three sub-classifications, mild, moderate and severe. Secondly, using the previous DSM–IV criteria for abuse threshold, anyone meeting any two of the criteria during the same 12-month period would receive a diagnosis of AUD under DSM-5.

#### An alternative, constructivist approach

Burrell (2002) suggests that modern perspectives of addiction can broadly be seen as coming under the umbrella terms of either a conventional ‘disorder perspective’ or

a constructivist perspective. History has shown that since the mid-nineteenth century, alcoholism has predominantly been perceived as a 'disorder', a progressive disease which a person will suffer permanently. From a disorder perspective, there is an assumption that there are certain substances (including alcohol) often termed 'psychoactive' or 'addictive' drugs that can cause a person to have psychological experiences and behaviours due to their pharmaceutical properties. The person is assumed to become addicted to those pharmaceutical properties and this addiction is seen as a disease. Constructivists may recognise that such drugs have psychoactive properties and that their use becomes a problem for some people; however, this does not mean a disease model has to be accepted. The disorder view believes that drug and alcohol disorders can be objectively defined. The disorder is regarded as more likely to occur in people with certain physiological or psychological predispositions or deficits. Therefore, they may always be prone to a relapse back to their old drug-taking even if they have abstained for some time. They are viewed as merely in remission when they abstain. In contrast to these assumptions, Burrell (2002) suggests that a constructivist approach offers a challenge to the disorder approach. Constructivism is not a theory which relates specifically to alcoholism, but it provides viable alternatives for how it can be understood. For example, instead of seeing alcoholism as being underpinned by unambiguous and accurate knowledge as with the disorder view, constructivism sees the problems that the alcoholic experiences as being best understood as arising from the personal and social meaning that they draw from their experiences. Therefore, from the constructivist position, the alcoholic adapts to social and personal realities that they either create themselves or in conjunction with other people. Constructivism assumes the alcoholic continually attaches different meanings and importance to events and experiences they encounter in their lives and to what others say and act towards them. The alcoholic attempts to make sense out of these experiences and their alcoholism. From a constructivist perspective, it is this sense of personal meaning which is the key issue involved in the alcoholic making the transition to sobriety successfully. I will be adopting this approach throughout the thesis and provide a rationale for this in chapter 3.

## **Organisation of the remaining thesis chapters**

### **Chapter Two – Literature search and review of theoretical approaches**

In this chapter, I begin by presenting my literature search strategy before moving on to discuss the relevant theoretical approaches to understanding alcoholism, achieving sobriety and the intervention measures currently available.

### **Chapter Three – Literature review of empirical research**

In this chapter I present a review of the relevant empirical literature, my research rationale and my research aim.

### **Chapter Four – Methodology**

Chapter four will describe the methodology, including the epistemology and theoretical framework of the research and my reasons for adopting an approach using Personal Construct Psychology as the theoretical framework. It describes the rationale for the methodological decisions made throughout the research process. It gives a full account of the design, inclusion criteria, the research sample, access and recruitment, data collection and analysis. The relevant ethical considerations are discussed and my reflexive thoughts on the research process are offered.

### **Chapter Five – Anticipating change**

This chapter is the first of three chapters presenting my findings. It describes how, initially, the participants anticipated achieving sobriety and imagined casting themselves into a new future. Further, it describes how they not only anticipated these changes but fully intended to hold onto their 'new self'. The chapter finishes by considering the participants' rationale for making changes and whether they planned or did not plan in order to make the changes.

### **Chapter Six – The Role of Social Relationships in Change**

This findings chapter emphasises the importance of the role of social relationships in the change process for participants. It describes the contribution of different forms of support in achieving and maintaining sobriety. The chapter finishes by showing findings relating to the roles of families and friends and of self-help groups in achieving and maintaining sobriety for the participants.

## Chapter Seven – Reconstruction

This chapter is concerned with how the participants appeared to have developed a different perception of themselves as they gradually changed. It considers the participants re-construing their selves and understanding the changes they have made. Lastly, it describes how the participants began to look to their potential futures and reflect on their past.

## Chapter Eight – Discussion

This begins with a brief summary of my main findings, which are then discussed in relation to existing theory and research. It states how I feel I have contributed to the field of alcoholism by exploring the role of personal meaning and its contribution to furthering our understanding of how alcoholics have achieved and maintained sobriety over relatively long periods. Further, I acknowledge the limitations of the research and present recommendations for future research and practice.

# CHAPTER TWO: LITERATURE REVIEW - SEARCH STRATEGY AND THEORETICAL FRAMEWORKS

## Introduction

This review comprises two chapters. This chapter (chapter two) considers the literature covering the theoretical underpinnings of alcoholism and recovery. Chapter three covers the empirical research addressing and challenging these theories. In this chapter, I will begin by presenting the literature search strategy. I will outline the relevant theoretical approaches to understanding and addressing alcoholism and sobriety, leading to a rationale for selecting the most relevant approach to guide my study and to build on existing knowledge.

## Literature search strategy

### Search terms

As I already had some familiarity with the range of theoretical approaches currently available, I had identified approaches that were relevant to my work. Two theoretical approaches were chosen to expand on further because of their predominance in the field and their influences on both professionals and alcoholics in both America and the UK. These were the biomedical and the bio-psychosocial models of alcoholism. For these reasons, I decided not to include other theories of achieving sobriety, such as psychoanalytical and reinforcement theories. My search therefore was for relevant theoretical and empirical research material pertaining to addictions in general in addition to alcoholism and achieving and maintaining sobriety.

The search terms included “the medical disease model”, “the bio-medical approach”, “bio-psychosocial approach”, “transtheoretical model”, “alcoholics anonymous” and “twelve-step approaches”. Further, I searched for literature on more recent theoretical thinking concerning the notion of recovery, motivational interviewing, self-determination theory, social identity theory and the idea of ‘change talk’ influencing people in stopping drinking and/or other drugs and maintaining this abstinence. In addition, I used search terms considering achieving and maintaining sobriety and maintaining longer term sobriety. For this I used the following search terms or phrases in various combinations: alcoholism, recovery, alcohol abuse, substance



abuse, sobriety, sober, abstinence, maintenance, relapse, relapse prevention, long-term sobriety, addictions.

#### Inclusion criteria

1. Peer reviewed primary research directly related to the research aims.
2. English language only.
3. Unlimited time period.
4. Theoretical framework literature.
5. Peer reviewed conference and discussion papers.
6. Grey literature.

#### Database and website searches

I sought advice from the appropriate subject librarian at the University of Huddersfield regarding my search strategy both before and after its completion. I began my search by consulting the electronic database catalogue (Summon) used by the University. However, in-order to improve my search, I additionally searched separately the electronic databases outside of Summon including Scopus, PsycINFO, PsycNET, PsycArticles, PubChem, PubMed and MEDLINE. Further, I accessed additional resources via the Internet, such as Google Scholar and the websites of the Society for the Study of Addiction (SSA) and Alcohol Change UK. The Alcohol Change UK website was particularly useful for extracting current statistics.

#### Manual searches

Following cross-checking of the reference lists of articles identified by my electronic search, a more traditional search of theoretical publications and empirical research was also undertaken by accessing the University of Huddersfield library for books and journals. I was aware that some sources would be duplicated in the electronic and manual searches; however, both searches were useful in also creating a 'snow ball' effect, whereby I found additional useful references and signposts to further relevant works of interest to my study.

## **Theoretical approaches to alcoholism and sobriety**

In this section I will begin by providing a brief overview of theoretical approaches to alcoholism, then I will move on to discuss in depth those that I consider the most relevant mainstream approaches and why. This section includes a consideration firstly, of the medical 'disease' model and the work of Jelinek since 1946 followed by considering more broadly the bio-medical approach and the bio-psychosocial approach, including AA and Twelve-Step Facilitation and the Transtheoretical Model (TTM) of behaviour change. In addition, the section includes an account of relatively new thinking and theory around recovery and self-determination, acknowledging how this can be seen as an important paradigm shift from the disease model. Motivational Interviewing and 'change talk' are discussed as part of this paradigm shift.

Concerning the aetiology or theory relating to the causes of alcoholism from a medical perspective, the medical 'disease' model and the bio-medical theoretical approaches of alcoholism assume that alcohol causes objectively identifiable and real disorders when alcohol is abused and take over any personal control (Schaler, 1998). The medical disease view includes genetic and other biological theories of alcoholism. A development away from these bio-medical approaches came with the bio-psychosocial approach (Engel, 1980). This resulted in more emphasis being focused on psychosocial approaches as well as physiological and biological aspects of alcoholism. This theory acknowledges the part that biology may play and the notion that a person may have a physical addiction to alcoholism, but it further acknowledges the roles of psychological and social factors in both achieving and maintaining sobriety. The approach considers how these factors interact with each other and contribute to our understanding of illness, alcoholism and our intervention measures.

A bio-psychosocial approach has been adopted by self-help groups such as AA and their twelve-step programmes and has been used in the UK and throughout the world as a major intervention measure. For example, according to an AA membership survey (2015), membership in Great Britain was estimated at between 33,000 to 40,000 people.

Further, the TTM (Prochaska & DiClemente, 1982) provides an integrative bio-psychosocial approach conceptualising the process of behaviour change. It is

probably the most well-known of the 'stages of change' models. According to Prochaska et al. (2006), it is used as an intervention measure both in the United States and by the National Health Service in the UK.

Other theoretical approaches include the psychodynamic theories. The theories include the views of Shedler and Block (1990), who argue that people abuse alcohol because they have inordinate dependency needs which go as far back as their childhood. There are also behavioural views, for example, the reinforcement theorists such as Hasin et al. (1985), who argue that many people take substances such as alcohol to self-medicate if under stress. This relies on the idea that as the alcohol reduces stress it becomes a psychological reward for the person. Further, there are socio-cultural theories which believe that alcoholism is formed by societies which create an atmosphere of stress or whose family's value or at least tolerate alcoholism or another drug abuse (Walsh, 1992).

Cultural expectations of alcohol use have been found to provide norms based on gender which either approve or disapprove drinking behaviour (Bussey & Bandura, 1999). For instance, Mexican traditional cultural expectations disapprove of women drinking but not men. Therefore, this likely contributes to differences in the rates of alcohol use by Mexican men compared to women, which are much greater than the differences between white American men and women (Castro & Coe, 2007).

In addition, Burrell (2002), argues that constructivist perspectives offer an alternative understanding of alcoholism and substance abuse in general which differs radically from many other approaches. As outlined in the Introduction, it is the personal meaning which is the key issue involved in the alcoholic making the transition to sobriety successfully. The constructivist approach includes examining alcoholism in the context of the personal construction of meaning (Klion & Pfenninger, 1997; Klion, 1993) using Personal Construct Psychology. Further, Willutzki and Wiesner, (1996) look at substance abuse from a social constructionist perspective, and Burrell and Jaffe (1999) write about the evolutionary constructivist perspective. 'An evolutionary perspective suggests that substance-centred selves (addictions) evolve in the course of a person's active efforts to construct meaning and adapt to construed social contexts'. All these three theoretical approaches can be seen as similar insofar as they all agree that substance use has to be understood from the

user's or alcoholic's perspective and as meaningful from the alcoholic's perspective. Therefore, the constructivist perspective can be seen as being under the umbrella of the bio-psychosocial model. This is in contrast to a medical theoretical perspective which sees a disorder or disease.

I will now discuss the medical model in depth due to its predominance in the field of alcoholism today. This approach is widely accepted in the UK and worldwide and has been the basis for much early intervention in alcoholism. In addition, I will move on to discuss bio-psychosocial approaches such as AA and 12-step approaches and the TTM which are also widely used in promoting change and therefore need close attention. The chapter also addresses more recent ideas such as the notion of 'change talk' in relation to the TTM, self-determination theory and contemporary thinking relating to motivational interviewing and its effectiveness in recovery. In chapter 3 I will consider constructivist approaches which appear to fit under the bio-psychosocial umbrella because the theories emphasise psychological processes and our social relations with other people in order to understand the alcoholics' attempts to change. Further, I will finish by considering the PCP approach in particular.

#### The medical 'disease' model and the bio-medical approach

In this section I will discuss the beginnings of the attempts to classify alcoholics into different types, the possible role of genetics in alcoholism and the interventions to treat alcoholism that are based on the medical model. The medical model approach identifies disease through observation, description and differentiation by medical examination of the alcoholic. As alcoholism is seen as a disease, it tends to be treated with medication in a similar way to other diseases or illnesses. As chapter one suggests, this medical model approach has informed a major part of the literature, research and intervention measures concerning alcoholism today. Its views have remained a very prominent force particularly as a result of the biological disease aspect of the model being adopted in the writings of AA (1952; 2001; 2002) and in the seminal work of Jellinek (1946) and his medical 'disease' model (originating in America). It only considers biological factors relating to alcoholism, for example, chemical changes in the brain and genetic factors. Further, it only incorporates phenomena that are measurable and quantifiable. This disease model in effect is a bio-medical model because this again focuses on biological factors and excludes psychological, environmental and social influences. The bio-medical

approach includes both more general biological and more specific genetic theories. Biological theories see alcoholism as being a result of a chemical disorder of the brain. Rose and Cherpitel (2011) state that alcoholism can be seen as a disease as many aspects of alcoholism are similar to other recognised medical conditions, such as type 2 diabetes and high blood pressure. It is seen as similar because it has identifiable symptoms, a biological basis and genetic heritability. Further, alcoholism has been adopted by the World Health Organisation's International Classification of Diseases and the American Psychiatric Association, who included it in the 1<sup>st</sup> edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (1952) and all subsequent editions.

Jellinek was the first to produce a 'scientific' investigation into various forms of alcoholism, describing it as a disease and encouraging the medical profession to claim responsibility for its definition, understanding and treatment. Medical theory believes that classifying alcoholics into subtypes is useful in alcoholism because it is thought these reflect differences in the neurobiology of the alcoholic (Hillemacher & Bleich, 2008). Further, it proposes that this identification may improve the effectiveness of the treatment they receive, such as medication (Pompo et al., 2008)

#### Beginnings of classifications

Jellinek's 1946 original study aimed to distinguish types of alcoholics, which he classified as being within his disease concept of alcoholism. A summary of its details was later published in his book in 1960. However, this review suggests his findings were based on weak evidence. They were based on a questionnaire completed by a very narrow and selective sample of 98 male AA members. Valverde (1998) points out that the questionnaire would only be relevant to white, middle class, male alcoholics in the 1940s. Of the original 158 questionnaires returned, Jellinek discarded 60 because they had collaborated with other members on their answers. Further, according to Fingarette (1988) he also excluded all the questionnaires completed by women because he only had a small sample of 15 completed questionnaires and their answers differed greatly from those of the men. It is argued this omission of women from his work possibly fuelled the notion that alcoholism only really applied to men, and further, that by excluding data on women it was not showing their perspective on alcoholism.

In his book, which he entitled '*Disease Concept of Alcoholism*' (1960), Jellinek appears to contradict himself by stating that he regarded some of the classifications as being a disease but not all of them. For example, he acknowledges and classifies five forms of alcoholism. However, with Alpha alcoholism (his first classification) he considered the alcoholic as having significant social and personal problems, but he felt they could stop drinking if they wanted to. Therefore, he argued they had not lost control and as a result they did not have a disease. Likewise, with his second classification, Beta alcoholism, he clearly states the alcoholic is not suffering a disease because the alcoholic is not physically addicted, only psychologically addicted. His third classification, Gamma alcoholism is described as the alcoholic being very much out of control as soon as they start drinking. With the Delta subtype the person has an inability to stop drinking (i.e. cannot abstain whatsoever).

Jellinek (1960, p.39) describes a further classification or 'species' (using his own words) known as Epsilon alcoholism or periodic alcoholism. He refers to this classification as the least known form of alcoholism. According to Rose and Cherpitel (2011) it is characterised by binge drinking resulting in a loss of control. Regarding all the above classifications, Jellinek is unclear as to whether these classifications are discrete types of alcoholism (so that a person could 'be' one or other of them) or that they are stages a person may progress through as they become more addicted. The classifications also appear unclear, particularly around whether the defining factor of 'disease' revolves around the issue of 'loss of control' in his first classification or whether, as in Beta alcoholism, his deciding factor appears to be psychological addiction, which he felt was not a disease, and physical addiction, which he felt was.

Therefore, it is suggested that Jellinek's classifications in 1960 actually limit the types of alcoholics which are within the 'disease' classification. Valverde (1988, p.111) suggests "*most of the types described might be alcoholics, but they are not diseased – because they do not suffer from loss of control*".

Despite the poor evidence produced for Jellinek's conclusions, such as the lack of robustness in his data collection (the questionnaires) and his arguably contradictory classifications of disease, key features of his work can be found in mainstream conceptions of alcoholism today. For example, the medical model still sees alcoholism fundamentally as a disease. Secondly, both medical model researchers

and clinicians still make efforts to classify alcoholics into subgroups that reflect differences in the underlying neurobiology of the person. They believe that identifying subtypes of alcoholic patients may improve the effectiveness of the subsequent treatment they use (e.g., the choice of medication), the treatment results and provide a better prediction of the future course of disease (Pompo et al., 2008). Therefore, it is argued, this continuing classification first developed by Jellinek is still having an influence on the medical intervention used for alcoholics today. For example, two different alcoholism subtypes were developed by Cloninger et al. (1996) known simply as Type one and Type two. They differ by the age of onset of the alcoholism, the relative contributions of genetic and environmental factors, gender and personality traits, and whether co-occurring psychiatric disorders (such as antisocial personality) are present. Type one is seen to have a later age of onset of alcoholism (25 years and older). Type one alcoholics are considered to have few sociopathic features and feel the need to drink to relieve stress and anxiety. They also have fewer alcohol related problems. Type two in contrast is seen in early age onset. These alcoholics have antisocial and impulsive characteristics and more severe alcohol related problems according to Kenna et al. (2004). These classifications do not necessarily exclude behavioural risk factors and therefore may represent a move towards a bio-psychosocial understanding. There were other classifications including that of Babor et al. (1992) containing similar features to those of Cloninger et al. Some further researchers also found that as well as biological factors defining classifications there were also social and psychological factors (Lesch & Walter, 1996), which again may indicate a move toward more of a bio-psychosocial model rather than a bio-medical model.

These different findings on the classifications suggest that some doubt may be cast on the biomedical models definitive understanding of alcoholism when it is debatable as to whether it also involves social and psychological factors in its classifications. Further, Babor and Caetano (2006) reviewed the research on subtyping and the established theories' usefulness in connection to both subtypes of alcoholics and substance abuse in general. Their review suggested that this previous research had produced mixed results in terms of the predictive validity of these classifications in general. Although they doubted the usefulness and validity of the classifications, they

did feel there was evidence to suggest alcoholism, at least in terms of age of onset and progression of the disease, are also partially determined by genetics.

### The role of genetics

In terms of the aetiology (cause or causes) of alcoholism the medical model today still makes the fundamental assumption that becoming an alcoholic is partly determined by genetic inheritance. Like many other diseases, the medical model believes that a genetic contribution plays a prominent role in many cases of alcoholism.

According to Vaillant (1983) and Kendler et al. (1994) studies of twins and adoptees have indicated that people can inherit a predisposition to substance abuse and dependence. Studies of twins have compared the concordance rates of genetically identical (monozygotic) twins with those of fraternal (dizygotic) twins. If a predisposition to alcoholism or other drug taking is inherited, then the alcoholism concordance rate of identical twins should be higher than that of fraternal twins. Kaij (1961) studied 174 male twin pairs where at least one twin had an alcohol problem. The findings showed that the concordance rate was 58% in monozygotic twins and 28% in dizygotic twins. Further, in a study by Hrubec and Omenn (1981) examining the medical histories of 15,924 male twin pairs to determine concordance rates for alcoholism they also reported a higher monozygotic rate of 26% contrasted with a 12% dizygotic concordance rate. This is around half the concordance rate reported by Kaij. However, Heath (1995) suggests the study by Kaij (1960) appears to be at variance with the general trend in research findings. Further, Kendler et al. (1994) aimed to determine any familial resemblance to alcoholism and how parents may transmit this vulnerability to their daughters. They interviewed 1030 pairs of female same-sex twins of known zygosity and 1468 of their parents in order to determine the presence/degree of alcoholism in these individuals. They examined a narrow definition of alcoholism requiring dependence where it is needed to perform basic tasks of daily living or tolerance whereby a person needs increasing amounts of alcohol to achieve the same result as in the past. They classified individuals as either unaffected or as having one of three levels of severity of alcohol problems. Using twin-family structural equation modelling they estimated genetic vulnerability to alcoholism to be at 51–59%. Genetic vulnerability to alcoholism was equally



transmitted from fathers and mothers. The research evidence therefore suggests that alcoholism may be partly genetically inherited.

Regarding adoptees, a study looked at the rates of alcoholism in males who had been adopted soon after birth (Goodwin et al., 1973). They studied one group of 55 adopted sons with biological parents who were alcoholic and another group of 78 adopted sons who had biological parents who were not. The sons of the alcoholics had no knowledge that their biological parents had been alcoholics. Approximately, 18% of the sons who had an alcoholic parent became an alcoholic themselves, compared to 5% of the sons of non-alcoholic parents. Therefore, the rate of alcoholism among the adoptees with a biological parent who was an alcoholic was 3.6 times greater than sons of non-alcoholics. Similar results were found in studies by Cloninger et al. (1981) and Cadoret and Gath (1978).

These studies on both twins and adoptees show some support for the view that a predisposition to develop alcoholism may be inherited. Research suggests it is likely that there may be a genetic link. For example, Rose and Cherpitel (2011) state that 40–60% of the risk for alcoholism is genetically determined and Tawa (2016) suggests 50%; however, there are also other factors involved. A variety of environmental features have been suggested as risk factors, for example family life (Fingarette, 1988), stress (Sinha, 2008; Poikolainen, 2000) and sexual and physical abuse (Enock, 2011). Therefore, research indicates that a genetic predisposition to the addictive effects of alcohol together with other environmental risk factors may both contribute to the development of alcoholism. However, it is acknowledged that modern understandings of inheritance do not separate out genetic and environmental influences, because the former operate through the latter. Nevertheless, even if genetic inheritance does play a part in a person becoming an alcoholic, this does not necessarily indicate that the person is unable to both achieve and maintain sobriety.

Today it can be seen that the medical model continues to recognise genetics and a variety of classifications and sub-types of alcoholism. Further, as already mentioned, it is believed by clinicians that these sub-types are thought to reflect differences in the underlying neurobiology of the person which may respond differently to treatments such as medication.

## The effectiveness of medications

I will now go on to consider the effectiveness of medications used as an intervention to achieve and maintain sobriety which are currently prescribed by medical practitioners.

Medications appear to be an integral part of the medical model approach today. They appear useful particularly in early sobriety to reduce the intensity of cravings and reduce the possibility of a lapse or relapse. A lapse is a temporary slip or return to previous behaviour whereas a relapse is a full-blown return to behaviour e.g., drinking (Marlatt & Donovan, 2005). Examples of these medications and their uses include disulfiram (Antabuse), which gives a toxic reaction if one drinks alcohol, creating an unpleasant reaction. It is referred to as a form of aversion therapy. However, this type of drug has now been replaced by an emphasis on drugs that target the brain chemical systems thought to be involved in alcoholism. One such drug is naltrexone, which it is argued blunts the emotional response to alcohol by reducing its euphoric effect (O'Malley et al., 1992; Volpicelli et al., 1992). When using the drug, studies found that patients abstained for longer time periods, drank less often and had less risk of relapsing to heavy drinking (Croop et al., 1995). However, it only works if the alcoholic is compliant with taking the medication. Therefore, in order to minimize the risk of non-compliance, a long-acting version of the drug is available in injection form. Further, it is claimed that both patients entering therapy with the aim of complete abstinence and alcoholics just wanting to reduce their drinking can benefit from the drug (Garbutt et al., 2005). However, although the study suggests that patients managed reductions in their drinking, it does not appear to suggest that by taking the drug they can completely abstain from drinking.

Chronic alcohol abuse forces several brain chemical systems to alter how they function in order to adapt to the alcohol intake (Rose & Cherpitel, 2011). When the alcoholic stops drinking, the altered function persists, causing the craving, insomnia and anxiety experienced by some alcoholics in early sobriety. The drug Acamprosate (Campral) attempts to reduce craving and many of the symptoms of withdrawal from alcohol. Studies suggest that this increases the rates of total abstinence and the length of time abstinent (Kranzler & Gage, 2008). Further, higher doses can increase the proportion of patients who remain abstinent for up to twelve months (Paille et al., 1995). However, regarding all medications for alcoholism they only work if the

patient is compliant with taking it. Further, this compliance is often poor with alcoholics (Swift, 2007). This review of the studies thus far leads me to acknowledge the usefulness of medication albeit in time-limited, short-term circumstances. Rose and Cherpitel (2011, p.194) state "*medications are never intended as sole treatment*". Therefore, medication alone does not appear to necessarily equip the alcoholic to achieve longer term sobriety (judged as two years and above, Hill and Leeming, 2014; Klingemann, 2012). Although research suggests that medical intervention is useful for 50% of severe alcoholics (with repeated significant distress and problems functioning in life) in achieving sobriety (Cunningham, 1999; 2000), this does not acknowledge the limitations in the current treatment system. For example, most current medical treatments approach alcoholism as if it were an acute illness requiring a short-term plan of care (White et al., 2003). However, at the same time alcoholism is increasingly seen by the medical profession as a chronic long-term illness (Rose & Cherpitel, 2011). Therefore, in order to augment this short-term medical intervention, other much more long-term intervention methods are needed. Challenges to the bio-medical model encompass the model's assumptions regarding the continuing classifications of alcoholics, the aetiological assumptions regarding the role of genetics and the effectiveness of medication as an intervention measure.

## **Summary**

Regarding the usefulness of classifications, this review suggests Jellinek's early study (1946), resulting in identifying classifications, was based on weak evidence. Both medical model researchers and clinicians still make efforts to classify alcoholics into subgroups and some studies constitute evidence of the validity of subtypes (Pompo & Lesch, 2009). However, doubt has been cast on the predictive validity of classifications in general (Babor & Caetano, 2006).

Studies suggest that becoming an alcoholic is partly determined by genetics. However, this is just one factor among many. It could be argued that placing alcoholics in definitive categories amounts to telling them what is wrong with them and dictating their future without seeing their situation from their perspective. This may mean the alcoholic will not forge their own personal autonomy to own their problem with alcoholism or plan their own future. Further, even if genetic inheritance does play a part in a person becoming an alcoholic, this does not indicate that the person is unable to both achieve and maintain sobriety.

The effectiveness of medications as an intervention measure in achieving and maintaining sobriety (which appear to be an integral part of the medical model) can sometimes be questioned. For example, drugs such as Naltrexone are only useful if the alcoholic is compliant with taking it, and evidence suggests compliance is often poor (Swift, 2007). Further, medications appear useful for short term crisis intervention work but do not appear to be as effective for long-term recovery and maintaining this recovery (Vaillant, 2003,1995, 1983). Therefore, it is suggested that although medications may have their place in the recovery process, they do not address socio-cultural factors which may involve a much more eclectic mixture of methods. As Fingarette (1988, p.27) suggests, *“heavy drinking and alcoholism are merely labels that cover a variety of social and personal problems caused by the interplay of many poorly understood physiological, psychological, social, and cultural factors.”*

The limitations of the bio-medical model and of drug treatments have led some, such as Prochaska (1979); Fingarette (1988); Peele (1995); and Laudet and Stanick (2010), to see alcoholism as a result of a more complex interplay of biological, psychological and social factors, hence an approach known as ‘bio-psychosocial’.

#### The bio-psychosocial approach

In recent times the focus of research and theory has moved from an emphasis on the medical disease model of alcoholism to an emphasis on bio-psychosocial issues such as self-determination, personal autonomy, choice, agency, and motivation in relation to recovery. These theories have resulted in a move towards Motivational Interviewing becoming a major intervention method in the goal to achieve abstinence, sobriety, and recovery from alcoholism and other drug use. This will be discussed later in the chapter. However, first I will discuss how the bio-psychosocial approach theorises alcoholism and discuss the intervention measures pertaining to this approach.

This approach was developed by George Engel in 1977. Engel (1980) attempted to refocus alcoholism from the sole emphasis on biological and medical factors and to place more emphasis on the social and psychological aspects. According to Lazarus and Colman (1995), Engel’s model considers both the internal (psychological, cognitive and physiological) elements and external (cultural, social and

environmental) elements that may contribute to alcoholism. Engel considers how these factors interact with each other and contribute to our understanding of illness, alcoholism and our intervention measures.

Like the bio-medical approach the bio-psychosocial approach acknowledges the role of biology and the notion that a person may have a physical addiction to alcoholism, but it further acknowledges the roles of psychological and social factors in both the causes and treatment of alcoholism. In terms of causation for example, people with experience of childhood traumas are more likely to become addicted (Lo & Cheng, 2007), whereas those with strong social support networks are less likely to become addicted (Blomqvist, 1999). In addition, the onset and experiences of physical illnesses such as diabetes have to be understood not just as medical conditions but also as due to cultural shifts in social norms and expectations around eating and diet. Psychological factors may include feelings of shame, lack of self-esteem and feelings of a depressive nature. The social factors could include the person's housing, neighbourhood, financial situation, work, home life and network of friends or lack of friends.

It is argued that examples of bio-psychosocial intervention measures are seen in AA and its use of Twelve-Step Facilitation (TSF) methods and in the Transtheoretical Model methods discussed below. They are viewed as bio-psychosocial because although they all acknowledge biological factors, such as a genetic vulnerability, they also acknowledge the role of social factors, such as family circumstances and relationships and psychological factors, such as coping skills, self-esteem and mental health.

#### AA and the Twelve-Step Facilitation (TSF) method

Although medical treatment alone does not appear to be enough to achieve longer term sobriety, Weiss and Kueppenbender (2006) suggest that medication can increase the chances of the alcoholic being able to take part in intervention measures, such as AA interventions, and its associated therapies, such as TSF.

Following acute medical intervention, the person is often referred to a chronic disease (recovery management) model (White et al., 2003; Gubi, Marsden-Hughes, 2013). Further, having completed any further prescribed medical treatment, the

alcoholic is possibly discharged to some form of self-help group that offers TSF and is organised by groups such as AA or other self-help groups.

According to White (2010), a central principle of AA is that recovery from alcoholism means much more than merely stopping drinking from an otherwise unchanged life. AA additionally sees a major change in the person's character, identity and their relationships with others. In order to achieve these aims, they offer psychological and social therapy. These methods are understood to help a person psychologically by offering the support and encouragement of others. In addition, they help to explore and reframe the alcoholics' assumptions, beliefs, attitudes, perceptions and their unconscious patterns of processing information (cognitive restructuring).

Many alcoholics who attend AA have difficulties in keeping their emotions and behaviour from becoming overwhelming and they need a degree of self-regulation. AA refers to these difficulties as character or personality trait defects, making the ability to express and experience both emotions and feelings problematic. Therefore, AA encourages honesty and openness within its groups in addition to emotional support and the sharing of experiences that try and address these emotional problems (Khantzian & Mack, 1989; Rowan & Butler, 2014; Kihara, & Kitaoka, 2019).

With the TSF approach, the alcoholic learns to recognise and alter or restructure their unhealthy attitudes and thoughts (Steigerwald & Stone 1999; Rowan & Butler, 2014; Kihara, & Kitaoka, 2019). It sets out some guided recommendations, principles and methods of action seen as a way of life in order to change. It requires the alcoholic to admit that they have no control over their alcoholism and acknowledge the strength that can be gained through a 'higher power'. Secondly, it recommends utilising an experienced member of the group (the alcoholic's sponsor) to analyse and amend previous mistakes and learn how to live a different life using new methods of behaving. Lastly, the alcoholic should move on to act as a mentor to those newer to the AA programme and work through these recommendations with their sponsor. In a systematic review of both AA and other twelve-step programs (Kelly et al., 2020), the review identified 27 relevant studies which included 10,565 participants. All the studies varied in their design. The authors' general conclusions were that there was evidence that both AA and TSF interventions were more effective than other methods such as CBT for increasing abstinence rates. Further, their methods were at least as effective as other alcohol-related interventions.

Other research also points to the successes of TSF; for instance, Rowan and Butler (2014) found in qualitative interviews with 20 lesbian alcoholics (aged between 50-70) who attended AA and received TFS that 75% of their study participants cited the effectiveness of TFS in both attaining and maintaining sobriety. Further, Kihara and Kitaoka (2019) in their study of 36 males from AA found that the participants had both achieved sobriety and maintained their sobriety by adopting and practising the 12 steps in AA and making daily steps to regulate their emotions. In addition, following a three-year quantitative Canadian study, which aimed to consider mutual (self- help) group participation and predominantly looked at AA but also Narcotics Anonymous, SMART Recovery and Women for Sobriety (Kelly et al., 2006), found that these groups are helpful for many types of people. Their study consisted of 227 people with substance use disorders, with 27% being female. They were assessed at 1, 2 and 3-years post discharge from hospital. Their findings revealed that the use of self-help or mutual help groups such as AA following intensive outpatient treatment may be useful even for people with only modest levels of participation and was a cost-effective resource.

However, there are also limitations to the twelve-step approach, for example both AA and the twelve-step model emphasise the notion of spirituality, which is argued by Mendola and Gibson (2016) to be off-putting for some. Mendola and Gibson also argue that the twelve-step emphasis on 'powerlessness' can make some people have a loss of confidence as a result. Further, they feel that there is a lack of consistency in some of the philosophy of the twelve-step model, for example the position by the founder of AA in AA literature that alcoholism is an illness (Wilson, 2001) appears to contradict the AA view that it is a spiritual problem (Wilson, 2005). In addition, Mendola and Gibson point out that AA literature (Wilson 2001) claims that alcoholism is not a moral failing of a person, but AA then contradict themselves by also suggesting that people should "make a moral inventory of ourselves" (AA 12 Steps and 12 Traditions, Step 4, Wilson, 1952; 2005) and "remove all defects of character" (AA 12 Steps and 12 Traditions, Step 6, Wilson, 1952; 2005). It is argued that these points, if nothing else, may confuse the person reading this literature.

The literature review thus far suggests bio-medical interventions (medication and detoxification) appear to be successful in the early part of achieving sobriety. In addition, psychosocial measures are also important to enable a person to maintain

this sobriety. Further, rather than regarding alcoholism as an acute problem, the literature suggests it is now seen as a much more long-term condition (Rose & Cherpitel, 2011) requiring a move away from an acute model with time-limited therapy towards a model of sustained life-long recovery management (Gubi & Marsden-Hughes, 2013). It is argued that there are many pathways to both initiating and achieving sobriety (Granfield & Cloud, 1999; Klingemann 2012). For example, rather than just stopping drinking being a single event, often a person can lapse or relapse on a number of occasions and attend self-help groups and other therapeutic activities sometimes for years before they finally achieve sobriety (Vaillant, 2003). Therefore, there is a need for interventions to consider more long-term strategies that focus on all aspects of the alcoholic. This includes not only their physical and mental health and well-being but also the social context in which they live. Therefore, it is argued that more eclectic approaches should be considered. In relatively recent years there has been a shift in focus in ideas about 'recovery' and also approaches which aim to achieve this goal. As White and Cloud (2008) have stated, there has been a 'paradigm shift' from the disease model to relatively new thinking regarding recovery and approaches with the key idea being an emphasis on self-determination. This change in thinking has led to a greater focus on bio-psychosocial theories and interventions in recovery from substance use in general. One such bio-psychosocial theory is that of the Transtheoretical Model of Behaviour Change.

#### The transtheoretical model (TTM) of change

The TTM is not the only 'stage' model. Researchers have produced different ways of dividing the change process into a variety of steps or stages, namely Horn (1976), Marlatt and Gordon (1985) and Rosen and Shipley (1983). All these stage models can be regarded as similar to the TTM model insofar as they all consider alcohol or smoking and agree that at least three basic stages exist, including deciding to change, acting on this, and maintaining this change.

The TTM (Prochaska & DiClemente, 1982) provides an integrative bio-psychosocial model conceptualising the process of behaviour change. It is probably the most well-known of the 'stages of change' models. It began as a descriptive way to assist medical model clinicians to develop appropriate intervention measures for people with addictive behaviours (Povey et al., 1999). The TTM believes changes in behaviour involve a transition through a set of discrete stages which people are



assumed to move through sequentially (DiClemente, 2007). However, it is accepted they may relapse and move back to an earlier stage. There are six stages: pre-contemplation (not yet considering change), contemplation (considering but not yet acting), preparation (planning), action (carrying out plan), maintenance and termination. Regarding the sixth stage 'termination', Prochaska et al. (2006, p.275) state that "*as for true termination there is little consensus among the experts*" and "*alcoholism for example, is usually seen as a lifelong disease*". Therefore, "termination" remains a debatable issue, and in this thesis I have regarded it as not applicable.

The TTM consists of stages, processes, and interventions. While the stages indicate when the movement in intentions and behaviour take place, the processes are the self-change strategies describing how these moves happen. They provide a guide to practitioners in terms of the development of interventions. These measures are the means by which the alcoholic will move through the stages. Interventions should match the stage the alcoholic is deemed to be at. This is achieved by targeting the processes that are thought to influence this movement. The processes regarded as most important when a person is moving from pre-contemplation to contemplation are '**consciousness raising**' (having more awareness about the drinking), '**dramatic relief**' (experiencing negative emotions as a result of alcohol) and '**environmental re-evaluation**' (considering the negative impact of the drinking or the positive impact of sobriety in the context of their physical and social world). Moving from contemplation to preparation involves '**self-re-evaluation**', assessing the kind of person you could be and assessing the pros and cons of changing. Preparation to action involves '**social and self-liberation**' (development of awareness of alternative ways of living and a commitment and ability to change). At the action to maintenance stage these involve '**counter-conditioning**' (healthy behaviours replacing drinking) forming '**helping relationships**' (accepting support from significant others), '**reinforcement management**' (increasing the rewards for the positive behaviour change and decreasing the rewards of the problem behaviour) and '**stimulus control**' (removing reminders or cues to engage in the problem behaviour and adding cues or reminders to engage in the recommended behaviour). **Table 1** shows the processes of change that bring about movement between the stages shown at the stages where they are thought to be most useful.

Table 1 The processes of change

Stages of change				
precontemplation	contemplation	preparation	action	maintenance
<i>Consciousness raising</i> .....>				
<i>Social Liberation</i> .....>				
<i>Dramatic relief (emotional arousal)</i> .....>				
<i>Environmental re-evaluation.</i>				
<i>Self-re-evaluation</i> .....>				
<i>Self-liberation/commitment</i> .....>				
<i>Counter conditioning</i> .....>				
<i>Helping relationships</i> .....>				
<i>Reinforcement management</i> .....>				
<i>Stimulus/environment control</i> .....>				

Note: The above information is based on the work of Prochaska, Norcross & DiClemente (2006) and Miller & Rollnick (1991).

The TTM was developed following an earlier study by Prochaska (1979). At the time, he analysed the current therapeutic methods to obtain a synthesis between therapeutic systems dealing with change. As a result, he reviewed 300 therapy outcome studies and analysed and compared 18 of the most successful leading systems. Some had incorporated elements of the Health Belief Model (HBM), Locus of Control, Motivational Interviewing (MI), Cognitive Behavioural Therapy (CBT) and Twelve-Step Facilitation into their programmes. He found that these approaches were the most helpful. Subsequently, in 1982, Prochaska and DiClemente developed their own model based on the 1979 research. This model integrates concepts from other theories such as the Health Belief Model (HBM), the concept of Locus of Control, Cognitive Behavioural Therapy (CBT), Twelve-Step Facilitation (TSF) and Motivational Interviewing (MI). According to Prochaska et al. (1992) and Miller and Rollnick (1991), the TTM draws upon these theories in the following ways: when a person is at the precontemplation stage they may often not even consider becoming sober, believing they have not got a problem or that it will negatively affect them (the Health Belief Model is drawn upon here). Further, they may have just accepted and be resigned to their unhealthy behaviour because of past failed attempts and believing they have no control (external Locus of Control is drawn upon). Further Motivational Interviewing may be used. When contemplating sobriety, they may

struggle with ambivalence, weighing up the pros and cons of their current behaviour and the benefits of and barriers to sobriety. Here, both the HBM and MI are drawn upon in the TTM. In the preparation/planning stage, CBT is utilized. In the action and maintenance stages, CBT and TSF are drawn upon.

Within the TTM and both at the precontemplation and contemplation stages it is suggested the interventions based on the HBM model may be effective in change but only if the alcoholic values their good health more than their desire to drink. These health beliefs include their perceived susceptibility to developing a health problem, the seriousness of the consequences and the perceived benefits and barriers to abstaining. The combination of these four factors is believed to indicate a person's readiness to act. There are two further concepts, namely, 'cues to action' activating the readiness to act by exposure to factors that prompt action, and self-efficacy (Bandura 1976). As the TTM relies to some extent on the HBM and MI, it is worth briefly engaging in some critique of these in relation to the TTM.

A suggested limitation in this approach appears to be in its effectiveness being dependent on whether alcoholics believe that stopping drinking will improve their health and that this improvement has enough importance and benefit to warrant the change as they see it. For example, if they see their health as being of low importance and socialising and being confident in order to achieve social acceptability as of higher importance, they may not move out of these two stages and stop drinking. Therefore, this emphasis on health may be too narrow an assumption of what might be regarded as important to evoke change. In a review of 46 HBM studies, Janz and Becker (1984) argue that many behaviours, such as smoking, are habitual and may become independent of conscious health-related decision making. In addition, Glanz et al. (2008), comment that the HBM does not account for the impact of emotions on health-related behaviour. For example, the alcoholic being scared or not scared of dying due to drink. Therefore, these limitations suggest the HBM does not fully take into consideration the emotional or social context in which the alcoholic lives. In addition to the HBM being utilized by the TTM at both the pre-contemplation and contemplation stages, Motivational Interviewing (MI) is also used.

Motivational Interviewing (MI) (Miller, 1983) focussed originally on problem drinking. It assumes that as the alcoholic is responsible for any decision to change there should

be no resistance to stopping. Miller had found that direct argument and aggressive confrontation just increases the alcoholic's defensiveness and reduces the chances of them changing. For example, Miller et al.'s study (1993) found that the more counsellors confront alcoholics about their drinking, the more the alcoholics will drink. MI is defined as a "client-centred, directive method for enhancing intrinsic (internal) motivation by exploring and resolving ambivalence" (Miller & Rollnick, 1991, p.25). The acknowledgement of this ambivalence is a crucial part of motivational interviewing. MI is increasingly being seen and used as a stand-alone intervention in addition to its use as a possible intervention as part of the TTM. Therefore, it will be discussed in more detail later. A key element of MI is 'change talk' or the language clients use in MI to indicate their aspirations to change. This suggests that the TTM (at least in its use of MI) recognizes the effectiveness of this for helping the person change the way they think about themselves and their situation — and that such change is important in achieving sobriety and ultimate recovery.

CBT focuses on the role of a person's thought processes and in particular the part 'distortions' or irrational beliefs play in sustaining problem behaviours. It focusses on training new thought habits. Beck (1976) suggests three levels of cognition are apparent here, including our core beliefs about self, others and the world around us, our dysfunctional assumptions or conditional 'rules for living' and lastly our negative involuntary thoughts in certain situations. According to Peele (1995) self-efficacy is also a crucial part of CBT in proving to the alcoholic that they have the skills and competence to take control of their own lives. Any success in terms of 'recovery' is seen as due to the alcoholic's own personal work and can therefore reflect back on their self-image. It is argued this is in direct contrast to the medical model approaches where a person's medication and the prescribing doctor may be seen as responsible for their abstinence. Further, with CBT, anything that is perceived as not successful is seen as a learning opportunity which they can use to improve their self-management and rebuild their confidence. This again contrasts with biomedical models, where relapses are often seen as a failure.

Below is a summary of the alcoholic's TTM journey as a whole, describing the stages, processes and the corresponding intervention measures suggested by the TTM.

*Pre-contemplation stage*, i.e. not yet considering or intending to change, believing they have not got a problem or denying it (DiClemente, 2003). Often seen as a defence mechanism (Johnson 2003) and psychodynamic issue (Prochaska et al., 2006) whereby alcoholics can be reluctant, rebellious, resigned or rationalising about their drinking often due to past failed attempts. Interventions based on three theories are used to overcome this stage: a focus on the person's weak internal Locus of Control and the use of MI to improve self-efficacy. Further, interventions based on the HBM may make them more aware of the threats and benefits of drinking or abstaining. The processes involve consciousness raising, dramatic relief, and environmental re-evaluation.

*Contemplation stage* The alcoholic is considering but has not acted to change yet. However, they are aware that a change is needed. At the same time, they may be struggling with ambivalence considering the pros and cons of change and need to overcome this ambivalence. This again can involve interventions based on the HBM where they may be prompted to change when they become aware of the seriousness of the health consequences of continuing to drink and the benefits of abstinence. One such consequence could be having to face up to different forms of stigma through anticipating others becoming aware of their alcoholism. One form of stigma is 'self-stigma' (Ritsher & Phelan, 2004). This stage may also benefit from the use of Motivational Interviewing in helping them resolve any ambivalence towards change and prevent them getting stuck with indecision. The processes include consciousness raising, continued dramatic relief (or emotional arousal), continued environmental re-evaluation and self-re-evaluation.

*Preparation stage* The person continues attempting to weigh up the pros and cons of drinking (Janis & Mann, 1977) and making the choice to move to another stage. It also involves 'self-efficacy' (Bandura, 1976) reflecting the degree of confidence the alcoholic would have in moving from preparation to action. CBT (Beck, 1964) techniques are also employed at the preparation stage, helping the alcoholic to realise they have the skills and confidence to plan and control their own lives in the future. The processes involved at this stage include self-re-evaluation and self-liberation.

*Action stage* The person makes steps to stop or reduce their drinking. Many people may be vulnerable to lapsing or relapsing and returning to the earlier stages of

recovery. At this stage both the use of CBT and TSF methods (both described earlier) are deemed appropriate. The processes include self-liberation, counterconditioning, helping relationships, reinforcement management and stimulus control.

*Maintenance' stage* is said to be reached after 6 months of abstinence. However, I could find no empirical evidence confirming this point. Further, Prochaska et al. (2006) suggest surprisingly little advisory information at this stage only citing utilising refusal skills and not entering situations which may put them at risk of more drinking. They should also revisit the reasons why they stopped drinking in the first place and focus on the benefits of sobriety. The processes include counter conditioning, helping relationships, reinforcement management and stimulus control and they advise the use of CBT and TSF.

Considering these five stages, it can be argued they have a number of flaws. Firstly, the lines which are drawn between the stages appear arbitrary without a robust criterion in order to decide what stage someone is at in their transition to sobriety (Sutton, 2001; West, 2005; Etter & Sutton, 2002; Littell & Girven, 2002). For example, Littell & Girven found that after reviewing 87 TTM studies to find whether discrete stages exist with sequential stages between them, the empirical data did not validate this nor was there convincing evidence that there were discrete stages. It is argued that this is important because if the stages are not as discrete as the model suggests and there is uncertainty about being able to identify what stage a person is deemed to be at this may mean they could be given the wrong advice about the appropriate intervention measure to use. Therefore, it is argued if an alcoholic is unsure about what stage they are deemed to be at, this may mean they will be unsure of the self-change strategies to adopt describing how these moves happen (the processes) or have a full understanding of the type of intervention to use.

The notion that people move through the stages and progressively improve may be questioned. For example, Callaghan et al. (2007) found that alcoholics progressing to the action stages do not necessarily show greater improvements in their drinking behaviour than people remaining in the pre-action stages. Further, alcoholics remaining in the pre-action stages, in time, do show statistically significant and clinically important improvements in drinking behaviour.

This suggests that the stages only offer a partial understanding of the alcoholism journey. However, in contrast to the study by Callaghan and colleagues, Heather et al. (2009) found that by using different methods for assigning the stages of change their research reinforced the assumptions of the TTM. Therefore, these two opposing arguments suggest that the TTM's theory is still open to debate.

Further, the implication of the TTM that people typically make coherent and stable plans concerning their changes to sobriety is not necessarily always accurate. It is suggested both smoking and alcohol are drugs containing addictive substances, and a heavily addicted person can perceive it as impossible, or at best difficult, to stop or even reduce their drinking or smoking even after intensive therapy and persuasion. Therefore, it is argued similarities may be drawn with a study on smoking cessation (Larabie, 2005), whereby participants were asked whether they had planned their last attempt to stop. A majority (51.6%) of stopping attempts were reported as unplanned with no preparation at all, not even going as far as finishing their current packet of cigarettes. Further, participants reported that successful attempts to stop were more likely to be unplanned.

There appear to be no clear lines signifying the stages in order to decide which stage the alcoholic is at, therefore making it difficult to decide on an appropriate intervention. The evidence suggests that it is debatable as to whether alcoholics achieve their transition to sobriety in such a discrete and sequential stage-like manner and that they have necessarily significantly improved having been assessed as moving to a further stage. For example, an assessment by the TTM where it is deemed the alcoholic has transitioned to another stage does not always equate to a definitive progression or improvement (Callaghan et al., 2007). Therefore, it is suggested the stages only offer a partial and basic understanding of the change process. Further, the implication of the TTM that people typically make coherent and stable plans concerning their changes to sobriety are not necessarily always accurate (West, 2005). It is noted that some people are successful in overcoming addictions without having a plan in the traditional sense (Larabie, 2005).

Although the TTM adopts some of the new ideas and interventions aimed towards ultimate recovery from alcoholism such as MI and change talk, it could also be argued that on first sight the TTM does not fully achieve the goal of allowing the individual to totally make their own choices and decisions towards recovery. For

example, the paradigm shift mentioned earlier emphasises agency and choice for the individual as key principles of change but the TTM provides pre-set strategies or processes of change to guide the individual. However, the use of MI and change talk as an integral part of the TTM does allow for a person to develop a sense of self and will be further considered in the discussion chapter.

Self-determination theory (SDT) (Deci & Ryan, 1985) may offer a further perspective and framework for understanding motivation related to possible interventions for recovery from substance misuse and offer a person a greater choice and agency in how they achieve their recovery.

### **Self-determination theory**

According to Chan et al. (2019) self-determination theory (SDT) works on the assumption that individuals have an innate need to obtain well-being, growth (developing ourselves) and health. Although we all have the desire and the capacity to obtain health and well-being through our own efforts, this is dependent upon having the right type of motivation. SDT can be seen as part of the move away from the interventions that are 'done' to the person and led by the doctor or therapist to an approach that recognizes and values the perspective of the alcoholic and sees the importance of their ownership of the change process. In order to encourage a person to achieve a specific goal, such as stopping or reducing drinking, there is a need to be aware of two types of motivation: intrinsic and extrinsic. Intrinsic motivation applies to an individual's involvement in behaviour which is satisfying to them for example, increased pride and self-esteem. Extrinsic motivation refers to behaviour carried out to gain positive external outcomes, for example social acceptability and/or praise from others.

It is thought the theory may add to the theoretical framework of the TTM (Kennedy and Gregoire, 2009). The TTM does not put emphasis on either the internal or external factors relating to a person's motivation to change. However, according to Kennedy and Gregoire, SDT considers the origin of the motivation by producing a framework for understanding internal and external origins or sources of motivation and the effects on intervention outcomes. SDT makes the point that although it acknowledges that both internal and external motivation can be helpful, it is internal motivation that is the most essential. SDT sees people with higher internal motivation



as having a better prospect of improved intervention outcomes. However, the opposite is seen with people with high external motivation but with an absence of internal motivation where much fewer positive outcomes are a result. Ryan et al. (1995) further notes that people with higher internalized motivation levels had lower levels of dropping out of any interventions. In addition, they found that people with both high internal and external motivation were more likely to continue with their interventions. External motivation was a positive factor in results but only if internal motivation was also present.

Chan (2019) argues that when attempting to apply SDT to drug and or alcohol use it is thought that solely offering some form of external motivation (e.g., a person not drinking and attending a self-help group to avoid a community service order from court if they do drink) is not enough to encourage them to stop drinking or taking drugs. If this is the only intervention it can lead to a person only stopping or reducing their intake due to fear of the possible outcomes if they did not stop or reduce their intake. SDT suggests that rather than an external motivator, a person needs an internal sense of control and autonomy (Cleverly et al., 2018). Cleverly further suggests there is a need to build good relationships, respect the individual's choices of intervention; provide a safe environment to practice their new behavior; offer acceptance, warmth, understanding and support, and unconditional positive regard. As a result, this may assist in facilitating their internalization and achieve autonomous self-regulation, therefore helping a person to stop or reduce their intake of drugs or alcohol due to their intrinsic motivation.

In sum, it is necessary to nurture a person's intrinsic motivation to encourage change. An individuals' choices, feelings and emotions are paramount and need to be understood and supported by others. Therefore, when a person becomes motivated by something internal, those around them need to take some form of action to validate and support that motivation. Making positive changes such as giving up alcohol or other drugs need to be seen (by others) as crucial to the addicted person in terms of their individual aspirations to move forward in their life. If a person does not have appropriate and helpful significant others around them their aspirations may be thwarted. SDT can be seen as a change in thinking and theoretical perspective addressing recovery from alcohol or other drugs. A major type of intervention that has developed from this change in thinking as that of

Motivational Interviewing. As briefly noted above, the TTM will advocate the use of MI in certain situations as an intervention measure to aid the process of recovery. However, the recent theorists and researchers outlined below see Motivational Interviewing as also useful in its own right as a stand-alone method. MI is an intervention that both acknowledges and adopts the ideas of SDT that change is centred on the individual rather than the therapist. Further, both SDT and MI can be seen as being consistent with constructivist theory. Constructivist theory emphasizes the point that it is the personal meaning and construction of this meaning from the alcoholic's perspective that is essential in making recovery successful. This individual construction of meaning it is argued has a degree of fit with the views expressed in SDT and the intervention measure of MI which both appear to strive for individual choice, agency, and autonomy in recovery which is 'self-determining'. Therefore, constructivist theory, self-determination theory and MI all have a common goal and can be useful when applied together.

### **Motivational Interviewing (MI)**

It is acknowledged that relatively new thinking now sees MI as a predominant method of intervention that has developed as a consequence of the change in thinking from the medical disease model to new understandings of 'recovery' characteristic of more bio-psychosocial understandings of alcoholism. According to Sarpavaara (2015), MI is a clinical style that is now used all over the world and is a well-recognized therapeutic method. The general spirit of MI is its focus on the individual client and their relationship with their therapist. The assumption is that the individual in counselling has what is needed to make changes in their lives (Miller & Rollnick, 2013).

As noted earlier, MI is a "client-centered, directive method for enhancing intrinsic (internal) motivation by exploring and resolving ambivalence" (Miller & Rollnick, 1991, p.25). The acknowledgement of this ambivalence is a crucial part of motivational interviewing. The assumption is that most people entering counselling, for example for their alcohol addiction, will have conflicting motivations. They may have good reasons to change their current behaviour; however, they will be aware of the pros and cons of remaining as they are or changing. This situation can result in a person being ambivalent towards change. Any persuasion from the counsellor at this point is deemed as fruitless because it would involve acknowledging only one set of

reasons for their decision, i.e. only their reasons for not changing. If the client adopts the opposite position, this may lead to resistance since they also have a set of 'good reasons' (in their eyes) for their decision not to change, therefore lessening the possibilities for change (Miller & Rollnick, 1991; Miller et al., 1993; Rollnick & Miller, 1995). The theory of MI is that it may strengthen a person's individual and intrinsic (internal) motivation aimed towards a specific goal (such as reducing or stopping drinking). It aims to achieve this by attempting to elicit and consider an individual's own personal reasons for either remaining as they are or changing in some way. A key factor involved in the MI process is paying particular attention to the language of change (Sarpavaara, 2015). Several studies have focused on the individual's language when they have been interviewed and regard it as a key indicator of the future success or failure of the MI outcome. These studies appear to show how MI can increase the amount of 'change talk' (Campbell et al., 2010).

Change Talk is a key feature of self-determination theory. This can be defined as statements made by a person that indicate that they are moving towards making positive changes to their problematic behaviour (Rosengren, 2009) and it is connected to successful behaviour change. Regarding achieving sobriety, the overall aim of MI is to elicit as well as reinforce people's change talk in relation to alcoholism. Change talk is regarded as being linked to enhanced motivation to change. This acknowledges the importance that MI places on both listening for and eliciting change talk as a key counselling skill (Miller & Rollnick, 2013).

In addition to Change Talk, its opposite is known as 'Sustain Talk'. A person may use sustain talk to convey to the counsellor that they want to remain as they are, their concerns about changing and/or worries about the prospect, their reasons for not changing and their need to remain as they are. It is thought that an effective MI counsellor recognises the contrast. Hallgren and Moyers (2011) suggest a person's language when used within treatment sessions, in other words their 'change talk', can either indicate their motivation for changing or sustaining their present position and remaining as they are with their substance-use behaviour. Further, it is thought (Moyers et al., 2009) that when a person hears themselves speaking and clearly advocating change, they are more likely to believe in the benefits of change and subsequently act upon these verbal commitments. Therefore, current thinking is that change talk is a key mechanism of change (Moyers et al., 2009). Change talk has

been found to predict outcomes in MI (Sarpavaara, 2015). Glynn and Moyers (2010) have shown that change talk can be elicited by the behaviour of clinicians; however, we have limited knowledge about the intrapersonal factors such as attitudes, self-esteem and a person's decision making that may elicit this language, including a client's baseline motivation to change.

However, it is noted that in the study by Hallgren and Moyers (2011), that change talk used in motivational counselling sessions was not found to be associated with the TTM concept of readiness to change. The concept of readiness to change comes from the stages of change model and indicates what stage a person may be at in their recovery. A critical element of MI is assessing a person's readiness to change. As mentioned earlier, the TTM believes that we move through discrete stages (Prochaska et al., 2006). In each of these stages, motivation is thought to be different depending on what stage a person is at; that is, it will differ in terms of the quality of expression of the language used (e.g., considering the advantages and disadvantages of changing verses making a clear commitment to alter your behaviour) and also in the quantity of the motivation, for example motivational strength is thought to increase as the person moves through the stages. Therefore, it would be expected to see both qualitative and quantitative differences in change talk at the different stages of the TTM.

Hallgren and Moyers' study considered whether the change talk of 117 participants in Motivational Enhancement Therapy (MET) sessions differed between clients based on the TTM concept of readiness to change. Readiness and stages of change were assessed using both categorical and dimensional variables derived from the University of Rhode Island Change Assessment and Stages of Change Readiness and Treatment Eagerness Scale which was administered before the first treatment sessions. They found that higher overall readiness to change did not necessarily mean more overall change talk. Therefore, readiness to change and change talk are more than likely reflecting two separate constructs, each one involving different elements or dimensions of a person's motivation. Hallgren and Moyers suggest the TTM concept of readiness to change and change talk need to both be further explored, and neither should be substituted by the other.

The theories of the TTM and SDT and the intervention method of MI indicate that people, both on a one-to-one therapist/client basis and/or as part of a person's

network of 'significant others', can either positively or negatively affect the alcoholic's aspirations. This individual person or network of people together with a person's social environment can be seen as part of the potential recovery resources which a person can draw upon to hopefully initiate and sustain recovery from alcoholism (Granfield & Cloud, 1999; Cloud & Granfield, 2004). These recovery resources have been termed 'recovery capital'. Due to recovery capital being of critical importance to recovery I will now move on to discuss present day notions of the term 'recovery' and what it means before discussing the theory of recovery capital.

### **The meaning of 'recovery' and its achievement**

Best and Laudet (2010 p.2) have noted:

The addictions field is now overflowing with references to 'recovery' with service providers and workers increasingly designated as 'recovery-focused', although in many areas there is confusion as to what it means in practice and what needs to change.

It is argued that recovery means much more than simply stopping drinking. It is also viewed as having a successful life. Laudet (2007) regards recovery as still poorly understood. This is reinforced by Best et al. (2011), who suggests that there are debates around the meaning of recovery including the nature of the problem the person is recovering from. For example, does it only include total abstinence from drugs or alcohol, or does it also include other areas of functioning in addition?

The notion of substance 'misuse' and the interventions offered to achieve recovery relating to alcohol or other drugs has experienced a 'paradigmatic shift' (White & Cloud, 2008, p.22). In the past, recovery has often focused on medical interventions. This is contrasted with an understanding of what recovery means to the individual, an experience that is intimately immersed in the social environment in which the person is located (Best & Laudet, 2010). As a result, therefore, recovery never ends but is always seen as a continuing process of achieving a better life.

Some qualitative research has attempted to seek their alcoholics' perceptions of themselves and how they define recovery (Laudet, 2007). The majority of the participants in Laudet's study saw recovery as the years of abstinence a person had achieved; however, many defined it as including a new life and self-change. Best

and Laudet (2010, p.2.) suggest the essence of recovery relates to a lived experience where a person has achieved a better quality of life and...

A sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom, and aspiration that are experienced rather than diagnosed and occur in real life setting rather than in the rarefied atmosphere of clinical settings.

In order to improve the chances of a person recovering from alcoholism or other drug use, we draw on both our own resources and the internal and the external resources available around us in our environment, hence the term 'recovery capital' being of critical importance.

Recovery capital (RC) according to White and Cloud (2008, p.22) refers to "*the breadth and depth of internal and external resources*" that a person can use to initiate and maintain recovery from alcoholism. Granfield and Cloud (1999) offer a further explanation defining RC as the spectrum of both external and internal resources that can be utilized to instigate and sustain recovery from both alcohol and other drug problems. They further suggest that both the quality and the quantity of recovery capital play a fundamental role in predicting a person's success. RC includes levels of personal optimism, feelings about the past and future, social support networks and relationships.

In sum it is thought that increases in RC can trigger the onset of a turning point and the beginning of the end of a person's use of either/or drugs or alcohol, promote coping abilities and improve the quality of life of people in long-term recovery (Laudet, Morgan, & White, 2006). However, RC is not equally distributed across individuals, groups or whole communities. People with few family supports or support from the general community gain little from just having individually focused 'treatment' that does not also involve the family or community as part of their support (Moos & Moos, 2007). It is therefore noted that "environmental factors can augment or nullify the short influence of an intervention" (Moos, 2003, p.3). The above theories possibly reinforce the point that medical model interventions alone or any other intervention that does not recognise the role of the wider social and societal context for the person's problem are not enough for most people to be able to sustain either short term or long-term maintenance of abstinence from alcohol or any

other drug. As Simpson (2004) points out, addiction therapy must involve much more than clinical intervention. Webb et al. (2020) suggest that a predominant factor in supporting people to recover is the use of self-help groups (which are viewed as a form of recovery capital). In addition, a crucial part of recovery is that the recoveree develops a positive identity which can support them through their recovery journey (Best et al., 2018).

### **Summary of theoretical approaches to alcoholism and sobriety**

In terms of causative factors, the medical 'disease' model, and the biomedical theoretical approaches to alcoholism assume that certain powerful addictive substances cause objectively identifiable and real disorders when alcohol is abused and take over any personal control. The approach acknowledges both genetic and biological causes. As alcoholism is seen as a disease it tends to be treated with medication in a similar way to other diseases or illnesses. Medical theory believes that classifying alcoholics into subtypes is useful in alcoholism because it is thought these reflect differences in the neurobiology of the alcoholic. Further, it proposes that this identification may improve the effectiveness of the treatment they receive, such as medication. These classifications are still used today; however, some of the factors leading to the classifications are not necessarily biological factors and appear to consider psychosocial factors as well, which may represent moves towards a biopsychosocial approach. These different findings on the classifications may cast some doubt on the bio-medical model's definitive understanding of alcoholism when it is debatable as to whether it also involves social and psychological factors in its classifications. Past research also casts doubt on the predictive validity of these classifications. The approach assumes that alcoholism is only partly determined by genetic inheritance; therefore, other factors such as stress levels and family situations may play a part.

In terms of intervention measures, medications appear to be an integral part of the medical model approach today; however, the evidence suggests that non-compliance with taking it is a problem and I could not find any evidence that it can maintain sobriety longer term (two years and over). The limitations outlined have led some researchers and practitioners to a bio-psychosocial approach.

The bio-medical approach acknowledges psychosocial as well as physiological and biological factors in alcoholism but sees it fundamentally as a disease. However, the bio-psychosocial approach incorporates all levels of understanding, including psychosocial, physiological, and biological elements of alcoholism, but does not fundamentally treat it as a disease. The bio-psychosocial approach has been adopted by self-help groups such as AA and their twelve-step programmes. Further, the TTM outlined above can also be seen as a bio-psychosocial approach. Based on the empirical evidence reviewed regarding the TTM, it is argued that there are no clear lines between the stages. Further, it is questionable as to whether movement between stages happens in such a sequential manner or that a person has definitely improved when moved to a further stage. Also, alcoholics do not always make coherent plans as suggested. However, there appears to be considerable evidence in supporting the view that bio-psychosocial issues are important in understanding alcoholism and achieving sobriety. This is reinforced by the fundamental shift from the disease model to new ideas about recovery and theories of self-determination. SDT focuses on giving the alcoholic the sense of being in charge of their problem, in other words a sense of agency. This sense of agency is also apparent in the intervention of MI. This shows the fundamental difference between these contemporary ideas of recovery and those of the medical model. Rather than a feeling of being in charge of your own recovery efforts with the medical model approach, things are done *for* the person by the medical 'experts'.

SDT considers the internal and external origins of motivation and the effects on intervention outcomes. The theory sees people with higher internal motivation as having a better prospect of improved intervention outcomes, including lower drop-out rates from interventions, and that only offering external motivating factors is not enough. As a result of this contemporary thinking and theory, MI is now construed as an important method of intervention. The assumption is that the individual has the capabilities to instigate their own changes. MI attempts to enhance their intrinsic motivation by eliciting and considering a person's individual reasons for either remaining as they are or changing. A key element of MI is taking a close note of the language of change used (change talk). It is thought MI can increase the amount of change talk directed towards positive change away from substance use. Further, that a person hearing themselves speak about these positive changes may help them to



become more likely to carry them out. Important to achieving recovery is the quantity and quality of both people and facilities around us, i.e. 'recovery capital'. However, this could be limited by resources not being equally accessed or distributed. The bio-psycho-social theories of SDT, MI and Change Talk and the sense of personal agency they promote show particular promise to me.

To add to these existing theories and to hopefully augment some of their ideas, I am drawn towards constructivism as a theoretical framework that adopts a bio-psycho-social approach.

The personal construction of meaning, it is argued, has a degree of fit with the views expressed in SDT and the intervention measure of MI, which both appear to strive for individual choice, agency, and autonomy in recovery which is 'self-determining'. Therefore, constructivist theory, self-determination theory and MI/Change Talk all have a common goal. Constructivism may also explore a further relatively untapped area in terms of alcoholism recovery, that of personal meaning in change. It is acknowledged that constructivism is not a theory of alcoholism *per se*, but a psychological approach that has been used to understand a variety of psycho-social phenomena that include alcoholism as well as mental health problems more generally. Therefore, I have not presented it as a theory of alcoholism (in the same way that the disease model and TTM suggest) and will discuss it in more detail in the next chapter.

Having now critically discussed the principle theoretical models, in chapter 3 I will move on to review the empirical literature specifically relating to achieving and maintaining sobriety to evaluate effective approaches and highlight gaps in the evidence.

# CHAPTER THREE: LITERATURE REVIEW - EMPIRICAL RESEARCH

## Introduction

Having provided some details and discussion of the theoretical approaches to alcoholism, including achieving and maintaining sobriety, in chapter 2, I will move on to discuss the empirical research identified by my search. It should be noted that some of the studies included in this review refer to addictions other than alcoholism, such as smoking, heroin, marijuana, and cocaine addiction. However, it was felt they were useful examples of where I could extract some of the same principles/concepts from this wider body of research into my study. To begin, I will present the results of my literature search.

## Results of the search

The search produced 488 publications. It was found that having included the term 'addiction', this identified studies on addictions to shopping, gambling and sex in addition to more relevant studies on drugs and alcohol. Therefore, the manageability of the search results was improved by eliminating any of the studies which, although considered as addictive behaviours (for example, compulsive gambling and addiction to sex), were not considered as addictions to substances. Problem or pathological gambling although commonly thought of as an addiction is not included with other addictions within the DSM-IV. However, it is included in the DSM-IV under impulse-control disorders (Jazaeri & Habil, 2012). In addition, over-eating was excluded because, although it did relate to a substance, it was not considered to be an addiction to a drug (for example alcohol, nicotine or heroin). As a result of my search and eliminating less relevant publications, in total, 148 relevant publications were identified, including theoretical papers, books, two grey literature documents and empirical studies. Of these, 91 empirical studies of relevance were identified. Subsequently, I entered the brief details of these studies into a matrix for closer scrutiny as shown in **Appendix Q**. The matrix quickly told me the author, date of the research, aims and findings, therefore allowing me to compare the material to determine its scope across time and assist me in identifying differences and similarities in the literature and in linking it to my broad research questions. Using this preliminary general framework, I was able to identify key issues within the

research field. Publications not included in the original matrix were added as new literature that was revealed during the course of the study.

The literature included empirical studies conducted in 15 countries: America (53), Canada (5), the UK (11), other European countries (14), Australia (1) and Asia (7). Sixty-four used quantitative methods and 27 used qualitative methods. These incorporated longitudinal studies, meta-analyses, randomised controlled trials and cross-sectional studies. The following outlines a general map of the research field and key themes drawn from the literature. This is followed by a summary of the findings and my resulting research aim.

### Key developments

**Table 2** indicates my appraisal of the various key developments the research studies have focussed on over the years. The appraisal is a result of directly considering the publications identified by my search process.

Table 2: Summary of the key developments in empirical studies

1946-1960s	Studies focussed on defining alcoholism and identifying the different types of alcoholics seen as having a disease; for example, Jellinek (1946). Using a sample of 98 male alcoholics, his findings indicated five classifications of 'disease'.
1970s	Beginnings of shifts towards studies indicating alcoholics becoming sober, sometimes for over 12 months, without necessarily using medical or other formal and professional treatment. Some studies looked at spontaneous recoverees and their coping strategies using little or no professional help to achieve sobriety and maintain it. The late 1970s and 1980s saw studies focussing on developing stage models of change, e.g. the Transtheoretical Model (TTM). This period also saw the beginnings of other studies acknowledging the usefulness of the views of the alcoholics themselves and finding that recovery was a long process and not a single event for the alcoholic. Others began to look at the effects of stigma on the alcoholic.
1980s	The 1980s also saw a trend to consider longer term sobriety, e.g. longitudinal studies by Vaillant (1983, 1995, 2003) which considered alcoholics achieving and maintaining sobriety and long-term sobriety.
1990s	A focus on medical classifications continues. However, some of these later classifications appear to have moved on from biomedical approaches and acknowledge psychosocial factors. The 1990s also indicated less emphasis on clinical treatment and more on psychosocial issues related to, for example, remission, relapse (which was the partial or total focus of 12 of the studies), spontaneous remitters and the TTM. This decade also saw the emergence of constructivist approaches. For example, Buirs and Martin (1997) found benefits of role play in imagining positive possibilities for self. Other studies began to acknowledge the importance and value of personal meaning for each alcoholic going through change.
2000s	Continued with studies which found the values of psychosocial issues and the values of AA, indicating its benefits which have continued to grow up to the present day.

2008+	Continued with studies indicating the importance of psychosocial influences, e.g. overcoming stigma and the influence of family and friends. There was also an emergence of new ideas and empirical studies concerning recovery, Self Determination Theory / TTM, Motivational Interviewing / Change Talk, maintaining a positive identity and Recovery Capital. Ideas of this kind, for instance Recovery Capital began in the late 1990s (Granfield & Cloud, 1999), began to emerge in empirical studies around 2008-2009 and have gathered pace in more recent years.
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## Overview of the research field

The studies cited below refer to the broader field of addiction (including, opioids, nicotine and alcohol). They suggest that researchers have focused on issues such as factors possibly resulting in substance abuse, for example considering the association between solitary drinking and alcohol problems in adults (Skrzynskie & Creswell, 2020). Also, factors which may influence a person's success at stopping substance misuse, for example, age as a predictor of quit attempts and quit success in smoking cessation (Arancini et al., 2021), and factors such as the effectiveness of various interventions such as MI, for example effectiveness of MI used to reduce opioid risk (Borsari et al., 2021). Further, there is an increasing amount of empirical research on recovery from addictions in general using digital technology (Webb et al., 2020) and studies suggest recoverees appear to have benefitted from online websites.

When looking at the addictions field as a whole, alcohol and alcoholism appear to play a growing part in the area of research. There is also an acknowledgment and increase in studies on dual diagnosis or poly-drug dependency. In the past, much of the research on alcoholism focused on the effectiveness of interventions. Today's researchers appear to have shifted the focus onto the client/participant in both understanding and researching addiction. There is increasing interest by researchers in facilitating research involving a co-production between the participants and the researchers whereby participants are equal partners in the research process (Webb et al., 2020). This shows a shift towards a more service-user-led involvement in research studies. In addition, concerning alcohol addiction together with other addictions, there is an increasing emphasis on people developing their own self-determination to recover (Kennedy & Gregoire, 2009; Chan et al., 2019). Research has shifted from pathology and intervention focus to a recovery focus (White

2004;2005). Research on all addictions is now more about being person-centred, family-centred and recovery-focused.

Past empirical studies on alcoholism were dominated by a focus on medical 'disease' theory and medically orientated interventions that gave explanations and instructions by medical professionals, e.g. classifications, (Jellinek 1946, 1960; Cloninger et al.,1996; Babor & Caetano, 2006; Hillemecher & Bleich, 2008; Pompo et al., 2008). Past studies were concerned with finding medications to assist people to stop drinking but were not focused on a wider psycho-social picture. Studies were concerned with the effectiveness of medications. The drug, disulfiram, created an adverse unpleasant reaction if a person drank alcohol. It was hoped the person would stop drinking due to the fear of having a toxic reaction (Garbutt, et al.1999). However, more recent research has focused on not using a physical deterrent (as in disulfiram's aversive properties) but trying to increase the amount of time a person remains abstinent by reducing the euphoric effect the person receives when drinking as found with the drug Naltrexone (O'Malley et al.,1992; Volpicelli et al.,1992). It was also found that by taking Naltrexone, people drank less, abstained for longer periods and had less risk of relapsing (Croop et al.,1995). Studies on the drug Acamprosate (Campral) found that it increases the rates of total abstinence and the length of time abstinent (Kranzler & Gage (2008). Studies on both Naltrexone and Acamprosate appear to have possibly lengthened a person's abstinence period with a view to making them more amenable to other therapies in addition to medication. Researchers questioned whether there were also social and psychological factors involved in recovery (Lesch & Walter,1996), indicating a move toward more bio-psychosocial involvement.

One such bio-psychosocial involvement is that of AA. In the past concerning AA, the emphasis on anonymity has made empirical research difficult (Mattson & Allen, 1991). The focus of AA's research has moved from considering the effectiveness of AA on recovery to examining the role of spirituality in AA (Tonigan, 2003, 2007) and psycho-social factors such as self-efficacy on the success at stopping drinking (Connors, Tonigan, & Miller, 2001). Researchers today still have a strong focus on AA and twelve-step work (White, 2010; Rowan & Butler, 2014; Kihara, & Kitaoka,2019; Kelly et al., 2020).

There continues to be much research and debate focused on behaviour change such as the Transtheoretical Model (Prochaska et al., 1992). However, research on the maintenance of long-term recovery requiring sustained personal change at present tends to be focused on either self-help group support, such as AA and Narcotics Anonymous (NA) (Kelly et al., 2011, 2020), and/or involves what resources are available in the community in the form of recovery capital assisting in long-term change (Best et al., 2018). Today's researchers appear to continue to have an increased focus on bio-psychosocial issues, and there is an increasing interest by current researchers in people sustaining recovery over the longer term. This bio-psychosocial research appears to sit alongside studies focusing more on medical theory and practice (particularly American studies). My study fits into a small part of the bio-psychosocial approach within constructivism, namely PCP, asking the question about the role of personal meaning in recovery. At present there is little evidence of any empirical research in this area looking at the issue from a PCP perspective.

Of the 91 empirical studies reviewed for this thesis, 12 of them either specifically or partially considered relapse or lapses and the kinds of intervention measures presently utilized to either prevent or delay further relapses. Seventeen of the studies considered long term sobriety and 52 were related to either achieving sobriety and/or shorter-term sobriety. Ten of the studies related to relatively new thinking around recovery in general looking at Self-Determination Theory, Motivational Interviewing/Change Talk, Identity Change and Recovery Capital.

Before 2000, there appear to be relatively few studies concerning maintaining sobriety for longer periods. Klingemann (2012) and Hill and Leeming (2014) suggest a period of two years' sobriety as constituting long-term sobriety. As mentioned in Chapter 2, long-term sobriety is defined in this thesis as sobriety for 2 years and above. In the past 20 years, my search identified 17 studies relating wholly or partially to maintaining long-term sobriety as already defined. However, this included studies looking at addictions other than or as well as alcoholism e.g. heroin and alcohol. Twelve studies appear to have solely studied long-term sobriety from alcohol. Of the 11 UK studies identified by my search, only five considered some aspect of achieving longer-term sobriety. One of these focused primarily on the difficulties of the experiences of stigma in achieving longer-term sobriety (Hill &

Leeming, 2014) using an AA sample. Gubi and Marsden-Hughes (2013) aimed to find a definition of recovery which was inclusive and achievable, again using long-term AA members. Best et al. (2011) aimed to understand the long-term process of recovery by investigating the recovery journeys of alcoholics or heroin addicts in Glasgow. Saunders and Kershaw (1979) looked at what issues the alcoholic saw as significant in their recovery and focussed on spontaneous recoverees, and Webb et al. (2020) explored identity transition in substance use recovery over time. As mentioned in Chapter 2, there appears to have been a fundamental change in theoretical emphasis relating to recovery. These new ideas have led to new theories such as Self-Determination Theory (SDT) (Deci & Ryan, 1985) and intervention approaches such as Motivational Interviewing (MI) and Change Talk (Miller & Rollnick, 2013) together with a recognition of the importance of Recovery Capital (RC) (Cloud & Granfield, 2004; White & Cloud, 2008). This thinking about recovery from alcoholism and other drugs appears to have shifted in emphasis from a medical pathology and intervention focus to interventions based on bio-psychosocial theories of recovery.

My review of the empirical literature enabled me to expand upon and give research examples of the theoretical work presented in Chapter 2. As a result of my search of the empirical studies, I identified four key themes which were seen as particularly relevant to my research question relating to achieving and maintaining sobriety:

- 1. Understanding relapse;**
- 2. Achieving sobriety;**
- 3. Maintaining sobriety including maintaining long-term sobriety;**
- 4. The importance of motivation, agency, recovery capital and a positive identity.**

### **Understanding relapse**

This section firstly considers alcoholism from a bio-medical perspective, seeing it as a chronic relapsing condition. Further, it considers the usefulness of medication in preventing relapse, particularly when combined with psychosocial interventions in some cases. It discusses how psychosocial issues can also have a part to play in this prevention.

Many researchers regard relapse as an inevitable consequence or outcome of alcoholism which will happen at some point. This is often perceived as a form of

'failure', as noted with the classic disease model (Jellinek, 1946). According to Jellinek's classifications of alcoholism as a disease, some people may progress through the different stages, whereas others may stop at a particular 'developmental stage' as Jellinek (1960 p.37) refers to them. Drawing from his research findings, Jellinek argued that alcoholism is a progressive disease and a 'relapsing condition'. Further, he concluded that the condition is a permanent or semi-permanent element within a person that can re-emerge at any time. This is reinforced by Vaillant et al. (1983) in a study considering the long-term outcomes of their sample of alcoholics and finding that 95% had relapsed at some point. By implication, this may mean the alcoholic is viewed as never 'cured' but is seen as always in remission. It also suggests that relapse is inevitable. However, although research suggests relapse may happen, there are also alternative and more optimistic perspectives; for example, relapse is also viewed as a 'learning opportunity' by both Peele (1995) and Fingarette (1988). This view is supported by a study by Schachter (1982) on smokers who, having experienced several relapses, had still managed to find and learn new ways of coping as a result. Schachter reported that success may follow several relapses, and a lapse does not always lead to a full relapse (Vaillant et al., 1983). Therefore, even if it is the case that relapse is an inevitable consequence of alcoholism and other addictive substances, this does not rule out the possibility that sobriety can be regained following relapses.

Some studies appear to have found ways of either preventing relapse or at least delaying it happening, therefore enabling the individual to maintain their sobriety for longer. For example, Agnosti et al. (2012) found that CBT used in conjunction with the drug Naltrexone could reduce the frequency of relapse in some situations. Also, in two quantitative studies O'Malley et al. (1992) and Volpicelli et al. (1992) found that a combination of Naltrexone and some form of supportive therapy was effective in relapse situations. Similarly, Rosner et al. (2010) found that the addition of medication such as Acamprosate to psychosocial programmes could be useful when dealing with relapse. This reinforces the point that biological and psychosocial factors both have a part to play in achieving sobriety.

Further, there is strong evidence of psychosocial issues also contributing to relapse. These issues are indicated in a study by Yeh et al. (2009), who found alcoholics exposed to high-risk drinking situations or the alcoholic's level of temptation can lead



to relapse. In addition, an Indian study (Singhal et al., 1992) reported several emotional and environmental situations which may put a person at risk and were precipitators of a relapse, such as conflicts with the family. Also, Sureshkumar et al. (2017) suggest that relapse is influenced by how the alcoholic copes with stressful events, including family conflict, pressure from peers, finance and a temptation to drink. Further, Gokbayrak et al. (2014) in a longitudinal, quantitative study of 521 smokers found that a factor which could cause relapse was emotional distress and that it was not necessarily due to the severity of the addiction.

Therefore, rather than relapse necessarily being an inevitable consequence of alcoholism as the bio-medical model appears to understand it, the evidence suggests that a range of psychosocial factors may be important in understanding relapse. These psychosocial issues include the role of family, the level of risk of further drinking, such as returning to old drinking haunts or meeting other alcoholics from the past, and the alcoholic's ability to overcome these factors. The research evidence on relapse in sum appears to tell us that an awareness and acknowledgment of a combination of biomedical and psychosocial factors may be significant in either reducing the frequency of relapse and/or preventing it happening in the first place. The studies also suggest that achieving future sobriety is potentially possible regardless of how many lapses or relapses a person may experience. Psychological, social and environmental influences appear to all play a part; therefore, an acknowledgment of these factors can play a major role in recognising the risks of relapse and avoiding it happening.

Similar factors can also play a crucial part in achieving sobriety. This next section moves on to consider the factors that research has found to be important in understanding the achievement of sobriety.

### **Achieving sobriety**

Achieving sobriety from any drug is a difficult and often long and complex process. In this section I consider initially how both alcoholics themselves and professionals have used medication to achieve this goal. Further, I consider how some alcoholics have achieved sobriety using psychosocial measures in contrast to medical interventions. In addition, I consider how a few studies have made attempts to understand the experience of alcoholism from the alcoholics' perspective, for

example, studies indicating alcoholics recalling their past negative drinking experiences and regarding this as being a catalyst for change.

There are different ways in which alcoholics have attempted to achieve sobriety. In the last chapter looking at theoretical approaches, it was found that many studies still advocate the effectiveness of medication (Agnosti et al., 2012; Rosner et al., 2010). However, it could be argued this is merely abstinence from alcohol and not true sobriety or recovery as Best and Laudet describe it (see Chapter Two). Further, the overwhelming emphasis in the majority of all the studies identified appears to have shifted towards a focus on the psychosocial contributions to achieving sobriety rather than medication. An example of such a shift is seen in studies which refer to spontaneous recoverees.

Spontaneous recoverees can be seen as people who have used little or no formal professional support, either medical or otherwise. For example, in one of the UK studies, Saunders and Kershaw (1979) in a qualitative follow up study of 162 alcoholics in Clydeside were interviewed about what they saw as significant in their recovery. They found that they talked about their life changes such as their job and marriage as being significant in their recovery. However, they also found that although spontaneous recovery does happen, it was only in people drinking but at a lower level (drinking less) compared to alcoholics requiring treatment. Similarly, in a meta-analysis of 40 studies on spontaneous recovery, Sobell et al. (2000) found that participants, although seen as spontaneous recoverees by the researchers, continued to drink at a low level. Russel et al. (2001) in a quantitative study of 833 'naturally recovered' people (without any treatment) and 138 problem drinkers reported that the recoverees said they had achieved sobriety by having stable marriages, avoiding risk situations, having a higher self-esteem and having a social network of people who drank less, all of which were psychosocial issues.

Further, psychosocial influences were emphasised rather than medical interventions in the following studies on achieving sobriety. Vaillant et al. (1983) carried out a prospective study of 100 patients admitted for alcohol withdrawal who were followed for 8 years after their discharge. At the eight-year stage, 25% had achieved stable sobriety for 3 years or more. They found that the experience of attending AA groups and other self-help groups offering companionship and spirituality gave good psychosocial outcomes. Also, that factors other than professionally organised

treatment on its own may have a substantial effect on the outcomes for the alcoholics. Further, in a Swedish qualitative study by Blomqvist (1999), it was found that with many addictions, receiving social support such as practical support and encouragement from the person's family, friends and significant others can help to change addictive behaviour. In terms of psychosocial influences, Dennis et al. (2007) used data from 1,162 people entering treatment and subsequently followed up for 8 years. They found that key influences relating to the duration of the abstinence included mental health, coping responses and the level of housing, peers and social and spiritual support.

The psychosocial influences of 12-step programmes appear useful in achieving sobriety. For example, in a quantitative study by Dawson et al. (2006) concerning 4422 alcoholics, they found that those that participated in 12-step programmes in addition to medical treatment had almost twice the chance of achieving sobriety compared with those who only received professional treatment.

Other studies suggest that the recall by alcoholics of the negative consequences of their past drinking had been a major catalyst and turning point in them now achieving sobriety. For example, Connors et al. (1998), in a quantitative American survey of 142 (male and female) alcoholics, examined male and female attributions associated with the onset and termination of specific relapse events and factors associated with the achievement and maintenance of abstinence periods. The women participants said that the factors associated with stopping drinking included 'feeling bad emotionally' however, this point was not a factor mentioned by men. This leads me to conclude that there may be gender differences in these attributions, or at least in what men and women will admit to. Further, factors (relating to both women and men) for achieving and maintaining sobriety included the alcoholic avoiding what they perceived as 'risky people and places'. In addition, they cited using self-help groups and receiving treatment as useful. Particularly concerning men, a further important factor was them recalling past drinking problems and their consequences. Also, Vaillant and Hiller-Sturmhofel (1996) reported further on their longitudinal study which had been running for 55 years at the time. This study charted the drinking behaviour of 724 men, 194 of which met the DSM-III criteria for alcohol abuse. Their findings revealed that when his researchers considered non-treatment related factors associated with abstinence, they found that it was reinforced by the negative social

consequences of their past drinking, such as the loss of jobs and the threat of divorce. In addition, in the qualitative study by Best et al. (2011), they completed semi-structured interviews with 100 alcoholics and 100 heroin users who had not taken the substance for the last 12 months. The purpose of the study was to gain an understanding of their recovery journeys. They found that the main catalysts for prompting change were usually negative experiences of taking the substance; alcoholics were likely to cite their dislike of their compulsion to drink and having health problems because of their drinking. Further, they did not like their behaviour when they were drunk, seeing it as chaotic, and having the realisation that their perceived appalling behaviour was impacting other people. In a study by Dunlop and Tracy (2013) of 37 participants who had been sober for 4 years, they found that when an alcoholic has a narrative describing a positive personality change following the negative experiences they have had, this can predict a positive future behaviour change in them. Those participants that showed self-redemption were more likely to maintain sobriety in the following months compared with those who were non-redemptive. Their findings suggest that production of self-redemptive narratives may stimulate prolonged behavioural change and indicate a psychological process which is useful in maintaining change.

In addition to the experience of negative consequences of drinking affecting the alcoholic themselves, studies have reported a recognition of the effects on others by alcoholics. Rowan and Butler (2014) in a qualitative phenomenological study wanted to gain an understanding of how 20 female older lesbian adult (aged 50-70) alcoholics had managed to achieve and maintain sobriety. They utilised structured interviews to gain an understanding of their lived experiences. Their findings revealed that 40% of the alcoholics mentioned recalling the consequences of their past drinking on employers and health care providers, which prompted them to change.

However, in another UK study, Hill and Leeming (2014) add a caveat to these studies suggesting that in recalling these negative experiences there is also a need for this to be tempered with trying to maintain a positive perception of oneself and one's identity whilst achieving and maintaining sobriety. They had examined alcoholics who self-identified as 'in recovery'. They studied six adults who attended AA and had been in recovery for between 5 and 35 years. They examined how

alcoholics view themselves and how they made sense of how others perceived them. For example, Keyes et al. (2010) had already found that the public view of alcoholics is often negative, often leading to perceptions of stigma which may affect the alcoholic's chances of achieving sobriety. Keyes et al. completed a study of 34,653 people in America to consider whether perceived stigmatisation of alcoholism was associated with a lower likelihood of receiving alcohol-related services. They found that people with a lifetime diagnosis of an alcohol use disorder were less likely to use alcohol services if they perceived a higher level of stigma because of this diagnosis. However, Strom and Barone (1993) found that both early and late recovery from alcoholism were associated with positive self-beliefs about themselves. Further, Hill and Leeming found that their participants who were aware of the stigmatising image of alcoholism found that they could reduce this potential stigma or at least reduce its impact on them by being an 'aware alcoholic self' who accepted that that they were addicted to alcohol as a mark of self-awareness as opposed to them having an identity as a social deviant. This gave them the identity as a more knowing and valued person, which gave them a positive sense of self. They perceived this self as different from their previous 'unaware' alcoholic self.

It is argued that the psychosocial influences already outlined above are clearly important catalysts in both achieving and maintaining sobriety. Further, unlike previous studies focussing on medical treatments and classifications (Jellinek 1946; Cloninger et al., 1996), where it is argued the professionals diagnose and offer treatment, there are also studies which consider the alcoholic's views of their own situations. In a study conducted by Orford et al. (2006) they considered the participants' accounts to develop a model of change. They aimed to develop a model of change both during and after the alcoholics had received treatment looking from the participant's perspective. The participants were drawn from subsets of consecutively selected clients of the UK Alcohol Treatment Trial (UKATT) with 211 participants being followed up at 3 months and 198 at 12 months. Five treatment agencies in three areas of England and Wales were used. Treatment was viewed by the alcoholics as enabling various changes in terms of their thinking and/or increased support of various kinds from family and friends and new ways of acting in relation to their drinking. They concluded by suggesting that models should be broadened so that treatment is seen as part of a much wider and complex system

involving cognitive, social and behavioural changes. This appears different from other approaches. It considers all aspects that make up a person, e.g. their emotions, thinking and behaviour, rather than only focussing in one area as in the medical model. Other examples where there is evidence that the researchers have attempted to understand the experience of alcoholism from the alcoholic's perspective are shown by both Dyson (2007) and Hill and Leeming (2014) already outlined. Hill and Leeming's study appears to enable the participants to feel empowered to express their own views on their own situations rather than others speaking for them.

In sum, the studies on achieving change and sobriety tell us that biomedical intervention such as medication still contribute to achieving sobriety. This is often augmented with psychosocial intervention, with the two working together. However, some alcoholics achieve sobriety without or with little professional input such as that of doctors and other health care professionals. This raises the question of whether alcohol services should be predominantly focussed on medical interventions. It is suggested therefore that further research is focussed in this area. Important psychosocial factors include having stable relationships, employment and attendance at self-help facilities. Further, there have been studies attempting to understand the experience of alcoholism from the alcoholic's perspective. By acknowledging the participants' perspective of their individual situations, it may be possible to understand how they both make sense of their alcoholism and how they construct their possible futures. By actively engaging the alcoholic in this way it allows them to own any changes made rather than 'experts' adopting this role. This engagement includes participants recalling and reflecting on their past negative experiences of drinking affecting both themselves and others which appears to be a key catalyst to change. Further, the study outlined by Orford et al. emphasises the point that change models should be broadened due to the complexity of alcoholism and change. The studies outlined to date suggest that to understand alcoholism it is necessary to address the various elements that make up the alcoholic person not just single factors such as a person's physiological state. The individual has much more complex needs covering their thoughts, emotions, social and behavioural needs. As a result, the views of Orford et al. appear to be saying it is necessary to

acknowledge, broaden, and combine all these elements to develop an effective model of change.

I have shown that enquiring into the perspective and experiences of the alcoholics themselves has provided insight into some of the psychosocial factors that may be important in change. Acknowledging the individual's view of their experiences of sobriety and their possible effects is particularly important to enable them and others in the future to maintain their sobriety. Understanding how people have achieved and maintained sobriety and particularly long-term sobriety, it is argued, is critical to address the future possible development of effective intervention measures.

### **Maintaining sobriety, including long-term sobriety**

For the purposes of this study, 'maintaining sobriety' will be defined as sobriety for between 6 months (Prochaska et al., 2006) and under two years. The term maintenance refers to a person consolidating the gains achieved so far and aiming to maintain this state. However, it is not a static period, the person will have to work to keep it. Further, maintenance is therefore a long ongoing process and when you include long-term maintenance the range that I refer to in this thesis may be 6 months to a lifetime and the person could still relapse at any time. As stated above, long-term sobriety is regarded as 2 years and above.

The section begins by addressing research which I suggest would fit under the title of 'maintaining sobriety' and outlines the limitations of medication for longer term sobriety. Further, it considers the effectiveness of psychosocial factors, including various forms of social interaction either in conjunction with or as a replacement for medical interventions such as medication. It also considers studies which suggest further moves towards approaches addressing the individual's own perspective on their situations regarding their alcoholism. The section then moves on to discuss research which considers maintaining longer term sobriety of two years or more.

Klingemann (2012), acknowledges that most of the empirical studies on alcoholism focusses on the early recovery phases and that less research is focused on the maintenance of this sobriety over the longer term. Hill and Leeming (2014) also point out that there has been limited research on long-term 'recovery'.

### Maintaining sobriety (6 months to under 2 years)

Some studies have suggested (to a limited extent as mentioned earlier) the use of medication such as Acamprosate (Campral) to assist in maintaining abstinence. For example, Kranzler and Gage (2008) completed a re-analysis of three double-blind, placebo-controlled trials on Acamprosate; 998 alcohol-dependent people were included in the studies, with the majority abstinent at randomization. The rate of complete abstinence was significantly higher with Acamprosate than with a placebo; however, the evidence only indicates sobriety for a year. The research did not look beyond this period. A further study, again using a quantitative placebo controlled randomised double-blind method, found that higher doses of Acamprosate can maintain abstinence for up to a year when used in conjunction with some form of psychotherapy (Paille et al., 1995). However, it still leaves us unclear as to whether it would be just as effective in maintaining longer term sobriety i.e., two years or more. Further, there is evidence that other non-medical, psychosocial factors have assisted in achieving this aim.

Examples of evidence of psychosocial issues being involved in the maintenance of sobriety are indicated in further empirical studies. For example, Moos et al. (1982), Humphreys et al. (1997), Beattie and Longabaugh (1999), Blomqvist (1999) and Moos and Moos (2007) cite the importance of positive family relationships in assisting in maintaining sobriety. Further, Yeh et al. (2008), in a qualitative study using an AA sample and an open-ended questionnaire and in-depth interviews of 9 participants who had achieved sobriety for at least 12 months, examined the influences which may have affected their prospects of maintaining this sobriety. Their findings revealed that the participants needed to feel empowered, have positive family relationships, stable employment, and stable finances.

The studies below additionally found that various other aspects of the alcoholic's life can have an influence on them maintaining sobriety. For example, Moos and Moos (2007), suggested that work of some kind, i.e. being employed and having sufficient finance to live on are also important elements of maintenance. Further, Blomqvist (1999) found that changes in relation to work, a change in a person's lifestyle where their drinking had caused them to feel living had become intolerable and a change in their living arrangements, i.e. the vicinity where they live and type of establishment, are all factors used to assist in maintaining sobriety. Volunteer work may also



provide a basis for self-forgiveness and help a person improve their self-esteem (Klingemann,1992; Burman,1997).

### Maintaining longer-term sobriety

Before 2000 there was a small number of studies which looked at the achievement of longer-term sobriety. These again focussed on psychosocial factors; for example, the qualitative study using semi-structured interviews by Rychtarik et al. (1987) showing a five- to six-year follow up of broad-spectrum behavioural treatment for alcoholism. Broad-spectrum treatment involves not only behavioural techniques such as desensitisation or assertion training but also cognitive restructuring, interpretation, and reflection. They found that of the 62 original participants, 10 were found to be still abstinent at the end of the 5-6 years and the findings revealed that the psychosocial benefits of social support had played a valuable role in maintaining recovery. Further, Vaillant (2003) following his longitudinal 60-year study of the course of alcohol abuse amongst men cited the psychosocial value of self-help groups.

The level of positive social interaction on an individual or group basis was found to be particularly important. For example, in a retrospective qualitative study, Margolis et al. (2000) looked at identifying any factors which helped 14 participants with a history of alcohol and other substance abuse. They had been in recovery for between 2 and 16 years. They found that psychosocial influences, such as informal self-help groups, family support, peer support and spirituality, were helpful in assisting with long term recovery.

Examples of the benefits of psychosocial support of some kind are also indicated in a small-scale study by Laudet et al. (2002). They looked at the long-term recovery of people who attended either AA or NA. They used a self-administered questionnaire which was sent by post to 90 recovering alcoholics and drug users to study the intervention methods they used. A total of 51 completed questionnaires were received, a 57% return-rate. Although 71% of the participants reported alcohol as their primary substance, all but one participant had been a polysubstance user. The length of the participants' abstinence ranged from 5 months to 36 years. The participants were asked to describe their most significant experience(s) that had assisted them to achieve and maintain recovery. Although 22% of the participants

cited experiencing treatment from professionals, they also found that various psychosocial factors were effective in assisting with long-term maintenance. These psychosocial factors included alcoholics using 12-step organisations such as AA and Narcotics Anonymous (NA), having social and community support, such as the support from peers, family and friends, spirituality, and the need to be a responsible parent. However, the most common psychosocial factor cited as the most important reason for maintaining sobriety was the participants experiencing the escalating consequences of their substance abuse. Further, Yeh, Che and Wu (2009) again using AA participants in another qualitative Taiwanese study looking at the process of recovery specifically from the perspective of the alcoholic, also talk of the effectiveness of interventions such as AA and 12-step programmes, the support gained through interaction with their families and self-help groups, and the strength gained through the spirituality aspect of AA.

Research indicates that different kinds of social interaction, whether as part of a group, a family, a friendship network, work environment or on an individual basis, can be invaluable in maintaining sobriety including longer term sobriety. For example, regarding interaction within families, Petterson et al. (2018) completed a Norwegian study using qualitative semi-structured interviews on 18 alcoholics who had been abstinent for 5 years. The aim was for them to explore the reasoning behind the alcoholic's decision making after previous long-term substance use. The participants mentioned a few psychosocial factors playing a part in their decision to achieve and maintain sobriety. The participants spoke about the pressure and concern from close family members helping in their decision to stop.

Laudet and Stanick (2010) considered motivational predictors which may indicate a person's level of commitment to continue abstaining after they had completed a treatment programme. Having a participant sample of 250 polysubstance users they completed computer assisted semi-structured interviews. They attended either AA or NA for their substance use. They found that predictors of the chances of the alcoholic continuing to maintain sobriety included peers in self-help groups imparting skills to cope with the temptations, improvements in a persons' quality of life and support from their social network of friends to maintain their sobriety. They particularly noted that friends' support for maintaining abstinence can predict

subsequent future longer-term abstinence. Best et al. (2011) in their empirical study further cited the value of peer support.

The value of peer support is shown in the UK study by Gubi, and Marsden-Hughes (2013) which had used an AA sample of long-term members. They interviewed 8 alcohol dependent participants (applying DSM IV criteria) achieving long-term recovery from 8-48 yrs. and analysed their lived experiences using IPA. They found psychosocial factors aiding long term recovery such as alcoholics both hearing and observing their peers' (and other members) success stories when they were going through the process of change.

Further psychosocial influences affecting long term sobriety are considered in the study by Hill and Leeming (2014). Participants were able to maintain this long-term sobriety by continuing to construct an 'aware alcoholic self' who accepted that they were addicted but managed to maintain an identity as a more knowing and valued person which enabled them to be this positive self. However, they were also aware of their vulnerability to others' potentially negative remarks which could affect their recovery. In a further piece of research Kihara and Kitaoka (2019) completed a study of 36 members of AA looking at the emotional experiences of Japanese Alcoholics Anonymous members striving for sobriety and attempting to identify new sources of support. Their findings revealed that long term sobriety was achieved through gaining an attitude of acceptance of themselves being an alcoholic and sticking to their goals of achieving and maintaining abstinence. Lund (2017) in a qualitative retrospective study looked at how spirituality relates to guilt and shame during the process of recovery. They used one to one interviews with 21 participants who were all substance users who had achieved and maintained abstinence for at least 3 years. They considered that self-conscious emotions are at least partially socio-culturally constructed. They found that faith is seen as a cultural tool that is influencing how we define and cope with guilt and shame in recovery.

Regarding maintaining sobriety and particularly in maintaining long term sobriety, psychosocial factors appear crucial. Further, the studies outlined suggest the importance of taking into consideration the participants' perspectives of their individual situations looking at both their needs and difficulties such as the effects of continuing stigma and what it means for the individual alcoholic trying to maintain sobriety.

An area of further improvement for all the studies on long term maintenance mentioned so far would be to also broaden the focus of participant samples. At present we may only have a partial understanding of long-term maintenance of sobriety because many of the samples refer to participants attending AA, Yeh, Che, and Wu (2009) and Hill and Leeming (2014) in their studies recognise this limitation. Both acknowledge that future research could study individuals who are non-AA members which may offer a different perspective on their successful journeys and offer different abstinence characteristics. As Hill and Leeming (2014, p.20) suggest, others recovering in different contexts may develop alternative stories of transformation which do not have the acceptance and management of an 'alcoholic' identity as a central concern.

The studies suggest the focus of researchers has changed; we have moved on from diagnosing and classifying and looking at an alcoholic's journey as one of inevitable relapses with limited prospects of long-lasting maintenance of sobriety.

Contemporary researchers are now focussing much more on a variety of psychosocial factors that can influence the alcoholic's prospects of both achieving and maintaining long term sobriety. The theoretical review outlined in chapter two indicates what can be construed as a fundamental shift in thinking regarding alcohol dependence and recovery by both theorists and researchers in relatively recent times. These also focus on the importance of psychosocial factors in achieving and maintaining sobriety and recovery from alcohol and /or drug use. This leads me to my last broad theme outlined below.

#### The importance of motivation, a sense of agency, recovery capital and a positive identity

Some theory and practice today relating to alcohol and/or other drug addiction and recovery indicates a clear move from an emphasis on disease theories and related intervention practice to new theories of recovery and subsequent approaches to interventions. This theory and practice refer to a person- led agentic framework whereby people develop motivation for themselves and are assisted to develop this, a development led by them. Therefore, it is a person- led approach to gaining motivation. One cannot just give people motivation or force them to have it; a person needs to find motivation themselves and be responsible for achieving this. Further,

the person needs to have a positive view of themselves and develop a positive identity. Lastly, the notion of 'recovery capital' includes some psychological 'human' capital such as a person developing their own self-awareness, self-esteem, and self-efficacy. It can be seen that all these qualities are self-determining factors which can assist in recovery from alcohol or other drug addictions. These factors can be seen as a shift from the medical disease model doing things for a person to an emphasis on much more self-determining agentic factors. The focus is on the recovery being led by the person through self-determination and the concept of MI and some forms of recovery capital are consistent with that. This is because MI focuses on intrinsic motivation. Therefore, motivation from within ourselves and therefore self-determining and drawing on, for example self-help groups which imply self-determination. It is noted that some forms of recovery capital lie outside this remit, for example there are things you do not have control over however, in this section I will focus on the areas within a self-determining framework where a person does have control. Within this section I will review research relating to intrinsic motivation, change talk, the role of positive social networks and 'recovery capital' more broadly, and social identity.

As outlined in chapter two there appear to have been some relatively new ideas concerning the role of motivation in the recovery process. Motivation and in particular intrinsic motivation has been found to be important in recovery. In an American study by Kennedy and Gregoire (2009) they aimed to consider the possible links between two of the motivational theories outlined in chapter two which have been used in relation to addictions and recovery from substance use namely the TTM and SDT. The study focused on the possible links between the TTM and SDT with the aim of ascertaining whether the two theories could complement each other. They sought to determine whether the type of motivation described by SDT could predict a particular stage of change as described by the TTM namely the precontemplation, contemplation and action stages. They wanted to find out whether higher levels of external motivation would predict membership in the pre-contemplation stage of change and whether greater internal motivation could predict a recoveree entering the contemplation and action stages. They were trying to find out how important both intrinsic and extrinsic motivation were in the pre-contemplation, contemplation, and action stages. They found that internal motivation was more important in recovery.

Data for the study was gained from the Drug Abuse Treatment Outcome Study (DATOS) (2004). Data was collected from face-to-face interviews with participants aged eighteen and above. The participants were recruited from four different drug treatment methods or procedures: outpatient methadone maintenance, long-term residential, outpatient drug free, and short-term inpatient. These participants were drawn from 96 drug treatment programs from 11 American cities. A first interview was conducted as soon as possible after admission with a second a week later. Following basic questions regarding ethnicity, gender, marital status, age at admission etc. the questions asked about substance use and treatment history.

Within the study sample of 10,010 participants, 8,725 completed both the first and second interviews. The researchers' findings revealed that there was a significant relationship between the source of the motivation i.e., intrinsic, or extrinsic and a person's stage of change. Higher levels of intrinsic motivation were much more likely to be seen both in the later contemplation and action stages than in the earlier precontemplation stage. Therefore, it appears as though having or developing higher levels of internal motivation are much more important to nurture recovery than external motivation, in line with the claims of SDT.

It is known that motivation, and intrinsic motivation in particular, has been found to be a fundamental incentive for change and recovery from drug and alcohol use. To encourage intrinsic motivation, it is necessary to provide support for the recoveree's autonomy, competence, and relatedness (Deci & Ryan, 2000). The rationale is that when a drug user/drinker perceives themselves as confident in stopping taking drugs /drink, and receives empathetic understanding, unconditional warmth, love, support, and care within their relationships, it is likely they will have an increased well-being and be intrinsically motivated to abstain from drink and/or drugs (Patrick & Williams, 2012). Therefore, without this sense of relatedness (without significant others) their move towards change will be thwarted due to experiencing negative emotions.

Looking from the perspective of SDT, the drug user's psychological experience is a crucial factor in drug taking or abstaining. If the drug user's needs are met this may lead the person to be sufficiently intrinsically motivated to stop drinking and /or taking drugs. The three needs of autonomy, competence and relatedness can be seen as interrelated. A drug user's autonomy and competence to abstain can be encouraged through supportive relationships with significant others (relatedness).

Chan et al. (2019) using a qualitative methodology, considered the psychological experiences of their sample of 103 participants and particularly looked at their reasons for taking drugs or their reasons for not doing so. They considered the importance of intrinsic motivation in recovery, in meeting the user's psychological needs such as their willingness to carry out certain actions (autonomy), develop new skills (competence), and a sense of connectedness (relatedness).

Their results indicated that the participants had a psychological need for 'relatedness' (a social connectedness or relationships with others). As noted above this can be seen as having a strong degree of fit with SDT and its assumptions outlined in chapter two where people have an innate need to achieve well-being, and health. Further, this connectivity with others offering a supportive, warm, and empathetic relationship can achieve intrinsic motivational behaviour which is personally rewarding and enjoyable to the recoveree (Chan et al., 2019). According to SDT the aim is to achieve autonomous self-regulation, for example being motivated from within ourselves therefore, 'self-determining'. It is suggested this intrinsic motivation can make recovery sustainable (Ryan & Deci, 2000); therefore, this type of motivation may be important to maintain long-term sobriety. It could be argued that quite the opposite effect may happen with extrinsic motivation, for example a person may only stop their drinking or drug taking to avoid coercive discipline and control offered, for instance by police, courts, and institutions. It is argued this form of coercive control may push a person into further acts of drug taking (Deci & Ryan, 1985). Chan et al. conclude by saying that relatedness is an essential factor in determining the user's decision to use or not use drugs or alcohol and we should focus more on nurturing the user's psychological needs with a particular emphasis on improving connections between the user and significant others and their relationships.

The type of the language used in our relationships with others can be crucial in encouraging recovery. It has been found that the type of language used particularly the use of group change talk in MI, can be clearly associated with a decrease in alcohol consumption. It can be seen from the review presented so far that the concept of motivation has been utilized in current intervention methods relating to attempts to recover from addictive substance use. As mentioned in chapter two, relatively new ideas and thinking now sees MI as a major method of intervention in

its own right. Inextricably linked to MI is the quality and quantity of the motivational language used by the participants that is, the use of change talk and sustain talk. As mentioned in chapter two, change talk is a key feature of SDT. Change talk can be defined as statements made by a person that indicate that they are moving towards making positive changes to their problematic behaviour (Rosengren, 2009). Sustain talk is the opposite where people make utterances that they want to remain as they are.

D'Amico et al. (2015) looked at the effectiveness of using MI as an intervention measure for groups of both alcohol and marijuana users. Using a randomized clinical trial of an adolescent group they analysed the change talk from 129 recorded group sessions. They considered the effects of group-level change talk on individual alcohol and marijuana outcomes. The outcomes included looking at the participant's past-month intentions, the frequency, and consequences of their substance use, their motivation to change, and positive expectancies. D'Amico et al. found that the facilitators use of open-ended questions and reflecting their change talk back to them brought about an increase in the group's change talk, i.e., the member's arguments in favour of change. This increase in the group's use of change talk appears to have created a snowball effect further encouraging even more change talk. This group change talk was also associated with a decrease in intentions to use alcohol and embarking in heavy drinking 3 months later. However, sustain talk within the group had the opposite effect, with decreased motivation to change and increased intentions to use substances. Therefore, it can be seen that both the group facilitator's speech and the subsequent responses from the participants each could affect the group and also the individual's recovery.

In addition to the influence and importance of the behaviour and speech of other group members and facilitators on an individual in MI sessions, it has been found that significant others such as family and friends and the meanings they hold for the recoveree, are also important to an individual's recovery. The importance of the connections to significant others and the use of positive social networks in stopping or reducing addictive substance use is well-established in the addiction literature and has been emphasized in the review so far. This importance of positive social networks and relationships is further reinforced in a study by Sarpavaara (2014). The qualitative study considered the meanings substance users attach to significant



others such as friends and family members during motivational interviewing sessions used with people on probation in Finland who were also addicted substance users (alcohol and/or other drugs). The study was based on 82 MI interview sessions from 12 different probation offices which were videotaped and transcribed.

The researchers analysed their data by firstly ascertaining what the client aimed to achieve, such as cutting down their use of alcohol, cannabis, or other drugs. They then searched for the videotaped sequences that are central to the point of view of this aim and coded the client's change talk in these sequences. In positive change talk, the client is moving towards change, while in negative/sustain change talk the talk is about their intention is to remain the same and maintain the status quo. The researchers then searched for and analysed all the utterances concerning family and friends from the client's change talk.

They found that the participants attached various meanings to their family/friends, which were diverse from the point of view of the client's motivation. These meanings included perceptions of their families as being supportive to their changes, or they were seen as someone they wanted to emulate, or they saw them as a sufferer as a result of their drugs or drink, or an obstacle to the changes. Concerning their friends, they sometimes saw them as an obstacle to change, or an obstacle they had overcome, a reason to change, or a support to change. The study suggests that these significant others played an important role in the client's motivation to change. Most often these significant others were perceived as a motivating factor; however, sometimes the meaning of for example the family was constructed as an obstacle or a threat to change. Sarpavaara cites a heavy drinking relative of a participant as a possible threat to his or her change.

The studies' conclusions refer to significant others such as family and friends who can either encourage and promote change or hinder a person wanting to change. Therefore, in addition to promoting intrinsic motivation, significant others appear to be an important factor either helping or hindering change indicating that the role of social factors are also as important as intrinsic motivation. It seems that these significant others may well be crucial in supporting a person in the process of change and as an element of recovery capital. Significant others together with the wider network of people and resources available in their social environment may, it is

hoped, contribute to promoting a person's transition from alcoholism to sobriety and sustained recovery by using this recovery capital.

It has been acknowledged throughout this thesis that the process of recovery often constitutes a long, complex, and difficult journey. For this journey to be successful as mentioned above, it is assisted by a recovery network of people and resources. It seems that these significant others may well be crucial in supporting a person in the process of change and as an element of recovery capital and involves a person gradually building up recovery capital to assist them in this process (Cano et al., 2017). However, it is further noted that successful recovery may also be dependent on the type and quality of this capital. This is indicated in Laudet and White's American study (2008) where they considered some of the attributes of recovery capital in assisting in recovery from cocaine or heroin addiction. In their study of 312 participants, they wanted to find out whether higher levels of recovery capital would prospectively predict sustained recovery, better quality of life and people having lower levels of stress in their lives after one year of being in recovery. Secondly, they considered the differing effects of recovery capital on the outcomes at different stages in their recovery. Their sample consisted of inner-city ethnic minority people who were interviewed on two occasions at a one-year interval. The interviews aimed to find out whether recovery capital may predict sustained recovery, an improved quality of life and a lowering of stress levels and their results found that they did. Their findings suggest that an appropriate amount and quality of recovery capital (which in this case included social support, spirituality/religion, and 12-step resources) may encourage and assist a person to sustain their recovery. Therefore, the amount and quality of recovery capital may be a strong predictor of a successful and sustained transition to sobriety and recovery.

It has been further shown that maintaining longer term recovery from substances (such as alcohol) is related to recovery capital in the form of the type, quality and composition of the peer groups a person is exposed to that is, groups who are still using a drug as opposed to those where there are fellow recoverees (Best et al. 2009). This is further reinforced in an analysis of alcohol outcome data following the COMBINE randomized clinical trial in America (Longabaugh et al., 2010) where they found that a strong predictor of recovery from alcoholism is a person's transition from a social network of people who are supportive of drinking to a network which is

geared towards recovery. Therefore, a major barrier to overcome in achieving abstinence and recovery is a person's movement from a substance using social network of people (addicts) to a group focused on recovery such as AA or other self-help group and/ or a supportive network of friends or family.

Further, a strong supportive recovery network together with developing a positive change in their social identity focusing on recovery rather than addiction can assist people in the recovery process (Longabaugh et al., 2010; Best et al., 2014, 2018). Beckwith et al. (2019) found that a strong and positive recovery identity can be linked to the amount of non-substance using social networks a recoveree is exposed to. In their study they used Social Identity Mapping in Addiction Recovery (SIM-AR). This is a visual method of capturing social group memberships. In addition, they looked at each of the groups member's substance using- status. This acted as an indicator of the normal use of substances within the group. The researchers wanted to examine the relationship between changes in social identity and the substance using norms of the social groups. Using 155 participants they completed the SIM-AR plus measures of substance using and recovery identities and substance use shortly after admission to a residential therapeutic community. A proportion of the participants (65%, N=101) completed the SIM-AR measures again 6 months later. They found that the severity of substance use at the follow up was linked to changes in both social identity and the composition of the groups. Beckwith et al. found that the strength of the participants substance using identity was related to the proportion of their social group members who showed heavy substance use. Therefore, the fewer social group members who were rated as showing heavy substance use the stronger the 'recovery identity' of the individual.

As briefly mentioned at the end of chapter two a crucial part of recovery is that the recoveree develops a positive identity which can support them through their recovery journey (Best et al., 2018). This requires a move from seeing themselves as an alcoholic or user to a person in recovery. This journey may mean moving from an environment associated with people who are alcoholics or other drug users to perhaps a non-drinking self-help group to begin to construct this change in identity. In a qualitative study by Webb et al. (2020) they aimed to explore this identity shift in the journeys of people in long term recovery. They considered the identity changes amongst six participants recovering from substance use. They considered the

narratives captured from interviews which had been videotaped from all the stages of their recovery (ranging from the early stages to over three years later). They found that the participant's identities changed over their journeys of recovery. This shift in identity moved from one of gratitude towards others and dependence on them in the early period of their recovery to a gradual movement towards exploration and risk taking, to later distancing from other members of the group of recoverees. The recoveree is transitioning from a social identity within the group whereby they still have a need to belong and be validated by others to a movement away from social identity to a period of exploration and risk taking at the mid-stage in their recovery. They then move on to distancing themselves from a recovery group. Therefore, longer term recovery can be perceived as an identity growth (Webb et al. 2020) to an individual and agentic identity where their further recovery is self-determining. Finally, they moved on even further to "an apparent self-possession and independence" (Webb et al. 2020 p.8). This study suggests how a recoveree as part of their recovery journey moves from a reliance on others in early stages of recovery perhaps guiding them along their journey to where their journey becomes much more agentic and self-determining. The person becomes empowered to make their own choices and decisions and in the latter stages of recovery they achieve an inner confidence together with their independence to continue with their recovery journey. All the above section on empirical studies pertaining to recovery relate to what can be construed as a move away from the more traditional mainstream approaches to achieving and/ or maintaining sobriety and recovery, for example the medical disease model towards more of an emphasis on bio-psychosocial solutions. These solutions promote self-determination, a sense of agency, choice, and empowerment but in particular a focus on the importance of increasing internal motivation through change talk and the role of recovery capital such as supportive social networks.

## **Summary**

The research suggests that achieving sobriety and maintaining this state is much more complex than merely deciding to stop drinking. It is more of a process rather than a single event and there are many different pathways that alcoholics have taken to achieve this. The use of medications and its limitations, and the more general physiological effects of alcohol use appear to be reasonably well understood.

Studies suggest the medical model continues to use classifications of alcoholic types to guide their decision about the most appropriate intervention. However, the validity of these classifications has been questioned. Medical practitioners together with many alcoholics find value in the use of medical interventions, however, the research also tells us that some people achieve sobriety without or with little medical treatment. Further, there have been many studies on the possible causes of relapse and suggested medical intervention measures. It seems that biological and psychosocial factors can work together to assist in preventing or delaying a relapse. The evidence also tells us that although relapse may be common, a person can still achieve and maintain sobriety in the future. Medication only appears to be effective in crisis intervention and sobriety of under 2 years. I did not find any empirical evidence for the effective use of medication for longer term sobriety as defined in this thesis.

The empirical research tells us that a bio-psychosocial approach remains prominent in both achieving and maintaining sobriety with studies emphasising the effectiveness of AA and the TTM. However, as pointed out in chapter 2, the TTM is still contested particularly around whether such defined stages (as claimed by the model) are useful ways of assisting in achieving and maintaining sobriety. The stages only offer a partial understanding of the alcoholism as there appears to be little evidence which refers to the maintenance stage.

Further, there are studies which point out the beneficial psychosocial factors of social interaction with family friends and self-help groups offering general support and encouragement. In addition, the review tells me we have some knowledge about the effects of stigma on alcoholics which may point to the usefulness for further research in this area. Another factor was experiencing the thought of the negative consequences of returning to drinking. Other studies suggest alcoholics both hearing and observing others success stories can aid long-term maintenance. Faith is seen as a cultural tool that may influence how we cope with maintaining sobriety. Religion has been found to be supportive and useful in achieving long-term sobriety. We now know that the alcoholic needs much more than just abstinence. The alcoholic also needs to experience a much more fruitful life that has personal meaning which encourages this change when looked at from their perspective.

Although there have been studies which have clearly developed the intervention measures now available and a move to acknowledge the part psychosocial factors can play in both achieving and maintaining sobriety, there still appears to be areas which are under researched and areas we need a further understanding of.

At present we may only have a partial understanding particularly of long-term sobriety because there appears to be not enough research conducted with non-AA samples. Further, I could not identify any other non-AA sample involvement in any of the studies on long term sobriety. This suggests we may have limited knowledge of non-AA self-help group members who could contribute a different perspective and develop our understanding.

The emergence in relatively recent years of new theories and empirical studies surrounding the theme of 'recovery' appears to have produced a fundamental transition from an emphasis on medical disease theories and intervention measures to approaches emphasising much more self-determining approaches with findings indicating the usefulness of these bio-psychosocial elements.

In sum, this relatively new theory and practice described above refers to a person-led agentic, self-determining framework whereby people develop motivation by and for themselves and are assisted to develop this for themselves. Intrinsic motivation is more important to a person than extrinsic motivation. If the drug user's needs for autonomy, competence and relatedness are met this may lead the person to be sufficiently intrinsically motivated to stop drinking and /or taking drugs. This autonomy and competence can be encouraged through supportive relationships which we should nurture. The quality and quantity of the motivational language (change talk) used can be crucial to successful recovery and has been associated with a decrease in alcohol consumption. Significant others such as family and friends together with positive social networks and the meanings they hold for the recoveree, are also important to recovery. Family and friends can either encourage or hinder change. Therefore, the role of social factors are as important as intrinsic motivation. Successful recovery may also be dependent on the type and quality of the network of resources and people involved in a person's recovery. Transitioning to people who are geared towards recovery may also mean a change or development in a person's social identity.

Further, chapter two explained how the theory of SDT and the intervention measure of MI together with an emphasis on the change talk used is consistent with constructivist thinking. They all value the self-determining qualities of choice, a sense of agency, and autonomy in recovery for the individual. However, we appear to have little understanding about the alcoholic's meaning-making processes which could have been significant enough to assist in change in terms of maintaining longer term sobriety. Some research points to the usefulness of a more constructivist approach, this is shown in the studies already discussed by Hill and Leeming (2014) and their research on stigma and the alcoholics constructing new identities for themselves. Further, it is also shown in the empirical work of Buirs and Martin (1997) with their participants constructing a different identity using their imagination. This leads me to further explore the usefulness of using a constructivist bio-psychosocial approach.

### **Adopting a Constructivist approach**

Constructivism claims that knowledge is not merely out there in the world waiting for us to discover it. Knowledge is always an interpretation of reality when looked at through our eyes therefore, knowledge cannot not claim to be a 'true' representation of the world. We all construct knowledge both individually and as a society. In this context 'knowledge' refers to our individual perception of the world and our position within it, our perception of others and of our relations with them. A key aspect of Constructivism is that the personal knowledge we produce is the result of making meaning from our experience. It is important to understand that although experiences may be similar, we do not all draw the same meaning from them and that our behaviour, our conduct, is a choice that we make based on how the world appears to us. People will only successfully change their behaviour if they can change the construal of the world that their behaviour is based on. Constructivism's focus on the importance of psychological meaning making processes (and the role of others in that meaning making) makes its emphasis psycho-social and on those grounds, it may be seen as one variety of psycho-social approaches to substance use. From a Constructivist perspective we therefore construct this meaning. The approach looks at the alcoholic's psychological processes and their social relationships to attempt to understand their behaviour. We aim to achieve an empathetic position whereby we put ourselves in others shoes to attempt to understand how others view their own world. Burrell and Jaffe (1999) argue that a

person's subjective experiences with and relationships to substances (such as alcohol) can depend predominantly on their personally constructed meanings. The alcoholic will derive how they individually act and think based on their construal of their world. Therefore, if we do not understand the meaning that lies behind the alcoholics' behaviour, we will not be able to usefully help them. It is argued personal meaning is important because it is concerned with the psychological reasons the alcoholic may have constructed following past experiences to make their choice or decision to achieve and/or maintain their sobriety. It may also influence the reasons why they relapse or choose to continue to drink. The alcoholic construes and makes their own sense of the social world around them and acts according to their own individual construction and personal meaning they make of it. A constructivist approach is concerned with psychological processes and our social relations with others. Therefore, the approach can also be seen as a form of a bio-psychosocial approach.

By being aware of how the alcoholic construes their world as they see it and by considering this personal meaning, we may add a further dimension to our understanding of both alcoholism in general and how alcoholics may achieve and maintain long term sobriety. This perspective gives power and autonomy to the alcoholic. We talk about the construction of knowledge and this construction is something people actively do themselves. Therefore, they make their own constructions putting them in the driving seat which gives them agency. A constructivist intervention is about harnessing that agency and not doing things to people but enabling people to do things for themselves by guiding them. Therefore, the therapist acts as a guide in contrast to a medical practitioner who perhaps is more of an 'instructor'.

This power, autonomy and sense of agency places the alcoholic in a position where they can bring about change- the alcoholics themselves have the power to effect their own change. Further it allows them to convey what personal meanings they have gained from their construing and their resultant anticipations or expectations for their futures. It is further argued that by providing opportunities for the individual to convey their own views of their difficulties and future aspirations they can begin to own the changes they have made and, as Burrell & Jaffe (1999) suggest, they can become agents making their own choices. Willutzki and Wiesner (1996) see



alcoholics and other drug users as autonomous people who are always being influenced by their social environment and their interactions with it; the choices they make to either drink or abstain will make sense and have personal meaning for them when seen through their eyes. Shaffer and Robbins (1991) suggest that in-order for clinicians to be effective in assisting in any change process they must understand how people make meaning and offer re-framings or reconstructions of these constructed subjective meanings. This reconstruing enables both the person and the clinician to have the opportunity to re-write the meaning of the person's experiences. For example, the alcoholic's previous negative experiences of failure and shame may be re-framed as an optimistic opportunity to gradually achieve and /or maintain sobriety. Winslade and Smith (1997) suggest encouraging clients to collaboratively construct non-medicalised narratives about how alcoholism affects their lives that promote agency.

This may be contrasted with the biomedical approach where professionals take up the role of making decisions on behalf of the alcoholic. The constructivist approach is concerned with understanding the alcoholic's perspective of the world as they see it and how they individually anticipate their own future in contrast to professionals directing their futures for them.

In contrast to the biomedical views, Fingarette (1988) suggests that it is necessary to stop looking at the assumed involuntary symptoms of a 'disease' and address a person's individual concerns. We can then begin to enable the person to reconstruct their lives. We have control over our own destiny. A person actively looks to gain a desired human experience from their addiction, regardless of whether this is gambling, shopping, drinking, sex, or eating food (Peele, 1995). Further, Peele suggests, the addict will look for the meanings the experiences evoke which will meet their needs. Therefore, to understand their experiences and relationships with alcohol it is necessary to understand how people construe their experiences and what meanings these have evoked for them personally.

Further Klion (1993) and Klion and Pfenninger (1997) looked at drug use within a constructivist and more specifically a Personal Construct Psychology (PCP) framework. They offer a contrasting argument to that of the biomedical 'disorder' or disease approaches. For example, a disorder approach focuses on behavioural and cognitive weaknesses and in encouraging the person to employ avoidance

techniques to withstand temptation. However, Klion (1993) suggests a person (in this case the alcoholic) does not need telling of the dangers or educating as to what is a healthy lifestyle. Instead, they ask why the alcoholic has placed drinking at the centre of their lives. For example, drinking may have become a core role for them (Klion & Pfenninger, 1997). The most important constructs are core constructs. They are 'core' in the sense that they are central to our way of being who we are. These constructs can cause considerable psychological impact if they are threatened. Therefore, a core role for a person may be to become a priest therefore fulfilling the belief that they can serve God this way. Constructivism (including PCP) argues that we all construct ourselves, using the meanings that our experience holds for us, so that in principle we can construct ourselves differently. Constructivism argues that the use of alcohol needs to be understood from the user's point of view and their individual construing of the world through their lens. From their perspective, it can be considered as a meaningful activity and not a disorder. Constructivism in general focuses on emphasising both autonomy and personal meaning. In contrast to a disorder perspective, as with the medical model, emphasising the controlling power of certain substances, PCP emphasises the power of the alcoholic themselves.

There has been a limited amount of research on achieving and maintaining sobriety conducted explicitly within a constructivist framework. Adopting such a framework means going further than merely taking the perspective of the alcoholic. It also focuses on what alcoholism and achieving and maintain sobriety means when considered through the lens of each individual alcoholic. This personal meaning, as mentioned earlier, is important because it is concerned with the psychological reasons the alcoholic may have constructed based on past experiences to make their choice or decision to achieve and/or maintain their sobriety. It may also influence the reasons for why they relapse.

I would suggest that elements of constructivist thinking can be seen in the empirical research focusing on alcoholics maintaining sobriety as seen in the study by Hill and Leeming (2014) already discussed who found that they could gain a greater understanding of how the alcoholic could partly overcome stigma by them construing and subsequently constructing an 'aware alcoholic' self whereby they were able to construe themselves as divorced from their previous self. Therefore, as the proponents of constructivist theory Klion and Pfenninger (1997) suggest, 'addiction'

can become an integral part of ones' identity and changing this identity becomes even more difficult. Further, the empirical study by Buirs and Martin (1997) involved participants imagining different versions of themselves. Buirs and Martin found that by using role play the participants were able to construct an imaginary view of themselves as a person no longer abusing alcohol. This enabled them to develop a new subjective perception of themselves resulting in them anticipating a positive, sober future.

Further constructivist thinking can be seen in the work by Klingemann (2012). This reports a Polish study carried out in 2007 which provided qualitative, in-depth semi-structured interviews with 29 alcoholics who had maintained their sobriety for a least two years. The traditional recovery approach in Poland uses a dominant disease model and abstinence-based approach to alcoholism. He found that recovery referred to for instance changing what you value in life, reinventing yourself, being encouraged by what your relationships with others mean to you, and reframing any experiences of dependency as not a 'weakness'. He concluded that when we challenge traditional concepts of recovery like the dominant one in Poland by contrasting it with more subjective accounts like his own approach, we find that only a minority of alcoholics conform to normative definitions of recovery. His study appears to support the constructivist views that alcoholism and addiction in general can be seen as having social, cultural and political aspects.

Luciano et al. (2014) studied 12 men with co-occurring psychosis and substance use disorder (alcohol and/or cannabis). Adopting a qualitative constructivist approach using semi-structured interviews, their topic guide explored the participants' lives before, during and after they had achieved sobriety. Participants were asked to reflect on their experiences. The participants were invited to reflect on their use of substances. Charmaz's (2006) constructivist grounded theory was chosen to analyse the data. It was chosen because of its emphasis on using the voice and experience of the participants and the active construction of the findings through interpretation. This is clearly a different approach to positivist approaches where it is assumed that the findings are 'discovered' through an external reality. As a result, the participants were able to describe how they had maintained sobriety for at least a year by building a supportive community, engaging in productive and meaningful activities, maintaining a healthy state of mind (finding introspection useful), and seeing the use

of self-help groups as an important catalyst for building change and constructing a new identity for themselves. The participants appeared to be constructing a new identity for themselves and a new self. In a further example of how a PCP approach can help us to understand the alcoholic Eiroa-Orosa et al. (2019) completed a study on 30 health professionals. Their aim was to consider the personal construing processes of substance abusers. The participants consisted of physicians ( $n=17$ ), nurses ( $n=11$ ) one pharmacologist and one psychologist. Using DSM-IV-TR criteria 15 of the participants had alcohol problems. Every individual has a specific way of construing events using their own constructs of their individual situation at the time. Therefore, if we can tap into these constructs of the alcoholic, we may be able to begin to understand why they drink and why in some circumstances they stop drinking. The assessment tool used to elicit the participants' constructs was the Repertory Grid, a PCP tool developed by Kelly (1955). The study used interviews asking the participants to think about the important and significant others in their lives such as parents, children, friends etc. as well as a disliked person to compare against and these made up the elements of the grid. They were additionally asked to construe themselves now compared with how they saw the ideal self. The similarities and differences between these elements were utilized to elicit constructs related to each individual substance user. More than 50% of the health professionals exhibited at least one implicative dilemma. That is, one of their desired constructs involving a change in themselves was associated with an unwanted implication concerning another construct. Implicative dilemmas could provide an explanation for why some people resist change. The lack of change in some of the participants suggested that the substance users may experience a large amount of distress whilst attempting to change a particular aspect of themselves which could give us a greater understanding of why they sometimes resist any change. The researchers hypothesised that health professionals whose construct system is conflicted in some way have more difficulties coping and resolving work-related tensions which could ultimately result in burnout. The work of Eiroa-Orosa et al. is just one PCP approach which I would argue gives us a further tool to increase our understanding of the possible reasons why we drink and the constructs which appear to go some way to enable a person to change if they so wish. In sum, the rationale for using a constructivist approach to research the achievement and maintenance of sobriety I would argue is different from those approaches using a disorder perspective.

Disorder approaches tend to view alcoholism as an objective truth. This can mean they can reduce or dismiss the impact of personal and social constructions and their meanings. From a constructivist perspective alcoholism is not viewed as an objective 'disorder' but a reflection of the alcoholic constructing some sort of order or meaning. As Klion and Pfenninger (1997) point out, their drinking may make sense to them. A constructivist approach assumes the alcoholic chooses to use or not to use alcohol, therefore, to gain a further understanding of their situation it is necessary to ask why they are choosing to take a particular action. Therefore, the approach does not assume the alcoholic is a weakened victim who cannot control their actions. Further, I would question whether this also means we could challenge the very nature of 'addiction' as seen from a medical model perspective. The person is not compelled to drink (under the constructivist approach) but chooses to do so based on what it means to them.

Constructivism tells us that, like all of us, the alcoholic will derive how they individually act, and think based on their construal of their world. However, we still have little understanding of the alcoholic's construing of their personal situations regarding their alcoholism and what any change may mean for them. If we adopt this approach, we may be able to gain insight into what it is about their perceptions that has not only led them to want to achieve sobriety but also maintain it for relatively long periods.

We know, through the studies already conducted, about alcoholics' lived experiences of their alcoholism. However, we appear to know much less about the alcoholics' construing processes and about the personal meaning they have drawn from these experiences. Previous studies particularly of long-term sobriety have exclusively used AA members as their research sample therefore we may have a limited knowledge of non-AA self-help group members who could contribute a different perspective and develop our understanding. This may lead me to question whether we have a comprehensive view of the alcoholic's perspective of achieving and/or maintaining sobriety, therefore, to add a further perspective I will use a non-AA sample. As a result of this comprehensive review of the relevant theoretical and empirical literature, I present my research aim as follows:

### **Research aim**

To understand the role of personal meaning in achieving and maintaining sobriety in a sample of alcoholics attending non-AA self-help groups.

## CHAPTER FOUR: METHODOLOGY

### Epistemology and ontology

This study is concerned with examining the subjective experiences of alcoholics and the meaning they have drawn from these experiences. It is concerned with attempting to ascertain what sense individuals have made out of their alcoholism, and their personal change.

In order to provide an epistemological and ontological framework for my research, this section begins by identifying its overarching philosophical approach; namely, contextualism. This position, according to King and Brooks (2015, p.19), assumes that context - in historical, cultural, and social terms—is integral to understanding how people experience and understand their lives. For researchers taking this position, all knowledge that can be obtained through research is always conditional and context specific. There is no single reality ‘out there’ which can be measured and objectively investigated. Both researcher and research participants are seen as conscious beings who are always interpreting and acting on and in the world.

Contextualism argues that there is no single measurable reality that can be objectively studied. Taking a contextualist approach attempts to, as King and Brooks (p.19) point out, “*achieve some kind of grounding in participant’s experiences and their social context for their results*”. That is, the ‘reality’ that the researchers are attempting to communicate in their account of their results is not an account that reflects objective reality. However, the report of their results broadly refers to a recognisable reality. This would be a reality that has been lived and experienced by the participant within an identifiable historical and social context.

Within this philosophical framework, the study adopted the general epistemological position of constructivism. A constructivist stance highlights human beings’ active and proactive construction of meaning and patterns of self-organisation (Mahoney, 1991; Neimeyer, 1993; Lyddon, & Adamson, 1992). It assumes that we have no direct knowledge of an external reality, but we adapt to personal and social realities that we create or co-create. Gillies and Neimeyer (2006) argue that we author our own life stories by reflecting, interpreting and reinterpreting what happens in our lives. We find meaning in our life events or invest them with meaning. This can be invoked by getting people to give their accounts in their own words. For example, Neimeyer

(2016, p.256), when discussing people going through a loss in terms of a bereavement, suggests, “*we ultimately construct a life story that is distinctively our own though we necessarily draw on the social discourses of our place and time*”.

In terms of the ontological position taken in this research, it has taken a relativist stance. Therefore, looking at the research from this position, knowledge and reality are always open to a range of interpretations that are dependent on our cultural, historical and social contexts. This can be seen in contrast to a realist approach which according to Crotty (2009, p.10), “*asserts that realities exist outside the mind*” and are therefore independent of us as human beings.

Constructivism is concerned with ‘*verstehen*’ (Weber, 1963) or ‘understanding’ the human experience with an emphasis on exploring meaning. This can be seen in contrast to ‘explaining’, as seen in other forms of research, such as that carried out within a positivist research paradigm, whereby a person is searching for ‘objective’ knowledge and the emphasis is on accurate measurement and prediction. This search for ‘explanations’ is often in the form of looking for causal relationships, for example, quantitative studies where correlation is utilized.

### **Theoretical Framework: Personal Construct Psychology**

The research adopted the theoretical framework of Personal Construct Psychology (PCP). PCP is consistent with a constructivist epistemology in that it is concerned with human experience and its resultant meaning. We construct our personal worlds from these experiences. PCP was developed by George Kelly (1955) and strives to understand people through their own individual and unique perspectives on the world. It is based on the principle that we understand any person by looking at their perspective of the world and not just as we may see it from our perspective. How we approach and interact with other people is the result of these past experiences and our perception of our present situation. A fundamental tenet of the theory is that of ‘constructive alternativism’. That is, there are many different ways of interpreting the same events or situations and therefore many possible ways that people may respond to them.

George Kelly’s development of PCP in the 1930s was pioneering. Kelly began his career working as a therapist, offering a psychological service to both children and adults. Unlike the wealthy clients of Freud, Kelly treated people who came from



relatively poor working-class backgrounds. There was no support from health or social security services, and this was the reality for people at the time. In terms of therapeutic methods that were available before Kelly, Butt (2008, p.8) explains that, "*The orthodox psychology of behaviourism and the parallel psychological universe of Freudian psychoanalysis were the only options*". Therefore, there were limited choices or options for psychotherapists to choose from. Moreover, Kelly (1955) found both behaviourism and psychoanalysis of limited use in his clinical work. He saw them as the "push and pull theories of motivation" (Kelly, 1969, quoted in Butt, 2008, p.8). Psychoanalysis viewed behaviour as the consequence of deep forces that push the person, whereas behaviourism saw the person being pulled by forces in the environment. They both believed that a person is determined by one force or another. Instead, Kelly's clinical experience suggested to him that it is the meanings that events hold for people that informs their conduct. For example, Neimeyer (2016), when writing about loss, comments that a person who may have experienced a personal life-changing loss will enter into a search for meanings relating to this loss, in order to begin to overcome it.

The meanings with which a person interprets events and 'construes' them, in PCP terms, are fundamental and essential in understanding their conduct, thoughts and emotions. PCP theory tells us that it is the accumulation of our actions and experiences that form the basis of our view of the world. Kelly (1955) laid out his theory formally as a fundamental postulate and eleven corollaries. The Fundamental Postulate states that "*A person's psychological processes are psychologically channelized by the ways in which they anticipate events*". This means we are heavily influenced in the actions we choose to carry out by what we expect the future outcome to be. The eleven corollaries are shown in **Appendix R**.

This form of thinking is different from that of the mainstream theories of behaviourism and psychoanalysis at the time Kelly was practicing and writing. Kelly was interested in the sense people had made out of what had happened to them. He saw events and experiences as two separate entities. People can go through the same event, such as going out for a meal and being served by a particular member of the staff. One person may perceive this event as a below average experience, feeling that the staff member was not very attentive, whereas another person may see it as a pleasant experience with the same staff member being helpful. What is important to

each individual is their perception of what has occurred. Therefore, from an objective position we may assume two people experience the same event in the same way; however, in contrast to this, their subjective experience of the event and its related meaning they have drawn from it may be entirely different.

Further, it is the meanings we draw from our perceptions that develop our theories of the world around us, that is, our 'constructions'. The ways we make sense of things are put to the test by means of our behaving in ways consistent with our interpretations. Kelly believed we all use behavioural 'experiments'. We can then determine if our construing enables us to make sense of our world or not. Kelly also used the term 'validation' when referring to one of the outcomes of these behavioural experiments, that is, when the prediction we make is confirmed.

We must understand how the other person sees the world, their behaviour and choices and what meaning they attribute to things in order to effectively communicate and have a meaningful relationship with them. PCP places the individual at its central focal point and strives to understand people through their own individual and unique perspective of the world. Events are construed through a system of meaning. The working tools of our world view are called 'constructs' and these are described below.

### **Constructs and construing**

A construct, in PCP terms, is a dimension of meaning. It is a way of differentiating between objects, events and people. Each construct can be equated to a line connecting two points or poles and constructs involve a contrast between these two poles. People vary insofar as using different constructs when looking at the same object or listening to the same person speaking. Two people may apply different constructs to the same event. For example, two students may attend the same lecture and listen to the same lecture but apply different constructs to this lecture. One may say they found it a time-consuming waste of his time in contrast to a valuable lecture which has saved future reading time, whilst another student may apply a construct pertaining to boring versus very interesting. Therefore, the same lecture can have different meanings for different people. They use different constructs to assess the same situation.

However, an individual's constructs are also to some extent drawn from the social world in which they live. In this sense they are not entirely personal to us. That is, every individual does not just use idiosyncratic constructs; for example, we as a society all use constructs such as 'tall' or 'small' and 'happy' or 'sad'. Therefore, we all grow up in a society which is full of constructs we all are influenced by and draw on.

Constructs can be differentiated from traits. Traits are one way we can understand personality and individual differences and a construct is another way of understanding how one person is different from another. Trait theory can tend to give a negative and bleak outlook on the chances of personal change; whereas constructs are in principle amenable to change taking place, this does not appear to be the case with trait theory. According to Eysenck (2013), personality is fixed and genetically derived and one cannot change one's genetic make-up. Therefore, a person may be described as an excitable person and another as a calm person and this trait is assumed to usually remain with them on a permanent basis. However, a personal construct can be defined as an individual's understanding of their surroundings which is based on their individual and unique experiences of the world. These experiences and constructs may change over time. Constructs become the basis for predictions about current and future experiences which channel behaviour into certain avenues. In other words, constructs are the ways people anticipate events.

Some constructs are seen as more important than others. The most important constructs are those which are 'core' to our sense of being. Kelly (1955, p.482) defined core constructs as *"those that govern a person's maintenance processes which maintain their identities and psychological existence"*. It is suggested that core constructs include issues such as our beliefs pertaining to religion, how we see things morally and our self-concept, the kind of person we feel ourselves to be. If these things are in danger of being threatened, it can possibly cause psychological harm. They include all constructs that are deemed important to a person's sense of self. This can have implications for personal change. That is, change can be very difficult, and this is particularly so if the desired change pertains to a person's core constructs and core construing. This point is discussed further below.

### **Understanding Behaviour: Anticipation**

In PCP terms, the person seeks prediction and formulates hypotheses about the world by construing events and verifies them by means of behaviour which can result in a validation or invalidation of what the person anticipates. Butt (2008) writes that, according to Kelly, it is the future not the past that intrigues a person. Further, it is the person's conduct and subsequent choices which arise from how they anticipate the future. Anticipation is a key concept in PCP, and it replaces concepts such as 'motivation', 'drive', and 'causality' found in other forms of psychology. Our anticipations guide our conduct, and this can be compared to other models of psychology such as behaviourism and psychodynamic theory. Kelly did not see the person as needing pushing or pulling into doing something. An alcoholic may not therefore need motivating. In effect they are continually and actively engaged in doing something. They are continually casting themselves into the near future, engaged in a constant process of anticipating it in order to make sense of it.

### **Choice and change**

PCP approaches have been applied to many situations which involve life changes. For example, Neimeyer (2000) differentiates between what he refers to as traditional models of grief and an alternative constructivist approach. He comments that in the traditional model, personal change is explained as a person experiencing a series of stages or phases of adjustment until the person achieves some type of 'recovery' or change. However, Neimeyer states (p.84), "*research has provided little empirical support for the presence of distinct psychological stages much less for a determined sequence of psychological states*".

Neimeyer proposes that the personal reality of someone dying, or a loss, would vary for different individuals as it does not have the same meaning for everybody. People are seen as active rather than passive participants in facing the challenges of the death or loss and this is the same when a person makes any change. Giving up drinking may be experienced as a loss by alcoholics even though most people would see it as a positive change in the same way that a person eventually overcomes a relative's death. Therefore, it is argued, much of Neimeyer's views on bereavement and loss and personal change can be equally applied to the change process experienced by the participants in this study.

Further, Neimeyer and Winter (2004) talk about work with clients dealing with major life changes of many other kinds besides bereavement, including assault, job loss and illness. When dealing with change in contrast to other forms of psychology, Kelly recommends a holistic approach to the person. Therefore, Kelly's approach is not about addressing merely behaviour or a person's thinking or how they feel, it pertains to a person's processes as a whole which would involve all these interconnected elements. Kelly's fundamental postulate refers to, "a person's psychological processes" and therefore does not separate out behaviour, thought and emotion. PCP, therefore, conceptualises a person holistically and any changes are seen as taking place at the level of the whole person. Changing our behaviour means an element of change in our construing.

Personal change is therefore about learning to construe the world and oneself differently to adopt a more useful construction of the world. PCP sees successful change not in terms of how highly motivated a person is to change but in terms of whether they can envisage a meaningful future self that is consistent with the desired changes. Butt (2008, p.72) argues that,

Sometimes people find themselves feeling, thinking and acting in ways that are problematic to them or to others. When this is the case, Kelly contended that it makes no sense to ask what motivated (or energises) the behaviour. This is the wrong question to ask. Instead we should ask why the person is choosing to act as he does. His contention is that we are not driven to act neurotically, but choose to do so.

Specifically relating to addictions to drugs (including alcohol), Willutzki and Wiesner (1996) view drugs users as autonomous people. They believe that the choices these people make (for example to change their lifestyle or giving up drinking or cutting down their drinking or to continue drinking/taking drugs) will make sense when looked at and considered from their own viewpoints.

Butt (2008) comments that when a person thinks about choice they will usually imagine, for example, someone musing over whether to have a vodka and coke or whether to have a gin and orange; that is, just two options to consider, both of which may be equally pleasing to the person. However, choosing is not always that straight forward, it can be difficult and complicated. Butt (2008, p.73) also reminds us that

choice can involve making choices between two unpleasant options. This can leave us with a dilemma, for example, an alcoholic can choose to drink and believe this will give them a certain level of confidence and in their eyes a degree of social competence. However, they may feel ashamed and guilty later for their choice. Alternatively, they could choose not to drink, feel a lack of confidence and be poor at interacting with others (in their eyes). However they may not feel the level of shame they would have felt drinking. Therefore, it can be seen that both choices in this scenario can be seen as not ideal for the alcoholic. Butt (2008, p.75) comments that "*change always involves a package deal*". Some people may be reluctant to change a certain aspect of their behaviour because they realise it would also involve other parts of their behaviour, which they did not want to change, changing as well. A person cannot just stop drinking alcohol without other aspects of their behaviour changing. For example, in terms of the core constructs mentioned earlier, the alcoholic may have a sense of self as a confident and gregarious person. If this is a core belief it would be critical to the person that they can remain confident and have a gregarious manner at all times. They may need to drink alcohol in order to achieve this demeanour. If they abstain from drinking, they may fear losing this and therefore resist the change to avoid losing their core construct and sense of self. Therefore, a person may be seen to resist change even though they have said they want to change and have asked for professional help in order to achieve it.

Butt (1998) argued we all have the freedom to change our construing. However, he was also aware that people may find it difficult to change or may resist it because their construing has become 'sedimented', as Butt (1998) puts it, drawing on Merleau-Ponty (1962). We are constantly making choices between alternatives presented by our own construing. People make what Kelly termed "the elaborative choice". In other words, the choice between the alternatives, as they see them, that gives them the better position from which to anticipate future events. When construing new situations, this either has the outcome of changing their construct system slightly to 'accommodate' the new experience, or the outcome is for the new experience to be seen as 'validating' the existing construct system. When the person systematically opts for the latter choice, this is when construing may be thought of as becoming 'sedimented'. The person may then exhibit a pattern of self-perpetuating

behaviour ending with unhelpful ways of looking at themselves and others becoming 'sedimented'.

We all develop our own individual constructs of the world around us. We may ignore advice if it does not fit with our own construction of ourselves and events. This may be particularly apparent if the advice would result in the need for a person to abandon or change core constructs. These can become our blinkers to moving forward. In other words, we are not open to alternative constructions and these blinkers can restrict how we see ourselves in the future and could limit our ability to change.

### **Emotions and change: threat, fear and anxiety**

Kelly's conceptualisation of these emotions differs from the more usually accepted ones (e.g. emotions as 'hard-wired' physiological responses to danger, etc.). Kelly re-conceptualised some of the emotions in PCP terms, providing us with a more psychological understanding of these experiences than previously existed. His conceptualisation also emphasises the role of meaning making. According to Butt (2008, p.44), Kelly contended that what we call emotions are our experience of transitions in our construct system. Threat, fear and anxiety are particularly relevant to change and therefore worthy of focussing on in more detail. Kelly saw threat and fear as responses to an imminent change to our core construing in the sense that we anticipate that we are going to have to change. People may resist a change in their construing and do this because any change will mean they would have to re-construe the sort of person they thought they were. Kelly (1955) defined threat as the awareness of an imminent comprehensive change in a person's core structures. He defines fear slightly differently, as an imminent incidental change in a person's core structures. This slight difference it could be suggested is only a matter of degree. That is, the difference between 'incidental' and 'comprehensive'. Kelly saw fear as relating to sudden, unknown or unfamiliar events.

A threat appears more severe (in PCP terms). This is because we anticipate being unable to continue to 'be' the same person as we were. This can affect our future choices and how other people see us. For example, the alcoholic who has always had a sense of self as a confident and popular person, providing they drink, may anticipate that they will become quiet and shy without alcohol. It is argued that fear

and threat are our experiences of recognising imminent change to our core structures. Both involve disruption to our core constructs. Often people assume that change is just a simple matter of deciding to do things differently in the future. However, everything will change, not just the aspects you want to change. A comprehensive change in a person's core constructs is what occurs in an identity crisis and one's views of oneself are shaken and need to be reconstrued. The emotions of threat and fear are two main emotions that may lead a person to resist change.

PCP sees anxiety as where a person becomes aware of certain situations that are not within their range of understanding or control. We are 'anxious' when we are unable to comprehend events. Subsequently, we cannot make sense of them using our existing construct system. When the world around us changes (or we are entering uncharted territory, like a new way of life) our construct system can sometimes no longer guide us predictably through events. The person cannot envisage the future. For example, a person who is told by the courts that they must (against their will) attend an AA group may be entering uncharted territory, being forced (in their eyes) to make a new sober life in which their present construct system does not give them any guidance and they experience general unease and anxiety.

### **Validation in Social Relations**

Relations with others are very important in PCP. It is a very social psychology in that it sees other people as directly implicated in the kind of person we can be. Validation is an important concept in our relations with others, especially when we are attempting personal change. We are constantly being validated by others and people are always involved in the maintenance of one's sense of self through validation. Validation does not necessarily mean others' approval, but rather that they confirm our predictions and, especially, our core constructs. In the case of personal change, we need support from others in order to validate our 'new me'. Who we are is therefore not just dependent on ourselves, it also depends on the other people we share our lives with. What we make of ourselves also depends on how others construe us.

### **Using PCP in empirical research**



PCP methods have their roots in therapy but are now increasingly used in research. The overall focus of PCP, whether used as a tool in therapy or in a research capacity, remains the same. The purpose is always to access a person's meaning-making systems, in other words, to understand a person's construal of the world.

Some PCP methods were devised to elicit bipolar constructs, for example, the Repertory Grid, which has predominantly been used in quantitative research. However, there are many other methods which are qualitative in nature and do not necessarily aim to elicit bipolar constructs. These include the Salmon line (Salmon, 2003), Pictor technique (e.g., King & Ross, 2004), self-characterisation sketches (Kelly, 1955), and Rivers of Experience (Lantaffi 2011). For example, the Pictor technique, derived from Hargreaves' (1979) work in family therapy, has been used to explore inter-professional working in health and social care settings, and the self-characterisation sketch (Kelly, 1955) has been used to study the impact of work placements on students' sense of self as professionals (Burr, McGrane, Sutcliffe & King, 2019).

There are many other methods that have been developed by PCP practitioners and researchers which have been used for both therapeutic work and for research. PCP methods have also been used to look at issues outside the remit of psychology. For example, Walker and Winter (2007) cite examples in organisational and business settings where PCP is utilized. PCP research with individuals within organisations has been seen in the work of Fransella, Jones and Watson (1988) in a range of applications within business and industry. PCP methods have also been adopted in research in the fields of market research, health and education.

PCP has been applied using existing qualitative research methods, notably in interviewing. These methods include techniques such as laddering (Hinkle, 1965) and Tschudi's ABC technique (1977), which aims to look at the reasons for people's resistance to change. The Kellyan interview can be seen as another method of researching. In a paper by Burr and Butt (1997) entitled 'Interview Methodology and PCP' they give an example of interviews conducted which were clearly within a PCP framework and show how the PCP interview can be used as a research method. They used a 'Kellyan' approach when designing an ordinary semi-structured interview. They had been approached by a chemical manufacturer to help with

evaluating a training programme for their supervisors. Burr and Butt saw the research as drawing on Kellyan principles. The interview aimed to adopt a 'credulous' approach drawing from the client's view of his world. A number of the questions were explicitly linked to PCP principles. For example, they asked "*what does a good supervisor do that a poor one doesn't?*" This question attempts to invite a contrast and therefore keys into the idea of constructs. Another question asks "*what were the biggest surprises when you started your job?*" to explore the PCP principle of anticipation. They also asked: "*How do you see your job changing in the future, and how do you feel about that?*". The purpose of this question was to establish anticipations and implications for future training. A Kellyan interview appeared appropriate for my study because it would allow me to ascertain the alcoholics' construal of their alcoholism in the past and to convey their aspirations and anticipations for the future. This would hopefully give me a greater understanding of how they saw the world looking through their lens.

## **Methods**

### The design of the study

The research adopted a qualitative, interpretive methodology. Bryman (2008, p.394) suggests that qualitative researchers, "*claim that their contextual approach and their often prolonged involvement in a setting engenders rich data*".

This level of rich data appears crucial in order to try and understand the world through the eyes of the individual participant alcoholics and their interpretation of it. The aim of qualitative interpretive work is to try and gain an in-depth account of the particular phenomenon in question (in this case alcoholism and the achieving and maintenance of long-term sobriety and of the meanings people attached to experience and behaviour). According to Lopez and Willis (2004), these meanings are not always apparent to the participants, but they can come to understand their own meaning by telling their story.

### Method of data collection

I decided to utilize semi-structured interviews with the aim of keeping the interview participant at the centre of the study and to ascertain their individual interpretation of the events which had affected their changes; as Bryman (2008, p.438) suggests, "*the emphasis must be on how the interviewee frames and understands issues and*

*events- that is, what the interviewee views as important in explaining and understanding events, patterns, and forms of behaviour”.*

The semi-structured interview provides, as Bryman (2008, p.438) also suggests, *“Insights into how participants viewed the world by having the qualities of being relatively unstructured”*. Further, it has the advantages of allowing for further elaboration on particular answers, because of its semi-structured, almost conversational nature. In a semi-structured interview, it was envisaged that there would be much more focus on the interviewees’ point of view, whereas in structured interviews, the interview reflects what the interviewer is concerned about. In addition, the relative lack of structure actively encourages the participant to depart from the researcher’s agenda in order to talk about issues that they feel are important to them. The participant is given the permission to talk about what is important to them and has personal meaning for them.

#### Designing the PCP-informed interview

An overarching principle that applied to the entire topic guide was that as Bannister and Fransella (1993, p.10) point out, *“persons differ from each other in their construction of events”*. Therefore, it was important to gain the participant’s interpretations of their experiences and an understanding of what they perceived as relevant in explaining and understanding behaviour and events. The research was interested in the meanings people attach to behaviour and the different ways people conceptualise change. For instance, did they construct different visions of themselves, which then carried them into the future? The guide always referred to the participant’s perspective and was not interested in what an observer may think is the right way or wrong way of dealing with a situation. Kelly (1955, Vol.2) talked about adopting a ‘credulous approach’ and ‘elaborating the world view of the client’. Therefore, it was important for me to not only acknowledge and take the participants’ stories seriously but to listen with the belief that whatever the participant is saying to me is ‘true’ when seen through their eyes.

Burr and Butt (1997) point out that participants may not find it easy to articulate their views and likewise it was thought that the alcoholics in my research may not have found this easy. Burr and Butt point out that the power of a PCP approach is in its usefulness in encouraging the participant to talk about important issues about

anticipation and change. It was anticipated both through my previous master's research in the area of alcoholism and sobriety (Westwell, 2012) and my own past personal experience, that the participants would have a story to tell. The topic guide began with an invitation to the participant to tell their unique story. This was achieved by utilizing an initial very open-ended question, namely, "*can you tell me your particular story of how you have achieved sobriety and how you have maintained that change?*". This question was to allow the participant not to be instantly pigeon-holed or categorised as a typical alcoholic but allow the participant to tell their own story that pertains only to them in their own way and in the order and pace they wished to tell it. Secondly, it was used to allow for the following up of any issues raised and for further expansion of these points. This first introductory question was intended to encourage the person to be reflective and stand back from their changes and evaluate how they feel and why. Following this question, a series of questions were asked, guided by a 'topic guide'. This guide followed a number of loosely defined topics to be covered.

A number of theoretical issues have broadly informed the development of the topic guide questions (the original topic guide which was subsequently altered following two pilot interviews is shown in **Appendix B**). These issues included encouraging the individual participant to convey their interpretation of their experiences and how they viewed themselves at the time. Secondly, successful 'change' was perceived as a planned event in the trans-theoretical model of DiClemente and Prochaska (1982). Therefore, one question to the participants looked at whether this notion was true for them. The guide also covered looking at the effects of others on a person's change and whether there were signs of any significant turning points, that is, experiences which had such significant meanings for the participant that they perceived them as instigators for the changes. Therefore, a crucial question included in the guide was to ask the participants what the experiences and events had meant to them. The guide also addressed the PCP ideas regarding anticipating and looking at the future, self-construal and validation. In addition, how did the participants interpret others' construal of the changes they had witnessed. That is, what did they feel other people in their lives thought of them now they had changed?

The topic guide asked questions such as "*what made you think you needed to change?*". This question was intended to encourage the alcoholic to express their

personal view of what things look like from their perspective and was important to them in their changes. A question which asked the alcoholic if they felt anyone helped or hindered them in their recovery was intended to look at possible contrasts between family and friends whom they perceived as being good for their recovery and those they perceived as bad. It also addressed the issue of validation (in the PCP sense) and other forms of support. Questions were asked to try and obtain the alcoholics' construing surrounding anticipations and implications for the future, for example, questions such as "how do you imagine your life in five years' time?". In addition, a question asked about how they felt others may potentially see them in the future and how they felt about this for example, "*how do you imagine other people will view you in five years' time?*". These questions looking at implications for the future were also intended to encourage the alcoholic to offer their perceptions of any issues which have arisen which they may not have anticipated. Some questions such as "*how do you feel you have managed to maintain the changes you have made?*" were intended to encourage the person to be reflective, stand back from their recovery and articulate how they feel and why.

Questions did not always follow the same order, and additional questions were used, and others omitted if thought appropriate. As Robson (2008 p.270) points out when referring to semi-structured interviews in general they may have:

*Predetermined questions, but the order can be modified based upon the interviewer's perception of what seems most appropriate. Question wording can be changed, and explanations given; particular questions which seem inappropriate with a particular interviewee can be omitted or additional ones included.*

#### Developing the inclusion criteria

My criteria were basically self-determining ones. Therefore, my aim was to include in the study people who had perceived themselves as previously having difficulties with alcohol. They perceived that they had now managed to overcome these problems. In order to achieve this aim, I was reluctant to use objective criteria such as DSM-5 (2013) criteria, however I felt it was useful to draw upon in my recruitment materials. Therefore, the participants voluntarily either included themselves or excluded themselves from the study. If the potential participant perceived themselves as having difficulties which they had now managed to overcome, this appeared more valuable to my research than me recruiting people based on objective criteria,

particularly when some of them may not subjectively see themselves as having a problem. Further, other people who may not fulfil all the DSM criteria may still see themselves as having difficulties with alcohol. Nevertheless, I felt that some of the features of the DSM could be useful in helping the participants to self-identify themselves as potential participants.

The definition of alcoholism, according to the latest DSM-5 (2013), can be condensed to the following key points:

1. Increasing quantities of alcohol are drunk over a longer duration than a person intended.
2. The person continually wants to cut down their drinking or control it, but this is unsuccessful.
3. Much time is devoted to either finding or recovering from the results of drinking.
4. The person craves drinking alcohol.
5. Persistent drinking begins to affect the person badly in their life at work, school or home.
6. Regardless of continuous social and/or interpersonal problems the person continues to drink.
7. The person relinquishes important work, social and leisure pursuits due to drinking.
8. The person drinks when it risks their physical health and well-being.
9. Regardless of their awareness that the drinking has more than likely caused them to have physical and/or psychological difficulties they continue drinking.
10. The person can increasingly drink more and more.
11. They suffer bad effects if they stop drinking too quickly.

The above features of the DSM-5 were drawn upon in the information sheet (**Appendix E**) distributed to prospective participants. The information sheet followed the DSM-5 insofar as it utilized a number of overarching points, such as the compulsion to drink (DSM-5 points loosely covered in 2,3,4,5,6,7,8 and 9) and the

lack of control over the drinking as a result (points 5,6,7,8 and 9). Later, the prospective participants used the information sheet details to make up their own minds as to whether they felt they were eligible to take part. The work involved a certain degree of trust (that the person had changed their lifestyle as a result of decreasing/withdrawing any alcohol intake). It did not exclude people who continued to drink but nonetheless clearly said that they had maintained lifestyle change. According to Peele (1995) and Prochaska & DiClemente (1992) total abstinence is not always necessary for recovery, therefore this possibility was acknowledged within the sampling strategy.

### The inclusion criteria

Prospective participants were deemed appropriate for inclusion in the study if they regarded themselves as previously having a compulsion to drink and felt it had become out of their control; they had experienced this for a period of at least five years but now regarded themselves as having successfully maintained a change in lifestyle for at least one year (with no upper limit). This one year of abstinence or reduction in drinking has been used in previous studies and is generally regarded as a credible criterion for maintaining sobriety (Yeh, Che & Wu 2009). No exclusion criteria were used.

### Sampling

The study used homogeneous sampling; this requires the selection of cases to further look at a particular group of interest. The group will have common characteristics. This is the opposite of using maximum variation sampling. A current debate within qualitative research is that between attempting to achieve homogeneity vs. diversity (Robinson, 2014). The homogeneity vs. diversity dilemma consisted of, firstly, to aim for a diverse sample which would offer me a wider sample range of participants which would reflect the geographical areas. Secondly, to choose a homogeneous sample which would offer a group of alcoholics who all met my inclusion criteria but may not include people from different ethnic backgrounds if they did not attend the groups. My sample was taken from those who all attended a self-help group because of alcohol issues. Robinson (2014) talks about a number of types of homogeneous samples including demographic, geographical, physical, psychological and life history homogeneity.

In this study a 'life history' homogeneous method of sampling was chosen because the research questions related to the specific characteristics of a particular group, i.e. alcoholics maintaining sobriety, who could then be examined in more depth.

Robinson refers to life history homogeneous samples as being those where the participants have past life experiences in common with each other. Eventually, it was decided that one of the aims of the research sample would be to achieve a certain level of diversity within the specific alcoholic population who fulfilled the defined inclusion criteria but also came from a variety of backgrounds having varying characteristics. I felt this gave me a better chance of capturing as many views as possible. This diversity was achieved by being aware of issues such as the age, sex, economic and social backgrounds, ethnicity, culture and geographical location of the participants. Therefore, I completed a matrix (shown in **Appendix H**) which gave me a guide as to the age, sex and geographical area in which the participants lived. I wanted to attempt to include as wide an age range as possible, therefore I chose not to exclude anyone on the basis of age. Further, I did not want to exclude anyone on the basis of any of the other factors mentioned above. I was also aware that my sample in terms of these factors would be heavily dependent on the mix of people who chose to attend the self-help group. Further, on this point I had hoped that by choosing these particular geographical areas there would be a mix of people from different ethnic backgrounds; however, there were no black or Asian attendees within the groups. The aim was to remain mindful of these issues in order to avoid ending up with participants all having very similar backgrounds in addition to them all experiencing the effects of alcoholism over many years.

A number of operating organisations within the North of England were considered as sources of recruitment for the study. The organisations were narrowed down to those who specifically dealt with alcohol recovery rather than more generalised substance-related organisations. It was thought that this would give me a better chance of recruiting a substantial sample from organisations specialising in alcoholism. Subsequently, the sample was drawn from one organisation, namely an Alcohol Advisory Service based in the north of England. In order to achieve the desired level of diversity, it became apparent that it may be wise to draw the research sample from the four different groups that this Alcohol Advisory Service had to offer. These consisted of both mixed and same-sex groups operating in different



areas of the North of England. The Alcohol Advisory Service ran a service based in two geographical areas (north and south) with two groups in each area. Both these areas had elements of economic deprivation and unemployment and both also had a relatively high population of ethnic minority Asian communities. The south area incorporated less deprivation than recorded in the north. It was deemed appropriate to sample both areas in case there were participants from other minority ethnic groups, e.g. black or Eastern European people.

For the study I aimed to recruit around 20 people. This was considered an appropriate number for the study. Referring to qualitative PhD studies using interviews, Bertaux (1981) suggests 15 participants as being the smallest acceptable quantity of participants for a PhD piece of research. Although this was not a large study, my professional and personal background experience was used as guidance as to the size of the study, and as Jette, Grover and Keck (2003) suggest, being experts in a particular subject may lower the quantity of participants required. The participants in my study may be regarded as having a form of expertise in the experience of alcoholism in the sense that they had lived this experience for many years and were therefore thought of by myself as 'experts' with in-depth personal knowledge of the phenomena of alcoholism. Lee, Woo and Mackenzie (2002) further suggest that studies using in depth interviews may need fewer participants. Lastly, my intended sample size of approximately 20 participants was expected to capture at least some of the diversity of people attending the groups.

### **The Alcohol Advisory Service**

The Alcohol Advisory Service was essentially four self-help groups. It was originally the idea of a local hospital-based consultant psychiatrist who had a particular interest in helping alcoholics wanting to achieve sobriety. It was a group set up as a registered charity funded by a Primary Care Trust. Originally, the psychiatrist would attend some of the meetings to offer general support and advice to the meetings and offer specialist medical input in terms of advice where appropriate. Since his death some years ago, the groups have continued with various members acting as chair to the groups, often assisted by a second chair. All the chairs to the groups have had their own issues with alcohol and the idea is that they can offer their experience to the group in an advisory capacity. On average across all four groups, approximately

30 people attended at each of their weekly meetings. Approximately 70% were male and 30% were female.

### **Gaining access to the groups**

Working in an environment with alcoholics who can be seen as a vulnerable participant sample can be very demanding. Therefore, in order to obtain the trust and acceptance from the participants, and gain access to them, I needed to negotiate slowly and carefully over a period of time. I feel this trust and acceptance was partially gained through my previous professional work (in the capacity of working as a qualified psychiatric nurse over a number of years and as a qualified social worker often working with alcohol 'recovery' organisations). This previous experience gave me an initial level of credibility and empathetic understanding with which to carry out the work. I felt the participants needed to be aware of what would be required of them, particularly regarding the time commitment and the possible psychological issues they may need to work through. Further information had to be offered on what the data produced would be used for and the need to be convinced as to my integrity. A letter asking for a formal agreement for permission to come and speak to the groups was made to the organisation's chairperson, who acted as the key gatekeeper to the organisation. This letter can be seen in **Appendix C**.

### **Recruitment**

After gaining formal approval in the form of a letter (see **Appendix D**) from the chairperson of the Alcohol Advisory Service on behalf of its various meetings to carry out a presentation to the service, a meeting was arranged to address the first two groups together in the south area. They had been told about my proposed attendance and told about what I wanted to ask them to do. At this meeting, 32 people attended who were all recovering alcoholics. They were all at different stages of overcoming their alcohol dependency. Some people were attending for the first time, whereas others had been sober for many years and had also attended the group for some time. The group consisted of people from all walks of life with ages ranging from people in their early twenties to people in their seventies and eighties. The meeting was held in a large open room with the chairs arranged in a circle. Following an introduction by the chair of the group regarding who I was, where I was from and the general nature of my proposed research, the floor was left open to me.

I had prepared copies of the 'information sheet' (mentioned earlier) and a 'consent form', which were distributed to the group at the start of my presentation (copies of the information sheet and the consent form are shown in **Appendix E**). The information sheet was presented first and the information within it was verbally explained to the members at the meeting. It gave the members some general details concerning the intended research and was presented to help the prospective participants decide whether to take part or not. It covered a short description of me, followed by details of the purpose of the study, what organisation was supervising the work, who could take part, issues relating to confidentiality, details regarding additional support available if required from another separate agency and my contact details. The group was encouraged to ask any questions regarding anything they regarded as relevant or were unsure about. The second part of my presentation consisted of me outlining the consent form. It was explained that the consent form would need to be signed before the interviews took place and only if the person felt comfortable about the details and understood them all. A question-and-answer session followed this part of the meeting. A further identical meeting was carried out in the north area with the two groups who met there.

### **Ethical considerations**

Full ethical approval for the study was gained from the ethics panel from the School of Human and Health Sciences, University of Huddersfield. A number of ethical issues were identified; right to withdraw (and how to withdraw data) confidentiality, anonymity, risk of harm and researcher support and safety.

### **Informed consent**

A consent form was asked to be read and signed only if the prospective participants understood that their contribution to the study would be entirely voluntary and that they were not obliged to take part. In addition, they were asked if they felt they had been fully informed about the nature and aims of the research and that they had the right to withdraw from the research at any time, including after the interview had been carried out and without having to give a reason.

### **Confidentiality**

The participants were asked if they consented to their words from the interviews being quoted (using a pseudonym) and informed that the information would be kept

by the university for five years. The interviewees chose where they wanted the interview to take place and where they felt comfortable in terms of ensuring their privacy and confidentiality. This resulted in both pilot study interviews (as outlined below) being conducted in the participant's own homes and the rest of the participants opting to be interviewed within the Alcohol Advisory Service establishments in both North and South geographical areas or at the University of Huddersfield. For any work which was audio recorded and written up verbatim, the data was kept securely on a password protected computer data base. Hard copies were kept in a secure locked environment.

### **Anonymity**

Identifying features such as names of participants or organisations concerning the study were anonymised through the use of pseudonyms. This level of anonymity was continued throughout the study concerning all reports produced and any verbal presentations. All data collected on any individual had all identifying features such as names and addresses deleted.

### **Risk of harm**

Within the development of the research study, there was a specific area of ethical research which needed addressing. This pertained to potential participant vulnerability. Vulnerability can be seen in the context of this study as meaning that the participant had a possibility of being emotionally distressed by the interview process. To this end, a completely separate organisation agreed to offer support in the event that any problem should arise. The organisation worked with people with alcohol problems and supported them in changing their behaviour. It provided help for individuals, families, and communities. The prospective participants were given information about the organisation within the initial information sheet distributed to each individual and were informed of the choice of whether to use the Alcohol Advisory group for this kind of support or this separate organisation. (See **Appendix F** for this organisation).

### **Researcher support and safety**

For my own psychological support I had developed a number of sources to support me in the research. This related particularly to how I dealt with issues which may be similar to my own past situation. These included two close friends, a social worker

and a clinical psychologist who supported me during my Masters study and a network of people who dealt in alcoholic related issues. In addition, I had the support of my supervisors for academic support and also the student disability support services. For my own safety at least two people were informed of when the interviews were taking place. For the two home visits, a person was outside in a car with a mobile phone.

Other than previously using the Alcohol Advisory Group for elements of my Masters research looking at alcoholism, I had not used this organisation for helping in my own sobriety for over 15 years, therefore I did not see any conflicts of interest in the work.

### **Pilot study**

Two pilot study interviews were conducted in order to refine the interview topic guide where necessary. The participants were both self-identified alcoholics who I was made aware of from previous personal experience but had not actually met before. The pilot participants chose to have the interviews in their own homes. One male and one female participant were chosen. The male participant 'Chris' (pseudonym) had abstained from drinking for over thirty years and one female 'Martha' (pseudonym) had abstained for a much shorter period of just two years. Martha had not attended any formal alcohol groups for help and had only used a religious group as a form of support and advice. Chris had attended a number of groups over the years, including various branches of AA (both in England and abroad) a Buddhist group and many non-medical therapeutic alcohol help groups. In addition, he had used medical help, including hospital in-patient care and community care services. Neither of them had attended the Alcohol Advisory Service used for the rest of this research.

The purpose of the pilot study was to look at the interview process and whether it was meeting the needs of the research questions. Secondly its purpose was to look at my own performance in the interview situation and whether there was scope for improvement. It was recognised that following the pilot interviews, further questions were needed. One of these related to past change attempts and another question related to maintaining change. This revised topic guide is shown in **Appendix G**.

The questions relating to past change attempts were primarily used to gain some preliminary information about whether these past change attempts had helped or perhaps hindered the person in achieving sobriety. Secondly, they were used to try and gain information about whether any methods or therapeutic resources had been tried; for example, GP services, community-based services or hospital-based services, or whether other self-help groups such as AA had been tried. Lastly, they were used to gain information about why these services had not worked.

The question relating to maintaining change was added to attempt to specifically focus on not only achieving sobriety but maintaining sobriety. As the two pilot interviews did not come from the same advisory group as the main sample, it was thought wise not to include them as part of the main sample.

Relating to my own performance in the pilot interview situation and whether there was scope for improvement, I thought it was necessary for me to develop my listening skills, such as reflective and clarifying techniques. This was true particularly when the participants' answers might not have appeared clear enough or it was deemed further expansion of their answer would be of benefit. As a result, I felt that repeatedly listening to and reading the transcripts of previous participants would improve the future style of the interviews. It was thought that this may be possible by making myself more aware of potential areas where prompts have worked in the previous interviews and where further clarification may be required at times.

## **Procedure**

Permission was granted for me to conduct the interviews on each of the organisation's premises. The setting appeared appropriate for private one-to-one interviews. Both the buildings consisted of large meeting rooms and smaller offices which allowed for more intimate conversations. The participants were welcomed and asked if they would sign the consent form giving me permission to go ahead with the interview. A private office situated away from any other groups which may have been operating on any particular day was offered by the group to be used as and when necessary for the interviews to take place. The room was comfortably but basically furnished with chairs and a table for writing notes. Tea and coffee facilities were also available. The participants were also given a short briefing about the expected length of the interview and reminded that the interview would be recorded. They were

reminded about their right to withdraw from the interview at any time during the process. After the audio recorder had been switched on, the interview began. Following the interview, firstly, they were asked if they had anything else they would like to tell me and, secondly, they were given time to ask any questions about any of the interview process or questions which had been asked. Lastly, they were reminded that a summary of the research would be available for them (upon request) to look at when the research was complete. The interviews lasted for between 50 and 90 minutes each.

For an outline of my participant sample and a summary of their details please see **Appendix H**. Below is a breakdown of some of the key basic details of the participants, followed by a table further summarising the details.

### **Summary of participants' living and working arrangements, age of starting drinking, relapses and support**

Eighteen participants were interviewed. Three of the participants lived alone. Fifteen of them were either married, living with a partner or a dependent. Three of the participants did not have any children.

Regarding employment, three of the participants regarded themselves as high functioning alcoholics (they were dependent on alcohol, but they perceived themselves as functioning very well in society). One of these had now retired. Eleven of the participants were working either full time or part time. The remaining seven were either retired or not working at the time of the interviews.

Of all the 18 participants, only three said they started drinking at or over the age of 18. Eight participants were fifteen or under when they started drinking, two said they were 13 years of age.

The interviews indicated that the majority of participants had relapsed in the past. Only one person felt they did not have any family to support them. Regarding support from their GP, two participants said they had never consulted their GP regarding medication and/or advice.

All the participants were still attending the advisory group which was the focus of this study. Two participants had also attended only one AA meeting in the past and two participants had been to two meetings. They chose not to continue, feeling that AA was either too religious or they did not like having to wait before they could speak.

Another participant was currently attending both an AA group and the advisory group at the same time.

Participants talked of NHS hospital admissions as a result of their alcoholism, with two reporting long stay treatment, one under a section of the Mental Health Act. Two participants had received private hospital care. Two received private counselling sessions and two went on anxiety and stress training courses.

The most recent abstinence period per participant was between 2 and 10 years, with a mean abstinent period of 6.19 years at the time of the interview. The participants may have tried numerous ways of changing in the past and had various relapses. Therefore, their choice to change refers to the decision that had led to their period of abstinence at the time of the interview. Therefore, the findings need to be seen as a snapshot of the participants journeys to sobriety in the context of their often difficult and complex routes.

### TABLE 3 Summary of participants' details

Key to support (in addition to this self-help group: GP = General Practitioner, AA = Alcoholics Anonymous, Priv. H. = Private Hospital, SHG. = Self Help Group, Priv. re = Private Rehabilitation, C = self- help Courses looking at anxiety + stress management, S. = Sectioned under MHA, RO= Religious Organizations, H = Hospital

Participant	Relationships	Children	Employment	Age when started drinking	History of relapse?	Type of support	Yrs. Abstinence at interview
Mick	Married	2	Full-time	13	Yes	GP	8
Kath	Single	2	Not working	13	Yes	GP, AA	4
John	Married	3	Full-time	18	Yes	GP, Priv. H.	10
Neil	Married	2	Retired	19	Yes	GP, Self HG	10
Kevin	Divorced	0	Full-time	15	Yes	GP, Priv. re	3
Mark	Married	4	Not working	15-16	Yes	GP	4
Susan	Widowed	2	Not working	14	Yes	GP, C.x2, SHG	3



Tracy	Married	2	Not working	16	Yes	GP, AA	8
Tony	Widowed	0	Part-time	15	Yes	S., C.x2,	8
Frances	Married	2	Retired	17	Yes	GP	5
Tom	Married	2	Full-time	14	Yes	RO,	10
Lisa	Married	3	Retired	25	Yes	GP, H,	7.5
Mathew	Divorced	5	Full-time	15	Yes	H.	4
Jane	Single	1	Full-time	15	Yes	GP, AA	6
Janet	Married	1	Full-time	17	Yes	GP,	8
Bob	Married	2	Part-time	16	Yes	GP, H	6
David	Partner	0	Full-time	15	No	None	5
Harry	Married	2	Full-time	17	Yes	None	2

### **A reflexive note on the interviews**

Crucial to my Constructivist position was my ability to adopt a reflexive approach with the research. In order to achieve this reflexivity, I needed to locate myself as the researcher within the context of my research and acknowledge that:

It is recognised that the closer our subject matter is to our own life the more we can expect our own worldview to enter into and shape our work (Shah, 2006, p.211).

Therefore, I was aware that my own past experiences would influence my research. Constructivist qualitative researchers regard their data as always a co-construction between researcher and participants. Nevertheless, it is still then the case that I needed to reflect on whether my own past experiences were influencing my interpretation too much. As a result, I needed to be fully aware of my own values and possible biases, the possible implications of some of my decisions, and my personal presence in the situation I was investigating. For example, when I was collecting data from the participant's interviews and particularly when analysing this data, I was conscious of the pitfalls of my own experiences possibly influencing my decision of what was relevant in answering the research questions. For example, what may have appeared to be considered merely a peripheral piece of information may have been later seen as a valuable piece of information. There was a danger that I may see things that are influenced by my own experiences of alcoholism, and I needed to be aware of this. Nevertheless, in order to be reflexive, I continually looked back at

my own experiences of alcoholism and questioned myself about whether I was just placing my experiences on to their experiences. Further, I looked for differences from my own experiences and actively sought to cover all the participants' experiences.

The actual process I went through involved me completing numerous readings of the interview data and my subsequent interpretations, this in itself constituted a form of reflection. This enabled me to challenge the previous interpretations and reflect and revise them. It also enabled me to examine my own experiences of alcoholism and how they may have influenced and shaped the way in which I interpreted that which was said (Mauthner & Doucet, 2003).

One of the advantages of me having a history of a drink problem was my capacity to share my own experiences with the group when I was initially recruiting people to take part in my research. I felt this was an advantage insofar as the group could see that if they chose to take part in the interviews, I would not be expecting a doctor/patient relationship but more of a peer/peer relationship.

King (1998) suggests that in order to complete qualitative research successfully, there is a need for the researcher to be reflective. As a result, I felt there was a strong requirement for me to look and reflect on the nature of how I have gone about my personal involvement in the process of the research. Subsequently, I have acknowledged my position on a personal level as a person who has now abstained from alcohol for over twelve years, as outlined in the introduction to this thesis.

Throughout the study, I have acknowledged the feeling that I have, to a certain degree, 'insider knowledge' of the phenomena of alcoholism. This situation has had to be balanced with the aim of being an effective researcher striving for a type of subjective truth. My early involvement in self-help groups because of my own personal issues with alcoholism introduced me to how they operated. These groups included numerous branches of AA and the self-help group I recruited from in this study (albeit over 15 years ago). To a large extent, I feel this allowed me to gain a certain amount of trust, acceptance and credibility with the prospective participants and gatekeepers to the group. This level of trust, acceptance and credibility, I feel, was gained through becoming part of the alcoholic community and being, as they said, 'the same as them', with similar problems as well as similar hopes, fears, expectations and aspirations. Over time I feel I gave the participants some

assurance that I was part of their community and that this research was being completed for the benefit of the group as a whole. One of the main ways of gaining this trust was to be consistently honest and to share my own problems as well as listening to theirs. During the interview process, I became aware that I was also a person attempting to change my own way of life. It is acknowledged that the people attending the self-help group when this study took place were an entirely different group of people from when I attended the group 15 years earlier and all of whom were not known to me prior to the study. Nevertheless, when moving from a position of a person needing help and advice as a fellow alcoholic, I now felt I was playing a dual role. This position was both as a group member and as a researcher 'looking in'. This made me feel like the goal posts had been altered to a certain extent. It felt in some ways like 'a poacher-come-gamekeeper' scenario or a convict advising on a prison governors' meeting. This could have had the effect of making the participants mistrust me. However, I felt my past experiences of alcoholism, which I had made clear to them, appeared to have the opposite effect and developed trust in my reasons for completing the study. It made me realise that as a researcher you cannot expect people to always welcome you readily with open arms and you cannot demand this level of access. Both the general members and the participants were involved because they were helping me and not the other way around. This view on the situation I feel hopefully continued in my analysis. There was a need for me to be very mindful that I did not let my own personal past experiences of alcoholism unduly influence how I interpreted the data I collected.

## **Analysis of the data**

### Choosing an approach

There were two approaches which I considered to conduct this study, namely, Template Analysis (TeA) King (2012) and Thematic Analysis (TA) Braun and Clark (2006).

According to Brooks, McCluskey, Turley and King (2014) both King's TeA and Braun and Clark's TA have an emphasis on flexibility and the development of a hierarchical coding structure. However, they also have differences. In Braun and Clark's version of thematic analysis, the development of both themes and a coding structure take place after the initial coding of all the data, whereas in template analysis it is normal

to produce this initial structure of the template having only coded a proportion of the research sample. Themes are defined late in the process within Braun and Clark's TA, in template analysis themes are often produced much earlier at the initial template stage. This can act as a guide to future coding and the development of the template. In TA, Braun and Clark do not specify the number of levels of coding however, it is usually one or two levels of sub-themes. In the TeA approach they often utilize four or more levels.

After considering the attributes of each method, I finally decided to opt for TeA as my preferred approach for the following reasons:

TeA is compatible with many epistemological positions, including constructivism. Therefore, it could be used in a constructivist position similar to my own, whereby the researcher assumes that there are always a number of ways of interpreting an event and approaching a topic from varying perspectives. Further, as I was becoming more and more aware of the complex nature of alcoholism recovery, I needed an approach that could cater for and capture the details of the complex subjective narratives of my participants. Therefore, I anticipated I may have needed four levels of coding as suggested by Brooks, McCluskey, Turley and King (2014). In addition, according to King (2012), TeA commonly can handle between twenty to thirty participants. As I had 18 transcripts to analyse, I needed a clear, structured, and systematic approach for the analysis and TeA appeared to offer all these features. The structure and level of detail in the template would allow me to keep track of the themes emerging and give an overview of how the work was progressing, therefore, preventing me from losing sight of my original research aim.

#### Brief overview of TeA

TeA is a technique aimed at organising and analysing data thematically. The key feature of TeA is that the researcher produces a list of codes placed on a template which represents the themes identified from the data collected from research participants. The template is arranged in a way which encapsulates the relationships between the themes which have been identified by the researcher, often involving a structure which is hierarchical in nature, i.e. using a numerical system to identify themes, sub-themes and sub-subthemes, etc. King (1998) comments that in this form of qualitative analysis an initial template is produced after a proportion of the

total interviews have been completed, for example four out of twenty completed interviews. This first template is then applied to each of the remaining interviews in turn in order to analyse the text. The researcher works systematically through the full set of transcripts to identify sections of the text which are interpreted as relevant to the researcher's research aims and marks them with one or more relevant code(s) as guided by the initial template. As a result of this process, any inadequacies in the initial template will become apparent; therefore, these will involve revisions being completed. These revisions may involve inserting new codes which are not covered by the existing template. Further, the initially defined codes may be deleted either because it is found that they substantially overlap with another code, or it just appears to have no use. Revision is also necessary where it is found that the code was too narrowly or too broadly defined to serve any purpose. Lastly, codes may need to be moved either up or down the hierarchical structure of the template or moved into a different place altogether. Revisions of these kinds will need to be made after coding each successive interview. At the end of the process the researcher needs to revisit all the interviews and re-code them using the final version of the template.

#### Development of the template

Brooks, McCluskey, Turley and King (2014) comment that Template analysis often, though not always, begins with a number of *a priori* codes which are strongly expected to be relevant to the analysis. For my first attempt at template analysis, I decided to use some *a priori* codes. To this end, **Appendix I** shows this first attempt at providing a list of suggested codes to use. In order to achieve this list, I utilized my own personal past experiences of alcoholism and my experiences whilst nursing and as a social worker. This gave me six *a priori* themes to work from in advance. However, on reflection, I became increasingly aware that my first attempt at producing *a priori* codes was in danger of just reflecting my own experiences of alcoholism. However, my goal was trying to gain the participants' individual perceptions. Subsequently, I felt this would not offer any meaningful contribution to the work. In my case, the *a priori* codes did not really help me to organise my work in a way that had the potential to thoroughly bring to light the psychosocial issues that were evident in the change process. It was felt that using *a priori* codes could unduly influence a situation that requires the analysis of the stories of participants without

making too many assumptions about their transitions or change processes. Therefore, my initial thoughts of using *a priori* codes were later rejected. In addition, this decision was made because it was felt that by creating *a priori* codes it would go against my PCP principles of keeping the work as close to the participant's interpretation as possible and not to be influenced by my own or others' thoughts. Secondly, another PCP principle which I acknowledged was that there are always multiple interpretations to be made of any phenomenon. Further, as King (2012) suggests, a researcher using Template Analysis from this position would likely take a bottom-up approach to the development of the template and therefore would be less likely to use any *a priori* codes. In order to ensure the data was addressing my research aim I always kept them at hand throughout the process.

Following the interviews and the production of corresponding transcripts, my next task was to devise an initial template. King (2012) suggests that normally this is completed after the coding of a sub-set of data.

My study participants had come from varied and diverse backgrounds, and I wanted to acknowledge some of this diversity in my initial template. In order to do this, I looked at four of the completed transcripts. The transcripts consisted of a male and a female participant from the north area and a male and a female from the south area. Their ages ranged from 32 to 72 years. Their present abstinence periods ranged from three to ten years. Further, they had varying occupational backgrounds, including a social services residential worker, a former university lecturer, a former secretary, and a building society employee. To help me in the process of fully immersing myself in the thoughts and feelings of my participants, I read through the printed transcripts several times, quickly at first, then at a slower pace in order to thoroughly familiarise myself with the data. Once I was satisfied that I was fully conversant with the transcript's contents, I began highlighting particular words and sentences (by hand) which I felt may be relevant in terms of answering the research questions. After further reading, I began to write short memos and comments in the margins of the transcripts to help me highlight points of initial interest and possible relevance. This was my first level coding. **Appendix J** shows a segment taken from one of the interview transcripts (Mick) complete with rough early comments written in the margins. These comments were my first impressions of the interview. At this

stage, the comments from all four interview transcripts were written on 'post-it' stickers. These were later referred to as my early tentative 'codes'.

As a result of this initial work, I was able to construct an initial 'list' of codes. These were not simply noted because of the frequency with which the same words or sentences were being used, but because in my judgement, they were more relevant in answering the research questions. On occasions, 'lone' single quotes or quotes and ideas said by only a few people in the interviews were included as codes if they were deemed to be possibly useful. As King (1998) commented, if a sole participant makes a comment which appears to be useful, the researcher can produce a theme which encapsulates it and include it in their template. King also commented that with qualitative research in general, there is a need for the researcher to be reflexive in their work. Therefore, it was felt important for me to reflect on my contribution to the process of the research and how it has influenced the study. In looking specifically at data analysis, reflexivity was important here in terms of me not dismissing key statements and comments because of my own previous experiences of alcoholism. Therefore, if I was in doubt, I included the words, comments, and subsequent codes. At this stage, I was conscious not to try any hierarchical coding or produce sets and subsets, but to simply place the ideas in a simple list. **Appendix K** shows a segment of the typed list of the potential codes drawn from these initial four transcripts.

Following this first level coding of the transcripts, the next stage of the analysis was to begin to arrange the template. This was achieved by simply moving the stickers around on a large table and arranging the codes into clusters that I had interpreted as having some relevance in answering my research question, i.e. the role of personal meaning in achieving and maintaining sobriety. The third stage of the analysis was to bring these clusters together under higher order codes. These were used to describe the broader themes that had been identified. A simple word document was used to show this work.

**Appendix L** shows the initial template produced (1<sup>st</sup> iteration). At this stage of the work, I felt like it was very much at its infancy and that on reflection, many of the working theme titles identified in the 'columns' didn't achieve any real understanding of the change process. For example, titles such as 'past' 'present' and 'future' did not really tell the reader much information or tell a coherent story. Further, it did not show any form of hierarchical coding or numbering in its structure. After further

thought, this template was put to one side. A second iteration of the template (**Appendix M**) produced an outline which I felt may have the ability to produce information which was much clearer in terms of focussing on the two main research questions. It also began to indicate the beginnings of a coherent story. Note that the template includes a numbering system set against the codes produced. This method of coding the themes incorporated higher order codes forming a hierarchical structure to the template. This template was then used to code all the other transcripts. The 4<sup>th</sup> interview transcript ('Kath') is shown as an example of a completed transcript together with highlighted areas of interest, written 'memos' and numerical coding corresponding to iteration two and completed again to show its development in iteration 15 of the template. This is to show how the template developed from virtually the start to finish shown at **Appendix N**.

On reflection, following even closer scrutiny of the work produced to date, I felt another interesting development may be to attempt to produce two separate templates. These templates would attempt to differentiate between the stages in the stories of the participants. One of these stories would relate to achieving sobriety and the other to maintaining sobriety. The reason for this was in order to test out whether this would allow for a much clearer focus on the two main research questions of a) achieving and b) maintaining sobriety. On reflection, the issues perceived by the participants as relevant to achieving sobriety may have been different from those seen as relevant to maintaining it, therefore it was thought that two separate templates would allow for these differences to emerge and this point was reinforced by one of the participant's comments where he stated, "*I found good reason for staying stopped and I think that's slightly different from just stopping.*" Therefore, I decided to produce a third iteration which could hopefully address this issue (see **Appendix O**). This third iteration involved developing two separate templates addressing 1) the participants achieving sobriety and 2) maintaining the sobriety.

The idea of two templates was compatible with King's views (1998), where he suggests that you can have more than one template for a single study and particularly where people's different perceptions and experiences may not be adequately captured through the same structure of themes. It also allowed me not to get easily distracted by other more peripheral drinking issues which were recorded in



the transcripts and which the participants would sometimes stray towards. Using the two templates, I was able to revisit my initial 'list' and identify themes which had a specific focus on each of the two issues involved in my question.

However, when the two templates were looked at closely it could be seen that in many areas the overall themes of 'achieving change' and 'maintaining change' were very much overlapping and it was difficult to clearly differentiate between what could be seen as purely an 'achieving sobriety' issue and that which purely involved 'maintaining sobriety' for the individual. Apart from the very early aspect of choosing or making the initial decision to change the issues in achieving and maintaining change appeared similar and the same issues arose in both templates. It is suggested that this indicated that transitions to sobriety for participants were often a gradual, complex and messy process. For example, reference is made to participants stating that their families had encouraged them to change and become sober by taking them to the self-help groups, getting involved in the self-help groups and showing their approval when the participant had been deemed to do well. Participants felt this was a continuing process that had taken place over the years. Therefore, I felt it was not wise to try and classify these events into either 'achieving sobriety' or 'maintaining sobriety' when they pertained to both.

It became apparent that the issue of codes crossing boundaries similar to this ran through the whole 3<sup>rd</sup> iteration. What appeared to be developing was the participant's perception that the notion of 'achieving sobriety' and 'maintaining the changes' for each individual had different timescales with different events having different meanings to that individual. As a result, I decided that although the attempt to separate the issues into two separate templates was useful in serving as a learning point, it did not really serve my further purpose. Therefore, in the 4<sup>th</sup> iteration, I reverted back to one template. The areas of the template shown in black, bold italics indicate their origins from the 3<sup>rd</sup> iteration where they had been placed in the 'maintaining sobriety' template and the areas marked in plain black had been previously placed in the 'achieving sobriety' template. It is suggested that this indicates the difficulties a researcher could fall into if they persisted in attempting to find clearer demarcation lines. For example, attending a self-help group can be seen as both a method of achieving sobriety and maintaining the changes.

This 4<sup>th</sup> iteration appeared to be now capturing a better range of psychosocial issues I felt needed addressing and were becoming properly thematic and coherent in nature. However, I felt the template could be further improved by moving the 'extent of planning' codes into a new higher code entitled 'recognising the need to change' indicating its higher level of importance to the participants. Further, I felt that the section looking at 'basic maintenance techniques' shown at theme 7.0 in the 4<sup>th</sup> iteration should also be moved under the higher code of 're-construing the change process' in the 5<sup>th</sup> iteration. This simplified the template down to just five sections rather than the seven seen in the 4<sup>th</sup> iteration. In addition, some further new codes were added to the 5<sup>th</sup> iteration following the reading of the extra new transcripts. These new codes included issues under the headings 'missing family support' at (3.2.2.4), group hindering change at (3.7.5), sense of being in control (5.2.3) and 'the decisional balance' was added to (5.4.1) indicating further that choosing to change did not always appear easy for the participants. At this stage, fifteen of the interviews had been coded.

In the 6<sup>th</sup> template, it felt appropriate to change some of the headings used to more descriptive headings as used in PCP theory for example, 'validating or not validating the new sober me'.

In template 7 there were some minor changes in order to better describe what the participants were saying to me in terms of how their experiences were now telling them that their future may be different from their pasts, and they could now envisage their new self as a result. In reality at this point, they had not actually 'moved' but had imagined and anticipated the change.

The 8<sup>th</sup> iteration also had only minor word changes such as 're-construing others' to convey how the participants were now seeing other people through a different lens now they were not drinking. Further, in the 9<sup>th</sup> iteration, the words 'maintaining a common construction of the relationship within a group' are used as I felt this more closely adhered to a constructivist and PCP theoretical framework and the sense of what the participants had expressed to me.

In template 10, there are further minor word changes and a simplification of some of the headings. In the 11<sup>th</sup>, I wanted to further reflect the PCP influences of the

research completed; for example, using words such as 'choosing to change', emphasising the notion of choice and personal autonomy.

In the 12<sup>th</sup> iteration, there were a number of changes including omissions, codes moving and new additions to the wording. The purpose of these changes was again to simplify and make the participants stories more coherent and to better describe what the participants were saying.

In the 13<sup>th</sup> iteration, as well as minor changes, the issue of stigma is added as this appeared to be an important issue upon closer scrutiny of the transcripts. Further, it also includes much more direct and poignant theme changing from a much more generalised 'personal health concerns' to 'health, death and the need to drink' which were the specific issues concerning the participants rather than just health in general. It is also now much more specific, focussing on 'the role of family and friends in maintaining changes.

The 14<sup>th</sup> iteration talks of 're-construction' in the sense that the participants appear to be describing how having now been sober for some time were able to see themselves as successes whereas previously they could only view failure. Further, they were now able to stand back and reflect on the research process their individual journeys had taken them on. The 15<sup>th</sup> and final iteration of the template (**shown below**) further refines the re-construction acknowledging that they were really expressing notions of firstly re-construing themselves as feeling they had achieved some kind of success in their eyes and a degree of self-respect and self-belief now, they had maintained sobriety. They also had put across the notion of feeling more in control and a feeling of being more trusted. Further, they had changed what they valued in life which included both themselves and particularly family members. Lastly, they now felt they were able to look to the future as well as reflecting honestly on their pasts and could see that their change processes were not always what they expected.

## **TEMPLATE ITERATION FIFTEEN**

### 1. Anticipating a new sense of self

#### 1.1 Imagining the 'new me'

##### 1.1.1 Imagining a sober life / a life still drinking

##### 1.1.2 Imagining a confident self

- 1.2 Anticipations of *keeping a 'new self'* - aspirations to return to normality
- 2. Recognising and owning the need to change
  - 2.1 Being honest with myself: fear of change
  - 2.2 The desire to maintain or regain a lost reputation
  - 2.3 Health, death, and the need to drink
  - 2.4 Choice and planning
    - 2.4.1 Turning points, anticipating loss, and owning the decision to change
    - 2.4.2 Planning change
- 3. The role of social relationships in change
  - 3.1 Role of family and friends in maintaining the changes
    - 3.1.1 Family support for change
      - 3.1.1.1 Showing approval
      - 3.1.1.2 Practical help and involvement
      - 3.1.1.3 Not wanting to let family down
    - 3.1.2 Family and friends validating or not validating the new sober me.
    - 3.1.3 Re-construing and valuing relationships with others
      - 3.1.3.1 Re-construing events and people differently without drink
      - 3.1.3.2 Recognising others' praise and encouragement
      - 3.1.3.3 Recognising the effects of my drinking on others
  - 3.2 Role of self-help groups
    - 3.2.1 Learning strategies for sobriety from other group members
    - 3.2.2. A reminder to remain sober
    - 3.2.3 Helping and encouraging others in continued sobriety
    - 3.2.4 The group as a social outlet vs. dependence on the group
- 4. Reconstruction
  - 4.1 Re-construing self
    - 4.1.1 Being a success, gaining self-belief/self-respect
    - 4.1.2 Confidence and sense of being in control
    - 4.1.3 Feeling trusted
    - 4.1.4 Feeling more rational
    - 4.1.5 Change in values
  - 4.2 Looking forward and looking back
    - 4.2.1 Life to look forward to
    - 4.2.2 Change process wasn't what I expected

King (2012) suggests that one of the most difficult decisions to make when developing one's template is making the decision to stop. In order to do so, I firstly wanted to ensure that there were no sections of the text which had not been thoroughly read and considered for their relevancy in answering the research questions. As a result, there was a need for me to revisit the whole set of data contained in the transcripts together with the templates produced so far. Further, I revisited every transcript and re-coded them to fall in line with any changes. Although this was a time consuming and at times a frustrating process, it allowed for a rigorous scrutiny of the text. This process enabled me to ensure that the template structure all made sense and fulfilled its function of providing a structured and coherent 'plan' ready for the eventual writing up of the findings. A further aspect of the work involved me making lists of identifiable quotes that participants had said in their transcripts which showed examples of an overarching code or theme.

**Appendix P** shows the quotes taken from the transcripts relating to just a small section of the final template. This began to give me a clear audit trail of the work in the sense that the pseudonym of any participant and transcript reference could be matched to any quote and any line in the text. This information was invaluable in producing illustrative examples in the write up of the findings.

The following three chapters indicate my participants' complex journeys from alcoholism to achieving sobriety and then maintaining this sobriety over a longer period.

# CHAPTER FIVE: ANTICIPATING CHANGE

## Introduction

This chapter reports the findings from the first two themes of the template: 'Anticipating a new sense of self' and 'Recognising and owning the need to change'.

'Anticipating a new sense of self' describes how the participants moved towards change. For all the participants it began with 'imagining the new me', imagining and casting themselves into a new sober future, anticipating a new sense of self, a confident self. It also describes their anticipations of holding on to their new self and their desires to return to 'normality'.

'Recognising and owning the need to change' includes the participants feeling the need to be honest with both themselves and others about their drinking habits and discusses their fears of change. It discusses their desire to maintain or regain a lost reputation and their perceptions of their health, of death, and their need to drink. Lastly, it describes the issues and turning points involved in the participants making the choice between drinking and becoming sober and the degree of planning that this involved.

## Anticipating a new sense of self

This theme encompassed two sub-themes. Firstly, the participants were imagining their new self, their new 'me'. They imagined life being sober compared to their life still being drunk. In addition, they imagined being sober and still being a confident person. Secondly, the theme addresses the participants' views of themselves as anticipating keeping their new self and outlines their differing perceptions of aspiring to 'normality'.

### Imagining the 'new me'

The participants imagined two situations: one where they now experienced sobriety and the meanings this would provoke for them, and another scenario where they were still drinking and explained what this would mean for them. They also described how they imagined a new, confident self.

Mick recalled imagining himself as a new sober person:

***I knew it was just a matter of time before I would stop. I even pictured myself having stopped, the new me, all sober, walking down the street and feeling good about myself. Not pissed and meandering... great! I just needed to commit myself to putting my thoughts into practice.***

Mick has clarified and confirmed in his imagination the benefits of sobriety for him. At the time, he then needed to gradually prepare to put these actions into practice in the real world. It is a good example of Mick anticipating his possible future and projecting himself into this future in his imagination. Mick's imagination was enabling him to almost rehearse the anticipated future changes he was soon to put into practice in a real-life situation. He is rehearsing it in what he perceives as a safe way initially, that is, his imagination. He is almost testing out whether it works for him in his imaginary world. If it did work for him, he would try it out for real.

Mick also imagined his life still drinking:

***I could see myself living a life of misery, I couldn't look at myself in the mirror, without thinking this is me the man who has lost his wife, his friends, his job and his life all because of alcohol... I wasn't scared of dying believe you me... as you know... alcohol takes that fear away permanently but, as I said earlier, I was scared of dying in alcoholism so to speak... alone... and not being able to make any sense of things that had happened to me. I saw myself as not being able to make any sense or meaning of why I had been born in the first place, pointless really.***

The last sentence of this quote may illustrate Mick's anguish at foreseeing not being able to make sense out of his drinking experiences. He wanted to see some meaning which clearly was not there in his eyes. He found it difficult to face up to himself when he imagined the loss of his wife, friends, and job. Although Mick does not talk of shame, this is what he is indicating. He has feelings of shame just anticipating that this maybe his future if he did not stop drinking. In effect he was foreseeing being reminded of a shameful reality in his eyes, constantly looking back at him. His words 'believe you me' it is suggested, was Mick attempting to place emphasis on the notion that he really meant what he was saying and wanted to convince me about this. This emphasis was a clear indication that dying was not an issue for him *per se*. He is making a subtle distinction between dying, which he appears to accept, contrasted with dying 'in alcoholism' which he perceived as pointless with no meaning which did not make sense to him. Mick had not actually experienced this crisis but only imagined the crisis giving him early insights to prompt change.

In their past drinking lives, the participants often only felt confident in social settings when they were drinking. Now, some of the participants imagined not drinking and still feeling confident. For example, Tom confided:

***This thinking about what it would be like sober was when I would be about fifty... I was sort of practising in my head what it would be like in different situations like meeting up with my sister-in-law again because last time I saw her we had had a fall out because I had been a bit drunk... I imagined myself talking properly again and sensibly and it felt good... I also imagined doing a speech at a wedding sober and this thought scared me because I had done best man speeches but always under the influence of alcohol, a lot of alcohol.***

Earlier in the interview, Tom had commented about his lack of confidence in social occasions. In this quote it is argued, he has gained some confidence at least now thinking about being able to complete tasks that in his eyes would require an improved confidence.

Similar to Mick, Tom seems to be mentally rehearsing his future anticipated scenarios in advance. He appears to also imagine the negative aspects of change such as the speech scaring him if he had not had a drink and he was able to mentally rehearse these as well. Therefore, although he was still scared of making a speech, he had built up his confidence to imagine it as a realistic possibility without having to revert to drink.

Jane contrasted her thoughts in her imaginings to those in her real world:

***When I was coming round from the booze, I would sometimes go into a sort of daydream and began to imagine myself as a real confident person, but in reality, I knew I wasn't that confident really. I began to think that, if only I could kick the habit, I could be confident without the drink, be normal and not have to worry about whether I had showed myself up or embarrassed someone... and not have to worry that the effects of the booze were going to wear off. I would imagine these sorts of things and sometimes long for a time when I could be properly sober, sad really isn't it? At times, I would also imagine relapsing back to drinking. These thoughts really did fill me with fear.***

Jane talks of almost entering a dreamworld where her imagination is going into overdrive. She contrasts two different worlds. She draws a distinction between what she perceives as her real world where she lacked confidence but yearned for it and her imaginary world. In her imaginary world she sees the possibility of being confident without having to revert to drink. She feels she has the chance of being 'normal' and not making the social mistakes that have caused her embarrassment in



the past. She could be using her imagination to entertain the thought that she may be able to be confident without the drink in her real world. She appears to perceive that others who are not alcoholics would just see these levels of improved confidence as just normal, and it saddened her that they would just take it for granted. After all these positive imaginary thoughts, these are contrasted with her thoughts of relapsing which evoke fear. Similar to Tom, she explored these feelings and rehearsed them in the relatively safe haven of her imagination.

### **Anticipations of keeping a 'new self' – aspirations to return to normality**

When the participants were in their early stages of sobriety, all eighteen were adamant that they both anticipated and intended to hold on to and keep this 'new self'. They gave examples of aspirations to just return to what they perceived as 'normality'. Matthew said:

Well, I wish to live for a while yet and I want to continue to enjoy how I am now, just a normal carry on really. I want to continue seeing my family and watch them grow up... you know, just the normal things that people strive for when they are not 'propped up' with alcohol or any other drug for that matter.

Matthew appears to be happy and wants his new life to continue. He does not want the abnormal and false life he perceived drink had caused. He just wanted an authentic self not 'propped up' with alcohol. He equates his normality to watching his family grow up. Mark also perceives normality as being a happy family life. When asked how Mark anticipated his life sober, he confided:

It sounds a bit wet really, but just doing normal things at first. I am starting seeing my kids, who aren't kids anymore and cooking again instead of my wife doing it all.

Other participants also regarded returning to family life as normality. Frances recalled that, in her drinking days:

***My daughter and my niece who had two [children], had both told me they were not going to let me have their kids until I sorted myself out. They said they loved me but couldn't trust me... well I could have died there and then... but I suppose I still carried on having a tippie.***

It is suggested that Frances was expressing conflicting emotions and needs. Firstly, her upset at not being able to see her grandchildren because of her daughter's lack of trust, and her need to resume normality through her babysitting. This is contrasted

with her need to still drink. Now in her early days of sobriety, and doing what she perceived as normal things like seeing her grandchildren again, she confided:

The biggest piece of encouragement I got was when my daughter started bringing the kids round again... when they gave me responsibility like babysitting again and I began driving again, I felt my world was being put back into place.

Frances's last sentence in her quote, "*I felt my world was being put back into place*", suggests her return to a previous state of normality. She perceived this normality as including her being trusted and able to babysit again. It is acknowledged that Frances was still in the beginnings of her process of change at this time. Her reference to encouragement pertains to her being encouraged to continue with her process of change.

The above participants wanted what they individually perceived as normality. The perception of normality was somewhat different for each participant. For example, Matthew saw normality as just being able to watch his family grow up. Mark had similar ideas talking about seeing his kids and taking on some of the work of his wife, and Frances being given responsibility again. It could be argued that wanting 'normality' may have been perceived as a replacement for the chaos of their drinking lives.

The use of imagination has emerged as a key finding in the change process. The examples above may indicate that imagination could play a key role in a person's transition to sobriety. This includes the facility to imagine both good and bad aspects of possible future scenarios and being able to prepare for them, as in the cases of Mick, Jane and Tom. When looking from within a PCP framework, I would argue that these imaginings by the participants can be seen as an insight into the PCP process of 'anticipation'. The participants are anticipating their possible future self through the vehicle of imagination.

### **Recognising and owning the need to change**

This section is concerned with the different ways in which the participants began to see clear reasons why they perceived the need to change. It emerged that the participants had often been dishonest about the extent of their drinking. They cited fear, threat and anxiety about change as being the main contributory factors for this. Some participants talked of their need to maintain or regain a lost reputation and

they talked about issues which fell under the term 'stigma'. They expressed their views on the balance between their health, possible death due to drink and their perceived need to continue drinking at the time, contrasted with making the decision to stop. They acknowledged that their drinking habits were damaging their health and were aware that this could possibly lead to their death as a result. However, some participants still continued to drink. Lastly, they talked about their decisions to change and how they had planned or had not planned for this.

#### Being honest with myself: fear of change

The participants revealed that they had been dishonest both with themselves and with others including lying to those they were close to and their doctors. They had hidden alcohol and lied about their drinking habits. They lied because of the fear, threat and anxiety of their lies being discovered, but also feared the implications of sobriety for them. Harry expressed some of these emotions in the following quote:

***I was constantly aware that I was lying to both myself and my wife and the kids about my drinking. I was hiding my booze in the garage, the top of cupboard, the loft, a wall outside, you name it... I had so much fear, worry... anxiety... to be honest, I was shitting myself about anyone finding out. I felt threatened that one day I would be found out but... I also feared sobering up... I felt I desperately needed to man up to these fears of changing.***

Harry appears to be in a dilemma; if he continued to drink, he feared being found out in his deception, but if he abstains, he fears the consequences. He also perceives himself as possibly an inadequate man who is failing if he is unable to combat his fears of change. He has a need to now overcome his fears and perceives this to being a 'manly' task to achieve. In a further quote he states:

***I was still working as an accountant, so I had a lot to lose in that direction both in terms of the money and my personal reputation which I had tried to guard deeply all the time.***

This quote indicates that he was thinking about both the practical good reasons to change (his job and money) and his psychological well-being, for example, not wanting to lose his perceived status and reputation.

Other participants also recognised their need to change but also expressed fears about change, for example, Janet confided that:

***To be honest, I was scared of having to change my ways, drinking made me feel relaxed and comfortable, whereas walking around sober for evermore, put the fear of God up me. At times I realised eventually I needed to be honest with myself and stop lying through my back teeth about my drinking just because I am scared of changing what I have got used to.***

In the past, Janet was comfortable maintaining her status quo and continuing drinking. At that moment in her life, Janet perhaps feels it was 'better the devil you know' and was scared of changing her familiar way of life. She contrasted her drinking to sobriety. Regarding sobriety, she described this in extreme terms of 'putting the fear of God up me', whereas drinking equated to being relaxed and comfortable. This suggests that at the time Janet is referring to, she is still in a dilemma about which option to choose. Both options appear to her as having advantages and disadvantages and reinforced the idea that choice is not always easy. In PCP terms, Butt (2008, p.73) refers to choice as sometimes agonising. If a person construes two pleasurable options to choose from (for example a pizza or a curry) the dilemma may be relatively easy to solve. However, if the dilemma has marked disadvantages coupled with advantages this can be much more difficult. Tschudi (1977) working within a PCP framework, devised the ABC method in order to assist clients to articulate the negative side of what seems, on the surface and to outsiders, as a positive change.

John, an engineer with ten years' abstinence, recalled that:

***I was kidding myself and I felt so guilty about kidding her [his wife]. The kids knew I was drinking, and I knew this. I would try and overcompensate by buying an over- the- top expensive present when I was drunk. I suppose I was frightened and unsure of how I would cope in the sober world at first, so I refused to go there for ages. Instead, I hung onto what I knew best and carried on drinking.***

John was afraid of the unknown entity of change and took what he perceived as the easier option of not changing for a long time. Like Jane, he valued the familiarity and safety, in his eyes, of his drinking world. He took the view that it is better to follow the devil he knows, which is drinking. He perceived that this would make his future more predictable and safer for him. Butt and Bannister (1987) make the point that people will often choose not to change a problematic behaviour because it is familiar and safe.

Tom, a 64-year-old builder, remarked:

***Stopping could mean a major change for me. I thought it could change me into someone where I didn't recognise myself. Perhaps, a quiet soft type of bloke... I had always thought of myself as a man's man ye know, it was my image, my reputation.***

Tom's reluctance to change appears to be because he perceived sobering up had the possibility of him seeing a quieter softer side of himself, an image he did not want others to see. He believed he had a reputation as a "man's man" to keep up and sobering up could change this perceived notion of masculinity. Tom was scared of this possible change. He chose the devil he knew rather than abstinence at this time in his life. It is suggested that Tom perceives drinking as a masculine prerogative. Sobering up in his eyes would mean him running the risk of showing a 'softer' feminine aspect of his self which he didn't want people to see and could spoil his reputation.

The participants indicated elements of feelings of fear, anxiety and threat particularly where they were in periods where they were contemplating change. Due to these feelings, a number of the participants initially (before they had stopped drinking) wanted to remain the same as they had been in the past.

### **The desire to maintain or regain a lost reputation**

Some participants felt the necessity to change because they recognised their need to regain what they had perceived as their previous good image/reputation and credibility, before succumbing to alcohol. Others, like Harry, felt their reputation and/or their credibility was important to them, and they wanted to maintain it. There was a variety of different ways people valued their reputations. For example, some of the participants related it to their jobs whereas others saw it as pertaining to their reputation as 'a man'.

Neil, a former lecturer, confided:

I'm not rich but I could afford my slow suicide. I would have lost my partner, certainly my reputation... but you can get away with being a drunk... a functioning alcoholic but you can't get away with being a bum.

Neil creates a division in his mind between what is acceptable to him and what is unacceptable. Being a drunken, functioning alcoholic is acceptable, but not being considered a 'bum'. It is suggested that Neil perceives the ability to function (even if

badly) would be acceptable to him and arguably that he would be accepted by society as being 'normal'. He is also indicating what he thinks he can "get away with" in other people's eyes. If he was a drunk who was not doing anything worthwhile, he would be considered abnormal and have a discreditable status. It is further suggested Neil listed what he potentially would have lost if he had carried on drinking. In the 'list' he appears to perceive losing his partner on the same level of importance as losing his reputation. The evocative terminology used by Neil, in terms of describing himself as not wanting to be thought of as a 'bum', was also used by Jane:

I what do you feel would have happened to you if you hadn't stopped drinking?

*P Well I don't know for sure; I don't think I would have been on the streets; my family would have stopped that. If only to maintain their reputation... and I don't think I would have died... but I think I would have lost something that is very dear to me and that's my reputation in the outside world... I wouldn't have liked my guard to have dropped where everybody thought I was a bum... this would crucify me... I have a need to uphold my reputation*

I Can I ask you what your vision of a 'bum' is in relation to the way you have just described yourself?

*P A loser, a failure, someone you wouldn't want to know. To be honest, someone who, before I ended up drinking too much where it was causing me problems... I would have described as a typical 'alco'... with a cider bottle in a brown paper bag, sounds awful now doesn't it?*

Jane appeared to regard 'a bum' as a person who is a failure and equated this to a stereotypical alcoholic and a person that others would shun. It is suggested that she feared being ostracised from others if she did not change. She previously saw herself as this type of person but now sober, she sees herself differently as having a certain degree of self-worth and now fitting into her community. This is indicated in her following comments:

***I now think I am worth much more than this. I am back on district [nursing] and can hold my head up high when I am talking with my neighbours, and I don't think they are going to turn away and ignore me. They just treat me like all the other neighbours***

Jane now appears to see herself as back in her creditable employment and seen as 'normal' and accepted in her community.

Janet, a health authority manager, also valued her reputation:

***I suppose my past as a nurse and working as a manager for social services had given me the illusion that I had a reputation to uphold. I didn't want to lose this image I had in my head at the time that I was better than the normal alcoholic because I was still working, still functioning.***

Janet, in a similar sense to Neil, saw herself as a high functioning alcoholic (Benton 2009) because of her working in a high-status job whilst still drinking. Further, similar to Neil, in her eyes, she sees the ability to 'function' as the line she draws between someone who can maintain their reputation and those that cannot. She possibly feels she is at least holding it together on the outside as long as she keeps working and she feels no one is aware of the extent of her drinking. It is suggested this maintains her perception of herself as having a good reputation.

### **Health, death and the need to drink**

For some participants, concerns regarding their health were key to their decision to change; for others, any worries about dying were not an issue. We may assume logically that that if a person thinks and knows that their drinking may eventually result in their death, the person would take action to abstain from drinking. However, the examples below indicate otherwise. To many people it would seem obvious that if your behaviour is going to kill you, you change your behaviour because it is more important to stay alive. However, a PCP approach tells us that the problematic behaviour becomes understandable when we have insight into what the alternatives mean for people.

The participant's level and type of concern regarding their health and possibly dying due to drinking varied depending on the individual. Some participants were concerned about their levels of physical health but were not always over concerned about their mental health. Others were concerned about 'going mad' and others seem more concerned about dying, rather than anything else. Others were not concerned about dying through drink but would be concerned if they died of an illness which was unrelated to their alcoholism. Some of the participants said that in the past they had placed much more emphasis on their ability to be able to obtain

and consume alcohol rather than on what they saw as their physical and mental health. All the participants had long histories of drinking and had experienced stark reminders about their health from medical professionals in their pasts. For example, Kevin, a 37-year-old university-educated man presently working as a marketing executive, said regarding his health:

***I was still holding onto this idea of this coolness thing, the idea that it was cool to drink but there you go. I didn't give a shit about supping 'til I died, no, I liked my booze too much.***

***I wasn't particularly well. They thought I might have leukaemia, because it got to a point where I was covered in bruises. You could flick me, and I would literally bruise like that [shows arm] and that scared me, because I didn't want to die of leukaemia. The doctor said it's not good news that it wasn't leukaemia, because you're probably going to die quicker through alcoholism than what you would have done through cancer.***

These two quotes indicate that Kevin showed little concern about his deteriorating health or the possibility of his dying due to drinking alcohol, but he did show concern about dying through leukaemia. It is suggested that Kevin's perceived need and desire to drink at the time outweighed any health concerns. This previous prioritisation of drink over health is also shown by Kevin reflecting on his past drinking; elsewhere in the interview, Kevin had said:

***I used to wear it as a badge of honour being able to drink, because there were people who did manual labour and that, and then me that I felt came across as a bit academic and physically weak in a way, and the barman would say 'fuckin hell... watch this lad sup and I used to think that was brilliant because I thought at the time that I had impressed him.***

This quote indicates that Kevin was not really interested in his drinking damaging his health. He indicates what he sees as things that are meaningful to him and therefore take priority in his life. For example, he was more concerned with taking pride in his ability to drink substantial amounts. His perception of this was that it may put him on an equal standing with other men who did manual labour who he appeared to look up to. It therefore compensated, in his eyes, for his perceived physical weakness and poor image as an academic. It is suggested that by drinking heavily in this manner, he was able to view his behaviour as a much closer version of the identity of manhood he felt he wanted to emulate. It is also suggested that his repeated use of the phrase "badge of honour" when referring to his ability to drink, could also be associated to his personal ideal of being a 'manly hero'. It is suggested Kevin's reluctance to change at this time could be linked to his perceived need to see himself



as a 'real man'. Therefore, he could be seeing his heavy drinking capabilities as an opportunity for him to fulfil his whole life narrative as a 'real man' and to retain this as his preferred identity at the time.

Others only mentioned concerns about their health in terms of their mental health. This concern about mental health was expressed by Mick. He confided that he had worried about "going mad" because of his drinking, and he gradually became aware that he needed to change:

***I was not really thinking straight... my mind was all mixed up... I realised how pointless it all was and it was getting me nowhere... I realised something had to change like you do. I was vegetating, I couldn't think straight or work anything out rationally. I was concerned that I was going mad at the time. Yes, I had to change.***

Mick further described how he had worried about dying only if he was confused and disorientated due to alcohol. This had further given him the impetus to change. He said:

***What I did worry about was not exactly dying... because people would tell me this all the time if I didn't stop drinking, no, it was the fear of dying an alcoholic... where I was so pissed I didn't know what I was doing and just dropped dead in the gutter or something like that. These were things I imagined could happen to me and it scared me fucking stupid.***

Mick perceives that dying as a drunk would be an unnecessary and meaningless death. His strong language "it scared me fucking stupid" perhaps indicates his fear of dying in this way. This can be contrasted with Kevin's situation. Kevin was scared of dying of leukaemia but the thought of dying through drink did not appear to be an issue and was perceived as giving him some honour. For Kevin it meant possibly leaving this world (in his eyes at the time) as commanding a degree of respect and honour from his peers. Therefore, unlike Jane who feared being ostracised because of her drinking, Kevin felt that his heavy drinking was key to his acceptance with his peers at the time. Many of the participants initially drank to gain social acceptance but now did not drink because of the fear of being shunned by society.

### **Choice and planning**

Some of the participants were adamant that they had to feel they owned the changes themselves rather than trying to change because of the advice or coercion of others. They had made the choice to stop drinking when they had realised for themselves

that stopping was the only way forward for them. They often experienced low points in their lives which sometimes acted as turning points for them. In addition, they sometimes felt they were going to lose the relationships they valued if they did not stop drinking.

### **Turning points, anticipating loss and owning the decision to change**

Most participants said that, although they had experienced pressure from others to change, they felt they were ultimately responsible for making the decision to change. The participants described initially dismissing other people's views, including those of professionals in the field of alcoholism, unless it gave them a moment (or moments) of insight that change was necessary. They would often realise themselves that they had a problem but deny this to other people, including their families. In the following example, Mick is not denying he has a problem either to himself or others but wants to make his own decision to change. Mick expressed the view that when he was drinking, he felt he had almost developed an aversion to anybody telling him what to do. He confided:

***Well, you see, I had had enough of rules and regulations at school, where you were told what to do and it just made me worse and made me not want to do things even more. No, I needed to make up my own mind about how to go on in life and not be dictated to. It's my life and I needed to think for myself and not be preached to. A group like AA would have had the opposite effect on me ye know, make me drink more because they were constantly telling me that I must not drink.***

Mick had enough self-awareness drawn from his past experiences of authority to acknowledge that he was now to a certain extent anti-authority. He is almost allergic to attending a group such as AA as he perceives it as yet another authoritative 'rule making' body. Mick wants to be in charge of his own life, particularly regarding his drinking and his future decisions. He conveys the feeling that he needs this level of autonomy which in his past may have been missing. This may have resulted in him doing the complete opposite of what others asked of him or advised him to do. Further, this would give him some autonomy and freedom over his future choices. Researchers such as Miller & Rollnick, (1991) suggest that an alcoholic, in a similar way to any other person, will often do the very opposite of what they have been told to do. Their rationale for this is that it often occurs where a family member or a professional working in the field confronts the person aggressively and the person can feel threatened. In the following quote, it is suggested Mick had only initially

stopped or cut down his drinking to please others. He had therefore not fully accepted or committed himself to this advice. However, later in the quote, he strongly indicates that his self-help group experiences had given him insight and a moment of realisation that change was needed.

Mick explained that:

***Even when I first came to a [self-help] group here, deep down I still wasn't sure, I still wasn't committed, I was kidding myself and just attending to keep my family happy. In fact, in the first three months of attending, I was still having a drink and would turn up half cut, but it was still making me think out my own way forward on my terms. It just suddenly clicked for me proper this time! If all these fuckin people from all walks of life all with horrific tales about what has gone on in their lives with debt, illness, bastard separations and what have you. I would ask myself, how come they have managed to come here all clean smart and sober and, even more important, they appeared and said they were happy. It hit me like a ton of fuckin bricks I can tell you, it meant something special to me, I thought I need some of that and quick.***

The group itself appears to have given him a moment of insight that he needed to change. On this occasion, Mick had experienced other participants' troubled stories and witnessed their successful changes. This contrast in their fortunes had given him this necessary insight. He appears to have had a moment of self-realisation, "*it hit me like a ton of fuckin bricks*". It made Mick realise that he could have the potential to better his life, like others in the group had already done. He now also wanted to achieve the same as them as a matter of urgency. He still was not going to readily accept the advice of the group; this would take time. But he was beginning to acknowledge that the group offered a vehicle or platform in order for him to gradually work out his own ways to change and achieve autonomy. He changed on his terms and was in charge of the process. The group acted more like a platform for which he could solve his own problems rather than as an advisory group *per se*. He had a change in his perspective on what his future life could be by witnessing the other successful members of the group and he wanted the same for himself. Mick was seeing things that he had not seen before. It is suggested that this was a moment of re-construal.

Previously, he had construed other group members as just other alcoholics going through the motions of attending the group possibly just to please others. However, he had now re-construed them as valuable role models and he could envisage a

realistic chance of emulating them. He thought that as they were from a variety of backgrounds and if all kinds of people could do it why shouldn't he?

David, whose life revolved around football and his football friends, gave another example:

***I think a pinnacle for me was when my mates told me I was a pisshead, they had told me this a lot in the past but, I used to ignore them and put it down to just lads' talk. It was when I could see they were more than just angry with me if you see what I mean. One of them had pinned me against the wall and told me straight about my drinking and how it was pissing everybody off. I had nearly got them all into bother a few times with me picking fights I could not handle and them having to sort things out for me. This was a big turning point for me.***

Despite David having been consistently told that he was 'pissing everybody off', he appears not to have recognised any need to change at this stage. On first glance, this could be interpreted as denial if considered from a positivist perspective where he would be seen as denying an objective reality. However, from a constructivist viewpoint it is argued David at this point is construing his heavy drinking as merely doing exactly the same behaviour as his football friends. He therefore accepts that he drinks a lot but sees it as an acceptable part of his everyday culture of his peers, not as a problem. However, he later re-construed his perceptions of his friends. He began to realise the signs that his behaviour and their response to this behaviour could not just be regarded as merely 'lads' talk'. In this quote, David refers to this particular moment of anger as being a 'pinnacle' for him. This, it could be argued, means he regarded the moment as a turning point for him. He may have perceived this moment of anger as different from their usual outbursts, even though to other people it may have appeared very similar. Nevertheless, it is David's perception of the event that I was interested in and how it gave him insight to change. It is suggested that David recognised the support he received from his friends. He also began to realise his behaviour was affecting his friends in a detrimental way and he could possibly lose them. David realised that he needed to change in order to save something that meant a lot to him, namely his friends. David's re-construal of his friends' behaviour towards him had begun to head him towards sobriety.

Mick and David had both initially not taken much notice of others until they experienced a situation that evoked a moment of insight (Mick had not taken much notice because although he did not deny he had a problem with drink, he wanted to

make his own choices and decisions for doing something about it; David did not take much notice because he did not recognise it as a problem at this point in time). This insight appears to have given them the impetus to re-construe others and their drinking selves. That is, Mick seeing how others with similar problems to his own had managed to successfully change and importantly were happy about this, and David realising he could lose his football friends if he carried on drinking. Mick and David both said they remembered that they had experiences which had a profound effect on them, followed by what they recalled as significant moments of insight, which prompted change for them.

In the past, some participants talked of periods when they were drinking and felt they had no reason to stop. However, perceived moments of insight and re-construal of their drinking and relationships had gradually given them a change of mindset whereby they could now see good reason to abstain. For example, David confided:

***I couldn't really understand the harm I was causing because of my drinking. I didn't really see the point in stopping drinking at first. It was not until my head cleared of the stuff that the mist cleared, and I could see the point of it all.***

David began to re-construe his drinking problem and its effects on others, whereas in the past any damage he may have caused others was completely missed by him. He also began to see clear reasons why it may be beneficial for him to continue to change as he gradually achieved sobriety.

Other participants also talked about finding good reasons to change following moments of insight; for example, Lisa explained a number of reasons why she wanted to change and appeared to sum them up as wanting something better for herself:

***I wanted to get rid of the chaos and mess. I wasn't bothered about other people seeing me drunk, so it wasn't my image. It was more to do with me being fed up of feeling like I was feeling, that's what it was. I had got sick of the feeling, it was so bloody repetitive what I did, and it was pointless, and I wanted something better, it certainly wasn't about me thinking what others thought about me, it was what I wanted, I just knew that I wanted something better.***

Lisa found her own good reasons to change regardless of what others thought of her. Her reputation did not seem important to Lisa. This appears unlike some other participants. It could be reasonably assumed that “*chaos and mess*” was referring to

what she perceived her drinking had culminated in regarding the organisation of her life in general. It was her decision, and she owned this decision. Lisa was adamant this decision had not been evoked by what others in general may have thought of her. She was tired of her life which she perceived as following the same meaningless routines which were unproductive, and not achieving or taking her anywhere. She needed a stronger reason for living and she perceived moving towards sobriety as a way out of her old ways of living. Again, here she has re-constructed her drink problem and now wants a better life for herself where her life had a clear rationale to support the change. As she appears clear about what she wants and appears to own these choices.

It can be seen by the examples below that the family can be seen as very influential in the person's change. However, this influence is not about listening to and acting on the advice given by others. It was the anticipation of a potential loss or damage to these relationships which led to a moment of insight that in turn initiated the changes. For example, Neil a 72-year-old former lecturer in economics said:

***My partner [his wife]... told me I was an alcoholic and had a drink problem. Course, I came out with all the pat answers, you know, it's my problem what the hell are you worried about, always the counter argument. I always turned it round to, not my drinking but her reaction to my drinking. So that was the only person who confronted me about my drinking.***

Clearly, in this example offered by Neil, his wife had shared her feelings and concerns with him about his drinking. However, although Neil heard and understood what she said, he appears to have dismissed her concerns and avoided answering her questions. Neil may have been convinced that he could not afford to view his problem for what it really is. He is possibly denying the extent of the problem to himself and its effects on his wife. He perceives his wife's response to his behaviour as her problem, not his, as it would be too threatening to admit this to himself. Neil was arguably adopting the PCP concept of 'hostility' here. The PCP concept of hostility tells us that Neil may be trying to extort evidence from his drinking behaviour that validated his behaviour. From a PCP perspective if he is constantly trying to prove he is right and his wife is wrong; he is therefore acting in a hostile manner to protect himself against what was being said to him: "*I always turned it round to not my drinking but her reaction to my drinking*". However, later in the interview, Neil

confided that he had met a new partner (following the divorce from his wife) and began to take notice of her:

***I latched onto this girl, wonderful girl, she's a director of a company, she was giving me hell, I didn't know she swore until she started giving me hell about my drinking and I said yeah, I'm going to do something about it, the usual story and I came across a [name of self-help group] leaflet somewhere.***

It could be suggested that Neil, who had dismissed his wife's advice, was now beginning to change his views with his new partner. He appears to have been shocked by his new partner's assertive stance towards his drinking. He also appears to have a high degree of respect and positive regard for this new partner. He has re-constructed her from being somebody who never swore, to somebody who now was prepared to swear at him for his drinking and appeared to have told him some home truths about the extent of his drinking. This extreme change in how she responded to him appears to have influenced him. Although he did not appear to fully accept what she was saying and responded as he had done in the past with his wife, "*I said yeah, I'm going to do something about it, the usual story*", he also says he found an old leaflet informing him about the self-help group. Again, it could be reasonably argued that because Neil valued his partner so much, her assertive, angry response may have prompted him to anticipate that he may lose his new partner if he did not change, and he said he had not drunk since this moment. Later in the interview, Neil talks of his past ten years of sobriety and his role as being the chair of the self-help group. Following this moment of insight that change was necessary, Neil appears to have now begun to take responsibility for his actions and stop denying to himself and to others that he had a problem with drink. Another example of this was shown by Tracy who talked about her daughter being honest and open with her about her drinking and the depth of honesty was a turning point for Tracy. Further, it shows how much this experience contributed to giving her the impetus to change:

My turning point of actually making the decision to stop and ask for help, probably came after a conversation on the phone with my eldest daughter, where she said to me, all I can remember from my childhood is you sat there with a glass of wine on a night erm and just sitting there watching telly and drinking and you are doing the same thing with [child's name], which is my youngest daughter, and it just rattled around in my brain for a couple of weeks and I just sort of thought, if that's made her

so angry and upset with me I thought, I just don't want the same unfriendly feeling happening with my youngest daughter.

Tracy began to re-construe her problem and acknowledged the damage she was causing her daughters. It is suggested she had recognised the reasons that evoked the 'turning point' for her. She begins to outline her daughter's perception of her drinking. It dawns on her that she was repeating this behaviour with her youngest daughter. She appears shocked that this was her daughter's poor perception of her. She reflects and ruminates about this and anticipated losing or at least severely damaging her relationship with her younger daughter in the same manner as her eldest daughter.

In sum the key issues in this section are the participants reporting how they have in their eyes experienced 'turning points' and 'moments of insight' which have led to the way they have constructed their move towards owning of the future change towards sobriety.

### **Planning change**

This is a key issue in the literature on change, particularly concerning both the arguments for and against the trans-theoretical model of behavioural change concerning addictive behaviour (Prochaska et al.,2006; West,2005; Sutton,2001; Prochaska & DiClemente (1982,1983,1984,1992). I asked participants about the extent of their planning. The participants' quotes indicate that the majority of them showed few or no elements of planning. Planning did not appear to be an essential key to success in the participants' eyes. The majority of the eighteen participants in the study stated that they had not planned their recovery in advance. However, many of the participants felt that they knew where they wanted to be, i.e. sober (the solution) even though they did not necessarily have a plan for how to get there. Indications of this are shown in the following example recalled by Kevin:

It wasn't planned in terms of setting a date and throwing all my stash away and what have you. The reason I did it this time was because I really wanted it. It meant something for me, even if that was just freedom from being dictated to by a substance called alcohol.

The impetus to change is indicated here by Kevin. He feels the changes meant a great deal to him at this time. The change is coming from him because he really



wants it to happen, “*freedom from being dictated to by a substance called alcohol*”. It can reasonably be assumed that he, like others already mentioned, wanted to regain some control over his perceived destiny. At this part of his change, he did not want alcohol to be in control anymore.

A few of the participants expressed the view that they felt that the decision to change was “right at the time” or it was just a ‘spontaneous happening’. For example, Janet said she had not planned her change because:

***I didn't want the thoughts of having to just stop at first; it made me very nervous and anxious. I needed to come to my own decision and confront the inevitable big hangover when I felt ready and not be threatened by it.***

It is suggested Janet shows elements of fear and anxiety when anticipating imminent change. She wanted to change but only on the proviso that it was on her own terms. This enabled her to own the change, making it less threatening.

This is re-enforced by Janet saying:

***If I had planned to stop drinking, I would have drunk more just worrying about all the shaking and being sick when I stopped. Oh no my change was much more, just like that, ye know... spontaneous.***

Only three participants appear to indicate that they had a plan for their recovery in the sense that they could state how they had thought of the things they would do in order to change. This is indicated by Jane:

***I did write down what I was going to do, and I looked at this on a regular basis to remind myself, like when I was going to the meetings [the self-help group meetings].***

Overall, it emerged that change involved the participants feeling that the changes they made had come from them and that they not only owned the changes but were in control of their own decisions. This can be summed up in Tracy's comments:

***What I do find strange is when people say... you can't have a drink can you... and I just say yes, I can if I want to... but I choose not to... I hold onto this notion... it is my decision... my choice... I feel I have the control.***

It can be seen that Tracy's final comments emphasise the point that she felt she had control and that it was her decision and her choice.

## Summary

These findings indicated that some of the participants initially anticipated many of the changes to themselves through firstly imagining them. It is argued that this use of imagination played a key role in their change process. They imagined what it would be like if they did not drink and liked the imaginary feeling of sobriety and the implications this could potentially have for them. They also imagined what life still drinking would have been like and what this would have meant for them. They may have used these imaginings in order to anticipate what may happen if they didn't stop drinking. They appeared to use these imaginations as a method of almost rehearsing what would happen if they tried it out in reality. A number of the participants expressed emotions about the changes they made, which included fear, threat and anxiety. For some, this imagining also allowed them to practice their new role or new self without danger of them failing in some way. This 'imaginary rehearsal' of the changes basically allowed them to practice their new changed self in a safe way and it also allowed them to alleviate some of their fears, threats, and anxieties which they anticipated may affect them in their futures. A number of participants talked of imagining and thinking about the costs and benefits of stopping. These dilemmas showed that choice can be a complex and difficult balancing process at times.

Following this anticipatory phase, the participants appeared to recognise that they needed to change. The participants were now aware the changes would not solve all their problems and certainly not quickly. This was particularly apparent with the relationships between the participant, their children, and their grandchildren. In addition, they showed indications that they were beginning to have a new sense of themselves as a person who had changed. For example, they could see themselves as confident people without the need for the 'crutch of alcohol'. Further, many of the participants expressed the view that they had realised that the choice and decision to stop rested with them. They did not have to rely on other people to eventually persuade them to change.

All eighteen participants were adamant that they both anticipated and intended to hold on to and keep this 'new self'. They also gave examples of aspirations to just return to 'normality' without alcohol. However, even the notion of normality had

different meanings for each individual. They made the general point that the process of change, and life in general, continues to be difficult even in sobriety.

On reflection, the participants acknowledged that they had lied to others who they were very close to. They then felt the need to be honest and transparent about the nature and extent of their drinking in order to achieve successful change. Many further recognised their need to regain what they had perceived as their previous good image and/or good reputation 'as a man' who showed (in their eyes) masculinity. Some of the participants recognised that they had health concerns of some sort. The participant's level and type of specific concern varied depending on the personal meaning the participant had attached to their health, the possibility of them dying and the kind of death they imagined. This meaning allowed me to gain an understanding as to why all alcoholics in this position do not just begin to abstain. This would appear at first glance to be the logical thing to do considering they have been told that drinking had a strong risk of ruining their health or causing their death. Recognising the need to change having acknowledged the difficulties alcohol had brought them was an important step towards change. However, there was evidence that many of the participants still perceived any change as causing them to feel fear, threat and anxiety. The participants also expressed concerns about feelings of shame through drinking.

It emerged that some of the participants had disregarded the advice of professionals and of close family friends whilst they were still drinking but had made the choice to stop drinking when they had realised themselves that stopping was the right choice for them. Therefore, they felt they had really made up their own minds to change regardless of what others had advised or persuaded them to do. In addition, following a turning point or points, they needed to feel that they had an individual choice and responsibility to change and needed to own the decision. They describe how it was when they had gone through an experience (or experiences) that led to a moment of insight that change was needed, that they began to act. These personal constructions of their experiences led to them making their decision to change, having anticipated that they may lose their friends and family if they did not change. It is acknowledged that the participants' experiences may have been much more complex and messier, however this is how they currently construed the events at the time of the interview. They appeared to have recognised the value of their relative's

support (which was usually a partner or children) and did not want to lose this relationship.

Although some participants had a plan for their recovery, the majority said they had not planned but felt that they knew where they wanted to be, i.e. sober (the solution). The idea of planning as a contentious and somewhat debatable issue will be further explored in the Discussion chapter of the thesis. The next chapter now moves on to look at another area which my findings suggest was crucial to the participants in both achieving and maintaining sobriety, the role of social relationships.

# CHAPTER SIX: THE ROLE OF SOCIAL RELATIONSHIPS IN CHANGE

## Introduction

This chapter is concerned with social relationships and the value that participants in the research placed on practical support and a form of support known as validation from others in their personal change to sobriety. Validation in a PCP sense is seen as different from the practical support which is more traditionally offered, and this will be illustrated later in the chapter with examples from participants. The role of family and friends in change was shown to be particularly important for all the participants, particularly in maintaining the changes.

Several of the quotes in the previous chapter suggest that social relationships did play a part in the participant's decision to change. Participants were often initially dismissive of advice; however, they recognised the effects of their drinking on both friends and family, and these have been key turning points for them. They recognised the importance and value of their social relationships in their lives and the anticipated loss of a relationship and the need to maintain it appeared to be a main influential factor which guided their choice to change.

This chapter presents two main themes. The first theme, 'Role of family and friends in maintaining changes', shows how the further contributions of family and/or friends in the change process were perceived by the participants as crucial in enabling both the changes to be made and their maintenance to be continued. It describes how the participants perceived relatives, friends and colleagues as contributing to the changes. They did this by showing their approval and encouragement for them. They also gave examples of their involvement in supporting change by providing practical help, such as taking the participant to the self-help group meetings and to the hospital or doctor. Further, it describes how some participants expressed the views that they didn't want to let their family down by drinking again. The theme describes how participants often felt supported by others but occasionally felt unsupported and invalidated. This theme reveals the importance of the role of validation by others in enabling participants to both achieve and maintain their changes. Within PCP, validation is an essential part of the change process. PCP recognises that others (in this case family, friends) are directly implicated in the kind of person we want to be.

What we make of ourselves depends on how others construe us and whether they accept the changes we make.

It emerged that participants also began to re-construe their family and friends. These new perceptions of others were often seen in a much more positive and constructive light as the participant achieved sobriety. The findings indicate that the participants construed both events and people differently now they were sober. In addition, they now appeared to perceive others as people giving them praise and encouragement rather than people (as one participant said) “out to spoil my fun”. The findings also indicate that participants saw themselves as more able to see their behaviour through others’ eyes and understand the effect it had on them.

The second theme of this chapter addresses the role of the self-help group (where the participants were recruited) in change and its maintenance. It emerged that the participants saw their self-help group as having helped in their changes, for example, by giving them a reminder of the consequences of drinking again, acting as a facility to gain advice and as a social outlet to fill the void from not drinking. However, the participants recognised a need to keep a balance between attendance and the world outside the group, to avoid the danger of over-reliance on the group.

### **Role of family and friends in maintaining the changes**

#### Family support for change

In this sub-theme I illustrate three different aspects of family support. These include whether or not the participants perceived any form of approval from their family, the family offering practical support and the participant not wanting to let their families down.

#### Showing approval

Participants expressed their feelings about whether they valued and/or missed any kind of family support they had personally received. For example, David confided that he missed the support he felt his father (now deceased) would have potentially given him in the changes he had eventually made:

***One thing I do miss... is that I sometimes miss my dad who would have I think, spurred me on not to drink just by giving me encouragement to keep sober and he was always there to say he was proud of me about anything whether it was me being in a wheelbarrow race when I was***

***about 8 or when I passed my 11 plus, he was always proud and he showed it by his actions.***

It is suggested that David wanted this feedback as acknowledgment of what he had achieved in terms of changes. He wanted encouragement and an acceptance of what he was doing. It seems that David perceived his father's unconditional regard "*he was proud of me about anything*" as a form of encouragement he now did not have. This acknowledgment of his changes could have helped him in this progress and reinforced his change as being the right choice to make.

The participants also showed evidence that they had relationships with other family members where they were all proud of the participant and the participant was proud of them in the actions they had been involved with. For example, Matthew when referring to his relatives, confided that:

***They know I am constantly trying to improve myself by not drinking and they are fully aware of what would happen if I did have a drink. They give me verbal encouragement and are telling me constantly that I am doing the right thing and now I know I am fully aware of what I have put them through. I am as proud of them as they show they are proud of me.***

Matthew emphasises his relentless and never ceasing efforts to better himself. His relatives appear to be constantly confirming with him that he is doing the right thing. This approval through their confirmation is unfaltering, which in turn reinforces his ability to not doubt the stance he is taking to maintain his sobriety. Both Matthew and his relatives have reciprocal pride for each other and openly show this. Matthew also indicated that he now takes responsibility for the effects his behaviour has had on his family.

Bob confided that although his family did not say they were proud of him, they expressed relief that he had changed:

***I feel they are not exactly proud of me, but they are relieved I have finally got myself back together again. They tell me this, which I feel means a lot to me and encourages me to continue with my recovery. My family and friends have been more important to me in my recovery than all the meetings I have been to.***

Bob, in a similar way to Matthew, really appreciates his family letting him know of their relief that he was making changes to his self, and this encourages him. The positive effect on Bob's family appeared to be central to him maintaining his sobriety. In addition, he indicates that his family's relationship with him had enabled his changes much more than his attendance at the groups had achieved. Concerning

Matthew and Bob they both convey the thoughts that it is the understanding of what their change and subsequent new selves means to their family members. As their families were now showing relief and a degree of pride for their changes this appears to enable them to continue maintaining their sobriety. Arguably this may also indicate that Bob and Matthew have become more involved in wanting to maintain and nurture their relationships with their families.

Some of the participants did not always have such a positive perception of their family situation. In contrast to Bob's experiences, Jane remarked that she received contrasting messages from different members of her family:

***I know my elder brother is proud of me and he tells me this a lot, but my mother, I don't think she cares either way as long as she can get to her golf club dinner (laughs). I suppose I am laughing but really, I should be crying, I have a useless mother in terms of her understanding, and she gives me fuck all in terms of encouragement or support and this can get me down sometimes and it certainly doesn't help me one jot.***

Jane suggests she feels hurt by having to take 'second best' to something as trivial as a golf club dinner - she laughs at this point, but then comments that she should be crying - she actually finds it very upsetting but possibly uses laughter to dismiss it as something unimportant. Jane may have a strong need to be understood by her mother. It could be suggested that Jane emphasises her exasperation with her mother. She points out in very strong language how 'useless' she was regarding her lack of understanding and encouragement for her changes. Her last comment "*it certainly doesn't help me one jot*" may imply that (in her eyes) her mother SHOULD be helping her, and the implication seems to be that rather than helping her she was actually making it harder for her. This uncaring attitude appears to upset Jane. She perceives this attitude as showing a distinct lack of support, in contrast to her brother.

#### Practical help and involvement

Various other forms of support were indicated by the participants. Some relatives showed support by not only taking the person to the self-help group but contributing to the discussions themselves. Tom said:

***My wife came with me a few times at first when I came, and she got involved with the group as a support, which was hard for her speaking in front of a group, because she had never done that sort of thing in her life before. I really admired her courage to get up in this way. For fuck's***



***sake who the hell would want to help a pissed-up twat like me after all the aggro I had given her? It meant a lot to me and spurred me on.***

The strength of Tom's language indicates his almost disbelief that having previously felt he had given his wife a lot of aggravation, she was still prepared to help him. It meant a lot to him that she was committed to doing something which she found difficult to do. Tom appears to elevate his wife in his perception, he seems to be in disbelief that anyone would want to help "a pissed-up twat" as he describes himself by comparison - it emphasises how he esteems her. The fact that she was prepared to do this for him also strengthens his desire to change.

Similarly, Bob's wife went to the meetings with him but made an additional contribution. For example, she talked to the group about how Bob's drinking affected her rather than just how it affected him:

***My wife came to the meeting with me and contributed by explaining her side of things, you know, from her point of view. By listening to her it gave me a better picture of the whole situation, and this would spur me on not to drink for a bit longer.***

It may have been unusual for Bob to have to listen and pay attention to his wife (the speaker) without interruption as was the norm with the self-help group. This would be different from hearing her side of things at home where he may have just dismissed her. Further, Bob rather than just 'having' to listen to his wife he appears to now want to understand what her views of the situation are, and he is given new vigour by what she says in his attempts to change.

#### Not wanting to let family down

Some participants had felt they did not want to let others down by succumbing to drink again. They wanted to maintain their present sober selves in the eyes of others. This would enable them to feel good about themselves in the future.

Relapsing would have the opposite effect. In addition, they felt it would make their partners and children unhappy and let down as well. The participants may have felt a degree of accountability and responsibility for now maintaining their changes because they had promised this future sobriety. Accountability and responsibility can be seen as important concepts in much of the alcoholism literature Fingarette (1988) and Peele (1995) suggest the alcoholic is accountable for their actions and are in charge of their own destiny. This is in contrast to Jellinek's (1960) and AA beliefs that

alcoholism is a disease therefore a person cannot be held either accountable or responsible for their drunkenness.

Further, regarding not wanting to let their family down the participants may have felt a failure for not being able to fulfil the promise they made to keep sober. In other words, they have not fulfilled their part of the bargain. An example of elements of these feelings is shown in the comments made by Jane, the ex-district nurse, when she was expressing her thoughts regarding being and remaining a sober person:

***I think it means contentment, pride, and achievement. The fact that I don't think I have let down those who really cared about me achieving my sobriety. That I don't think I have let those people down, like my brother, like my nurse manager, like my close friends and it has meant a lot to me that I have not let them down for six years and I will maintain this for the next six years because I still have the desire not to let them down in the future.***

Jane is adamant she is not going to let the people down who care for her recovery - it appears as though she recognises the level of investment they have placed in her emotionally in terms of her recovery and she does not want their attempts and investment to be in vain. Jane appears to put emphasis on the length of time she has abstained and anticipates an equally long time in the future where she will not let them down. Jane outlines what sobriety meant for her, "*it means contentment, pride and achievement*". As a result of her past drinking, she may have felt she was a failure and be full of self-condemnation rather than contentment or pride. In addition to these three things, she sees as personally meaningful and beneficial to her, she also expresses her wishes and concerns to ensure others around her have not been and will not be let down in the future. She indicates her determination not to let those who have helped her down by relapsing.

Susan offers a further example of not wanting to let her family down when she was asked the following question:

I "how do you think you will be able to maintain the changes?"

**P** I remind myself of where I was, and I even have notes which I wrote at the time describing how bad I felt, and this definitely spurs me on... Like I have said, the help I get from my family and what they now think of me, and I don't want to let them down any more even though I am aware I changed for

myself. I don't want to let the people who help me sober up down by drinking again, and I don't get any kick out of the thought of drinking anymore

Like Jane, she appears to feel she owes something to her family for the support they have given and the faith they have shown. Susan makes the point that although she felt that she initiated the changes to sobriety, she acknowledges and values her family helping her to maintain change and she now wants to show this acknowledgment to them by continuing to remain sober. She appears to have a need for her family to maintain their present perceptions of her. She now does not want to invalidate their re-construal of her as a sober person rather than a drunk.

#### Family and friends validating or not validating the 'new sober me'

Validation focuses on the interpersonal relationships we have with others and is a key element of PCP. It refers to the importance of the cooperation of the other people around us to validate our sense of self. The participants indicate that what they made of themselves and their new selves was very dependent on how their friends and relatives perceived or construed them. In effect, friends or relatives either validated the changes the participants made by taking them seriously as this different person, or they did not accept them, invalidating their changes, and sometimes making it more difficult for them to maintain change.

For instance, Matthew confided:

***I have had the benefit of my family around me ever since, supporting me taking me to meetings and the doctors and giving me encouragement all the time. They have whole-heartedly accepted what I am - an alcoholic who is reformed if you like in so far as I have completely stopped drinking and turned my life around from a bloke given months to live to this new person now getting jobs and that.***

Matthew makes a contrast between a person given months to live versus a new self, achieving new jobs - he invites us to witness the distance he has travelled, and to acknowledge the change in him that his family has managed to recognize. Further, as well as the practical support given to enable the changes to take place, such as transporting him meetings or to the doctors. Matthew's family appear to have shown validation by accepting his change. "*They have whole-heartedly accepted what I am*" in the sense that they did not appear to place any conditions on this acceptance.

The concept of acceptance is evident in much alcohol literature (for example AA, 2001, 2002). This 'acceptance' includes the disease model (for example, Jellinek,

1960) where it is often regarded as a prerequisite to successful change and a signpost to relapsing, if acceptance is not apparent.

There were also indications of friends showing validation. This was evident in the case of Kath:

***I now have mates who are not really fully aware of how bad I was in the past and just see me and judge me on how I have been over the past few years. They seem to see me as having a completely different image or identity to that drunk. Some of them think I am right placid and easy going, which I am really I suppose. When I am with them, I am much happier because they treat me as a good person and not as a drunk. It keeps me going and makes me keep myself good.***

It is suggested that they were aware what has happened in the past even though they do not know all the details. Her new friends have only known the new Kath. They can therefore only validate the new Kath. This appears to have allowed Kath to fully adopt her new self when she is with them. This in turn has positively reinforced her sense of wellbeing. An interesting point of note was Kath's comment regarding "keeping myself good" this may indicate her construal that in her eyes she had been morally bad in her past by drinking? However, by now abstaining she was construing her new sober self as morally redeeming herself. Further, she needed the reminder of how her new friends see her in order to 'keep herself good' - she appears to need this pressure.

What appears important is that her new friends see and judge her on the merits of what they now see. Kath appears to indicate that in some ways she is still in the process of fully recognising her new self. She reflects, "some of them think I am right placid and easy going, which I am really I suppose". This validation of Kath's changes also appears to have enabled her to maintain her changes.

In a similar way to Kath's friends, Frances had a variety of responses from her relatives. For example, she said:

***For my wider family I think, it is a mixed bag really. Some of them do what I have said, ye know, look like they feel sorry for me and probably hide the drink and let everybody know that is what they're doing, but pretend they are still my most caring relative... but, are probably just wanting me to make another fool of myself, so that they can tittle tattle about me. But others, are great and accept what has happened and most importantly accept that I have changed.***

It could be argued that a part of her family is showing validation by accepting she has changed. They are indicating both an acceptance of what has happened in the past and at the same time, accepting her changed self. This can be contrasted with others in her family she felt were just wanting her to relapse again. It is interpreted that his was to fulfil their own needs. They may be reluctant to change their construal of her because it gives them an opportunity to gossip about her possible relapses and potential drunkenness which they appear to be drawing value from.

Further, my findings indicated that a small number of participants acknowledged that they had received little in terms of support or validation from family and friends. Some missed any form of contact either positive or even negative towards their changes. Tony, who had no close relatives since his wife died a number of years ago, summed up some of his feelings:

***It's a pity I don't have somebody close to me at times because I miss getting any kind of praise for doing well. I don't mean I want people to worship me, just some kind of acknowledgement that I have changed how I am, and I have improved. It's hard work just relying on your own thoughts all the time.***

Tony was receiving little or no feedback for the changes he was making; he was purely reliant on himself. The last sentence of the quote is particularly significant. It appears to suggest that even when a person is convinced in their own mind that they are doing the right thing, it may be difficult to maintain the changes if we receive no acknowledgment from others confirming this. It is suggested that Tony needs others around him who are able to accommodate and accept his new sober self. It indicates that social relationships are crucial to constructing and maintaining who we are. In addition, it reinforces the point that we are reliant on others to validate our actions.

Other participants talked of family and/or friends who they felt had hindered their recovery. For example, Tracy had a relative who preferred the drunken submissive non-questioning daughter as opposed to the assertive sober daughter she now saw. Tracy recollects that:

***The change to this sober person was difficult for me. People were used to manipulating me - they found it difficult to deal with me in the same manner when, all of a sudden, I had changed and could assert myself and say 'no, I don't want to do this and that', you know what I mean? Although I was miserable at times, I was finding my real self and my own voice, and I was starting to think more clearly.***

Later in the interview, Tracy further clarified her feelings and mentioned that:

***They had got used to the old, drunk me where they could tell me what to do and what to drink if they wanted to and I would be like a lamb to the slaughter. You know, very submissive, as long as you put a drink in front of me, I was happy. When I changed and didn't drink, I became a bit more assertive and voiced my opinions in an intelligent manner, they just weren't used to it, and I think it threw them a bit.***

In Tracy's case, her relatives did not appear to be prepared to change. They wanted to maintain their same old ways of relating to Tracy. They were more able to fulfil their own wishes of being in a position of control and manipulation if they could relate to the old Tracy they were used to. The new Tracy was a different entity, which they could not cope with initially. Tracy's attempts to change were hindered initially by these relatives who were prepared to invalidate her attempts in order to maintain their own perception of themselves. It is suggested that it indicates that our own behaviour (or in this case, Tracy's behaviour) has implications for others (her relatives) sense of self. As Tracy began to make steps to change and stop her drinking, her relatives appear to have been reluctant to change themselves, possibly anticipating feeling a loss of control.

Another example of where there appeared to be a total lack of validation was in the case of Mick, where his work colleagues actively encouraged him to continue drinking:

***The main people who hindered me were the lasses from work, they seemed to like me when I had had a few. They told me... they thought I was a good laugh. I thought I had to remain a mouthy, confident person to keep this good fun image, so I suppose it became part of what I had become, and I fully believed in this.***

It appears that Mick's work colleagues were reluctant for him to change because his drunken conduct gave them pleasure, regardless of its effects on Mick. They thought he was a "good laugh" when he was in this state. They possibly preferred him to be like this to fulfil their own enjoyment purposes. Mick was hindered in his attempts to change because he, on the one hand, initially was imagining the benefits he could acquire through sobriety, whilst at the same time having work colleagues telling him they liked him drunk. Unfortunately, for a time he internalized what his work colleagues were saying and believed the drink enabled him to create this image of a 'good, fun' person. It clearly shows (in PCP terms) how others can invalidate any efforts to change.

Frances had confided that she felt some people would never really show any acceptance for the changes she had made:

***I was at a wedding some time ago and my husband overheard one of my cousins say, "I will keep the bottle under the table out of her way, to avoid temptation". You see, my cousin couldn't move on, even after four years had passed, she still thought I might go for another drink given the opportunity. I have resigned myself to the idea that some people won't accept the change in me and probably won't even in twenty years. I think that's just something I will just have to live with.***

It could be argued that some people will not accept the changes people make. From a PCP perspective, these people are showing perhaps hostility because the participants transition to a new sober self threatens their own construct system. Boeree (2006) describes how when our constructs are challenged, we may become hostile. Frances's relatives may insist that their beliefs are valid despite their being indications to the contrary. In Frances's case, she feels validation will never be given. I will discuss validation and its links to PCP in more detail in the Discussion chapter.

### **Re-construing and valuing relationships with others**

This section gives examples of the participants re-construing both people and events differently now they are sober. It then moves on to examples of participants now considering the effects of their drinking on others, re-construing and now valuing their relationships with others. The participants now recognised the encouragement and praise offered by others. Their emerging new construal of their situations appear to have led to change. This sometimes included re-construing their family, friends, and work colleagues.

#### Re-construing events and people without drink

This section gives examples of findings indicating that the participants' perceptions of other people had changed when they were not seeing situations and people when having been drinking. It also describes how participants were now recognizing praise from other people.

Mick recalled his re-construal of his mother:

***Now my mind allows me to think about alternative ways of solving things without drink. I used to dwell on the fact that I was adopted and that this had caused me to drink, what a load of bollocks. Now I can think differently... I can now see that my real mother was a good person,***

***who tried her best to keep me and wasn't this awful person who had abandoned me. It was the drink that made me think this way.***

In his drinking past, Mick possibly used his mother and his adoption as an excuse for his drinking, perceiving her as “*this awful person*”. In his sobriety, he has re-constructed her as a good person. Mick appears to see that many of his constructs of people, events and experiences were formed and appeared real to him at the time but were affected by his alcohol consumption. Possibly Mick and others frame drink as preventing them from seeing things as they really are. From a constructivist perspective Mick would see and construct his own understanding of the world based on his experiences. Looking through Mick’s lens, these experiences would often be influenced by alcohol; however, looking at it from a different perspective this could be interpreted as Mick just wanting a plausible excuse for continuing to drink, therefore, he blamed his mother. Now sober, he may construct an entirely different view of the world.

A further example of re-construal of others is seen in the case of John:

***My wife began questioning me about where money had gone from the accounts, and when I blew up and threw the cards at her, she knew something was up. I thought at the time, that she was the enemy and a bad person, to the extent that that I lied about my drinking... In the end, when I had sobered up, I saw things differently, I knew she was a good person just trying to help me.***

John’s comment “*threw the cards at her*” referred to him throwing his credit cards from his wallet towards her.

It is suggested that John (like Mick and his relationship with his mother) knew his wife was a good person, and he now sees what he perceives as the real person. They both indicate now having a contrasting understanding of their relatives. For example, John previously had a negative view of her seeing her as “the enemy”. Arguably, he is seeing her as hostile towards him at this time, rather than supportive. He tells me it was the alcohol that led him to construe his situation in this way. He possibly had a need to blame the alcohol rather than see his past construal as driven by his own needs.

Many of the participants recalled focusing primarily on alcohol and forsaking all other interests including family and friends. Whilst drinking they did not really take on board the feelings and thoughts of others, prioritising alcohol instead. However, in



their change process, many of the participants expressed the view that they were now able to recognise other people's praise and encouragement for their decision to change.

John gave an example of where he had re-construed his wife and daughter:

***In my drinking days, I just didn't appreciate the fact that my wife and my daughter in particular, had been trying to help me, whereas I just saw them as people trying to spoil one of the only pleasures, I felt I had. I eventually re-looked at this situation, I needed my wife and my kids when they were around to help and support me, but most of all, I needed myself to support myself, if that makes sense?***

When John was drinking, he had thought that his wife and daughter were just making efforts to prevent his only pleasure, which was alcohol. However, he had now interpreted their actions differently as helping him to help himself. In this quote John appears to tell me that he has looked at this situation again and attempting to see other reasons for her behaviour. His notion of "*needing himself to support himself*" could be interpreted as him actively beginning to explore these different reasons for others' behaviour towards him in order for him to achieve a fuller understanding of himself.

#### Recognising the effects on others

Both Frances and Harry gave examples of where they had re-construed the effects of their drinking on others:

***I am now fully aware that I have upset a lot of my family and friends... I was always focussed on the drink; I didn't always care about how I was upsetting other people with my drinking. I think I now see things differently and I think I now put myself in their shoes and feel what they must have been feeling when I was at my worst. (Frances)***

Frances said she "didn't care" previously and was just interested in drinking. Now she sees things differently and has in effect re-construed her own behaviour towards other people like her family and friends. She appears to suggest in the quote that she was fully aware of how it was affecting others but chooses to ignore these perceptions at the time so that she could concentrate on the alcohol. Her comment that she now puts herself in their shoes is interpreted as meaning she now has a much more empathetic understanding of others. She looks at things from others' points of view and how they see things rather than only focussing on her own needs and wants. Seeing things as others construe them is a key aspect of Kelly's (1955)

PCP theory. In order for us to understand the other person as Butt (2008, p.31) suggests, “*it is the interpreted world of the person that the personal construct clinician or theorist is interested in*”. In the above scenario, Frances is also adopting the same position by putting herself in the shoes of others she has possibly upset whilst drinking. Kelly’s sociality corollary is relevant here in the sense that Frances is showing her capacity to construe the constructions of others.

In a similar way Harry confides how others see the world:

***When I was drinking, I didn’t really give a damn about other people, even my mum. I think I can safely say that my family has helped a lot just by sticking by me, particularly when there were times when I was really drinking heavily, my mum said, “I love you Harry, but I don’t like you anymore when you are acting the way that you are. I am begging you to stop this carry on”. I was sickened to hear her talk this way and slowly but surely, these sorts of situations began to really get to me, and I realised it didn’t just affect me. My drinking and my actions as a result, could affect a multitude of people and I began to think about these people more and more.***

It is suggested that Harry had re-construed his own behaviour and realised that his drinking did affect others badly. Being consistently and repeatedly confronted by the effects of his drinking, became almost ‘evidence’ he could no longer ignore. In the past it appears as though he was not aware of how his drinking was affecting his mother. However, in a similar fashion to Frances, he showed his unconcern at the time by saying he “*didn’t really give a damn*”. He described how gradually this situation appeared to affect him as he arguably began to look at himself more closely but also how it affected others and how they were feeling. It could be argued this acknowledgment of his own impact on others was a major catalyst in promoting his change. This effect on his mother is particularly apparent when he described how she talked of not liking him anymore and this sickened him-it was obviously very important to him.

### The role of self-help groups

This sub-theme reports on participants’ learning from other group members about various strategies to achieve and maintain their sobriety. These included the group members reminding the participants of their bad experiences linked to drinking and the process of helping other group members to achieve and maintain sobriety. This ‘reminding’ has similarities with the study of Yeh et al. (2008) where they found that

their participants emphasised the value of recalling the negative aspects of their former drinking selves. Lastly, it examines the issue of possible over dependence on the groups. All the participants said they had benefited from attending the self-help groups. They used the group to assist them to change and maintain these changes and sometimes to give them a social outlet away from their usual day to day activities and as way of filling the void left from alcohol. The participants found it beneficial to use a group of what they saw as like-minded people that had a common goal of wanting to achieve and maintain their sobriety.

Participants talked of learning from other group members' stories, ideas, and solutions to maintain their sobriety. For example, Kath said:

***The other people who were all the same as you and me, told me about what they had gone through and survived all their problems. They looked at things through different angles you know like seeing the cup half full instead of half empty, giving you hope.***

Kath appears to welcome and value the notion that people in a similar predicament to herself had managed to overcome their problems. She also appears to recognise that they had looked at the issues that challenged them and viewed them in a positive light rather than a negative one. Further, when referring to other group members she said that "*they looked at things through different angles*". This may be interpreted as meaning she saw the usefulness in the group being able to provide various ways of seeing things. Kelly (1955) refers to there being many ways of construing the same situation or looking at the same thing. He coined this 'constructive alternativism' (as described in the Methodology chapter p.80). It is suggested that these group members were doing exactly that. This had the effect of giving Kath a sense of optimism for her own future. The idea that the group saw the cup half full and not half empty indicates that the group was able to see alternative constructions which may be available to Kath.

Harry, Susan, and Matthew talked about how the group helped them in similar ways:

***The group are very good at reminding me of where a lot of them have been just a few years further down the line so, I am learning through some of their mistakes and there is always somebody new at the group, who would be explaining about some pickle or other they had got themselves in with the drink, and people would be giving the person advice about what they could do about it and I feel I have learnt a lot through listening to these conversations and throwing in my own***

***thoughts as well. So, the group has been good for these reasons.  
(Harry)***

***You get so much good advice from people who have done it for ten years or more but then you get people who are just starting out and it makes you think how bad it was at that stage it acts as a reminder and I thought with me I just don't want to go back to the beginning again and this spurred me on to continuing for longer and longer until I started seeing the results of longer term sobriety. (Susan)***

***I could see that others were the same as me or were in a better state than me and I wanted to learn from them and in a way, learn from some of their mistakes if you like. (Matthew)***

In the above quotes, all the participants appear to have benefited from observing and learning from people who had all gone through the same problems as them. They learnt from the other members' mistakes and by listening to their conversations. They all also felt it acted as a useful reminder of how bad they felt when drinking in the past and what things would be like if they drank again. Further, they all also gained from the general advice offered at the meetings. The participants found it beneficial to use a group of what they saw as like-minded people. Members who had remained free from alcohol for some time gave others hope that they could achieve the same results if they made similar choices.

Tracy, who occasionally chaired the meetings and gave advice to help others who were struggling, said:

***The meetings have given me an interest if you like, you know, joining the committee and chairing the meetings and what have you. It has given me a big part of my life, an interest without drinking, you know what I mean. It has sort of filled the void that would have otherwise been taken up by the drinking. Giving back has just made me feel so much better.***

What appears to be very significant is Tracy's reference to 'filling a void' in this sense, the group and its activities has become a large part of her life. Drinking became a major part of her previous lifestyle and the sense of this loss appeared to need a replacement to fill that gap. Tracy appears to be saying she felt chairing the meetings was enabling her to give something back to the group which she perceives as substantial and meaningful and filling this gap. It is suggested Tracy may have felt guilty for her past drinking and its effects on her daughters. She may have perceived that by partially repaying this 'debt' by giving her time to the group it was vicariously giving something back to her daughters and helping to fill her void.

Others saw the group as not only a therapy for their alcohol problems but also more of a social occasion which filled a void in their lives. For example, Neil recollected that:

You need to keep yourself occupied when you stop drinking 24/7. There is a void, what the hell are you gonna do? So, they say, do this, get a hobby. I made a coffee table in the garage, I ended up making twelve (laughs) daft things like that, you know. I made [the group] my hobby.

It appears as though Neil perceives the group as almost being of the same level of usefulness as his making of coffee tables. That is, similar to Tracy filling the void left by the omission of alcohol. He regarded it as giving him a hobby which occupied his time.

Although the participants expressed clear benefits from attending the self-help group meetings, other participants felt that they had possibly become too dependent and reliant on the group. The following quotes from Mathew, Frances and Jane give an indication of these concerns:

***I keep coming to the meetings, but I now feel I will be able to survive when the group is disbanded. Don't get me wrong, they have been very good to me, and I appreciate the advice the others give to me, but I think you also have to accept standing on your own two feet. I think it could damage you if you become too reliant on the group. (Matthew)***

***Well, I don't think the group is the only thing stopping me drinking. I see it as a helpful tool to help you but, it isn't the only thing. If it was, I would be concerned that I would have created yet another addiction in place of the drink, if I felt I had to come to this meeting. No, I think there is a happy medium for me, the group acts as a reminder and somewhere you can learn from others who are in the same situation as you, but I found that in the end I needed to stop the problem through myself. (Frances)***

***At times I think I went over the top with how many meetings I went to. I went to the woman's group which was women only, and the mixed group. I thought at some point I will have to wean myself off going to all the meetings and get back to real life as well. (Jane)***

All three participants had a need to function independently of the group and not to become overly dependent on it. Matthew perceived this dependency as equating to being 'addicted' to another 'drug' that is, 'group meetings' which he refers to as possibly damaging like drugs. Frances needed to keep a healthy balance between attending meetings and what she perceived as her real life in the outside world. She did not want to feel compelled to go to the meetings and wanted to make her own

choices and decisions. This point is reinforced by her words “*I needed to stop the problem through myself*”. Further, the words offer evidence of the need for the alcoholic to have agency and to own the changes. Jane draws similarities between her past drinking (dependent) self and her present feelings that she may have become over reliant on something (the group). As a result of these concerns, she feels she needs to ‘wean’ herself off the group which again, might mirror her past self where she was weaning herself off alcohol. Bob adds further reservations regarding the group:

***The group has really helped me but, I suppose it is not perfect and it is not the real world, I also didn't want to become too reliant on the meetings. I have met people who have not drunk for over thirty years but still think they need to go to groups like AA. This bloke sees it as a way of life, I prefer the reality of my family talking to me now, I don't see this group as a way of living for ever.***

Bob is now looking towards his future. He contrasts the group with the attributes of what he sees as the ‘real world’. He perhaps construes the group as almost a staging post or half-way house between drunkenness and reality, possibly leading to the real world which he sees as his family. The group is construed as a relatively safe haven of fellow alcoholics, whereas Bob’s view of his real world contains non-alcoholics who may not have the same level of empathy and tolerance, particularly if he relapsed. He perhaps construes his family as offering this level of ‘real world’ challenge. He appears to construe the transition from the world of continual attendance at group meetings as a ‘way of life’ towards other outside support as a major step forward in his recovery.

The notion of some self-help groups adopting a doctrine whereby the membership becomes a ‘way of life’ rather than just a time limited therapeutic method and the person assuming a lifelong identity of being an alcoholic is considered by Fingarette (1989), Vaillant, (1983), Peele (1995) and Alcoholics Anonymous (2001). This issue is often seen from two different aspects. The AA doctrine believes that attendance at groups should be accepted as a way of life, whereas the constructivist view of Peele is that people can recover from alcoholism by mixing with non-alcoholics. The evidence above concerning my participants appears to point to them wanting an appropriate balance, whereby in their eyes they can recognise and acknowledge their own problems, but still strive for and achieve sobriety by mixing with non-alcoholic as well as alcoholic people. The advantages and the possible

disadvantages of self-help groups will be further discussed in the Discussion chapter of the thesis.

## **Summary**

The role of family and friends was central in the changes being successfully maintained, for example, in supporting the participant by initially taking them to the self-help groups and/or getting involved in the groups and by contributing to the discussions. Even more significant was the roles of family and friends in validating the 'new me'. Participants expressed their need for acceptance of their situation including an acknowledgment that they had changed and needed this new self to be acknowledged. The participants also cited examples of where people had not provided validation or support. These situations appear to have hindered the prospects of changes taking place. It became apparent that the participants felt they needed their friends and family to show validation for the changes they had made in order for these to be successfully maintained. Further, they did not want to let other people down by drinking again and they recognised the effects of their drinking on others. They also now reconstrue and value people and relationships much more.

Lastly, participants placed value on the self-help group they were attending. The self-help group presented a variety of different ways in which they had assisted in both achieving sobriety and in maintaining sobriety, such as acting as a 'reminder' for the participants of what their previous life drinking had been like and sharing ideas about possible solutions to help in changing. Further, the group acted as a means of filling the void left in some of the participants' lives. It is also noted that as well as the advantages outlined, attendance at the group could possibly have some disadvantages. Some participants talked of being concerned about the danger of over-reliance on the group similar to their over reliance on alcohol and the need to remain aware of this danger. Chapter 7 moves on to describe how the participants were now re-constructing themselves, having both achieved and maintained sobriety.

# CHAPTER SEVEN: RECONSTRUCTION

## Introduction

This chapter is concerned with how the participants appeared to have developed a different perception of themselves as they moved towards sobriety. In PCP terms, they were re-construing both themselves and the problems they and others around them had faced with alcohol. The chapter theme of reconstruction is divided into two sub-themes, namely 're-construing self' and 'looking forward and looking back'

## Re-construing the self

This first sub-theme considers how the participants feel they have transitioned from a perception of themselves as a failure to construing themselves as a success and now having self-belief and self-respect. The past need for alcohol to achieve confidence is contrasted with the participants' transition to being confident without alcohol. The participants additionally talk about their perception of now feeling in control of their own destinies and feeling more trusted. Further, they feel they are now more rational. Lastly, participants give examples of how they have now had a change in the things they value, for example, previously valuing alcohol but now valuing their family relationships.

## Being a success, gaining self-belief/self-respect

The participants began to reconstrue themselves as a success, whereas, previously, many participants had stated that they had a low opinion of themselves and felt like failures whilst they were drinking.

Kath gave an example of this form of re-construal: she had re-construed herself from seeing herself as a failure to now seeing herself as a success. Moving from her past feelings of extreme negativity about herself to now beginning to feel much more positive:

***They [friends, family and others in general] thought I was finished long ago and would end up in prison or the looney bin, you know what I mean anyway, I see myself as a success in a way, not like I've got an ace job with promotions and that, oh God no, but I've pulled myself out of that shit pile, not smelling of roses but at least I am still here. When I was drinking, I saw myself as a total failure and sometimes I felt I would be better off dead, so compared with how I felt about myself then compared with now, well it's a very small miracle.***



Kath's perceptions may be viewed as rather humble and modest. She equates her success to "*not being in prison*" or "*in the looney bin*" and "*out of that shit pile.*" These strong, evocative statements indicate her low opinion of her past drinking self. She is equating her drinking to madness, criminality and being in a bad place; a 'shit pile'. She strongly indicates how low her mood may have been and her poor perception of her life at the time, referring to herself as "*being better off dead*". Her new perceptions of herself as opposed to the old self show an extreme contrast. For example, she contrasts her feeling of being better off dead with her new construal of being alive and well "*at least I am still here*". Kath also indicates the enormity of these relatively mundane successes to her "*it's a very small miracle*". This could suggest Kath finds her change in fortune almost unbelievable or even miraculous. She further indicates her modest perceptions of her future by seeing herself as a success on the basis that she has avoided criminality, madness and death by remaining sober.

The participants compared their past drinking lives with their present and anticipated future lives. They perceived that they had now gained a greater degree of self-belief and respect. Kevin confided:

***When I look at myself now, although I don't ever feel proud of myself, my abstinence from drink and how I now feel and now behave, well it gives me at least contentment and a bit of self-respect.***

Kevin does not make a direct comparison with his new self and his old self. However, he does indicate this with the comment, "*when I look at myself now*" which suggests he is reflecting and commenting on the change in himself. He may feel he has let himself down in the past because of his drinking and his present perceptions may tell him he has only achieved modest changes to date not worthy in his eyes of feelings of pride. This point is indicated by him using words such as "at least contentment" and "a bit of self-respect". This may indicate that his perceived modest improvements may still benefit from further work in the future. Only then will he feel he deserves to be fully satisfied and have a greater degree of self-respect. At the moment he is still saying, "I don't ever feel proud of myself"; this indicates that he does not want to claim too much for his present improvements. The self-respect he does acknowledge appears to relate to his perception that his continued abstinence and his resultant thoughts and actions are now more appropriate and acceptable to him.

Likewise, Mark reinforced this feeling of self-respect and additionally talked of confidence in his future, stating:

***I feel like I am not a specially gifted person, but at least a reasonably respected person as long as I remained sober. My wife is proud of me, and my little child has never known me drinking and this spurs me on to continue being sober. Due to the respect, I think I am getting and the respect I have for myself as well, I feel I can look into the future with more real confidence that all will be well and that my drinking days are over.***

Mark, in a similar fashion to Kevin, does not claim too much for his self-improvements since becoming sober, “*I am not a specially gifted person but at least a reasonably respected person*”. He appears to be modest about his success and feels it is reliant on him remaining sober. He appears to feel he is gaining both respect for himself and gaining respect and pride from his wife. These feelings are further encouraging him to maintain his sobriety. It is suggested that he feels that by keeping sober his daughter will never have a perception of him as a drunk, which further encourages him. His relationships with his wife and daughter appear very important to him. He also appears confident about his future, predicting with some conviction that he will be able to continue to maintain his sobriety. Mark’s situation may have a degree of similarity with the participant Kath mentioned earlier in so far as the benefits of friends only being aware of the ‘new me’. This could mean they do not have any previous views of them. However, Mark’s situation could be related to him feeling ashamed to think of his daughter as a child seeing him drunk or perceiving him as a drunk through her eyes.

Harry also remarked:

***My recovery has given me some self-pride back and a bit of self-respect back now I am not sneaking round hiding the drink which, as a grown man with a good job, I find hard to believe myself, I just need to maintain this abstinence and fully convince myself it is for ever and I can’t go back to drinking again ever.***

Harry has re-constructed his past behaviour. He appears to be implying that “*a grown man with a good job*” would not lower himself to such immature behaviour. He possibly sees himself as the “grown man” paradoxically acting like a guilty child. He sees a grown man with a good job acting paradoxically by hiding alcohol similar to a child possibly hiding sweets or toys they had stolen from another child. This situation now seems incredible to him and the opposite to how he perceives himself in the

present or wants to see himself in his future. He perceives himself as having changed considerably to an extent he finds it difficult to believe what he did in the past. His present and anticipated view of himself sober in the future evokes a feeling of self-respect and pride, provided he can remain abstinent. He has a slight element of doubt in his mind regarding whether he can remain abstinent. He feels this doubt will not go away until he has remained abstinent for a longer period of time, "*I just need to maintain this abstinence and fully convince myself it is forever*".

### **Confidence and sense of being in control**

Some participants talked of their perceptions of their previous drinking selves as only feeling what they saw as false, alcohol-induced confidence. Having now stopped drinking they re-constructed themselves as being confident, non-drinking, authentic selves.

Susan had felt she had little confidence following the death of her husband:

***My confidence waned, and I was back on the drink to build up my confidence again and then with this bereavement and grieving and what have you, I felt I needed the drink to bring back what I had lost.***

Susan was experiencing grief following the loss of her husband. She attempted to compensate a resultant loss of confidence by drinking alcohol. It could be argued that Susan construed herself at the time as a person who equated alcohol with confidence. She thought that it may act as a countermeasure to the loss of her husband. She would in her eyes "bring back what I had lost" by substituting her authentic confidence when her husband was alive with what she perceived as the chemical confidence alcohol could give her.

When Susan stopped drinking, her submerged confidence began to re-appear. Her abstinence coupled with the self-help group attendance enabled her to change her perceptions on life. Subsequently, she perceived her outlook on life as much more optimistic and she experienced examples of what sobriety could offer her, such as good friends:

***When I stopped drinking and I started at the group [the self-help group], my life gradually changed from then on. The confidence I never really had I think came to the surface. I was positive about everything and made some good friends.***

At the very beginning of Mick's interview, he had remarked,

***I was always needed to be an extrovert with the women and that, acting the fool and being the life and soul of the party was what I was about so to speak. Good times in a way [staring into space and looking down]. I was a bit of an extrovert, ye know.***

Mick had previously wanted to maintain his confident self-image as an extrovert who was popular with the opposite sex. He felt that to achieve this he needed to show an air of confidence. Therefore, in order to achieve this identity, he turned to alcohol:

I “Did you like to see yourself as an extrovert?”

P “Well yeah, I suppose I did, more popular and that, the beer helped”

He went on to say he felt he needed the alcohol to maintain his image as a fun-loving and confident person:

***I was a Jack the lad if you like, always out for a bit of fun. I felt at the time I needed the drink in order to maintain my Jack the lad image as this over-the-top confident bloke. I think I was trying to be Jack Wild ye know from Oliver. The drinking took over me in the end and I began to rely on it, I couldn't get enough.***

When Mick stopped drinking, he slowly began to re-construe himself as a person not needing to use alcohol as a crutch to bolster his image or confidence. Mick, after eight years of abstinence, now felt the following about himself:

***When I was drinking, I couldn't imagine a life without drink, socially I felt I would be crap and nervous. I wouldn't be able to converse with others. Do you know, I now feel much more confident because I don't have it in the back of my head that I might be making a fool of myself or end up saying silly things and upsetting people only because of the drink.***

Mick contrasts his previous drinking self and his present sobriety. Previously, he felt he would be “crap and nervous” without a drink. Now sober, he actually now feels much more confident because he is not worried about doing something silly as a result of drink - his anticipation of a social life without drink was not fulfilled, therefore he had not anticipated that there would be reasons why not drinking would lead to greater confidence. Both Susan and Mick, since abstaining from drink, felt they had gained a level of confidence which they previously construed themselves as not having without alcohol.

The participants also stated that they felt they were now much more in control of their destiny than they were when they were drinking. Mick said that when he was drinking, the drink ended up controlling his life and the actions he took:

***I am a physically fit bloke, and I could walk for miles to get another drink, it took over my life, drinking was everything to me at the time, it took over my whole way of thinking from when I got up, where is my stash I'm feeling rough, get me drink, force it down, ten minutes, feeling relief, relaxation, not really thinking straight, my mind was all mixed up ye know, what I mean.***

Micks' account emphasises the lengths he would go to in-order to obtain alcohol "I could walk for miles to get another drink, it took over my life, drinking was everything to me at the time". Drinking was central to his daily life at the time-he says it was "everything" to him, and his account suggests his whole self was taken up with drinking. Mick offers a mini description of the scenario at the time-from getting up, feeling rough, finding his drink, and drinking it to get some form of relief and relaxation. His story emphasises the treadmill he was on in his life. In Mick's scenario, he clearly felt as though alcohol was controlling his life at the time. Now sober, Mick confided:

I now make my own decisions about whether to go and watch my sons play rugby or have a day out with my wife... my time is not dictated by when I will need another drink, I am in control not Special Brew.

Mick makes it clear that he holds the notion of agency as important to his own well-being: "I now make my own decisions".

Many of the participants talked of taking back control of their lives now they had rid themselves of spending the majority of their time thinking about alcohol in terms of sourcing it, drinking it and recovering from its effects. They now felt empowered to make future lifestyle choices which they felt were not dictated by alcohol. An example of this empowerment can be seen in Tracy's situation. When asked, "what do you think the changes you have made mean to you?" she replied:

***They have given me back my self-esteem and a sense of being in control of my life rather than just plodding along. I feel that I can make choices and I'm doing things now that I never thought of doing before, like going to university. I would have never have done that whilst I was drinking.***

Tracy feels her changes towards sobriety have meant her life has been opened up to new opportunities like obtaining a degree. Her past drinking self had become in her eyes a person behaving in a routinized, unthinking way as opposed to making choices. She sees herself as now being empowered to find these new opportunities and is no longer restrained by her drinking life. She feels her past drinking blinkered

her views on the potential possibilities of her future. Now she is doing things she never thought of doing before. With her new personal autonomy, she now perceives herself and not the alcohol as being in control of her future. Others cited being free from the “chemical straight jacket” of alcohol which they felt in retrospect, had restricted their choices. Bob confided:

***My sobriety feels like I am free again... I am not under this chemical straight-jacket called alcohol which I feel ended up dictating where I could go, what I could do. Who I could see and what I spent my hard-earned money on, no I feel free now. Not having to worry about how I was going to top up my alcohol levels without anyone finding out, it means I am back with my family and friends in what I would call a real way and not an artificial alcoholic way***

Bob is expressing the view that sobriety for him means freedom. He explains this by using the metaphor of not being under the control of a “chemical straight-jacket”, which he felt was constraining him. In addition, in his eyes he saw the world in a false “*artificial alcoholic way*” when under the influence of drink, this suggests he perceives his new (sober) way of seeing as much more authentic. Now he feels free again and is empowered to make the choices of where he could go and what he could do in the future. He feels he is no longer concerned about having enough alcohol or being involved in the subterfuge and secrecy of drinking it. This sense of empowerment appeared to be extremely important to the participants in this study.

Some participants saw the need to further ensure they maintained their control of their own future by developing coping strategies and avoiding what they construed as ‘risky’ situations for them. They recognised that there are risks. It is suggested that their re-construal of themselves now meant they recognised the potential dangers for them and were able to avoid these.

Tom said he did not avoid places where drinking alcohol took place but kept away from situations where he might want a drink because he felt he would be at risk if he was in a confrontational situation and he wanted to be in control of this type of situation:

***I don't avoid pubs or anything like that, in fact my wife and me go a lot for Sunday lunches and that, no I have no problems with that, but I keep away from any confrontations or situations that will get me all worked up because that's when I would have used my fists or reached for a drink you know what I mean, so I choose the situations I put myself in more carefully, let's put it that way.***

Of particular note is the sentence at the start of the quote, “*I don’t avoid pubs or anything like that*”, which to an outsider observing appears counterintuitive. The logical and most sensible action would be to avoid pubs and alcohol. It could therefore appear as though Tom is going against his gut feeling of avoidance. However, Tom shows insight into what has led to him drinking in the past. Therefore, for him it was not the risk of temptation from being in a pub it was the danger of confrontations. By going to the pub with his wife for Sunday lunch in his eyes it achieved a degree of ‘normality’. Further that it made him feel in control, it was not going to be the alcohol that was in control anymore. Tom appears quite reflective and shows insight into his present and past self. For example, being aware that if he was in a situation where a confrontation took place that resulted in him becoming worked up he would then resort to alcohol arguably to release tension as opposed to getting into a fight. He also is aware of his empowerment to make the choice to not let this happen.

Lisa also talked of her re-construal of herself, saying:

***I am not frightened of the booze or anything like that, but my mind tells me I just don’t want to go there again. When I first got sober, I wouldn’t entertain going to a Christening or anything like that because I didn’t feel I would be strong enough for that. Even when we were meant to go to friends’ houses, I used to say no, I’ve got to keep myself safe. For the first three years after I had made that decision to stop, I protected that position and by protecting it I meant refusing to do things that I knew wouldn’t make me feel good. I would have made myself feel vulnerable that’s the word, but I don’t feel vulnerable about anything like that now***

Lisa describes a situation where, in the initial days of her sobriety, she doubted her self-efficacy; that is, her ability and perceived strength to withstand the temptation to drink in all situations. Again, similar to Tom, she indicates her level of insight and self-knowledge of her own vulnerability. She perceives that she must keep ‘safe’. This is interpreted as remaining safe from her own vulnerability and potential cravings to drink. Lisa’s self-knowledge and insight was therefore prompting her to adapt ways of coping with this vulnerability in an attempt to keep control of herself and protect herself in the early days of her sobriety. Lisa’s re-construal of herself led to a new confident self who was able to remain sober regardless of being exposed to any possibly tempting situations.

### **Feeling trusted**

Many of the participants cited examples of their perceptions of not being trusted in the past when they were drinking. Indications of this were shown in the case of Frances who had been told by her family that they felt she was not fit enough to look after their children when she had been drinking. Now she was sober, she clearly indicated that they now saw her in a different light. This appears to have had a positive effect on her. She now saw herself differently. This is shown in the following quote where Frances was replying in answer to the question, "*What do you feel your sobriety means to other people?*"

I think it means for what I call my small family, my husband, son and daughter and the grandchildren, I think more than anything it means they can trust me and rely on me again. Some people feel they are being used and abused having to baby sit all the time, well I can tell you now, it makes me feel over the moon, just doing normal things like this and not being side-lined like I was in the past which got me very down. I was seen as that funny grandma who says funny things and isn't trusted just to push a pram in a straight line.

The above quote suggests she perceives that her close family now trust her by allowing her to babysit again. In her past drinking days, she was not allowed to babysit. She had felt she was regarded as "*that funny grandma who said funny things*". She perceived her grandchildren as seeing her as someone who was slightly odd, did not make a lot of sense at times and therefore could not be trusted. This may have further made her see herself as an inadequate grandma not worthy and capable enough to fulfil her role.

It is suggested that Frances craves trust and sees it as a yardstick of her success or failure in regaining her relationship with her family members. By being allowed to babysit again, it has renewed her view of herself as a trusted person in her family. It is further suggested that from feeling rejected and being out of the family 'inner circle' she now has a perception of being part of her family again. This had in turn allowed her to re-construe her own thoughts and feelings. She now had much more positive feelings about herself and felt almost ecstatic about this. She uses the evocative phrase "*it makes me feel over the moon*" to show this.



Frances later said, “*the biggest piece of encouragement I got was when my daughter started bringing the kids round again... I felt like a whole person again and it spurred me on to remain sober*”.

Frances’ daughter had reinforced her feeling of being trusted again by bringing her grandchildren to her again. This appears to have led Frances to re-construe her perceptions of herself. She now indicated that she regarded herself as a ‘*whole person again*’ and this in turn encouraged her to continue in her sober state. A “whole person” indicates that she perceived her previous drinking self as a fragmented person because the perceived loss of her grandchildren made her not able to function as a whole person in her eyes.

Matthew indicated that building trust in his relationships with his family can sometimes be a slow process:

***The drink had got me paranoid about all sorts of things like me not being worthy of trust for anything. At one time, I thought they were just getting at me. As the years go by, they all seem to gradually trust me more and this spurs me on to continue much more than any medication would do which I couldn't take because of the history of bleeding. (Taking medication would exacerbate the bleeding from his stomach.)***

Matthew is referring to members of his family who he perceived were at one point constantly criticizing him due to his drinking and did not trust him. Now sober, he sees things through a different light. He feels they are not ‘getting at him’ but are gradually trusting him more and more. This trust appears to be highly regarded by Matthew in keeping his sobriety and he sees it as key to this. However, a further interpretation could be that his family had said he could not be trusted, and he saw this as them ‘getting at him’, which may be denial. That is, he perceived others as unreasonably attacking him rather than seeing their actions as a reasonable response to his drinking.

### **Feeling more rational**

Many of the participants felt they had now experienced a great improvement in their thinking compared with their past drinking selves. For example, Mick said:

***I lost my sense of reasoning and couldn't think of anything philosophically. This reasoning and the finer things in life like me meditating and watching my sons play rugby only returned after a couple of years really. I suppose what do you expect? You can't abuse your body since you were 13 and expect anything else.***

Mick cites his sense of loss about his ability to “*think of anything philosophically*” to be able to reason and meditate. He regards them as things he really values about his thinking capability. He feels that in hindsight he lost these functions at the time of his drinking. He cites examples of his loss of reasoning talking about how he abused his body and his inability to envisage the consequences at the time. Now sober, he suggests that he now has insight into the consequences of his drinking. He now feels he has regained some elements of what he had lost, for example, being able to meditate and watch his sons playing sports.

Mick had confided that physically he had recovered reasonably quickly. However, mentally this had improved very gradually:

***I had a desire for much more than that, not just to feel physically well again but to be sensible again not just some pissed up joker and understand the true meaning of life did not revolve around alcohol. These thoughts and gradual recovery spurred me on week after week and I began to enjoy the changes in me, I was thinking with a clearer mindset, I could reason things and needed to stop for a reason that made good sense to me.***

Mick compares his past drinking life as a “*pissed up joker*” to his need now to be sensible. Earlier on in the interview, Mick referred to his previous perceptions of having a joker image as his way of gaining popularity and that alcohol was a means to achieve this. It is suggested his comparison to being a joker could mean he could see others as not really taking him seriously when he had been drinking. Mick now has the new perception that alcohol would be detrimental to his aspirations to change and to allowing him to see the true meaning of life through his eyes. For example, doing sensible and normal family things like watching his children playing sports. He was now finding good reasons to do these things and continue to do them.

Neil also recalled poor thinking due to his drinking:

***When you get into a survival instinct you don't have to think about what you are doing. When I saw a drink, drink it. You know I thought in two dimensions, think of drink, and drink the drink. The only thing was the third dimension, the consequences and when you sober up whether you know it or not, you start to think in three dimensions. The drink, the drinking and the consequences, and the consequences stop me now from going back. So, I wasn't in a position to think properly, only when you're sober.***

Here, it is suggested Neil attributes his lack of ability to think properly about his actions and consequences to a “survival instinct” similar to the idea of fight or flight where we use automatic reactions rather than our thought processes.

Neil appears to describe himself as almost adopting a robotic ritual when he was drinking “*think of drink and drink the drink*”. He did not want to feel or think too deeply about what he was doing. He did not appear to see or want to see the potential consequences. He may have feared the consequences if he thought too much about it at this time. Sobriety at this time meant facing up to these consequences. In his eyes he was only able to see the consequences of his drinking after he had sobered up. The consequences through his lens appear to be fundamental to stopping him from “going back” to drink.

### **Changes in values**

Some participants appeared to have changed what they valued in life, just as they re-constructed and valued relationships with others (see chapter 6). Here they were valuing and prioritising alternatives to drink, such as family, their new ‘authentic’ self and themselves in general. For example, Frances talked about liking her new self and that she wanted to maintain it:

***I have changed what I considered valuable in life, for example I love my husband my two kids and my grandkids they are what are important to me now, not the drink, at one time when I was drinking it was all about being out and socialising and drink was part of that life. Now my image and being what I call false, because it was just the effects of drink, not real happiness, it was a chemical happiness, false, now that has all gone.***

Francis tells us that she now focusses on and values her family relationships rather than her drinking. She is contrasting herself now (where ‘real’, lasting happiness is to be gained from relationships with people you love) with a previous self, interested in only their ‘image’ (superficiality) and the ‘chemical’ happiness (a quick fix, a happiness that is not authentic, cannot be trusted and quickly dissipates) supplied by drink.

This mirrors much of what other participants have said relating to a discourse of seeing “what is really important”. This in turn offers us an insight into their constructs of their personal change to sobriety.

## Looking forward and looking back

The participants could now see a viable future for themselves to look forward to, a future in which they intended to continue to maintain their sobriety. Secondly, in looking back at their journey to sobriety some participants talk about how their original perceptions of what it would entail have altered considerably. They now show a re-construal of the change process.

## A life to look forward to

All the participants remained optimistic about their futures and did not appear to be dwelling on the past. They were now liking their new selves and wanted to continue to maintain this.

Susan, who had been abstinent for nearly three years, described her feelings towards the future:

***Well, I didn't feel like I had got a life when I was drinking, so the major positive thing is feeling that I have got a future without drink, I felt like I just existed before and now I feel like I have got a proper life to live for and get up in a morning for.***

***I'm working full-time now and one of my daughters is expecting again, so that's good, I can see a future ahead of me, I do it for me obviously, but I have a reason to carry on, my children and my grandchildren have given me that reason to remain sober and continue with it.***

Susan now appears to see a distinct contrast between drinking and sobriety. It is suggested that in her world, she recalls a negative past where she was just 'existing', but now sees a positive future with a meaning to live. She sees a proper, fruitful life contrasted to an existence. She also sees herself moving forward having reasons for doing things and she is fully engaged with her life, which she previously was not.

Many of the participants expressed the view that, in their drinking days, they lived for alcohol on a day-by-day basis and did not want to consider what their future may bring to them. Therefore, now their perceptions of life had been re-construed considerably and they now look forward to their futures. The participants began to anticipate and slowly see themselves in the future as not only sober but capable of maintaining this sobriety and the new self they had achieved. Now they had achieved what they perceived as their new self through abstinence, participants expressed the desire to maintain the changes they had made. The majority of

participants just wanted to maintain what they had now achieved and realised they could do this by maintaining their sobriety. Kath confided that:

***Besides not drinking, I see myself as a content person, not worrying about where the next drink is coming from, I will just continue with how I am now, nothing fancy or mind bogglingly different, my life has now been about that sort of thing***

Kath further remarked:

***You know you are never going to see me pop up on X-factor or ow't like that (laughs) no. It will be just plain old me, doing what I see as normal everyday things, but you know what, it won't be just the same old me because I know I have changed, I know I don't drink and all that, but the reason I don't go on about it all the time is because I have changed, and I like who I am now***

The words, “*but you know what, it won't be just the same old me because I know I have changed*” are an indication that Kath has re-construed herself, now seeing herself as a different person. What may appear to others as Kath's humble aspirations for her future mirror those of other participants. This modesty could reflect Kath's reluctance to push her expectations of herself too far at this stage in her change process. Further, it may relate to Kath and other participants experiencing negativity from others in their past drinking days making them feel unworthy of anything better than these aspirations. An alternative interpretation may be that because Kath has had such bad experiences in the past with alcohol, she is now content with the simple things in life. She appears to look forward to the future knowing she has changed. She likes her new sober self and is content just to maintain it at present. Other people who have not gone through these change processes may perceive Kath's aspirations as appearing very mundane, but for Kath and others in this position it is suggested this ‘normal’ is precious to them when contrasted with the chaotic alcoholics' lives they had led in the past.

### **“The change process was not what I expected”**

This section begins to chart the end of the participant's journey to date. The participants felt they had now gained a greater understanding of both themselves, their world and of the process of change. They had reconstrued their thoughts towards change and were now more aware of its limitations as well as the positives of their transition. Sometimes their previous thoughts and feelings about change did not match their present perceptions of it.

Harry talked about his former idea of stopping drinking and his perception of it now:

***I used to think that you could go to a detoxification clinic and stop there for a couple of weeks and that would be the worst of it over. How wrong I was, you have to be prepared for feeling anxious, depressed and still craving a drink at times. The reality is sobriety won't solve everything.***

Harry appears to be making the point that any problems in life will not necessarily go away just because a person has achieved sobriety. He had now changed his perceptions from believing that sobriety would be easy and relatively quick to achieve. He re-construed his thoughts and now sees its limitations. He talks of 'preparation', which may imply the need for alcoholics to be fully aware of these difficulties when attempting to achieve sobriety. He now understands that this type of change is difficult and can be a lengthy process. He had now gained insight into possibly having to accept that sobriety would not instantly solve his feelings of anxiety, cravings or feeling low in mood just because he had stopped drinking. These things take time and would require further work in order to maintain this changed state. The participants in this study seemed to have seen that giving up drinking can have its downfalls. For example, initially losing that false confidence to socialise and feeling anxious similar to Harry, but that gradually in time real confidence without alcohol will emerge for them.

Mark also appears to have re-construed his idea of change; however, here it appears to be quite different to Harry, where the process appears to have been much more difficult than he initially anticipated:

***I had it in my head that stopping drinking would be like being on a white-knuckle ride for ever more. I thought I would be always dying for a drink but wouldn't be allowed... relying on my willpower to stop myself. Now I'm off it, I have a different view. I admit it was hard at first, physically and mentally, but now I can think of other things and the drink has taken a back seat. In fact, it's got off the bus! My future looks good, bring it on.***

In this quote, Mark has reconstrued his idea of what change would mean for him. He has changed from focussing on the negatives of anticipating "a white-knuckle ride", whereby he would always be wanting a drink but would not be able to allow himself to have one before he went through the process of change. He appears to have been unprepared for the fact that as he became sober his thoughts of drink became less and less whereas he had imagined it would continue to be on his mind for evermore. Now, he is seeing the positive aspects of sobriety outweighing the

negative aspects of his process of change. In addition, his previous drinking self, like others, had focused his attentions primarily on drink. Alcohol has now not been the centre of his life; however, it no longer controls him or to adopt his metaphor “*drink has taken a back seat. In fact, it’s got off the bus!*”

John has also altered his perceptions of what achieving sobriety and changing would mean for him:

***Looking back, whenever the subject of stopping entered my head I thought of being even more miserable. I thought I wouldn’t be able to cope with the shakes and vomiting, I just couldn’t let go I suppose. Going to a big group of other alcoholics well, that really bothered me at first. Now I see it all differently, once I dipped my toe in the water, all that worry is forgotten, and I can get on with the rest of my life.***

John’s reference to “*dipping my toe in the water*” appears to describe him initially being reluctant, similar to a child being reluctant to enter the sea believing it to be too cold. However, upon entering the water things are not as bad as they anticipated. He appears to be telling me that the fears he had about the process of stopping drinking did not materialise. John feared changing initially, therefore, he held back from committing himself to any form of real action to change. He had a certain amount of anxiety at the prospect of attending a self-help group at first. However, his actual experiences of the self-help group and his subsequent changes now made him reconstrue his anticipations regarding change. He now sees his change process in a much more positive light.

Harry, Mark and John all differ in their re-construal of change. Harry initially felt change would be easy and relatively quick to achieve but later perceived its limitations and difficulties. This can be contrasted with Mark and John’s perceptions. They initially had very negative perceptions about what their anticipated changes would involve. Mark was surprised and relieved to find he was not continually thinking of alcohol and John found that having initially “dipped his toe in the water” of the self-help group, it was not scary like he had imagined.

## **Summary**

What appears evident is the number of participants who were encouraged and “spurred on” by the commitment, validation and support offered by significant others. The participants’ re-construal of themselves from negative opinions whilst drinking to more positive opinions of themselves whilst sober give strong indications that they

feel they are now able and willing to continue to maintain their sobriety. They now have generally higher opinions of themselves; they have more confidence, self-esteem and self-belief. They also feel more trusted by others, now having much more rational thoughts and general feelings of being capable of taking on responsibility again. This level of trust appears to further encourage the participants to continue to maintain their changes and to accept that gaining this trust can sometimes be a slow process. Further, they now feel much more in control of their destinies and appear to have a sense of empowerment to make future lifestyle choices which they felt were not dictated by alcohol. As a result, they appear to anticipate that their futures will be positive and successful ones. For some participants, they still had what may seem humble or modest aspirations, which may be interpreted as indicative of the point they are at within their process of change, or this new simpler life might be exactly what they want to achieve. Normal mundane things are enough for them or even prized, whereas others are more adventurous in their aspirations, for example, envisaging finding new partners and new job prospects.

However, they still had the normal problems of life to overcome just like anyone else. They were aware that there may be some negative as well as positive consequences to their sobriety in the future. They indicated that they have had to forfeit certain aspects of their drinking lives which they had previously valued in order to continue maintaining sobriety to date.

The participants could now see a viable future for themselves to look forward to. They were now liking themselves and were construing a negative drinking past contrasted to a positive fruitful future. Change was not always what the participants anticipated it would be. Their expectations ranged from thinking it would be relatively easy only to find out it was more difficult in practice to others expecting difficulties and then finding it not as bad as they initially expected.



## CHAPTER EIGHT: DISCUSSION

### Aim and summary of main findings

#### Aim

To understand the role of personal meaning in achieving and maintaining sobriety in a sample of alcoholics attending non-AA self-help groups.

#### Summary of main findings

The mainstream approaches to alcoholism emphasise planning and the need for people to understand how damaging heavy drinking is to their health, in order to motivate them to change. However, my findings challenge both of these assumptions.

The findings revealed the importance of the role of imagination and anticipation in the sense of the participants anticipating and imagining a new sense of themselves; particularly at the beginning of their journey through the change process, but also in imagining maintaining this sobriety. The findings indicate that this new self often aimed to achieve for the participants what 'normality' meant for them. The concept of planning for the participants was different than that advocated by the TTM, where it is seen as a key idea and a mainstream view of alcoholism recovery. My findings are different in the sense that the participants utilised their imagination and anticipation, particularly in the early stage. For example, within the TTM it is assumed the alcoholic will be sufficiently motivated to change to the extent that they will make conscious and coherent plans to do so. Rather than planning in this traditional sense, I found that my participants did not necessarily plan, describing it as more 'spontaneous'. The idea of anticipation could be a new way of thinking about what happens in these stages; for example, the idea of motivation may be replaced or at least augmented by the PCP idea of anticipation and imagination constituting the early stages of change. A recoveree's positive construction of themselves may begin with them imagining new positive ideas about themselves and an anticipation or expectation of a brighter, more fruitful future, such as sobriety, a new job or partner. Further, there was a recognition of feelings of fear and loss (of important relationships) as an important catalyst for change and a desire to repair damaged images, reputations, identities and overcome stigma. For many of the participants,

this was much more important and influential than their health concerns as a result of their drinking. There was an acknowledgment of the importance of different forms of social interaction in offering traditional practical support but also validation of the participants 'new self' (from family, friends, and support groups). The findings also suggested that the participants who were successful in their recovery had a sense of agency and needed to 'own' the change process they were going through. This meant the choices and decisions they made about their individual futures needed to originate from themselves (they needed to be in the driving seat) as opposed to being advised and guided by others. The findings indicated that the participants had expressed various key changes in themselves at the end of their journeys to date. These changes included changes in their values in life, confidence, self-respect, self-esteem, self-belief, feeling in control, being empowered and feeling trusted by others. Lastly, the process of change was not what a number of participants were expecting; their previous thoughts and feelings about change did not necessarily match their present perceptions of the process of change. For example, for some participants, the process was not challenging for others - it was more challenging or challenging in different ways from what they anticipated. It could be argued that being aware of what the process will be possibly like may help the alcoholic in getting started or in the process more generally.

My findings supported the importance of a constructivist biopsychosocial approach and adopting a Personal Construct position focusing on what the issues meant to the individual alcoholic. The PCP approach encouraged participants to convey how they had construed and made sense of their experiences which had led them to anticipate and act on these experiences. Further, it invited them to convey how their experience of the PCP concept of validation or invalidation by others had either helped or hindered their achievement and maintenance of sobriety.

#### Contribution to knowledge

The thesis presents an innovative approach to the study of recovery from alcoholism. The 'paradigm shift' in basic assumptions about recovery outlined in Chapters 2 and 3 tells us that our ideas of 'recovery' have fundamentally transitioned from seeing recovery from a disease model perspective, where things are done for the recoveree by practitioners, to the idea that recoverees are self-determining and are capable of making their own decisions about their recovery paths. However, much of

the existing research looks at change in the short-term: maintenance of sobriety in the longer term is under-researched. The thesis therefore contributes important new knowledge in this area. The key main contributions include the importance of anticipation and imagination in the initial stages replacing or augmenting traditional planning as seen in the TTM. A further contribution is the recognition of the importance of validation in the PCP sense as a form of social support and the anticipated loss of important relationships/reputations acting as catalysts for change.

## **Discussion of key findings**

### The role of imagination in anticipating, achieving and maintaining sobriety

The findings revealed that the participants began their journeys to sobriety by anticipating a new sense of self. Often, when people have been in the depths of their alcoholism, my findings suggest they cannot usually see how their lives will be in the future; however, this study found that the participants talked about imagining casting themselves into a new future self; for example, doing well at work and imagining possible promotions in the future, finding new partners, and generally feeling more confident without the need for alcohol. Further, regarding imagining and anticipating a new sense of self, it is suggested this may be a different approach to how we conceptualise this early stage of change. Such processes have not been considered in previous psychosocial approaches such as the TTM, MI or SDT. My findings suggest that for some participants this anticipated change caused a degree of threat, fear and/or anxiety. However, their use of imagination allowed them to 'rehearse' these changes in advance, therefore alleviating their feelings of threat, fear and anxiety to a certain extent. This point can be compared with the TTM approach. For instance, in the early phases of this 'stages of change' approach, it refers to a pre-contemplation stage, where a person has no intention to change and is not even thinking about change, followed by a contemplation stage where the person begins to think about change and then a preparation or planning stage. However, there is no evidence of a role for the concept of anticipation as in PCP. Like the TTM, people do go through different 'phases' before any changes take place. However, my findings suggest that rather than the concept of planning in the TTM sense, maybe we should emphasise the concepts and roles of anticipation and imagination contributing to the process. As discussed in the methodology (under the heading 'Understanding Behaviour'), the concept of anticipation relates to individuals always casting

themselves into the near future. They are involved in a continual process of anticipating and striving to make sense of their experience. Therefore, from a PCP perspective the person's 'anticipation' in effect could replace or augment what 'motivates' the alcoholic.

According to Di Clemente et al. (1991), the stages of change models describe how people change problem behaviour by having sufficient motivation to both plan for and reach various stages of change. According to TTM theory, motivation is an important first step towards behaviour change. Further, a person will not complete the desired behaviours until they are motivated to do so (DiClemente et al.,1999). In the TTM model, motivation is seen as the process that drives a person to meet their needs and wants to for example, progress to a different stage. This appears to imply that the passive or inactive person (in this case the alcoholic) would not take any action until they are either pushed or pulled into activity. This is subtly different from the process in PCP. According to PCP, we always have an innate need to project ourselves into the future by anticipation and construing (Kelly,1955). This is shown by my findings indicating the participants talking of how they had imagined a more fruitful and productive future life for themselves, imagining themselves behaving differently and therefore anticipating a different future for themselves. Therefore, these future predictions or expectations of our future replace, or it could be argued perhaps augment the concept of motivation when seen from a PCP perspective. In effect we do not need to be driven or motivated because we are always in action anyway, construing events and experiences and drawing personal meaning from them which subsequently give us our anticipations or expectations for the future.

Therefore, referring to the early stages of the TTM; if the unplanned stopping of drinking is so prevalent, and it is suggested that there is some objective evidence that it may be successful in the arguably similar addiction of smoking (Larabie, 2005), this suggests that the traditional perception of motivational 'planned' stages of change may be put into doubt. My findings provide some support for the idea that at least some unplanned attempts to stop drinking are successful.

It is argued PCP sees successful change not in terms of how highly motivated a person is to change, but in terms of whether they can re-construe their perceptions of the world around them, leading them to anticipate a meaningful future self that is consistent with the desired changes. It is argued that this anticipation of a meaningful

future may replace or at least augment the more traditional ideas of motivation and coherent detailed planning with the TTM. The alcoholic's past experiences may lead them to imagine a better life for themselves and anticipate a more fruitful future. They then act upon this anticipatory sense of a better life. They seek a prediction and experiment with this prediction with their behaviour. This results in their anticipations being validated or invalidated.

Empirical evidence of the value of imagination can be found in a study by Buirs and Martin (1997). They studied six substance users who were encouraged to imagine (in psychotherapeutic role play) two scenarios, one playing an alcohol/drug using person and one as a person where alcohol or drugs was no longer part of their lives. They found that although the participants found it easier to imagine the drug using self and express and explore their imaginary feelings in this scenario, to a lesser extent, they were still able to imagine and explore the feelings of a person no longer using alcohol or drugs. Therefore, it was found that by directly involving the alcoholic in role play and imagining their own constructions of their possible futures, this constructivist approach was able to assist the alcoholic to anticipate through imagination a better future for themselves.

In the alcoholic's situation, it is suggested this may extend our understanding of the usefulness of imagination as a therapeutic tool. Many of the participants in my study showed how they imagined themselves not being drunk and the imaginary positive feelings this gave them. In their study, Buirs and Martin suggest that this imagining may have helped their participants to produce new feelings and experiences about their addictions.

A further consideration is how imagination is linked to MI and Change Talk. As mentioned in Chapter 2, the overall aim of MI is to not only elicit but also reinforce people's change talk in relation to alcoholism recovery. MI places emphasis and importance on both listening for and eliciting change talk as a key counselling skill (Miller & Rollnick, 2013). Moyers et al. (2009) found that if a person hears themselves using language (change talk) advocating change they are more likely to act upon these verbal commitments. In a similar way to Change Talk I would argue that the idea of participants being encouraged to use 'imagination talk' to express their imagined changes may be a useful possibility. This idea as a possible

intervention linked to imagination will be further discussed within the recommendations for practice section of the thesis

A further finding was the ability of (admittedly a minority) of participants in my study to anticipate potentially negative outcomes of their drinking through imagining feelings and experiences of things deteriorating in their lives to an extent that would be unbearable and unacceptable in their eyes. This may be similar to the studies of Laudet (2007); Yeh et al. (2009); Laudet et al. (2002); Hill and Leeming (2014); Yeh et al. (2008) and Dyson (2007), who found that their participants talked of being at rock bottom as a point where they felt they need to change. However, the difference in my study was that in all these previous studies their participants had actually lived the experiences of being at 'rock bottom' before any changes took place. It is suggested that a novel finding in my study was the idea that some participants were imagining this 'rock bottom' scenario without it actually happening. Therefore, they were not only able to anticipate and rehearse this potential event in their imagination in advance but also had the choice to abstain from drinking in order to prevent it happening in reality.

The value of imagination in PCP has been expressed in different ways in the past. For example, Kelly (1955) as discussed in Fransella and Dalton (2000) and Bannister and Fransella (1993) suggested Fixed Role Therapy (FRT) as a useful PCP clinical technique in helping people achieve personal change. In FRT, a character sketch is drawn up for someone to act out over a few weeks. The person is aware they are acting, and they do not become the person they are pretending to be. It aims to enable a person to think differently and encourages experimentation. Its purpose would be to let the person experience a possible change in their behaviour, but in a safe environment and only for a limited length of time. The person would be utilizing elements of their imagination in role playing. Fransella and Dalton (2000, p.111) suggest "*with the protection of the counsellor's support and the mask of make believe*" (in applying this to alcoholism) the alcoholic can have the freedom to act differently without committing themselves to this way of being on a permanent basis. As Bannister and Fransella (1993) suggest, by using fixed role therapy they would not have to fundamentally change but just slightly change from their present role for a short length of time.

Positive and constructive use of imagination and role play is also consistent with other PCP thinking. For example, Kelly (1955) would possibly direct us towards the organisation corollary (outlined in **Appendix R**) and, more specifically, to where the person's constructs are left loose. A loose construction can be described as where we loosen up our thinking so that we are able to construe our experiences in a variety of new ways, not just ways that have become persistent, established and firmly fixed for us. Tight construing is where we are more committed to a way of construing, often because we consider it safe and something we know and are used to, even though it may not be useful or facilitative for us. PCP tells us we use loose constructions when we fantasize and dream. Boeree (2006) suggests this is where anticipations are broken free of their usual constructs and odd combinations of construing are permitted. The participants in this study had utilized their imaginations in order to imagine the benefits of the experiences of sobriety. PCP theory informs us that when we are being creative, we first loosen our constructions. Boeree comments that when we find a novel construction that looks like it has potential, we focus on it and tighten up. This may have been what the participants had done in this study having firstly imagined a new construction of themselves, 'imagining a sober life'. They may have been in effect, as Boeree suggests, imagining the idea of sobriety and then acting upon this idea and trying it out. It is suggested the participants were now finding new personal meaning and ways of behaving i.e., imagining sobriety and what it meant to them. It could be reasonably argued that the use of Fixed Role Therapy is effective in certain situations because it encourages this loosening of constructs.

Fisher and Savage (1999) comment that one way of loosening our constructs is by the use of play and imagination. Therefore, when we use loose constructs by using imagination to experiment, this can play a role in change because we can safely try out new things or as Kelly (1955) suggests 'experiment'. It is suggested that by using their imagination, the participants were using a method which they considered safe to try out 'new things'. This was without having to fundamentally change all elements of their existing personality in order to achieve some form of change.

My findings revealed a further example of how participants used their imagination. The literature suggests that relapse is influenced by how the alcoholic copes with stressful events including family conflict and pressure from peers (Sureshkumar et

al, 2017). Therefore, my findings suggest that some participants who still found ordinary activities of daily living stressful (even when sober) could overcome this stress, by using their imagination to rehearse anticipated future scenarios in their minds in advance of the event, for example attending a small family gathering without having to be drunk. Being able to achieve these tasks sober held a great deal of personal meaning for the participants and this use of imagination to rehearse these scenarios in advance allowed them to continue to remain sober and avoid the risk of relapsing back to drink due to their perception of a stressful event.

Therefore, it is argued that a person's ability to imagine, anticipate and therefore rehearse future possible scenarios in advance can also act as a potential coping strategy to avoid the risk of relapse.

#### The value of support, encouragement and validation of the participant's 'new self'

My findings gave examples of family and friends giving practical support by taking the participant to the self-help group meetings and to the hospital or doctors. Self-help groups can be seen as a particular form of support gained from positive relationships. This study's findings revealed how encouragement and practical support together with the importance of validation through positive relationships with family and/or friends and in self-help groups were perceived by the participants as crucial in enabling both the changes to be made and their maintenance to be continued. In my literature review (Chapters 2 and 3), I mention the value of validation when referring to both SDT and MI and MI's accompanying Change Talk.

Sarpavaara (2014), in his study considering change talk, recognizes the value of validation and invalidation and his findings appear to be consistent with my study in the sense that the findings recognize the varying construal's of people and how they may help or hinder their recovery at the time. Therefore, I am suggesting his understanding of change can be interpreted within a PCP framework through the concept of construing. SDT and MI both promote the notion that a recoveree's choices, feelings, emotions and decisions regarding their recovery paths need to be understood and supported by others. Further, achieving a positive change of behaviour needs to be seen by significant others as crucial to the recoveree's recovery journey and needs supporting and validating. SDT and MI are consistent with PCP in that they all recognise validation as a further form of support. It is an



important concept in our relations with others, especially when we are attempting personal change. We are constantly being validated by others and people are always involved in the maintenance of one's sense of self through validation. Validation does not necessarily mean others' approval, but rather that they confirm our predictions and, especially, our core constructs. In the case of personal change, we need support from others in order to validate our 'new me'. Who we are is therefore not just dependent on ourselves, it also depends on the other people we share our lives with. What we make of ourselves also depends on how others construe us. In terms of my participants' experiences, validation meant others in their lives behaving towards them in a way that was consistent with their new construal of themselves. An example of this acceptance of this new self was seen in the example of a woman being perceived as capable of babysitting again leading to the participant seeing themselves as a full part of the family circle.

Studies on achieving and maintaining sobriety from alcoholism, (Klingemann, 1992; Klingemann, 2012; Vaillant, 1995; Hill and Leeming, 2014; Yeh et al., 2009; Laudet et al., 2002; Yeh et al., 2008 and Dyson, 2007) and the theories outlined by Prochaska and DiClemente, (1982, 1983 and 1984) and Prochaska et al. (2006) all refer to the positive contributions of social relationships of various kinds. These have been found to be effective whether on an individual one to one basis, as part of a family dynamic or a self-help group. They have been regarded as being crucial to achieving and maintaining sobriety including long term sobriety. Significant others such as family and friends and the meanings they hold for the recoveree, are also important to an individual's recovery as are the use of positive social networks (Sarpavaara, 2014). My literature review considering motivation, suggests that family and friends can either encourage and promote change or hinder a person wanting to change. Therefore, in addition to promoting intrinsic motivation, significant others appear to be an important factor either helping or hindering change, indicating that the role of social factors are also as important as intrinsic motivation (Sarpavaara, 2014). Laudet and White (2008) suggest that successful recovery may also be dependent on the type and quality of the network of resources and people involved in a person's recovery, which I suggest will include the type and quality of the recoveree's relationship and interaction with their families. My findings suggest the dynamics of the whole family in terms of roles, values and how the members interacted and

related to one another were considered crucial for many of the participants successfully changing. Participants talked of the importance of positive relationships, for example families encouraging, supporting, and showing confirmation that they had been doing the right thing by stopping drinking. My findings and those studies reported in my literature review all suggest that different kinds of social support can have many benefits that may contribute to achieving sobriety from alcohol and other drugs over time. This general contribution of social support and interaction can also be gained from the work environment (Moos & Moos 2007); Klingemann (1992) and the contributions of the partners of the alcoholic (Blomqvist, 1999). My study's findings have been consistent with these ideas regarding partner support and the importance of the roles of families and friends and peers in supporting the individual (Moos et al. 1982; Beattie and Longabaugh, 1999; Laudet et al. (2002). However, in addition, a further form of support revealed by my findings was that of validation (in the PCP sense).

In addition to the kinds of support already outlined is the PCP idea of validation and its opposite, that of invalidation. As described in the methodology chapter, validation in the PCP sense could be described as a different form of support in contrast to practical support (e.g., taking a relative to self-help group meetings) and support by encouragement. My findings suggest that this is a form of support not usually mentioned in previous studies (with the possible exception of Hill and Leeming, 2014), where they refer to the importance of validation in regaining a positive identity). However, the use of validation was found to be a key element in my participants' successes in both achieving and maintaining their sobriety over the longer term. Kelly (1955) used the word 'validation' in the sense that validation takes place when a prediction we make as a result of our construing is confirmed by others such as family and friends. 'Predictions' can be seen as our expectations as a result of our construing, and these expectations are shown in our behaviour. If the alcoholic now construes themselves as having the ability to remain sober, they will act accordingly with the expectation (prediction) that others will respond accordingly.

Using PCP as an overarching interpretive guide for this form of validation, the following could be reasonably argued. The participants could not just decide to be a different sober person, it was not just their decision. It was found to be other people who would decide whether or not they would accept the new person and their new

ways of behaving. For example, if the participant wanted to become a 'new self' however well motivated they may have been (in the TTM sense), they needed their relatives and friends to take this new self seriously. This involved relatives not only accepting the changes, but showing this by (if needed), being prepared to change their own day to day roles and therefore showing validation for the changes. Family and friends may 'approve' the changes and may have been trying to advise the person in the past. However, they sometimes invalidated this 'new self' because it would mean they would have to adopt a different role in relation to the alcoholic for example, the participant who said she thought her family would not validate her because it would mean they would not be able to continue to manipulate her. Butt (2008) refers to change as always involving a package deal. The alcoholic may stop drinking but this may also entail losing confidence. Therefore getting what we want can sometimes also bring things we (or others) did not want but were perhaps unaware of.

However, I found that this different role was achieved for some participants in this study by families, friends and significant others showing acceptance of what the alcoholic wanted to achieve in life, treating them accordingly and therefore showing validation. Therefore, it is argued that others' perceptions, including the general public, are crucial in achieving the identity the participants want and subsequently in maintaining their longer-term sobriety. However, this form of support through validation is not always apparent. For example, Hill and Leeming (2014) (referring specifically to alcoholism recovery) found that there was no guarantee that others would accept the change to sobriety. It is suggested that we cannot always rely on all family members construing things in the same manner or necessarily supporting a person in the same way just because they are considered 'family' or 'friends'. Hill & Leeming suggest that we cannot be sure that others will accept the changes and value the person who is now not drinking. Further, they found that despite many years of abstinence their participants still expected to receive negative judgments from others regardless of how these others actually thought or behaved towards them.

My findings were slightly different from those of Hill and Leeming's in the sense that they revealed that a small number of participants talked of family and/or friends who, actually did negatively view the participants. Rather than offering support through

validation, they felt they had hindered their recovery. This form of invalidation was shown by relatives who for whatever reason were unable or reluctant to relate to the person in a way consistent with their new vision of themselves. The findings in my study refer to relatives who had become accustomed to the participants' drunken, unintelligent and unassertive conversations with their relatives or friends. Some participants revealed in their accounts that their relatives had become used to taking control of the situation and were subsequently thrown off balance when confronted with a sober and assertive person who was now taking control of their own life. Therefore, validation also involves significant others changing or adapting their behaviour in order to validate the alcoholic's new self. The TTM, SDT and the intervention method of MI/Change Talk also acknowledge that people in general who are involved with a recoveree can either positively or negatively affect the alcoholic's aspirations to achieve recovery by how they address their own behaviour. This point is further reinforced by my findings which suggest that the majority of the participants in the study sample did gain support, encouragement and validation from some people but not always from all other people. It is not clear from their accounts whether this had any long-term adverse effects on them as long as they were validated by someone. However, there was evidence that receiving no acknowledgement or any form of support or validation throughout their journey to sobriety did affect some participants. It is argued these findings further reinforce the critical importance that positive support and validation through social interaction can have in achieving and maintaining sobriety.

### Perceptions of planning

A possible contrast between the TTM model and my study was in the perception and subsequent definition of the extent of planning for achieving sobriety for the participants. Throughout the thesis I have challenged the traditional assumptions about how we plan by drawing on the PCP concepts of anticipation, imagination, and the role of personal meaning. For example, although the participants in this study had felt they had the personal autonomy to make their own choices and to plan ahead, only three had described planning their journey to sobriety. This was in the sense that they could state how they had thought of the things they would do to move from alcoholism to sobriety. However, DiClemente and Prochaska (1982) argue that people make conscious and coherent plans in order to be successful in

making changes. Contrary to the TTM theory, fifteen of the eighteen participants in this study expressed the view that it had been unplanned. This finding has a degree of fit with the findings of Larabie (2005) where the majority of participants also experienced unplanned change.

The TTM advocates that people consciously make detailed and coherent plans (or at least ought to make such plans even if they do not naturally do this) for their future transitions to sobriety. In contrast to this notion of 'planning' my findings suggest that participants anticipated their futures utilizing their imaginations. I am arguing that the TTM is right to believe that something happens to the individual before change occurs, which in the TTM case involves the notions of pre-contemplating, contemplating, and preparation/planning before any action takes place. However, I am suggesting that there could be an elaboration of the TTM stage idea. The possibility of the idea of a person experiencing an event and subsequently constructing a recovery pathway for themselves needs to be acknowledged by health care professionals as well as significant others e.g., family, friends, and self-help groups. Regarding the TTM, recognising and acknowledging both imagination and anticipation could be a new way of thinking about what happens throughout the change process. For example, the traditional idea of motivation may be replaced or augmented with the idea of anticipation and imagination also contributing to a recoveree moving through the stages.

Further, the participants in my study often had a number of small 'turning points' due to particular experiences causing a sense of unease for the participant. This led to a key process of re-construal over a period of time as participants began seeing things differently. There was not one type of event that had the same meaning for all, it was whatever each individual perceived as of importance to them. Therefore, we should be thinking more about personal meaning, anticipation, and imagination. My findings suggest that the earlier phase of change by the participants may be a build-up of small 'turning points'. These could be lengthy and less distinct than the stages the TTM advocates. This suggests the idea of much smaller 'turning points' may be a further finding in how we understand the process of change.

Further, my findings suggest the idea of traditional planning (conscious, coherent, and detailed as in the TTM sense) in this sample, appeared to be counterproductive for some of the participants. For example, some of my participants said that if they

had thought too deeply about the positive and negative implications of the changes they were going to make, the negatives such as the anticipated withdrawal symptoms, may have prevented them from wanting to change and would therefore be counterproductive. Further, it appeared as though the participants hadn't made any precise resolutions to change (for instance *'I am going to stop drinking on January 2<sup>nd</sup>*) and it was not expressed by any of the participants that the power of the decision itself was enough. According to the TTM, people decide to change having thought and weighed up the advantages or disadvantages of changing. However, it is argued that for the participants in my study, they showed that although they were well aware of the advantages and disadvantages of both remaining an alcoholic and of sobriety, the situation was more complex. Tschudi (1977), working from a PCP perspective, explains that we are often less able to anticipate and articulate the advantages of remaining as we are compared to the disadvantages of change. When we want to change, we can usually only see the downside of remaining as we are, and the advantages of changing. These 'pros' and 'cons' are not always easily articulated and relate to individual perceptions therefore, others advising a person of the 'pros' and 'cons' invariably fails. Further, the work of Butt (2008) and the idea of a package deal further reinforces the idea that achieving sobriety will always have gains but also disadvantages when seen from the individual's perspective. Tschudi developed his ABC method as a way of enabling clients to articulate their perceived disadvantages of change and advantages of not changing. My findings showed that the participants perceived certain potential losses such as a loss of identity, for example a person who formerly saw themselves as socially the "life and soul of the party".

For the participants in my study, the personal meaning drawn from the experiences has led them to imagine a better life. They have then acted upon this. Similarities can be drawn here between SDT and MI and PCP theory in the sense that all these ultimately aim to achieve recovery which is determined by the recoveree's own initiative to achieve a better life. Further, they all aim to create a sense of personal agency for the recoveree. From a constructivist perspective, they were empowered enough to take charge of the decision to change and own it, having firstly been aware that this change was due to the evoking of some significant personal meaning for them. Often participants did not recognise a planning process and they did not

identify their changes as being a 'conscious' and 'coherent' detailed plan of action. Through their eyes, they construed their changes as sometimes being more of a spontaneous unplanned act. It is suggested this perception of 'spontaneity' could have been alternatively described in PCP terms as the participants' gradual or sudden re-construal of an event or events having significant personal meaning which then promoted change. As mentioned earlier, these moments of re-construal and significant personal meaning can happen at any time. Therefore, a PCP approach tells us that we cannot force a person to change if the person is not ready to change and additionally, we cannot predict when that point of 'readiness' will be.

Some of the participants conveyed through their transcripts that they had modest future aspirations of just returning to a life of their individual perception of 'normality'. They no longer wanted to stand out from society as a drunk and valued this normality. It is suggested that for some of the participants what others may see as modest aspirations, by looking through their eyes they were seeing major leaps forward. It is argued that this is an example of where it is necessary to take note of the alcoholic's own subjective personal meaning of their alcoholism which will differ from one alcoholic to another. What is regarded as a success for one may be seen as a mediocre improvement for another alcoholic. It is the relative contrast between the drinking self and the sober self and what they anticipate are their future aspirations. These will include aspirations just to do what they consider normal everyday things which can be perceived as a big success from their perspective. Other studies such as those relating to the bio-medical approach (Jellinek, 1960), appear to have focussed on abstinence alone as their measure of success. However, this study's findings suggest that success was judged not only on abstinence and eventual sobriety but achieving their own view of normality as they saw it and were comfortable with.

Medical perspectives may view success in terms of an improvement in health and the TTM may view success as abstinence and eventual sobriety. However, my findings suggest an additional element, that of the alcoholic feeling content and comfortable within their own expectations of a normal lifestyle for them which they are able to maintain.

However, in addition to seeing the potential benefits of holding onto and maintaining their new selves, many of the participants also anticipated the potential downsides of

continuing to drink such as experiencing a major loss of a cherished relationship. This potential loss further encouraged them to change their behaviour, an issue I will now go on to discuss.

### Fear of loss as a catalyst for change

The participants both anticipated and sometimes experienced losses due to their drinking, for example the loss of a relationships with family which held highly significant personal meaning for them. Further, the fear of losing their reputation had a great deal of personal meaning for some participants. The participants began to take some kind of action at the time that they began to fear that they were going to lose important relationships that had strong personal meaning for them. The losses that the participants anticipated were not the same for everyone. It was the idiosyncratic meaning that the imagined events held for people that was important. This was particularly true pertaining to the participants health matters. An outside observer may for example, think that the thought of potentially dying due to drink may stop them drinking however, the idea of dying looking through the alcoholic's lens in this study did not necessarily have the same meaning for everybody. Nevertheless, this fear of loss if they did not take any action and change, acted as a catalyst for their changes. The study participants revealed that there came a point where they had a moment/s of construal or re-construal into something or things that had evoked significant personal meaning for them. On occasions this was an anticipated sense of real loss of a relationship if they didn't stop drinking. This could be described as an example of a low point (or personal nadir) in the alcoholic's life which is followed by a 'turning point' as described in the studies of Laudet (2007); Yeh et al. (2009); Laudet et al. (2002); Hill and Leeming (2014); Yeh et al. (2008) and Dyson (2007). These studies revealed that the turning point was where the alcoholic had lost something that meant a great deal to them and as a result they began to change.

This is similar to Vaillant's (1995) findings, where his participants experienced a job loss or feared losing a spouse who was threatening divorce. He found that these experiences and fears had acted as catalysts for change, rather than it being some form of professional intervention such as medical advice from a doctor which had persuaded them to change



However, in my study the participants appeared to have found the determination because the anticipated significant meaning of loss that their drunken behaviour had evoked meant they wanted sobriety so badly that they acted accordingly. They began to perceive their alcoholism as meaning losing friends, good relationships, and reputations.

As mentioned earlier, Laudet et al. (2002) refer to 'hitting rock bottom' as being a point where a person realises how much they have lost through substance abuse and how much more they could potentially lose if they did not stop the drinking. Further, Yeh et al. (2009) found that their participants talk of a personal nadir (hopelessness and uselessness) before the turning point happens. My findings indicated a further element to the notion of a personal nadir and resultant 'turning point'. The participants appeared to experience a number of smaller personal nadirs or low points and turning points which culminated in change rather than just one event. I would argue therefore, that change can be incremental in nature. This further reinforces earlier comments that achieving and /or maintaining sobriety is often a slow, complex, and difficult process. Further, the participants had sometimes anticipated the negative consequences of continuing to drink which had resulted in them avoiding a significant loss of some kind, for example, (for some participants) the significant personal meaning of a loss of their reputation (which looking through their eyes, had been a good reputation) or the loss of a relationship. Their perceived potential loss of their personal reputation and identity was much more important and influential than, for example their health concerns as a result of their drinking and again was much more of a driver for change than any health intervention measures.

It is suggested that this anticipatory sense or fear of losing reputations may have been further exacerbated by negative public opinion, leading to alcoholics being stigmatised affecting their chances of achieving sobriety (Dyson 2007; Keyes et al. 2010). My findings showed that some participants anticipated that others would see them as 'a bum' regarding their behaviour as an alcoholic. Further, Hill and Leeming (2014) talk of the stigma surrounding alcoholism and the need to uphold a positive sense of self when transitioning to sobriety. My participants managed to uphold a positive sense of self often through imagination. In other words, even before the change they were able to hold on to a new self through their imagination, for example imagining and anticipating finding new jobs or new partners by being sober.

In a sense, the use of their imaginations of their new selves almost 'drew' them forward towards their new futures. This is an example of where the concepts of imagination and anticipation may replace or augment that of motivation in our understanding of their change.

Further, besides these anticipatory and actual losses instigating change in people, there were findings recognising the critical importance of different forms of positive social interaction contributing to supporting the change process, as follows in the next section.

#### Support from self-help group settings

As mentioned at the beginning of this section, self-help groups can contribute an invaluable form of support through relationships encouraging social interaction between individuals. My findings have also revealed the benefit of social interactions and relationships to both give practical support and support in the form of validation in group settings to compliment and sometimes replace the role of families, friends, peers and others. Vaillant (1995) suggests that sources of inspiration, enhanced hope and an improved self-esteem are useful in enabling the alcoholic to maintain abstinence. He suggests both religious groups and participation in AA groups can provide sources of hope and self-esteem, provide group forgiveness and lessen feelings of shame over past relapses and its effects on others. However, Vaillant suggests the alcoholic does not necessarily have to attend AA type group-work to receive these enabling factors. It is suggested that other self-help groups (similar to the ones attended by this study sample) besides AA can fulfil these roles.

My findings suggest the participants found it beneficial to use a group of what they saw as like-minded people. They had a common goal of achieving sobriety which they felt they had achieved by listening to and learning from each other. One way of interpreting this is by applying social learning theory and vicarious learning (Bandura, 1976), however, PCP theory may suggest another way of looking at this. It can be interpreted using the PCP ideas of the commonality and sociality corollaries (as explained in **Appendix R**). The participants talked about what they saw as the advantages of the group. They felt the other members were on the same page as themselves and they could recognise themselves in others. It is argued the groups were successful because they fostered commonality, that is, group members will

share some similar construing as they are 'like-minded people' and also sociality (being able to see things from the other members point of view). This empathetic understanding is important because it promotes connectedness to other group members and a bridge of understanding between them. This social connectedness may be helpful in the sense that a recoverees' attachment to supportive relationships can give the person a feeling of belonging. A bridge of understanding can be nurtured because they are 'like-minded people' with similar problems and needs.

The participants appear to have benefited from observing and learning from people who had all gone through the same problems as them. My findings also revealed that participants found support by learning from other group members about various strategies to continue to maintain their long-term sobriety. One of the strategies included the group members talking to each other about their own bad experiences connected to drinking alcohol, therefore, reminding the participants of their own bad experiences linked to drink. This 'reminding' has similarities with previous studies (Yeh et al. 2008; Vaillant, 1995) where participants emphasised the value of recalling the negative aspects of their former drinking selves.

Further, it is argued by Humphreys et al. (1999) that enhanced friendship networks within self-help groups dealing with substance abuse can be beneficial in recovery and therefore could be a means of therapy in itself. This is revealed in my study's findings whereby participants indicated that they used the self-help group for both therapeutic and social purposes and occupying their time. Further, they felt the group helped them fill the gap left after withdrawing from alcohol. This sense of 'loss' appeared to suggest a need for a replacement to fill that gap. Activities such as chairing the group meetings had enabled participants to feel they were giving something substantial and meaningful back to the group which filled this gap. It is argued that a common consensus of opinion may tell us that stopping drinking will always be seen as a gain rather than a loss. However, my study's participants talked of many gains but also tempered with some losses in a similar way to Butt's (2008) concept of change as a 'package deal' mentioned earlier in this chapter. Therefore, this evidence of additional support indicates the importance of self-help groups in maintaining long term sobriety.

However, my findings also suggest there is also a need to be aware of the risk of over dependency on self-help groups. For example, there was evidence from the

study that some of the participants did not want the feeling of dependency on the group and of feeling compelled to attend meetings which may equate to being 'addicted' to another 'drug' similar to their past addiction to alcohol. In sum, the participants did not want further feelings of compulsion, or addiction, with the need to be weaned off a particular intervention. They expressed the need to make their own choices and decisions in life by being empowered to do so. This self-determining nature of striving towards this independent self who makes individual choices and decisions about their recovery journeys, it is suggested, could lead to the recoveree developing a more positive identity. This point is reinforced to a certain degree by the findings of Hill & Leeming (2014) and Best et al. (2018) who advocate the need for the recoveree to develop a positive identity and view of oneself. This may allow them to stop construing themselves as a user or addict and develop a more positive and new view of themselves as a person with a different more independent identity. Webb et al. (2020) recognised this identity shift in their study with people who had achieved long term recovery for over three years. They were moving from seeing themselves as the kind of person who showed gratitude towards others and dependence in early recovery to one of exploration and risk taking and later distancing themselves from other group members. This is considered as a good move because it means they are experimenting with their new selves and new behaviours. This is not dissimilar from elements of my own findings regarding self-help groups where some of the members felt they needed the group initially, but later expressed views of feeling it was time they continued to maintain sobriety without the help of the group. This seemed a logical move for them to further their independence which improved their self-esteem and self-worth and a more positive identity. This can again be construed as a move away from more 'directive' approaches to recovery where experts did things for people, towards self-determining solutions of recovery, a sense of agency, choice and empowerment for the recoveree. This approach to recovery can encourage the recoveree to achieve a much more positive identity for themselves.

Achieving a positive identity in long term recovery may make the difference between a person either relapsing or continuing to maintain sobriety (Hill & Leeming, 2014). My findings suggest that in achieving a positive identity it is crucial that a person in recovery receives not only practical support such as taking a person to the doctors or

a self-help group meeting, but also the much subtler sense of support such as the PCP form of validation. During self-help group meetings and group therapy, the recovering alcoholic may transition from a person who perceives themselves as an addict with a corresponding addict identity, to a new 'recovering addict' identity (Orford, 2001). My findings suggest that partly as a result of their involvement in self-help group meetings the participants experienced to a certain extent, a change in their identities. These changes included things such as the participant changing what they regarded as their key values in life, changes in their confidence, self-respect, self-esteem, self-belief, feeling in control, being empowered and feeling trusted by others. Therefore, it is possible that recoverees may develop a new identity focused on recovery replacing the old identity which was primarily focused on addiction. This journey of a recoveree changing their perceptions of themselves and gradually moving away from seeing themselves as an addict to one where they have now developed a new view of themselves as a person in recovery has been coined by Buckingham et al. (2013) as 'identity preference change'. In addition to the above points regarding recoverees being involved in changing their identities by feeling more in control of their own future and empowered to make their own choices and decisions to change, my study's findings suggest a recoveree needs to own the changes they make in their recovery journeys. This important point is further discussed below.

### Owning the change process

My literature review indicated that there are approaches to interventions that 'direct' the alcoholic. For example, bio-medical approaches tend to explain to the alcoholic what their 'diagnosis' is and tell them how to solve their problems and prescribe treatment. Evidence of this is indicated in the biomedical studies of classification starting with Jellinek (1960) and the continuing beliefs that identifying subtypes of alcoholic patients may improve the effectiveness of the subsequent treatment they use e.g., the choice and prescribing of medication by doctors, the treatment results and the provision of a better prediction of the future course of the disease (Pompo et al., 2008). However, it is argued these bio-medical approaches almost discourage the alcoholic from having their own personal autonomy and finding their own ways to conduct their future lives. In contrast, PCP theory together with the theories of SDT and the intervention approaches of MI and change talk, always puts change in the

hands of the person themselves making us in charge of our own destinies and giving us our own personal autonomy. From the perspective of SDT, Kennedy & Gregoire (2009) found that if the drug user's needs for autonomy are met, this may lead the person to be sufficiently intrinsically motivated to stop drinking and /or taking drugs. PCP therapy would provide the opportunities for re-construal to take place. The participants in this study sample expressed the need to make their own decisions and choices for their futures. Further, by making their own decisions rather than others telling them what to do they could feel ownership of their decision to change and maintain sobriety. The participants in this study show evidence that they imagined their transition to sobriety and a new self without any professional telling them what to do. They showed evidence that they had the necessary personal human recovery capital to control their own futures, as described by White and Cloud (2008); Granfield and Cloud (1999); Best and Laudet (2010). For example, they had their own individual problem-solving capacities, self-awareness, self-esteem and self-efficacy in order to maintain their sobriety. Further, they possessed personal autonomy, capacity and ability to make personal choices in order to make their own decisions to both achieve and maintain sobriety. These findings appear consistent with the findings of Webb et al. (2020) who found that there was a shift from a reliance on support groups when people were in the early phases of recovery to moves towards self-determination and people making their own decisions about their futures when they were maintaining their sobriety in the longer term. Concerning drug users, Willutzki and Wiesner (1996) view them as autonomous people. They believe their choices make sense when considered from their perspectives. It is suggested this approach to drug problems is similar to a PCP perspective in the sense that both argue that substance abuse can be understood as a meaningful action from the user's point of view. This can be contrasted to medical approaches which see it as a consequence of a chemical disorder.

However, it is acknowledged that not all medically trained practitioners necessarily follow a completely directive approach. For example, Kelleher (2009) a consultant addictions psychiatrist suggested he had two main tasks in his work, keeping the alcoholic alive through harm-minimising concerning their alcohol use and secondly and pertinent to this discussion, enabling the alcoholic to understand their personal ability to make choices to change themselves. This idea of alcoholics being capable

of making the decision to change themselves appears to be also advocated in the ideas contained in SDT and MI. Within MI the assumption is that the individual in counselling has what is needed to make changes in their lives (Miller & Rollnick, 2013). It is argued that on first sight another major intervention approach namely the TTM does not appear to completely allow the recoveree to make their own choices and decisions towards recovery. Instead, it could be argued, the TTM provides pre-set strategies or processes of change to guide the individual. However, it seems possible that change talk could be one vehicle through which people can begin to construct a new sense of self and a different possible future. This may provide a connection between the TTM, its use of MI and change talk and a link to PCP. In a sense, this shows the importance of the MI aspect of the TTM because it is one of the places in the TTM which does seem to allow a person a certain degree of agency.

It is necessary to acknowledge the need for a person to make their own decisions for their futures depending on the unique personal meaning their experiences evoke for them. Future interventions may therefore need to have an increased emphasis on this view of personal choice and autonomy. This view appears to be consistent with that of Peele (1995) suggesting the alcoholic should choose their own type of intervention based on their values and beliefs. Again, as Peele (1995) suggests, any successes in the person's transition can then be attributed to the alcoholic encouraging their ownership of the decision to change.

#### Key changes in the person's sense of self

The findings further revealed that the participants saw key changes in themselves in their process of achieving sobriety in terms of not merely stopping drinking but altering their values in life, feelings of confidence, self-respect and feeling trusted. These key changes gave them an improved sense of self which is consistent with Hill & Leeming's (2014) study. Further, that the process of change was not what a number of the participants were expecting.

Vaillant (1995) talks of gaining an improved self-esteem which can assist in a person maintaining sobriety and similarly, Moos et al. (1982) and Beattie and Longabaugh (1999) suggested that having social support from friends, family and or significant others, can greatly improve a person's self-confidence which in turn can assist in

helping them maintain their changes. It is argued that many of these factors were also revealed in my research. For example, my findings suggest that the participants needed positive relationships to help them both achieve and maintain sobriety. Further, a drug user's autonomy and competence to abstain can be encouraged through supportive relationships with significant others (relatedness). People need supportive relationships and this relatedness may determine the user's decision to use or not use drugs or alcohol (Chan et al., 2019). We should therefore nurture these needs and relationships. However, in my study, they also experienced validation for their actions both on a one-to-one basis and through groups. This in turn gave them confidence, self-respect and self-esteem. Further, my participants became aware that they had the power to make their own decisions and take control of their drinking. By taking this control of their alcoholism, this again gave them confidence, self-esteem and respect to continue to maintain sobriety. Therefore, in addition to friends and family supporting a person's sense of self, the participants in this study appear to have used their own personal recovery capital which enabled them to make the changes. According to White and Cloud (2008) this personal recovery capital can be divided into physical and human capital. In this instance, I am referring to Human Capital such as having a new self-awareness of their addiction, a sense of meaning and purpose in their lives such as finding a new job or retaining their present one in order to re-construe themselves from 'failures' destined to relapse again as the majority had done in the past, to now being successful in their own individual way and subsequently gaining further self-belief, self-respect and confidence for themselves. Many of the participants talked of taking back control of their lives now they had rid themselves of their alcoholism. They now felt empowered to make future lifestyle choices which they felt were not dictated by alcohol. These findings of empowerment and taking back control, are consistent with the ethos of SDT and the intervention of MI. My findings also revealed that the participants previously valued alcohol but now they did not. Although they had always loved their relatives, they now increasingly valued them much more and recognised the importance of family relationships in achieving and maintaining sobriety. Most importantly they also now valued themselves and prioritised these thoughts and emotions that were so important to them and made them happy instead of alcohol.



It was further noted that the process of change was not always what a number of the participants were expecting. For example, some had changed their perceptions from believing that sobriety would be easy and relatively quick to achieve; however, having now re-construed these thoughts they were now aware that sobriety has its limitations as well as its gains. Another participant had expected the process of change to be much harder than what actually materialised. My findings suggest that the participants did experience the gains of sobriety but also some losses as a result. For example, participants who had previously seen themselves as experiencing confidence socially (when inebriated) could then initially experience a loss of confidence socially when sober and then only gradually realise they did not need alcohol to be confident. Further, they now understood that change is difficult and can be a lengthy process. For example, this loss of social confidence which only materialised when they were drinking, was gradually replaced in time with the gain of what they regarded as a much more authentic confidence when they achieved sobriety. It can be important to be aware of what may be ahead with the changes. If this awareness is not present the fears of the change process may prevent change happening.

### **Limitations of the research**

The sample of 18 alcoholics predominantly included participants who attended only one self-help group in one locality. Further, I only selected from one locality at a time. However, both the localities covered by the umbrella organisation known as 'North' and 'South' localities each covered a large town combined with a small town incorporating different wards and different population demographics.

Only one participant also attended a different form of group, (an AA group) at the time of their interview. Sampling participants in other additional geographical locations and/or considering people from different ethnicities and cultures may have produced different perspectives. For example, both the sample geographical areas contained communities with a strong Islamic tradition and the presence of Muslims where abstinence is high and therefore may have revealed different views amongst those people who were alcoholics. Further, drinking may be frowned upon in the participant's community and people may have much more stigma and feelings of shame and guilt attached to it.

Further, an area of the UK where there was a culture of more tolerance for drinking for example in Ireland, where people have been found to be less likely to abstain, may have a different perspective of alcoholism. For example, according to a report by Hurcombe et al. (2010) for the Joseph Rowntree Foundation, Irish people are less likely to abstain from drink compared to the general population and death rates due to alcoholism are higher for both men and women compared to that of England and Wales.

Likewise, this may apply to poly drug dependant people where perhaps people who have multiple addictions may feel that drinking alcohol is not their priority problem they need to address. Therefore, other cultures, environments and geographical areas may have different stories to tell regarding their journeys to sobriety.

Further, the self-help group (from which the sample was taken from), did not have an official set of beliefs or doctrine like AA. However, I was aware of the possibility that as the participants may have listened predominantly to the same sets of beliefs and principles of only a handful of people who chaired the group meetings, they also may have adopted similar views or common understandings and therefore, possibly given similar answers to my questions.

In addition, as they all saw themselves as successes at the time of their interviews, they may have focused on the positive aspects of their transition and dismissed the negative aspects feeling that this would be what I wanted to hear or they themselves wished to believe. It is further acknowledged, that the participant's accounts of their experiences were always going to be 'constructed' rather than their comments representing a 'true' account of what happened. They appear to have had strong desires to hang onto their new identities or selves which meant so much to them. As a result, it could be argued that although they were not trying to defend their past drinking levels, they may have only focussed on telling me about the positive sides of their transitions to sobriety in order to attempt to protect this new identity. They may have conveyed this more positive view of change than was warranted, to uphold their fragile new identities.

It could be suggested that the specific questions I asked in the interviews may not have allowed some important issues to emerge. For example, although the majority of the participants in this study said they had actually lapsed or relapsed on

occasions in the past, they had very little further to say about either lapses or relapses in their interviews. Further, it could have been a reflection on only wanting to focus on the positives or because I did not specifically ask them about these issues. Although the participants were given the opportunity to talk about relapse with relevant prompts, it is thought that either the prompts were not direct enough or it could be reasonably suggested that perhaps they wanted to maintain their positive identity of themselves as having now successfully maintained sobriety without a relapse for a relatively long period of time.

The desire to achieve diversity in issues such as the age, gender, economic and social backgrounds, ethnicity and geographical location of the participants was limited by the range of people who attended and volunteered to take part. However, the majority of people who attended the meetings and fulfilled the inclusion criteria did volunteer. **Appendix H** shows a summary of the participants in terms of age, gender, occupational and family situation. This diversity I feel was reasonably good in all the areas apart from ethnicity. For example, although I was aware of ethnic minority groups existing within the geographical area of my research (Pakistani making up 10% of the population and Indian accounting for 5%), there were no Asian or black people who attended any of the groups which averaged around 30 people at each meeting. Therefore, a further limitation of the study was the absence of any black or Asian people within my sample. In the report by Hurcombe et al. (2010) they found that not only are minority ethnic groups under-represented in seeking treatment and advice for drinking-problems in the UK, but also drinking may be hidden among women from South Asian ethnic groups in which drinking is denounced. Therefore, they may have offered a valuable alternative perspective. Although I present these under-representations as possible limitations, I also believe that the homogenous sample I obtained was useful for exploring in this particular group. It was a homogenous sample in terms of both geographical and life history (past life histories of alcoholism in common) as identified by Robinson (2014)

### **Suggestions for future research**

During my research I was informed that the self-help group would be terminated in the next few months therefore, it is suggested that a study could examine whether an alcoholic can still maintain their changes once the support of a self-help group terminates.

Even though all the participants had highly valued the group seeing it as one of the key factors in their sobriety, my findings also indicated that a small number of participants had also felt that they had needed to balance their attendance at the group with the possible risk of dependency. Some other self-help groups such as AA actively encourage people to attend as many meetings as possible and treat it as a lifetime commitment. As a result, people attend whilst in 'recovery' for 20-30 years or more. Therefore, a study could examine the possible risk factors associated with over dependency on self-help groups.

My literature review further revealed that there are alcoholics who are considered 'self-curiers' i.e., having not attended any form of self-help group or formal treatment programme (Peele,1995). Therefore, it is suggested this population could be valuable for further research. For example, can equally effective support measures be gained through other sources?

As I found that the participants had varying views as to what to expect from the change process, a useful piece of research could look at people's anticipations regarding the change process.

Further research may be useful looking at an exploration of the role of imagination in the change process relating to either alcoholics or other drug users, for example:

- a) A study on a user sample exploring what they imagine significant others thought of their successes or difficulties.
- b) A study on a different addiction group (besides alcohol) exploring their construal of the usefulness of imagination in recovery.

### **Recommendations for practice**

My findings suggest that the participants' construals of their experiences in the past were essential in understanding their conduct, thoughts and emotions. My findings additionally point to the ability to reconstrue in a more positive light. Therefore, future interventions should focus on facilitating opportunities for re-construal, for example it could be reasonably argued that the utilisation of imagination could be developed into a future therapeutic tool for other alcoholics wanting to achieve sobriety. In effect they can take this leap into the darkness and see how their lives may be in the future in a safe manner and from this they can anticipate and often rehearse their future. Its purpose could be to offer the alcoholic the choice to test out any possible changes

they choose to make in a safe environment and only for a limited length of time. One possibility would be to use role play techniques such as Fixed Role Therapy which they could adopt for say two to three weeks in order to 'experiment' with whether this new self can be successful under this slightly different experimental identity.

It is suggested that practitioners should acknowledge listen to, value and act upon what alcoholics have to say about their individual experiences and what sense they drew from these experiences. This is key to change and can be contrasted with hearing what they say in order to diagnose them to decide what stage they are at in their transition to sobriety.

As part of the TTM in addition to both acknowledging and acting upon the language used in MI through change talk, therapists and facilitators could actively encourage the use of what I would refer to as 'imagination talk'. It is suggested this would be where the recoveree as a result of their new experiences and subsequent imagination is both using imagination talk as well as anticipating new future behaviours and imagining carrying them out as part of their new future self. This talk or language stemming from their imaginations and anticipations may actually encourage their initial readiness to change.

Professionals and self-help groups could assist in enabling significant others such as family, friends and peers to recognise the importance of showing validation together with more general support to the alcoholic. This would enable the focus on treatment approaches to be closer to the social sphere rather than just the individual alcoholic. This therefore would shift the emphasis away from just believing the problem of alcoholism lies only with the individual and is more to do with the whole network of relationships.

### **Reflexivity**

In terms of reflecting on the research process, I considered whether my disclosure of my own difficulties with alcoholism and my subsequent achievement of sobriety was beneficial or detrimental to the participants' own disclosures in the interview process. Also, I considered whether it had been beneficial or detrimental for me personally.

At the introductory meetings held for the self-help group participants I shared the details that I also enclosed in the introduction to this thesis with them. Therefore, I was open and honest with them from the very start about my own difficulties with

alcoholism. It was acknowledged that some of the participants may still have felt a certain degree of stigma and nervousness about someone asking questions about this part of their lives. Further, I was aware that they may feel a degree of power inequality in our relationship. Hopefully, disclosing my own past experiences of alcoholism enabled the participants to feel like the interviews were more conversational in nature and peer to peer rather than a doctor -patient scenario. The dynamics of a professional relationship such as doctor-patient may be much more of an emotionally detached relationship than that of a peer-to-peer relationship where there may be shared experiences allowing for a degree of empathy in the relationship. Further, there may be power inequalities between the doctor and patient which could make the 'patient' guarded' and not entirely truthful about their problems.

One of the benefits of sharing my past experiences, was me possibly attaining a degree of credibility with the self-help group I studied. I felt this was a successful strategy as it also meant I could share a common understanding of their situation in a broad sense. An example of this was shown in my early interactions with the group (before the individual interviews) where they told me that they...

***...wouldn't take part if I had been some young buck who knew nothing about it all and was just trying to get a qualification in something... we have had to live and breathe alcoholism for years.***

Further, at the end of the interviews, all the interviewees asked for copies of the executive summaries of the thesis when available. This indicates that they felt the work would have something to offer to them in their recovery.

However, a possible potential personal downfall was the danger of my analysis not revealing issues because they were different from my own experiences. My own experiences as a result of my own alcoholism were of a supportive wife and close family encouragement to achieve sobriety and maintain it. Therefore, due to my own experience there was a danger that I may expect this kind of supportive relationship scenario or similar with others. In response to this potential danger, I took the precautions outlined below. As mentioned in my methodology chapter, I adopted a rigorous coding strategy vetting and scrutinising a total of fifteen iterations of my research template throughout the process. This was in order to attempt to ensure it

remained a coherent and accurate reflection of what the participants had conveyed to me.

My past experiences have made me aware that transitioning from being a full-blown long-term alcoholic to a 'non-drinking alcoholic' is a complex, gradual, lengthy and often messy process. Hopefully, by being open and accepting of how the participant was experiencing the world at the time and showing that I was taking their account seriously, it allowed me to gain an understanding of their problem as they saw it. For example, with some of the participants I was not only from a different generation, sex and geographical location, but their drinking experiences were entirely different to mine. However, by drawing on my own past experiences I was able to construe some similarities with their experiences and 'get inside their shoes' in order to look at their problems as they saw them and therefore understand what they were trying to convey to me. The participant's perspective is seen as critical in understanding the problem and the enabling of bringing about change. Our shared experiences of alcoholism may be understood in terms of Kelly's PCP notion of sociality, in the sense that our shared experiences allowed me to be effective in understanding their construing.

For me personally, the whole research process has allowed me to put my own problems in more context. For example, I became aware that others had experienced the same problems as me and had been successful in achieving sobriety in their own unique way. Conducting this research has required me on a personal level and as a fellow alcoholic, to put my own values and preconceived ideas about alcoholism to one side. This has allowed me to try and gain a more holistic picture of alcoholism and how it may affect others.

## **Conclusion**

The key messages drawn from my thesis tell me that PCP offers a different and valuable perspective to mainstream approaches to achieving and maintaining sobriety. This PCP approach has allowed me to gain a further understanding of alcoholism and other addiction recovery. For example, the key conceptual tools of validation/invalidation and anticipation has enabled me to contribute to knowledge regarding this field of work, extending our understanding of stages of change and emphasising the importance of understanding how we always cast ourselves into the

future in order to test out potential new ways of being. Of note is the contribution to the use of imagination and my new idea of 'imagination talk' possibly working alongside change talk encouraging us to change. Lastly, the experience of completing a PhD has made me more aware of the value of adopting a 'credulous approach (Kelly, 1955) when completing research by adopting a position of openness and showing a willingness to accept how my participants were seeing their past, present and future. This PCP approach I feel has allowed me to gain a further understanding into how some recoverees view their world.



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# APPENDICES

## Appendix A

### GLOSSARY OF TERMS

**Achieving sobriety** – this refers to the study participants having gone through the process of stopping drinking and now being sober.

**Alcoholic** – a person addicted or dependent on consuming alcohol. I had begun my research with the intention of using the term ‘chronic alcoholic’ to describe my sample as this term is used in some ‘alcoholism’ literature (Vaillant 1995) and I felt at the time captured the important features of my sample, that is long term alcoholics who had remained sober for between 2-10 years. However, further reading made me aware that it was primarily used to describe alcoholics from a medical ‘disease’ model perspective. Upon actually talking to my participant sample they all self identified themselves using the single word ‘alcoholics’. I have therefore revised my terminology to just ‘alcoholics’.

**Alcoholism** – addiction to the consumption of alcoholic drink

**Abstinence** – becoming alcohol or drug free

**Chronic alcoholic** – ‘chronic’ referring to illness persisting for a long time or constantly recurring.

**Lapse** – a temporary return to drinking. Or a temporary deviation from abstinence returning to alcohol or drugs. It may be used to describe a discrete, circumscribed ‘slip’ during a period of prolonged abstinence (Marlatt and Gordon 1985).

**Long-term sobriety** – this is defined as sobriety from two years and above.

**Maintaining sobriety** – this refers to the participants in the study now being sober and continuing maintain this sobriety for between 6 months and up up to two years.

**Personal meaning** – in my thesis this refers to it as being a contrast to theories such as psychoanalytical or behavioural theories. My argument is that a person’s behaviour is always a function of the meaning that events hold for people. It’s about

people having reasons for what they do. Those reasons are to do with the meaning those events hold for people.

**Poly-drug dependency** – an abuse of multiple drugs

**Recovery** – originally a medical term meaning process of getting better.

Regarding substance addiction Laudet (2007) sees recovery as going beyond only abstinence. It is an ongoing process of growth, self-change and of reclaiming the self.

**Relapse** – a full blown return to drinking

**Remission** - a medical term meaning a temporary diminution of the severity of an illness or pain. With the medical model of alcoholism or drug use the person is seen as having this condition permanently. Therefore, they may always be prone to a relapse back to their old drug taking even if they have abstained for some time. They are viewed as merely in remission when they abstain.

**Self-changers** - achieving sobriety without the use of formal intervention measures

**Self-help groups** - an informal gathering of people meeting with the common aim of helping each other with their problems e.g., drug or alcohol problems.

**Sobriety** – not under the influence of any mood- or mind-altering chemical (including alcohol) Sobriety can be seen as concerning other drugs in addition to alcohol. According to the Betty Ford Institute Consensus Panel (2007) when considering alcohol, sobriety can be defined as abstinence from alcohol. However, it is argued sobriety means much more than simply stopping drinking. It is also viewed as a successful life in recovery.

**Treated alcoholics** – people who have received formal medical intervention for their alcoholism

**Un-treated alcoholics** – individuals who have not received any formal medical intervention

**Spontaneous remitters** – abstinence occurring as a result of a sudden impulse without premeditation

**12-step facilitation (TSF)**- a group of therapies designed to help people abstain from drugs and alcohol by linking them and encouraging them to take part in self - help organisations practising the 12-step facilitation e.g., Alcohol Anonymous and Narcotics Anonymous.

## Appendix B

### TOPIC GUIDE (ORIGINAL)

#### Introduction

- Thank you for agreeing to take part in my research
- Do you want to ask any questions before we begin the interview?
- If it's alright with you I will now turn on the recorder and begin the interview which should last approximately one hour.

Can you tell me your particular story about why you feel you have managed to change and how you have managed to maintain these changes?

#### Suggested prompts:

- What made you think you needed to change?
- Why previous giving up methods if any, haven't worked?
- Planned or unplanned?
- Do you feel anyone/thing helped or hindered your change in lifestyle?
- Do you feel there was a turning point?
- What did these events mean to you?
- What did you envisage was going to happen if you didn't change?
- What does your change in lifestyle mean to you?
- What do you feel it means to other people?
- How do you now imagine your life in five years' time?
- How do you imagine other people will view you in five years' time?

Thank you that is the end of the interview, but before we finish have you anything you would like to ask me about?

## Appendix C



To:

Chair, [REDACTED] Alcohol Advisory Service

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Date: 10/11/14

Dear Mr [REDACTED]

My name is Gary Westwell. I am a 'non-drinking' alcoholic who has maintained successful lifestyle change for over six years. I am writing to you to ask for permission to carry out research with the help of [REDACTED] in order to complete a PhD thesis at the University of Huddersfield. The aim of this research study is to gain a greater understanding of the individual experiences and its personal personal meaning for people who have now achieved and successfully maintained their sobriety and lifestyle change.

I wish to invite those members of your organisation who see themselves as previously having problems with alcohol to take part in my research. They will regard themselves as previously having a compulsion to drink and felt it had become out of their control; they will have experienced this for a period of at least five years but will now regard themselves as having successfully maintained a change in lifestyle for at least one year.

I would like to ask for your permission to address your members in order to recruit participants. They will be invited to take part in one-to-one interviews at a place and time convenient for them. The interviews will last approximately one hour. They may



be asked if they would be prepared to complete a further interview at a later date which again would last for approximately one hour. Participants will be interviewed about why they feel they have managed to change and how they feel they have managed to maintain these changes.

I would like to distribute information sheets which will explain about the nature of the research and the participant's right to withdraw from it at any time and for any reason. If they agree to take part, they will be asked to sign a consent form prior to the interview. All the data collected from the participants will be kept on a password-protected computer and any identifying material, such as names, will be removed in order to ensure the anonymity of those participating. It is anticipated that the material will be used as part of my PhD thesis and in conference presentations and academic publications.

It is highly unlikely that participants will experience any negative effects as a consequence of taking part in the research. However, all participants will be provided with contact details for appropriate sources of support. I would of course be happy to answer any further queries you may have. If you are happy to give your permission for me to give an initial talk to your group and recruit participants through your organisation, I would be grateful if you could confirm this to me in writing. My contact details are as follows:

Gary Westwell, 12, Marsh Grove Road, Edgerton, Huddersfield HD3 3AQ or email, [u0970048@unimail.hud.ac.uk](mailto:u0970048@unimail.hud.ac.uk) or TEL: 01484 515335.

Yours faithfully,

Gary Westwell

## Appendix D

### Letter from Chairman



## Appendix E

### Information sheet and consent form



Gary Westwell, 01484 515335 (direct line)

Email: [gary.westwell@outlook.com](mailto:gary.westwell@outlook.com)

.....

#### INFORMATION SHEET

My name is Gary Westwell, and I am a 'non-drinking' alcoholic. I am currently completing a Doctoral thesis at the University of Huddersfield researching the experiences of alcoholics achieving and successfully maintaining sobriety and a lifestyle change. This information sheet is provided in order to help you decide whether or not to take part. I would like you to understand why the research is being undertaken and what would be involved. Please take the time to read this information sheet through and do not hesitate to ask me in person or through the contact details provided at the end of this letter if there is anything that is not clear or if you would like some more information.

What is the purpose of the study?

To gain an insight into the experiences of those people who have previously seen themselves as alcoholics who now feel they have managed to change their lifestyles

and have successfully maintained this change. The research may identify how others could be helped to change.

**Who can take part?** I am interested in talking to people who see themselves as having had problems with alcohol in the past. They will regard themselves as previously having a compulsion to drink and felt it had become out of their control; they will have experienced this for a period of at least five years and now regard themselves as having successfully maintained a change in lifestyle for at least one year.

If you think you fit this description, I would like to interview you on an individual basis in a place and environment of your choice and at a time which is suitable to you. The interviews will last approximately one hour. I would like to ask you about why you feel you have managed to change and how you feel you have managed to maintain these changes. The interviews would be audio recorded. I may ask you if you would be prepared to complete a further interview at a later date. This interview would again last approximately one hour. **Of course, you can withdraw your consent for either of the interviews at any time. You will be given notice of when (or if) any further 'second' interviews will take place after I have had the opportunity to evaluate the responses from the first interviews.**

**Will the information I provide be confidential?** All information collected from you during the research will be kept in secure conditions i.e., secured in a locked environment or if stored on computer this would be password - protected. It will be stored at the University of Huddersfield for a period of five years. Any identifying material such your real names and those of other people or organisations will be removed or changed by the use of pseudonyms in order to protect your identity. No other people other than the researcher his supervisors and examiners will have access to the information provided. The material will be used as part of my PhD thesis, and it may be necessary to use your words in the presentation of the data. An executive summary of the research findings will be made available to you on request.

**Additional Support** It is highly unlikely that participants will experience any negative effects as a consequence of taking part in the research. However, if you should need support the following is a local organisation who may be able to help:



**What should I do if I have any questions?** I will be happy to answer any queries you may have, both before and after taking part in the research.

Contact details

Gary Westwell, 12, Marsh Grove Road, Edgerton, Huddersfield HD3 3AQ or email, [gary.westwell@outlook.com](mailto:gary.westwell@outlook.com) or TEL: 01484 515335.

Thank you for taking the time to read this information sheet. Gary Westwell

## CONSENT FORM

It is important that you read, understand, and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details, please contact the researcher.

I have been fully informed of the nature and aims of this research

I consent to taking part in it

I understand that I have the right to withdraw from the research at any time without giving a reason

I give permission for my words to be quoted (by use of a pseudonym)

I understand that the information collected will be kept in secure conditions for a period of five years at the University of Huddersfield

I understand that no person other than the researcher his supervisors and examiners will have access to the information provided.

I understand that my identity will be protected by the use of a pseudonym and that no written information that could lead to me being identified will be included in any report or publication.

If you are satisfied that you understand the information and are happy to take part in this project, please put a tick in the box aligned to each sentence, print your name and sign below.

Signature of Participant:	Signature of Researcher:
Name:	Name:
Date:	Date:

(One copy to be retained by participant / one copy to be retained by researcher)

# Appendix F



INVESTOR IN PEOPLE

## APPENDIX (F)



Treatment : Recovery : Alcohol : [REDACTED]



16<sup>th</sup> January 2015

For the attention of Gary Westwell,

As previously discussed, [REDACTED] are able to provide support to any individual around substance misuse issues. This support could include elements of counselling, and would be incorporated into a package of treatment dependant on the individual's needs.

[REDACTED] are not able to provide psychosocial support or counselling on a drop in, ad hoc basis.

Kind regards,

[REDACTED]

☞

Team Leader

[REDACTED] - [REDACTED] [REDACTED]



## Appendix G - Revised topic guide

- Introduction
- Thank you for agreeing to take part in my research
- Do you want to ask any questions before we begin the interview?
- If it's alright with you I will now turn on the recorder and begin the interview which should last approximately one hour.

Can you tell me your particular story about why you feel you have managed to change and how you have managed to maintain these changes?

Suggested prompts:

- Have you tried to change in the past? (Additional prompt following pilot study)
- Why do you feel this wasn't successful? (Additional prompt following pilot study)
- What made you think you needed to change?
- Why previous giving up methods if any have you tried and haven't worked?
- Planned or unplanned?
- Do you feel anyone/thing helped or hindered your change in lifestyle?
- Do you feel there was a turning point?
- What did these events mean to you?

- What did you envisage was going to happen if you didn't change?
- What does your change in lifestyle mean to you?
- What do you feel it means to other people?
- How do you now imagine your life in five years-time?
- How do you imagine other people will view you in five years-time?
- How do you feel you have managed to maintain the changes you have made?

(Additional prompt following pilot study)

- Did you need help in order to maintain these changes?

(Additional prompt following pilot study)

- Thank you that is the end of the interview, but before we finish have you anything you would like to ask me about?

## Appendix H - Summary of participant details

\*PARTICIPANTS 1 and 2 were pilots therefore numbering starts at 3

**3. 'Mick'** (Male), aged 58, married, 2 children, lives with wife and children. Began drinking at the age of thirteen. He informed me that he had now been totally abstinent for eight years therefore he has not drunk since he was 50. Works full-time as a Care Worker. Hobbies outside work include playing and watching various sports. Had tried numerous attempts to stop in the past but all had failed. He had only attended this particular self-help group. He had used his GP services for advice and medication for his alcoholism. Lives in the North area

**4. 'Kath'** (Female), 32, lives alone. Her 2 children live with partner elsewhere. She began drinking at the age of thirteen. She said she had been abstinent for four years therefore she has not drunk since she was 28. She describes herself as an 'out of work former secretary.' Had attempted to stop in the past but failed. Had used her GP services for medication to alleviate the effects of her drinking. Following the advice of her GP she tried an AA meeting once but did not attend again. Her hobbies included reading. Kath lives in the North area.

**5. 'John'** (Male), aged 64, married, three children. His wife lives with him. His children live with their own partners elsewhere. He works full time as an engineer. Started drinking alcohol at eighteen. He told me he had now had ten years of total abstinence. He therefore has not drunk since he was 54. His hobbies included singing in a local choir and he was a regular church attendee. He had used his GP services for his alcoholism mainly for the prescribing of medication. In addition, he had used the services of a private hospital for a two-week period. However, he had relapsed back to drinking again. After trying prayer and meditation his local vicar suggested the Alcohol Advisory Service. He had not used any other self-help group. Lives in the South area.

**6. 'Neil'** (Male) aged 72, divorced lives with current partner. His children (two boys) live elsewhere with their own partners. Formerly in education. Now occupies his time

with the organisation and administration of the self-help group meetings. He frequently chairs meetings. Began drinking at the age of nineteen. He told me he had now not drunk for ten years. He had numerous relapses in the past having tried his GP services and being prescribed medication. He had used one other different self-help group in the past. He began attending the self-help group having seen a leaflet giving details. Neil lives in the South area.

**7. 'Kevin'** (Male) aged 37, divorced, no children, University educated, previously worked for Marketing Company, now works from home. He began drinking when he was 15 years of age. He stopped drinking three years ago when he was 34. Kevin tried the group when he was aged 27 and attended twice but relapsed on both occasions. He also had a number of private counselling sessions and a two-week spell in a rehabilitation clinic but relapsed after these as well. Kevin did not seek any further help for seven years when he started attending this particular self-help group again for the third time. He sees himself as a prolific reader and an intellectual. Kevin lives alone in the South area.

**8. 'Mark'** (Male), aged 57, abstinent for four years, following fifteen years of problems. Began drinking when he was 15 or 16 years of age. History of relapsing. He has abstained from drinking from the age of 53. Married (third time) 4 children now adults. Lives with his wife. Considered himself good at sport and it is now his hobby. Mark had been to his GP for support in the past and was given medication. He also asked for advice about attending the self- help group and was advised it would be a good idea. He lives in the South area.

**9. 'Susan'** (Female), aged 54, twice married, second husband died of cancer, dry for nearly three years. Therefore, she has abstained from drinking since the age of 51. Started drinking at 14 years old and described herself as drinking too much at the time. Has used her GP services in the past but she said they did not pick up that she had a problem. She has also attended various courses on relaxation and anxiety management to help her change. She has also attended other self-help groups in the past and has a history of relapsing. Susan lives in the North area.

**10. 'Tracy'** (Female), aged 55, married, 2 daughters, abstinent eight years former office worker. She now occupies some of her time as a committee member of the group. She also acts as a chairperson. She began drinking when she was sixteen and described herself as drinking more than her friends. She has abstained from drinking since she was 47. Had a previous attempt to stop and went to AA a couple of times with a friend but didn't like it. Tracy had been prescribed anti-depressants in the past by her GP and had many discussions about her drinking. Tracy lives in the South area.

**11. 'Tony'** (Male), aged 60, single, married but wife died, now lives alone. Works for housing association (volunteer). He has tried to 'detox' on three occasions in hospital and relapsed each time. He received counselling because of his suicidal thoughts in the past and was sectioned on one occasion. He said he was offered a six-week rehabilitation programme but refused this. Tony has now abstained from drinking for eight years. Therefore, he stopped drinking when he was 52. He has attended numerous courses to help him to abstain. Occupies his time with his dog and works part time. Tony lives in the North area.

**12. 'Frances'** (Female) aged 58 married ex NHS worker, 2 children. Lives with her husband. Abstinent for five years. Began drinking when she was 17 years. She has abstained from drinking since the age of 53. Her 'hobbies include looking after her grandchildren. She has started driving her car again and enjoys the social aspect of the group but doesn't feel she is over reliant on it. Lives in the South area.

**13. 'Tom'** (Male) Aged 64 married, 2 children. Lives with his wife and children, builder. Started drinking when aged fourteen. 10 years abstinence therefore stopped drinking aged 54. Turned to religious organisations initially for support. Went to a detoxification programme at a private hospital. Tom also went to a couple of AA meetings. He relapsed back to drinking again. Went to his GP but found himself lying about his alcohol intake. Tom lives in the South area.

**14. 'Lisa'** (Female) Aged 68 years. Began drinking at 25 (heavy drinking) Lisa has children who live in their own homes apart from one who lives with her and her husband. Her son has a mental illness. She has been 7 and a half years abstinent. Stopped drinking at 60 years. Had support from her GP and had a stay in hospital following a referral from her GP and stayed there for two months. Lisa lives in the South area.

**15. 'Matthew'** (Male) Aged 49. He is divorced and has five children, two of whom live with him and his girlfriend. He is a former factory worker and is now working as a freelance electrician. He has been abstinent from alcohol for four years. Stopped drinking when he was 45. Said the decision to stop was taken out of his hands by his consultant who said he would die if he continued, and this was whilst in hospital. He was in hospital for six months due to the damage caused by the alcohol. Mathew lives in the North area.

**16. 'Jane'** (Female) Aged 50, NHS worker. Does not have a partner, lives with her son who has learning difficulties. Began drinking when she was 15. She considered this as being quite normal. She has remained sober for six years. Jane used the GP service for medication to calm herself down. Jane attended both an AA group and the self-help group this research has focussed on. Stopped drinking when she was 44. Likes to occupy her time by doing what she described as useful things. Enjoys visiting places of interest. Lives in the North area.

**17. 'Janet'** (Female) aged 51, twice married, has one grown up son. Lives with second husband and son (when back from university). Worked for NHS then council as a Commissioning Manager. Began drinking at 17 years. Abstinent for 8 yrs. Therefore, stopped drinking when she was 43. Had attempted to cut down in the past but this failed. Wouldn't go into a hospital for support because she perceived this as having a degree of shame. Used her GP services for medication. Janet had a number of what she describes as total relapses and lapses. Lives in the South area.

**18. 'Bob'** (Male) Bob is 58 years old. Twice married has two children. Lives with wife and children. Worked as a hotel manager. Went to a private boarding school. Started drinking when he was sixteen. Bob has been sober for six years. Went to his GP surgery for support following persuasion from his wife but said it was his wife who had the problem. Admitted to hospital following a heart attack. Has only attended the one self-help service. Now works part time as a security officer. Lives in the North area.

**19. 'David'** (Male) Aged 35 years. Single. He described his mum as his only real family. He lives with his mum and has a girlfriend. David refers to himself as a football fanatic and spends the majority of his spare time watching football matches. Owns and runs his own travel agency. Fifteen when he started drinking. David has been sober for 5 years. Stopped drinking at 30. David did not seek help from his GP but when he felt he needed help he turned to this support group. Lives in the North area.

**20. 'Harry'** (Male) Aged 42 years. Married with two children. All live with him. Works full time as an accountant. Began drinking when he was seventeen. He had a past history of relapsing. Harry has been abstinent for two years. Says he has never consulted a doctor about his drinking. Refers to himself as a functioning alcoholic because he is still working full time. Lives in the North area.

	Total	Male	Female
30-39	3	2	1
40-49	2	2	0
50-59	8	3	5
60-69	4	3	1
70-79	1	1	0
	18	11	7

NORTH

male	female
6	3

SOUTH

male	female
5	4



## Appendix I

The suggested *a priori* themes I initially thought of were as follows:

ANXIETY, LOW SELF ESTEEM, GUILT, DEPRESSION, THE FUTURE AND  
COMPLACENCY.

## Appendix J

### Appendix (J) Transcript segment example 'Mick'

I 'Can you think of any event or anybody that helped or hindered you in achieving and /or maintaining your sobriety?'

P 'Well I was hindered at times because when I went out from work I was the one who people told me was the good fun 'life and sole of the party'. I suppose I did a bit of outrageous behaviour ye know, not too much but, enough. So some people were very disappointed when they met me on a night out and I wasn't what they expected. I was this reasonably sensible bloke who wasn't swearing and taking the piss out of people. I think it's sad really isn't it? They'd say why not just have a couple or its Christmas, it doesn't matter for once. It all definitely hindered me love. The main people who hindered me were the lasses from work they seemed to like me when I had had a few they told me so it wasn't just me under the illusion that they liked me drunk they told me. They thought I was a good laugh. I thought I had to remain a mouthy confident person to keep this good fun image, so I suppose it became part of what I had become and I fully believed in this. After a while I suppose you learn to be inappropriate without alcohol don't you (laughs). In terms of help it was experiencing this group with the thought of the guys rattling around all on their own with nothing but cold turkey, bloody hell they had found their solution, just don't drink and you can rationalise your thoughts given time and think things out like your problems and fears philosophically. If these guys could do it and make a success of it then so could I. It just seemed such a long time at first, particularly getting through the first three months and even more so before that with the physical problems of shaking like a shitting dog, puking and aches and pains everywhere. I don't know where they came from it was difficult at first but in the back of my head I knew it was the right way forward and that although it wouldn't solve all of my problems it would alleviate most and let me tackle the rest at least sober and if I did die in the process at least I would die in my own mind and not that of a can of lager'.

Living up to image?

Different when sober?

Hindered sobriety

liked when drunk

Peer pressure

Taking note of others

Making own choices and decisions.

## Appendix K

A segment of the list of potential 'themes' identified from the 'post it' stickers from early transcripts for producing the initial template

Introvert not as good as others no self-worth

functioning alcoholic not introvert after drink

partner told me I was an alcoholic not thinking clearly couldn't make the right decisions drink driving G.P. – Antabuse Relapse turning point own health interaction with others

your brain remembers the good things

help of the group to remind me drinking for survival consequences of drinking stigma regret

could have done better reputation personal image important made the group my hobby found self-belief found good reason for staying sober and that's different than reasons for stopping family pleased see myself as alive and sober in 5 years' time attendance at meetings working with others has helped maintain my sobriety thought of myself as a failure drank on tablets worried about what my future might bring not worried about death other people's thoughts about me bothered me

I didn't know whether I was better off being drunk and not caring about the future or sober and worried about the future

being sober became the new way I got used to it at first and then began to like it' sober meant doing normal things

I still need to get used to the idea that drink isn't part of my life takes years to get your thoughts clear I now see the benefits of not drinking never really liked the taste of alcohol

## Appendix L



<p>Past</p>	<p>family problems</p> <p>tried private residential detox</p> <p>tried G.P. medication and sign posting to agencies didn't always work or wasn't enough</p> <p>influenced by friends from a relatively early age to drink and become like others.</p> <p>Desire to be liked, to be confident and to be able to socialise</p>	<p>Problems were all in my head, thought I wasn't good enough</p> <p>I didn't know whether I was better off being drunk and not caring about the future or sober and worried about the future at the time.</p> <p>Suffered from loneliness and panic attacks.</p> <p>Felt I was on a downward spiral physically and mentally</p> <p>Had liver problems</p> <p>Near to death</p> <p>Felt guilty and hated myself for drinking and letting everybody down</p> <p>Family problems often became the turning points for change</p> <p>Could have lost partner and rest of family.</p>
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	<p>Strong desire to build a new life away from alcohol</p> <p>felt the drinking me wasn't the real me</p> <p>tendency to lie and make things up e.g., with G.P. s and family about drinking habits</p> <p>The decision to change</p>	<p>Felt I needed something different that didn't just solve the physical side of alcoholism</p> <p>Some friends hindered the recovery process and wouldn't accept the new non-drinking me</p> <p>Much better after moving away from or avoiding drinking friends and sometimes getting new friends</p> <p>Felt too shy and lacking in confidence, self- esteem and too different to be popular.</p> <p>Felt that alcohol would give me that confidence and to some extent it did for a short while.</p> <p>Made me worry about what my kids and the rest of my family and friends would think of me in the future if I didn't stop.</p>
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		<p>Needed a new identity, Imagined the new me initially</p> <p>I needed the alcohol to cope with life and give me confidence and get rid of my shyness</p> <p>Always hiding alcohol away from others</p> <p>Played my drinking down to others</p> <p>Wasn't really 'planned'</p> <p>It was spontaneous</p> <p>More circumstances than planning.</p> <p>Just woke one morning and thought I just have to change</p> <p>Imagined what it would be like to be sober.</p> <p>People telling me I needed to stop drinking including health professionals didn't make me</p>
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		<p>change. I had to make my own decision</p> <p>Thought I had nothing to lose by changing, knew it would have its disadvantages and wouldn't be easy.</p> <p>I had to personally see a good reason/s to change in order to do it.</p> <p>Realised that life wasn't about doing anything great.</p>
Present	<p>Using family support</p> <p>Recovering on my own or with the group</p>	<p>Recognition of strong need to maintain family.</p> <p>Recognition of the need for them to accept the changes in me and begin to trust again</p> <p>take my own choices and decisions of how and what to do.</p> <p>Need structured activity and to keep busy.</p>



<p>Present</p>		<p>Value of interaction with others to help remind of past and gain ideas to help cope, the group helps with this.</p> <p>Now have much more confidence and a higher self- esteem.</p> <p>Being sober has become the new way of life for me. At first, I just needed to get used to it but now I actually enjoy it. I think it takes years to get your thoughts clear.</p> <p>Now I don't think about drink on a daily basis</p> <p>I can now see the benefits of not drinking</p> <p>Not drinking has meant more confidence and a higher feeling of self-esteem and self-worth.</p> <p>Now I don't worry too much about what people think of me like I did when I was drinking.</p>
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		<p>I now like to plan for the future.</p> <p>I realise that alcohol itself isn't the problem its ourselves and how we cope with different situations.</p>
<p>Future</p> <p>2.</p>	<p>Initially couldn't see a future</p> <p>Aims for the future</p> <p>MAINTAINING CHANGE</p>	<p>Began to dare look at the future when sobriety took affect</p> <p>When drunk all I could do at first was to imagine another better life.</p> <p>Began to see good reasons for staying sober e.g., family, having a job, self-respect.</p> <p>Now just want to maintain what I have got and just do the normal things in life like looking after family relationships.</p> <p>Desire to keep my family proud of me.</p>

	The advisory group	Cannot see myself drinking again. I envisage being sober in five years' time.
Significant others	Family and friends	To keep the new-me and just to carry on doing normal things
	Others in your life	Try to avoid complacency – aware that relapse can happen
Views and perceptions	Looking at the world differently	Act as a reminder of what alcoholism can do to you. They remind me using common sense and straight talking. Done by people who are on the same wavelength as me.
	Accepting the true you	Give you ideas to maintain your sobriety e.g., relieving boredom, avoiding difficult situations, how to prevent relapse. Some move on to use groups as their 'hobby.'

		<p>Helping others helps them maintain sobriety</p> <p>Act as a support if they accept the change fully and begin to trust again but takes time.</p> <p>Being treated as a proper mum helps me maintain sobriety</p> <p>Avoid people who may hinder your progress e.g., 'old mates'</p> <p>Some evidence of stigmatisation.</p> <p>People are more likely to be proud of you if you maintain your recovery</p> <p>You can't live your life with nobody liking you, you need to be liked and respected.</p> <p>Helps me to continue by thinking of the things I have done in life rather than dwelling on the things I haven't done.</p>
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		<p>Seeing positives rather than negatives in life. e.g., positives of family life.</p> <p>Now I'm sober I can make rational decisions.</p> <p>Can get up in the morning and not worry about drink and concentrate on worthwhile activities.</p> <p>Thinking of the consequences of drinking</p> <p>I have found good reasons for staying sober and that's different from reasons to stop</p> <p>Being honest and truthful with yourself.</p> <p>Saying to yourself it's OK just to live a normal life similar to others</p> <p>Dealing with confidence issues without drink.</p> <p>If necessary, leaving social occasions when you have had enough of the situation.</p>
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		<p>Accepting that there will always be doubters as to your sobriety.</p> <p>Do it for yourself not just to please others</p> <p>Do it because it feels right for you</p> <p>Grandchildren, walking, looking after others in the same situation.</p>
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## Appendix M

### Coding Template Iteration 2 - 'choosing\achieving and maintaining sobriety'

#### 1. Role of Social Relationships

1.1 Some friends and family hindered the recovery process.

1.1.1 Wouldn't accept the new non-drinking me

1.1.2 Didn't believe I had changed 'doubters'

1.1.3 I could not be fully committed when someone else was telling me what to do.

1.2. Much better after moving away from or avoiding drinking friends and sometimes getting new friends

1.2.1 Old friends could encourage drinking

1.2.2 Some old friends wanted me to stay the same 'old me'

1.2.2.1 Still asked me if I wanted a drink

1.2.2.2 Stopped going around with drinking friends

1.3 Made me worry about what my kids and the rest of my family and friends would think of me in the future if I didn't stop drinking.

1.3.1 Not really bothered about death – it was other people's thoughts of me that bothered me

1.3.2. Wanted to be remembered as a hero not a dithering wreck.

1.4 Recognition of the need for people to accept the changes in me and begin to trust me again- Accept I could be a 'proper mum'

1.5 Thought a lot about how my family must have felt when I was drinking but little about how they feel now I have stopped.

1.6 Now I don't worry too much about what people think of me like I did when I was drinking - Stopped trying to be the same as mates/others.

1.7 Desire to keep my family proud of me.

1.7.1 What it would mean to my kids and my husband if I abstained.

1.7.2 View of what my kids would think of me in the future.

1.8 Recognising the importance of interaction with others.

1.8.1 The group reminding me of the disadvantages of drinking and of the tips to remain sober.

1.8.2 My family accepting me and my role e.g., being a 'proper mum' or a trusted babysitter of grandchildren.

1.8.3 My partner e.g., being honest and pointing out that I had a problem.

1.8.4 Working with and helping others has also helped me maintain my sobriety

1.8.5 Made the 'group' and talking to them my hobby.

## 2. Alcohol as Aid to Confidence

2.1 Felt too shy and lacking in confidence, self-esteem and too different to be popular.

2.1.1 Poor self-image

2.1.2 felt different

2.1.3 Not feeling good about myself

2.1.4 Lack of confidence

2.1.5 Low self esteem

2.1.6 Quiet and shy

2.1.7 Booze gave me that edge

2.1.8 Drink allowed me to fit in and be sociable

2.1.9 Introvert

2.1.10 With alcohol, no longer an introvert – felt very much in control

2.1.11 Lowers inhibitions

2.1.12 Superman

2.1.13 Gave me confidence for a short while – worried it would wear off.

2.1.14 Confidence the biggest reason for drinking and achieving things

2.1.15 Suffered panic attacks

2.2 Felt that alcohol would give me that confidence and to some extent it did for a short while.

2.2.1 With drink I was no longer an introvert.

2.2.2 Drink could make me as confident as everyone else

2.2.3 Self -image and reputation important.

2.3 I needed the alcohol to cope with life and give me confidence and get rid of my shyness.

2.4 Went on training courses to increase my confidence.

2.5 Not drinking actually increased my confidence and self- esteem and self-worth.

## 3. Alcohol as aid to self esteem

3.1 Dealing with self-esteem issues and confidence without drink

3.1.1 In the past I felt paranoid about things in general

3.1.2 Felt I was not as good as others.

## 4. Role of social others



#### 4.1 Avoided people who may have hindered my recovery

##### 4.1.1 Some old mates

4.1.1.1 Encouraging me to drink

4.1.1.2 Old mates didn't help

##### 4.1.2 Some work colleagues

##### 4.1.3 Some family members

4.1.3.1 Distant family members questioning my abstinence.

4.1.3.2 Being on my own and keeping away from my (abusive) husband helped me.

#### 4.2 You cannot live your life with no one liking you, you need to be liked and respected.

##### 4.2.1 Family very important to recovery

4.2.1.1 My recovery means a lot to them

4.2.1.2 Keeping busy looking after kids

4.2.1.3 Daughters took me for help

4.2.1.4 Family always supported me

4.2.1.5 Didn't want to let others down

##### 4.2.2 'Group' and interaction with others a main reason for sobriety

4.2.2.1 Working and helping others has kept me going for ten years.

4.2.2.2 When group finishes, I am concerned for my own sobriety.

4.2.2.3 My partner encouraged me to go to group meetings

4.2.2.4 The help group becomes like a family

4.2.2.5 You learn from listening to others.

#### 4.3 Do it for yourself and not just to please others

4.3.1 making sure it is your individual choice to stop.

4.3.1.1 just felt it was the right thing to do for me

4.3.2 Nobody else to blame

4.3.3 Recovering yourself

4.3.4 I wanted to get better

4.3.5 Individuality in general

#### 5. Moving to a new sense of self (anticipation)

5.1 Needed a new identity and initially just imagined the 'new me.'

5.1.1 Wanted a different life

5.2 Imagined what it would be like to be sober or still drunk

5.2.1 What would kids think of me in the future?

5.2.2 Dreaded the thought of what would I become in the future if I still drank and what would others think?

5.3 When I was drunk all I could think about at first was to imagine a better life

5.4 Anticipated keeping 'new self'

5.4.1 Keeping the new me and continuing to do normal things

5.4.2 Seeing things differently

5.4.3 Being my true self

5.4.4 Being honest with myself

5.4.5 Imagined a much more confident self

5.4.6 Seeing myself as a good mum or good father.

5.4.7 Being a trusted person who can baby sit

5.4.8 Thinking of new ways to solve problems

5.4.9 Having self-belief

5.4.10 Over time thoughts of drink dwindled

5.4.11 Get used to the idea that drink isn't part of my life anymore.

5.5 In the past I never dare think about the future – now I look forward to it.

6. Sense of self and confidence

6.1 Now have much more confidence and a higher self esteem

6.1.1 Found new friends

6.1.2 Now working full-time

6.1.3. Husband proud and praises me

6.1.4 children, husband and friends now seeing a much more confident person

6.1.5 Treating me like a proper mum.

6.2 Not drinking has meant I have much more confidence and a higher self-esteem and self-worth.

6.2.1 by accepting who I am and what I have done and not concentrating on what I haven't achieved

7. Changes in meaning system

7.1 Found good reasons for staying sober and that's different from reasons to stop.

7.1.1 Initially I couldn't find a good enough reason to stop; now I have a job and new friends and I want to maintain my sobriety

7.1.2 I feel my different attitude to life and what it means to me now helps me keep sober.

7.1.3 Can now see the point or reasons for living

7.1.4 Couldn't see the point in drinking in the end –no meaning or reason.

8. Negative perceptions of 'old drinking self'

- 8.1 Felt I was boring
- 8.2 Felt I was fat
- 8.3 Not likeable
- 8.4 Felt I was not good enough a failure
- 8.5 Felt I was inferior to others
- 8.6 No self-worth
- 8.7 Could have and should have done better
- 8.8 Thought I wasn't as good as others
- 8.9 Thought I was not a good father/mother
- 8.10 Felt ashamed and disgusted with myself
- 8.11 poor self-image
- 8.12 Feeling that I could have done better.

9. Planning recovery?

- 9.1 Totally unplanned
- 9.2 Spontaneous
- 9.3 Planned
- 9.4 Forced through necessity.

10. Turning points

- 10.1 Worried about what it would mean to my kids and husband.
- 10.2 Worried about when my partner was found to have cancer.
- 10.3 I was grieving for two deaths
- 10.4 Seeing how it was affecting my grandchildren
- 10.5 Realising how much you are upsetting others.
- 10.6 My grandchildren gave me a reason to carry on.
- 10.7 If I didn't make an effort my family would have given up on me.

11. Recognising the pros and cons of change

- 11.1 change would have its disadvantages
- 11.2 people will not instantly trust you -takes time to gain peoples trust again.

12. Positive perceptions of the future

- 12.1 think I'm doing well, much better than the 'old me'.
- 12.2 the respect I think I am getting now from others and the respect I now have for myself spurs me on to remain sober.
- 12.3 I can look into the future with real confidence and that means a lot to me.

## Appendix N

### APPENDIX (N)

(15)

(2)

Lady, 32, lives alone, out of work former secretary, 2 children (live with partner)

#### 'KATH' INTERVIEW TRANSCRIPT (P4)

(FOLLOWING INTRODUCTORY COMMENTS MADE BY MYSELF THE INTERVIEW BEGAN)

I 'Firstly could you begin by telling me how you feel you have managed to change and how you have managed to maintain these changes?'

P 'well I come from a bit of boring background not much to tell you really.

I 'Do you want to tell me more about this?'

P 'yeah if you want it's like, no well I'm thirty two now and I started drinking when I was thirteen just the usual cider and that from the offy nothing too much. I didn't like it that much, I just did it because I was with my mates and they did it. My mum would have gone ape shit if she had found out. Because my dad drank too much, he worked as a bouncer at night. He died of it, with bottles all around him when they found him in his flat. Sad bloody sad, but me mum was relieved, they had separated which people didn't do as much then. Anyway, my mum never drank

1.2.1  
1.2.2  
4.1.1.2  
4.1.1.1

Early start?

Copied friends peer pressure?

Genetic link?

Relief of mother

15

2

2

since, I felt I just drank normally like my mates until I was about 22. When my kids were young I just drank in the house I never really went out much. It was just too much hassle getting a baby sitter and what have you, just drank in the house, boredom really. My mind would go numb and I could cope when I was drinking at first, then I gradually built up more and more cider, onto strong lager, then on to spirits and what have you. If I had the money, I would sit counting odd coppers on my bed just to see if I had enough for a can. Sometimes, I would find an odd fiver I had stashed away and forgotten about. You forget don't you and I would get a bottle of vodka, cheap brand and all that. In the end, I realised I had a big problem when I fell in the alleyway trying to get some cans out of the dustbin where I had hidden them. I knew, I knew I needed some help then, I was about 26. My partner knew I was drinking a lot but didn't know how much I was drinking, no way. I wasn't working because of the kids and this allowed me to get away with it, I think, you just lie and lie don't you think? You lie to yourself as well.'

Home Drinker  
Never really went out  
Drunk due to boredom coping mechanism?

Gradual build up of drinking.

Began to realize she had a problem + needed help. was hiding drink from other.

Partner unaware of extent  
Not making 'allowed' her to drink.  
Lying to others and to self

2.1

2.1

4.2.1.5

I 'Did you get any help from anyone or anything ?'





15  
2.6

2

P 'I started by reading those books you know the one that did one on smoking and how to stop and then, the one on drinking. I didn't get it really, I couldn't understand what he was getting at, Alan Carr that's him. No, the books didn't work for me, although I do enjoy reading as a hobby usually. Then I tried AA, a local branch but there was too many there. I did not feel confident anyway with all me nerves on edge with the booze. So how was I meant to introduce myself and started telling all in front of about forty people. I thought sod that I only went once, too much preaching and telling you what to do. I went because I had heard of it and my Doctor had told me about it when I went to see him. He has known about my problem, he had given me minor tranquillizers or something to help calm me down. But I ended up drinking when I was taking them and it made me even worse. I tried to stop on my own for a while but somehow I just couldn't see the point'.

books - didn't work.

2.1

6.0

AA - didn't work.  
Too many people,  
not confident to  
speak.

only went once.  
didn't like being  
'preached to and being  
told what to do.  
referred by G.P. -  
Trangs - to calm down  
Made me worse  
Tried to stop on  
own at first -  
couldn't see the  
point

I 'Do you feel there was a turning point or turning points which began your changes?'

P 'Do you mean something that happened which changed me?'

15

2

I 'Yes an event or perhaps something that somebody had said that affected you in some way?'

2.4.1

4.2.1

P 'well a mixture of things when you put it like that. My partner the father of my kids had had enough and left, we get on OK to this day but he had the kids, it was voluntary really I loved them but the drink had taken over. It was either that or me ending up in prison for neglect it was the right thing to do in the end. Anyway, as well as this me

Many issues  
Partner left and took children  
Amicable.

4.2.1

mum died and I still miss her. But really it was because I am a bit selfish...I wasn't getting the kick out of the drink anymore, there didn't seem any point I was wasting all the money I had got on it enough was enough I thought I will just have to crack this one.

Mum died  
Main reason wasn't getting a kick out of the drinking.  
hitting rock bottom

I 'Can you tell me about anyone or anything that enabled you to stop or anyone who hindered you stopping ?

3.1

1.1

1.1.1

1.1.2

P 'I suppose my girl friends didn't help, they always want me to go out after my partner had left. I had told them I wasn't drinking but it was like talking to a brick wall. They

Kindness of friends told that I wasn't drinking.

3.1.2

4.1.1.1

didn't think I was serious, I was serious but did they listen, did they hell as like. They still tried to persuade me

didn't listen  
didn't accept I was serious.  
tried to persuade me



(15)

3.1.2

(2)

4.1.1.2

to go out anyway. I know it was up to me and my decision, but my friends certainly didn't help me.

My doctor was always telling me he couldn't cure me I was up to me, but my mates well they were something

1.1

else. My mum didn't help, when I was drinking or when I wanted to change my ways. When she found out I had a

drink problem, she had just clammed up and said nothing except, I knew it would happen. When I was trying to get

3.1.2

sober she didn't really show any interest. I think she just thought I would turn out just like my dad. Now I'm in this

2.4.1

1.8.1

group which was another turning point, they made me

realise I had the power to change. I should take no notice of me mates. They just didn't see that I was as bad as I

3.2

was, just like my partner hadn't. Anyway, I started coming to this group because I knew they wouldn't turf me out if I

had had one before I got there. Not a lot, just a couple to

1.8.1

calm my nerves. I just kept coming and started going to the woman only groups as well. The other people who

3.2.2

were all the same as you and me, told me about what

3.2.1

they had gone through and survived all their problems.

4.2.2

They looked at things through different angles you know like seeing the cup half full instead of half empty giving

you hope it was up to me to change no magic wand just grit and determination and just wanting to stop for good

reason.

Friends hindering change.

Doctor couldn't cure

Up to me.

Mum hindering change?

\* Not conveying any interest.

previews group as 'another t-point'

power to change.

Friends and partner didn't see the extent of drinking.

Drinks to calm nerves.

Kept going to groups

Learning from others vicarious learning.

Different perspectives? " perspectives.

Good reason

15

2

I 'What did you see as the good reason?'

2.4.1

4.3

P 'Well, not anyone else anymore, I realised that I just

Not being influenced by other people any longer.

4.3.1

had to do it for myself. My mates could sod off on this

1.2.2.2

occasion, I am number one tackling this problem. They would have dropped me like a ton of bricks if I had done some thing 'funny' because of the drink. Like embarrassing them in public. Even if I just didn't have enough money for another drink or to pay my rent, they wouldn't help. They were only interested if I was on top

Friends not helping / not caring + not really interested.

form, laughing and joking and splashing the cash. No, I

learnt that some others are really interested just in

Friends self-interest

themselves and you can get stuffed if you can't cater for

5.1

their needs. I wanted to change myself, I was sick as fuck

I wanted to change myself.

5.1.1

of being good old Kath, I needed to get away from my

5.1

drinking self you know what I mean? This was a good enough reason for me.

Move away from 'old self' to 'new self'?

I 'Do you want to explain a bit further?'

4.0

5.1

P 'Well, I read this book once about changing your identity you know like all your image and that. I was only

Changing identity? " " image.

a teenager but it really affected me. I thought what if I

Become a different person

could do that for real and become this different person.

Imagining becoming a different person?

15

2

Not just my name, but the whole job lot. How I could handle things differently anyway, I'm meandering again.

Doing things differently

I 'no please go on?'

1.1

5.1

P 'well I thought, I can change myself be a new person who didn't drink. If those mates drop me than that's their loss. I can get different mates other people do. I knew it would be hard at first, well not totally at first because I had had a few goes already to get off it. This time I thought...wouldn't it be fuckin fantastic to wake up and not want a drink and not shake and panic and all that, you

Being a new non-drinking person. It would be difficult.

history of relapsing.

5.1

understand this don't you. I wanted to be a new me just like the book I read when I was a nipper. OK so it wasn't gonna be all rosy and that but it was better than the old drinking all day shit, what do you think?

Wanted 'new me' sobriety not easy; but better than drinking

I 'Did you see yourself stopping drinking as a planned thing?'

2.4

9.1

P 'well no not really, I feel like I have had a number of goes at it what with going to the doctors, tablets, two goes, AA once, trying to do it all by myself and coming to this group. I had thought about it a lot, stopping, but I

Saw it as not really planned

2.4.2

4.3.3

never saw it as something I had to plan for no. I just did it Thought about stopping a lot, but if I did it

Two attempts Did it myself, with groups help.

saw it as something I

(15)

(2)

9.1 when it felt right and I could see the point for my own  
 good really. I don't think it was a plan, like deciding to  
 stop in three weeks or cutting down or telling someone to  
 look after my cards or planning not to go somewhere to  
 avoid it, or going into hospital to detox, no. I detoxed at  
 home, more comfortable, but it was frightening and I  
 wouldn't want to do that every week, I suppose I thought  
 5.1 there was another me inside, not just somebody who  
 didn't drink, that's the easy bit (laughs) says she! No, the  
 stopping drinking is easy drinking is just the physical  
 1.1 5.1 thing, I wanted to change my whole self. \* You know my  
 thinking and my approach to life. I've never known  
 anyone who has carried on drinking at the pace and  
 quantity that me and probably you have done and come  
 5.1 out of it with a clean slate, no, I just knew I needed to  
 change. Wanting to change was eating away at me. I  
 found it frightening and depressing to think about such a  
 1.1 drastic change but I knew it had to be done, it wasn't a  
 plan as such just a different state of mind a new me'

Changed when I felt right. Didn't receive it as a plan.

Detoxed at home. (frightening) Thought there was another me inside.

Stopping the drinking is easy, just ~~stopping~~ physical. I wanted to change my whole self.

Eating away. frightening and depressing to think about such a drastic change

I 'How do you see yourself now'

P 'Well I haven't drunk at all for four years, I can't say its been easy and it bloody well wasn't at first. Being sick and pining for another drink but, I think you get over this

15

2

bit pretty quickly. Then you are left to sort out the rest of you, you know your mind and shaking off the thoughts of wanting another drink. I think I got sick of thinking about it

Your mind + thoughts of drinking

in the end. The thoughts of drinking gradually went away and I just got on with it, thinking about other things and

Gradual change

2.1

building a new life. I can't kid myself that life is brilliant now like some of them tell you and it might be for them

New life.

1.4

but it isn't for me. I live alone, see my kids reasonably

1.7

frequently but they don't live with me. I just see them

See kids more often.

more often now. They are happy with their dad and I'm content with this. Don't get me wrong, I never got into any bother with the police and all that and I still have my mates if I wanted to see them. But they all still drink

socially and have their own families, I suppose we all get older don't we? But life's not that bad, it just doesn't have the highs and the lows like it used to have. It's all a bit

Stable, getting used to it

more stable and I'm still getting used to it. Some people say it takes about five years to get over it completely and

5.4.10

you are never cured. You just adapt and play the cards you have left I suppose. I see myself as lucky in a way,

never cured, you just adapt.

the fact that I'm still here now and can talk about it would surprise some people. Particularly those who thought I

lucky to be alive?

3.1.2

1.1.2

wouldn't even make it this far, the doubters they thought I was finished long ago and would end up in prison or the looney bin you know what I mean Anyway, I see myself

Doubters.

15  
4.1.1

2

12. as a success in a way, not like I've got an ace job with promotions and that, oh god no but I've pulled myself out of that shit pile not smelling of roses but at least I am still here. When I was drinking I saw myself as a total failure and sometimes I felt I would be better off dead...so compared with how I felt about myself then compared with now well it's a very small miracle.

Saw myself as a small dog success.

Previously a failure.

I 'What do you think would have happened to you if you hadn't changed?'

Well, I don't honestly think I would have been here talking to you now. I think my drinking would have eventually killed me. My mates would have probably come to my funeral but only to feel happy it didn't happen to them. My mother would have probably thought I knew it was going to happen just like her dad. That was the extent of her so called encouragement.

Death due to drink

No encouragement from mums.

2.3

3.1.2

I 'How do you see yourself in five years time?'

P 'well besides not drinking, I see my self as a content person. Not worrying about where the next drink is coming from, I will just continue with how I am now, nothing fancy or mind bogglingly different. My life has now been about that sort of thing, ye know your never

Content + not worrying  
Continue how I am now.

1.2

15

2

going to see me pop up on X-factor our own like that  
 (laughs) no. It will be just plain old me doing what I see as  
 normal everyday things but you know what, it won't be  
 just the same old me because I know I have changed. I  
 know I don't drink and all that, but the reason I don't go  
 on about it all the time is because I have changed the  
 way I am thinking about stuff with a much clearer mind.

'Humble' outlook

Her 'normality'

5.1

It's not just confidence, its being able to sort stuff out and  
 not making a mess of it. I used to dwell on little things  
 like the kitchen being in a mess or will I get up for work in  
 the morning because my alarm clock had bust. I would  
 get myself in a right panic over bloody stupid stuff. Now I  
 just either compromise and tell myself it doesn't matter  
 anyway or think of alternatives. Like I borrowed an alarm  
 clock from next door, then bought another one from that  
 place in the retail park next to Matalan.

Confidence

4.1.4

4.1.2

I suppose I see myself as a winner, not of big things like  
 money and jobs and that but small things. Well, what  
 things people would probably see as small things but they  
 would be big to me. Like overcoming my drink problem

Winner of small th

4.1.1

5.4.6

for four years, getting on with my kids much better, not  
 panicking over bloody silly things not being sucked into  
 a downward spiral of debt and divorce like some of my  
 old mates... I say old mates cause I can't see me going  
 round with a lot of them any more, life is too short.

Old mates

15

2

I 'How do you think your kids and the rest of your family see you now and in the future'

3.1.2

1.1.1

P 'well my mates don't think I have stopped really I think

1.1.2

they still think I cant cope without it and probably sneak a few in all the time like I used to. But that's up to them.

Sometimes I think they just wanted me to fail just so they had someone they could talk about. So that people didn't talk about them, its better if they talk about me than about

5.2.1

them. Oh yes, you said how did my family see me now,

6.1.5

well yes they still say they love me and want me not to drink anymore. It doesn't matter how many times I tell

3.1.2

1.1.2

them that it is all in the past. It still comes up in

1.1.2

conversations. They say 'do you still think of having a drink mum?' it doesn't matter how I used to try and

convince them. In the end I didn't bother and gradually, bloody gradually, the penny has dropped. I think I have

3.1.1.1

5.4.7

their trust now after four years. Well Rome wasn't built in a day! and all that, no I really do think I am more

4.1.3

trustworthy and reliable and I am not suddenly going to do one and not come back for a few days and that sort of

3.1.2

7.1.1

carry on. Its funny how I now have mates who are not \*

6.2.1

really fully aware of how bad I was in the past and just

6.1.1

see me and judge me on how I have been over the past

Friends not accepting changes?

Family not fully accepting?

Gradually, beginning to accept.

Perception of being more trustworthy and reliable.



15

2

few years they seem to see me as having a completely different image or identity to that drunk some of them think I am right placid and easy going which I am really I suppose. When I am with them I am much happier because they treat me as a good person and not as a drunk it keeps me going and makes me keep myself good my ex thinks I have turned over a new leaf which I suppose I have in a way. But it is much more than just stopping drinking, don't get me wrong, not drinking is very important but it isn't the answer it's much deeper than that. Some people I know still go to AA, they go nearly every day of the week sometimes twice a day and say it helps them. I don't think I could do that praying and all that higher power stuff. It seems more like being back at Sunday school from what I remember about it, them preaching what to do next, no I needed something in the real world to hang onto. Just going every couple of weeks to the group helps me, if only to remind me that you can easily mess things up again. More than that it gives me ideas when people talk about how I can do what other people have done to sort out their problems without turning to the drink. Because other people give me more respect, I think this has a knock on effect and I try and be respectful myself and I think it works.

Other perceptions

Maintenance?

Much more complex

Others going to AA

Attending the group: reminders 'ideas'

Reciprocal respect

3.1.2

3.1.1.1

7.1

3.2.2

3.2.1

1.8.1

4.1.1

1.8

(15)

(2)

**'What do your changes mean to you now?'**

4.1.2  
2.4.1  
3.4.2  
4.1.3

4.3  
4.3.3  
6.1.1

My change has meant that I now realise that I could do it myself. I didn't need my mum or my old mates to help me. My new friends mean a lot, they have accepted how I <sup>\*</sup> am now and treat me as such. The trust of my children and my new friends means everything to me.

Myself  
Meaning of  
new friends, accept  
Trust: friends  
& children.

**'What do you think your changes mean for other people?'**

4.1.3

5.4.7

1.7  
6.1.5

Again, I think they feel they can rely on me and trust me in the future. I don't think they did or would have if I was still drinking. I think my changes mean my kids feel more secure and it means they feel they have two parents not just one.

Reliable, Trust,  
Security  
A good parent.

**'How do you feel you are going to be able to maintain these changes in the future?'**

1.2

12.1  
12.3

P 'if your asking me whether or not I trust myself looking into the future and making sure I won't drink, I think the answer is yes. I do not see myself drinking ever again. I suppose everybody says that but I think it is true

Self efficacy?

(15)

(2)

I 'How do you think this will happen?'

P 'loads of things really, I don't think I will just be on a white knuckle ride for years and years really wanting a drink and denying myself of it. Like seeing buggers who diet all the time and are miserable because of it, no it's

S-1 having a different state of mind. Like I have said, I live alone and nobody made me stop, I wanted to do it. Its not because of guilt I haven't done anything wrong to anyone

S-4-9 else. I could have just carried on but something inside me not my doctor or this group for that matter...told me I and

2-4-1

4-3-3 I alone am making the choice to give up and better myself and I know why. It's for me, not anybody else. I have kept going for four years because of my own beliefs of seeing

7-1-2 no real reason to carry on drinking.' I know it was hard at

1-8 first and I knew that talking to other successful people who had not drunk for donkeys years, it wasn't going to be easy. The thought of giving up for good at first was daunting and too much to take in. Inthe end, I started

doing it for a week at a time in my mind, it seemed to

work. I also gave myself rewards for not drinking,

laughable really. It was like, here have a present for not being a pain in the arse (laughs).In time after a couple of

S-4-10 years the habits faded and were forgotten about. When I

4-1-4

12-3

saw more clearly, I could look forward to the next day and

'Something inside me, not my G.P. or the group'

(15)

3.1

4.2.1

(2)

1.7

1.8.1

1.6

1.8

*the next without feeling dread, fear and shame. So,*

*besides the group, my friends, the new ones and my*

*small family, it's a combination of things really that have*

*helped me keep away from the stuff and will continue to*

*do so. I think it mainly just has to be a want, an aim like getting a new car something you can strive for and have a reason to get up in a morning to carry on having a go at achieving it.'*

**I 'Well thanks for that Kath, your information will be very useful. Have you any questions to ask me?**

**P 'No, I don't think so. Thank you for letting me take part.**

**(SHORT DEBRIEF)**

*The future.*

*Combination of things*

# Appendix O

## Coding Templates – ITERATION THREE

### Template A 'Choosing and achieving sobriety'

1. Moving to a new sense of self (imagining to anticipation)
  - 1.1 Initially imagining the 'new me'.
    - 1.1.1 Imagined a sober life
    - 1.1.2 Imagined the feeling of sobriety
    - 1.1.3 Imagined the future still drinking
    - 1.1.4 Imagined a confident self
  - 1.2 Anticipated keeping 'new self'- aspirations
    - 1.2.1 Doing 'ordinary things'
    - 1.2.2 Being honest with myself
    - 1.2.3 Being a trusted person
    - 1.2.4 Upholding a good reputation
    - 1.2.5 A new identity
2. Moving towards a practical 'real' change
  - 2.1 Choosing support
    - 2.1.1 Attendance at Alcohol self –help groups
    - 2.1.2 Using GP and other NHS services
    - 2.1.3 Using private recovery services
    - 2.1.4 Combination of services
    - 2.1.5 Therapeutic courses
3. Role of Social Relationships
  - 3.1 Realisation that change is for self – not just to please others
  - 3.2 Pressure from others to change
    - 3.2.1 Family informing alcoholic of the problem/s
    - 3.2.2 Family encouraging recovery
      - 3.2.2.1 Showing approval
      - 3.2.2.2 Taking person to help
      - 3.2.2.3 Getting involved in group
  - 3.3 Family hindering change

- 3.4 Friends hindering change
- 4. Experiencing a new self
  - 4.1 As a success
  - 4.2 Seeing the benefits of self in terms of cognitive functioning
  - 4.3 Being seen by others as a trusted person.
  - 4.4 Gaining self- belief
  - 4.5 Confidence
    - 4.5.1 Confidence with alcohol
    - 4.5.2 Confidence in sobriety
- 5. Seeing a different vision of others
  - 5.1 Seeing things differently without drink
  - 5.2 Recognising others praise and encouragement
  - 5.3 Now having empathy for others
- 6. Re-construing the change process
  - 6.1 From not finding reason to stop to now having a reason
  - 6.2 Different vision of life
  - 6.3 Accepting limitations of change
  - 6.4 Acceptance that change wasn't easy
  - 6.5 Coping with relapse
- 7. Extent of planning
  - 7.1 No real planning
  - 7.2 Planned
  - 7.3 Forced due to health

## Template B 'Maintaining change'

- 1. Role of Social Relationships
  - 1.1 Effects of family
    - 1.1.1 Validation of 'new me' by family members
    - 1.1.2 Hindering Family
    - 1.1.3 Not wanting to let family down
    - 1.1.4 Appreciating sobriety means a lot to family.
  - 1.2 Effects of friends
    - 1.2.1 Hindering friends
    - 1.2.2 Finding new friends and different social outlets
  - 1.3 Effects of alcohol self-help group

- 1.3.1 Learning from other group members stories, ideas, and solutions to continue sobriety
- 1.3.2 Acts as a reminder to continue to remain sober
- 1.3.3 Working with and helping others in the group helps to encourage continued sobriety.
- 1.3.4 The group acting as a social outlet
- 1.3.5 The group acting as a hobby
- 2. Sense of self
  - 2.1 Confidence and self-esteem due to sobriety
    - 2.1.1 Found new friends
    - 2.1.2 Now working full-time
    - 2.1.3 Husband proud and praises me
    - 2.1.4 Children, husband and friends now seeing a much more confident person
    - 2.1.5 Treating me like a proper mum.
    - 2.1.6 Seeing myself as a good parent.
- 3. Changes in thoughts and meaning system
  - 3.1 Thoughts of drinking dwindle overtime
  - 3.2 Getting used to the idea that drink isn't part of life anymore
  - 3.3 My grandchildren gave me a reason to stay sober
  - 3.4 Sobriety aided good decisions
  - 3.5 Thinking of consequences of drinking
  - 3.6 Desire to maintain the new status quo
  - 3.7 New perceptions
- 4. Looking to the future not the past
  - 4.1 Looking to the future
  - 4.2 Thinking of good reason/s for sobriety.
- 5. Basic maintenance techniques
  - 5.1 Avoiding 'risky' situations
  - 5.2 Keeping busy e.g., walking groups
  - 5.3 Making time for self
  - 5.4 Regular attendance at meetings
  - 5.5 Group as a way of life
- 6. Seeing a different vision of self in the future- on sobriety
- 7. Now thinking of others

1. Moving to a new sense of self (imagining to anticipation)

1.1 Initially imagining the 'new me.'

1.1.1 Imagined a sober life

1.1.2 Imagined the future still drinking

1.1.3 Imagined a confident self

1.2 Anticipated keeping 'new self'- aspirations

1.2.1 Doing 'ordinary things'

1.2.2 being honest with myself

1.2.3 Upholding a good reputation

1.2.4 A new identity

2. Role of Social Relationships

2.1 Realisation that change is for self – not just to please others

2.1.1 Individual choice in recovery- initial rejection of professional intervention

2.1.2 Personal health concerns

2.2 Moving towards choosing support methods

2.2.1 Attendance at Alcohol self –help groups

2.2.1.1 Learning from other group members stories, ideas, and solutions to continue sobriety

2.2.1.2 Acting as a reminder to continue to remain sober

2.2.1.3 Working with and helping others in the group helps to encourage continued sobriety.

2.2.1.4 The group acting as a social outlet and hobby

2.2.2 Using G.P. and other NHS services

2.2.3 Using private recovery services

2.2.4 Combination of services

2.2.5 Therapeutic courses

2.3. Influence from others to change

2.3.1 Family informing alcoholic of the problem/s

2.3.2 Family encouraging change

2.3.2.1 Showing approval

2.3.2.2 Taking person to help

2.3.2.3 Getting involved in group



- 2.4 Family hindering change
- 2.5 Friends hindering change
- 2.6 Validation of new me by family members
- 2.7 Not wanting to let family down
- 2.8 Appreciating sobriety means a lot to family
- 3. Experiencing a new self
  - 3.1 As a success
  - 3.2 Seeing the benefits of self in terms of cognitive functioning
  - 3.3 Feeling that others now see me as a trusted person.
  - 3.4 Gaining self- belief
  - 3.5 Confidence
    - 3.5.1 Confidence with alcohol
    - 3.5.2 Confidence in sobriety
  - 3.6 Getting used to the idea that drink isn't part of life anymore
  - 3.7 Desire to maintain the new status quo
- 4. Experiencing a different vision of others
  - 4.1 Experiencing events and people differently without drink.
  - 4.2 Recognising others praise and encouragement
  - 4.3 Now having empathy for others
- 5. Re-construing the change process
  - 5.1 From not finding reason to stop to now having a reason
  - 5.2 Different vision of life
    - 5.2.1 Looking to the future not the past
    - 5.2.2 On sobriety
  - 5.3 Accepting limitations of change
  - 5.4 Acceptance that change wasn't easy
  - 5.5 Coping with relapse
- 6. Extent of planning
  - 6.1 No real planning
  - 6.2 Planned
  - 6.3 'Forced' due to health
- 7. Basic maintenance techniques
  - 7.1 Avoiding 'risky' situations
  - 7.2 Occupying time
  - 7.3 Making time for self

## 7.4 Recording past experiences

Coding Template – Iteration Five: NOVEMBER 2016

KEY: *italics* = NEW CODES ADDED

(BASED ON 15 OUT OF 18 CODED TRANSCRIPTS)

### 1. Moving to a new sense of self (imagining to anticipation)

#### 1.1 Initially imagining the 'new me.'

1.1.1 Imagined a sober life

1.1.2 Imagined the future still drinking

1.1.3 Imagined a confident self

#### 1.2 Anticipated keeping 'new self'- returning to normality without alcohol

### 2. Recognising the need to change

2.1 Being honest with myself

2.2 Recognising my need to uphold a good reputation

2.3 Personal health concerns

2.4 Individual choice in recovery

2.5 Extent of planning

2.5.1 No real planning

2.5.2 Planned

2.5.3 Forced due to health

### 3. Role of social relationships

3.1 Realisation that change is for self and not just to please others

3.2 Influence of family and friends to change

3.2.1 Family informing alcoholic of the problem/s

3.2.2 Family encouraging change

3.2.2.1 Showing approval

3.2.2.2 Taking person to help

3.2.2.3 Getting involved in group

3.2.2.4 Missing family support

3.2.3 Experiencing a different vision of others

3.2.3.1 Experiencing events and people differently without drink.

3.2.3.2 Recognising others praise and encouragement

### 3.2.3.3 Now having empathy for others

3.3 Family hindering or helping change- Not accepting\ accepting the new sober me

3.4 Friends hindering or helping change- Not accepting\ accepting the new sober me

3.5 Validation of new me by family and or friends

3.6 Not wanting to let family down

3.7 Attendance at Alcohol self –help groups

3.7.1 Learning from other group members stories, ideas, and solutions to continue sobriety

3.7.2. Acting as a reminder to continue to remain sober

3.7.3 Working with and helping others in the group helps to encourage continued sobriety.

3.7.4 The group acting as a social outlet and hobby

3.7.5 Group hindering change

## 4. Experiencing a new self

4.1 As a success

4.2 Seeing the benefits of self in terms of cognitive functioning

4.3 Feeling that others now see me as a trusted person.

4.4 Gaining self- belief/self-respect

4.5 Confidence

4.5.1 Confidence with alcohol

4.5.2 Confidence in sobriety

4.6 Desire to maintain the new status quo

## 5. Reconstructing the change process

5.1 From not finding reason to stop to now having a reason

5.2 Different vision of life

5.2.1 Looking to the future not the past

5.2.2 On sobriety

5.2.3 Sense of being in control

5.3 Accepting limitations of change

5.4 Acceptance that change wasn't easy - *the decisional balance*

5.5 Coping with relapse

5.6 Getting used to the idea that drink isn't part of life anymore

5.7 Avoiding 'risky' situations

5.8 Occupying time

- 5.9 Making time for self
- 5.10 Recording past experiences

## Coding Template – ITERATION SIX: MARCH 2017

- 1. Moving to a new sense of self (imagining to anticipation)
  - 1.1 Initially imagining the 'new me.'
    - 1.1.1 Imagined a sober life/ a life still drinking
    - 1.1.2 Imagined a confident self
  - 1.2 Anticipated keeping 'new self'- aspirations to return to normality without alcohol
- 2. Recognising the need to change
  - 2.1 Being honest with myself
  - 2.2 Recognising my need to uphold a good reputation
  - 2.3 Personal health concerns
  - 2.4 Individual choice in recovery
  - 2.5 Extent of planning - planning v. no real planning
- 3. Role of social relationships
  - 3.1 Realisation that change is for self and not just to please others
  - 3.2 Influence of family and friends to change
    - 3.2.1 Family and /or friends informing alcoholic of the problem/s
    - 3.2.2 Family encouraging change
      - 3.2.2.1 Showing approval
      - 3.2.2.2 Taking person to help
      - 3.2.2.3 Getting involved in group
    - 3.2.3 Experiencing a different vision of others
      - 3.2.3.1 Experiencing events and people differently without drink.
      - 3.2.3.2 Recognising others praise and encouragement
      - 3.2.3.3 Now having empathy for others
  - 3.3 Family and friends validating or not validating the new sober me - Missing family support
  - 3.4 Not wanting to let family down
  - 3.5 Attendance at Alcohol self –help groups
    - 3.5.1 Learning from other group members stories, ideas, and solutions to continue sobriety
    - 3.5.2 Acting as a reminder to continue to remain sober

3.5.3 Working with and helping others in the group helps to encourage continued sobriety.

3.5.4 The group acting as a social outlet and hobby v. dependence?

#### 4. Experiencing a new self

4.1 As a success

4.2 Seeing the benefits of self in terms of cognitive functioning

4.3 Feeling that others now see me as a trusted person.

4.4 Gaining self- belief/self-respect

4.5 Confidence

4.5.1 Confidence with alcohol

4.5.2 Confidence in sobriety

4.6 Desire to maintain the new self

#### 5. Reconstructing the change process

5.1 From not finding reason to stop to now having a reason

5.2 Different vision of life

5.2.1 Looking to the future not the past

5.2.2 Sense of being in control

5.3 Accepting limitations of change

5.4 Acceptance that change isn't easy

5.4.1 The tensions/dilemma's (The decisional balance)

5.4.2 Coping with relapse

5.4.3 Developing coping strategies

5.4.3.1 Avoiding 'risky' situations

5.4.3.2 Occupying time

5.4.3.3 Making time for self

5.4.3.4 Recording past experiences

Coding Template – Iteration SEVEN: MAY 2017

(BASED ON ALL 18 CODED TRANSCRIPTS)

#### 1. Anticipating a new sense of self (imagining to anticipation)

1.1 Initially imagining the 'new me.'

1.1.1 Imagined a sober life/ a life still drinking

- 1.1.2 Imagined a confident self
- 1.2 Anticipated keeping 'new self'- aspirations to return to normality without alcohol
- 2. Recognising the need to change
  - 2.1 Being honest with myself
  - 2.2 Recognising my need to uphold a good reputation
  - 2.3 Personal health concerns
  - 2.4 Individual choice in recovery
  - 2.5 Extent of planning - planning v. no real planning
- 3. Role of social relationships
  - 3.1 Realisation that change is for self and not just to please others
  - 3.2 Role of family and friends in change
    - 3.2.1 Family and /or friends informing alcoholic of the problem/s
    - 3.2.2 Family support for change
      - 3.2.2.1 Showing approval
      - 3.2.2.2 Taking person to help
      - 3.2.2.3 Getting involved in group
      - 3.2.2.4 Missing family support
      - 3.2.2.5 Family and friends validating or not validating the new sober me
    - 3.2.3 Experiencing a different vision of others
      - 3.2.3.1 Experiencing events and people differently without drink.
      - 3.2.3.2 Recognising others praise and encouragement
      - 3.2.3.3 Now having empathy for others
  - 3.3 Not wanting to let family down
  - 3.4 Attendance at Alcohol self –help groups
    - 3.4.1 Learning from other group members stories, ideas, and solutions to continue sobriety
    - 3.4.2. Acting as a reminder to continue to remain sober
    - 3.4.3 Working with and helping others in the group helps to encourage continued sobriety.
    - 3.4.4 The group acting as a social outlet and hobby v. dependence?
- 4. Re-construing the self
  - 4.1 As a success
  - 4.2 Seeing the benefits of self in terms of cognitive functioning
  - 4.3 Feeling that others now see me as a trusted person.

- 4.4 Gaining self- belief/self-respect
- 4.5 Confidence
  - 4.5.1 Confidence with alcohol
  - 4.5.2 Confidence in sobriety
- 4.6 Desire to maintain the new self
- 5. Construing the change process
  - 5.1 From not finding reason to stop to now having a reason
  - 5.2 Different vision of life
    - 5.2.1 Looking to the future not the past
    - 5.2.2 Sense of being in control
  - 5.3 Accepting limitations of change
  - 5.4 Acceptance that change isn't easy
    - 5.4.1 The tensions/dilemmas (The decisional balance)
    - 5.4.2 Coping with relapse
    - 5.4.3 Developing coping strategies
      - 5.4.3.1 Avoiding 'risky' situations
      - 5.4.3.2 Occupying time
      - 5.4.3.3 Making time for self
      - 5.4.3.4 Recording past experiences

Template Iteration Eight, September 2017

- 1. Anticipating a new sense of self (imagining to anticipation)
  - 1.1 Initially imagining the 'new me.'
    - 1.1.1 Imagined a sober life/ a life still drinking
    - 1.1.2 Imagined a confident self
  - 1.2 Anticipated keeping 'new self'- aspirations to return to normality without alcohol
- 2. Recognising the need to change
  - 2.1 Being honest with myself
  - 2.2 Recognising my need to uphold a good reputation
  - 2.3 Personal health concerns
  - 2.4 Individual choice in recovery
  - 2.5 Extent of planning - planning v. no real planning

### 3. Role of social relationships

3.1 Realisation that change is for self and not just to please others

3.2 Role of family and friends in change

3.2.1 Family and /or friends informing alcoholic of the problem/s

3.2.2 Family support for change

3.2.2.1 Showing approval

3.2.2.2 Taking person to help

3.2.2.3 Getting involved in group

3.2.2.4 Missing family support

3.2.2.5 Family and friends validating or not validating the new sober me.

3.2.3 Interpreting different constructs of others

3.2.3.1 Re-construing /Experiencing events and people differently without drink.

3.2.3.2 Recognising others praise and encouragement

3.2.3.3 Now having empathy for others

3.3 Not wanting to let family down

3.4 Attendance at Alcohol self –help groups

3.4.1 Learning from other group members stories, ideas, and solutions to continue sobriety

3.4.2. Acting as a reminder to continue to remain sober

3.4.3 Working with and helping others in the group helps to encourage continued sobriety.

3.4.4 The group acting as a social outlet and hobby v. dependence?

### 4. Re-construing the self

4.1 As a success

4.2 Seeing the benefits of self in terms of cognitive functioning

4.3 Feeling that others now see me as a trusted person.

4.4 Gaining self- belief/self-respect

4.5 Confidence

4.5.1 Confidence with alcohol

4.5.2 Confidence in sobriety

4.6 Desire to maintain the new status quo

### 5. Re-construing the problem; a change of perspective

5.1 From not finding reason to stop to now having a reason

5.2 Different vision of life



- 5.2.1 Looking to the future not the past
- 5.2.2 Sense of being in control
- 5.3 Accepting limitations of change
- 5.4 Acceptance that change isn't easy
  - 5.4.1 The tensions/dilemmas (The decisional balance)
  - 5.4.2 Coping with relapse
  - 5.4.3 Developing coping strategies
    - 5.4.3.1 Avoiding 'risky' situations
    - 5.4.3.2 Occupying time
    - 5.4.3.3 Making time for self
    - 5.4.3.4 Recording past experiences

#### Coding Template – ITERATION NINE SEPT 2017

1. Anticipating a new sense of self (imagining to anticipation)
  - 1.1 Initially imagining the 'new me.'
    - 1.1.1 Imagined a sober life/ a life still drinking
    - 1.1.2 Imagined a confident self
  - 1.2 Anticipated keeping 'new self'- aspirations of returning to normality without alcohol.
2. Recognising the need to change and addressing fear, anxiety, and threat
  - 2.1 Being honest with myself
  - 2.2 Recognising my need to uphold a good reputation
  - 2.3 Personal health concerns
  - 2.4 Individual choice in recovery
  - 2.5 Extent of planning - planning v. no real planning, to avoid anxiety
3. Validation and the role of social relationships
  - 3.1 Realisation that change is for self and not just to please others
  - 3.2 Role of family and friends in change
    - 3.2.1 Family and /or friends informing alcoholic of the problem/s
    - 3.2.2 Family support for change
      - 3.2.2.1 Showing approval
      - 3.2.2.2 Taking person to help
      - 3.2.2.3 Getting involved in group
      - 3.2.2.4 Missing family support

- 3.2.2.5 Family and friends validating or not validating the new sober me
  - 3.2.3 Re-construing of others
    - 3.2.3.1 Re-construing /Experiencing events and people differently without drink.
    - 3.2.3.2 Recognising others praise and encouragement
    - 3.2.3.3 Now having empathy for others
- 3.3 Not wanting to let family down
- 3.4 Maintaining a common construction of the relationship within a group
  - 3.4.1 Learning from other group members stories, ideas, and solutions to continue sobriety
  - 3.4.2. Acting as a reminder to continue to remain sober
  - 3.4.3 Working with and helping others in the group helps to encourage continued sobriety.
  - 3.4.4 The group acting as a social outlet and hobby v. dependence?
- 4. Re-construing the self
  - 4.1 As a success
  - 4.2 Seeing the benefits of self in terms of cognitive functioning
  - 4.3 Feeling that others now see me as a trusted person.
  - 4.4 Gaining self- belief/self-respect
  - 4.5 Confidence
    - 4.5.1 Confidence with alcohol
    - 4.5.2 Confidence in sobriety
  - 4.6 Desire to maintain the new self
- 5. Re-construing the problem; a change of perspective
  - 5.1 From not finding reason to stop to now having a reason
  - 5.2 Different vision of life
    - 5.2.1 Looking to the future not the past
    - 5.2.2 Sense of being in control
  - 5.3 Accepting limitations of change
  - 5.4 Acceptance that change isn't easy
    - 5.4.1 The tensions/dilemmas (The decisional balance)
    - 5.4.2 Coping with relapse
    - 5.4.3 Developing coping strategies
      - 5.4.3.1 Avoiding 'risky' situations
      - 5.4.3.2 Occupying time

5.4.3.3 Making time for self

5.4.3.4 Recording past experiences

Coding Template – Iteration TEN, DEC 2017 ore

1. Anticipating a new sense of self (imagining to anticipation)

1.1 Initially imagining the 'new me'.

1.1.1 Imagined a sober life/ a life still drinking

1.1.2 Imagined a confident self

1.2 Anticipated keeping 'new self'- aspirations to return to normality

2. Recognising the need to change and addressing fear, threat, and anxiety.

2.1 Fear and threat and the need to be honest with myself

2.2 Fear/threat of losing a good reputation

2.3 Personal health concerns

2.4 Individual choice in recovery

2.5 Planning vs. No real planning to avoid anxiety.

3. Validation and the role of social relationships

3.1 Realisation that change is for self and not just to please others

3.2 Role of family and friends in change

3.2.1 Family and /or friends informing alcoholic of the problem/s

3.2.2 Family support for change

3.2.2.1 Showing approval

3.2.2.2 Taking person to help

3.2.2.3 Getting involved in group

3.2.2.4 Missing family support

3.2.2.5 Family and friends validating or not validating the new sober me

3.2.3 Re-construing of others

3.2.3.1 Re-construing /Experiencing events and people differently without drink.

3.2.3.2 recognising others praise and encouragement

3.2.3.3 Now having empathy for others

3.2.3.4 Not wanting to let family down

3.3 Positives and negatives of self- help groups

3.3.1 Learning from other group members stories, ideas, and solutions to continue sobriety

3.3.2 Acting as a reminder to continue to remain sober

3.3.3 Working with and helping others in the group helps to encourage continued sobriety.

3.3.4 The group acting as a social outlet and hobby v. dependence?

4. Re-construing the self

4.1 Being a success

4.2 Better cognitive functioning

4.3 Feeling that others now see me as a trusted person.

4.4 Gaining self- belief/self-respect

4.5 Confidence

4.5.1 Confidence with alcohol

4.5.2 Confidence in sobriety

4.6 Desire to maintain the new self

5. Re- construing the problem; a change of perspective

5.1 From not finding reason to stop to now having a reason

5.2 Different vision of life

5.2.1 Looking to the future not the past

5.2.2 Sense of being in control

5.3 Accepting limitations of change

5.4 Acceptance that change isn't easy

5.4.1 The tensions/dilemmas (The decisional balance)

5.4.2 Coping with relapse

5.4.3 Developing coping strategies

5.4.3.1 Avoiding 'risky' situations

5.4.3.2 Occupying time

5.4.3.3 Making time for self

5.4.3.4 Recording past experiences

TEMPLATE ITERATION ELEVEN

1. Anticipating a new sense of self

1.1 Initially imagining the 'new me.'

1.1.1 Imagined a sober life/ a life still drinking

1.1.2 Imagined a confident self

1.2 Anticipations of keeping a 'new self'- aspirations to return to normality

2. Recognising the need to change: addressing fear, threat, and anxiety
  - 2.1 Fear and threat and the need to be honest with myself
  - 2.2 Fear and threat of not regaining a lost reputation
  - 2.3 Personal health concerns
  - 2.4 Choosing to change
  - 2.5 Planning vs. no real planning.
3. Validation and the role of social relationships in change
  - 3.1 Realisation that change is for self and not just to please others
  - 3.2 Role of family and friends
    - 3.2.1 Family and /or friends sharing their views of the problem/s
    - 3.2.2 Family support for change
      - 3.2.2.1 Showing approval
      - 3.2.2.2 Taking person to help
      - 3.2.2.3 Getting involved in group
      - 3.2.2.4 Valuing family support
      - 3.2.2.5 Family and friends validating or not validating the new sober me.
    - 3.2.3 Re-construing of others
      - 3.2.3.1 Re-construing /Experiencing events and people differently without drink.
      - 3.2.3.2 Recognising others' praise and encouragement
      - 3.2.3.3 Now having empathy for others
      - 3.2.3.4 Not wanting to let family down
  - 3.3 Role of self- help groups.
    - 3.3.1 Learning from other group members strategies for sobriety
    - 3.3.2. A reminder to remain sober
    - 3.3.3 Helping others to encourage continued sobriety.
    - 3.3.4 The group acting as a social outlet v. dependence on the group
4. Re-construing the self
  - 4.1 Being a success
  - 4.2 Better cognitive functioning
  - 4.3 Feeling that others now see me as a trusted person.
  - 4.4 Gaining self- belief/self-respect
  - 4.5 Confidence
    - 4.5.1 Confidence with alcohol
    - 4.5.2 Confidence in sobriety

- 4.6 Desire to maintain the new self
- 5. Re-construing the problem: a change of perspective
  - 5.1 From not finding reason to stop to now having a reason
  - 5.2 Different vision of life
    - 5.2.1 Looking to the future not the past
    - 5.2.2 Sense of being in control
  - 5.3 Accepting limitations of change
  - 5.4 Acceptance that change isn't easy
    - 5.4.1 The tensions/dilemmas
    - 5.4.2 Coping with relapse
    - 5.4.3 Developing coping strategies
      - 5.4.3.1 Avoiding 'risky' situations
      - 5.4.3.2 Occupying time
      - 5.4.3.3 Making time for self
      - 5.4.3.4 Recording past experiences

## TEMPLATE ITERATION TWELVE

- 1. Anticipating a new sense of self
  - 1.1 Initially imagining the 'new me'.
    - 1.1.1 Imagined a sober life/ a life still drinking
    - 1.1.2 Imagined a confident self
  - 1.2 Anticipations of keeping a 'new self' - aspirations to return to normality
- 2. Recognising the need to change: addressing fear, threat, and anxiety
  - 2.1 Fear and threat and the need to be honest with myself
  - 2.2 Fear and threat of not regaining a lost reputation
  - 2.3 Personal health concerns
  - 2.4 Choosing to change
  - 2.5 Planning vs. no real planning.
- 3. The role of social relationships and validation in change
  - 3.1 Realisation that change is for self
  - 3.2. Family and /or friends sharing their views of the problem/s
  - 3.3 Role of family and friends
    - 3.3.1 Family support for change
      - 3.3.1.1 Showing approval

- 3.3.1.2 Taking person to help
      - 3.3.1.3 Getting involved in group
      - 3.3.1.4 Not wanting to let family down
    - 3.3.2 Family and friends validating or not validating the new sober me.
    - 3.3.3 Re-construing and valuing relationships with others
      - 3.3.3.1 Re-construing /Experiencing events and people differently without drink.
      - 3.3.3.2 Recognising others' praise and encouragement
      - 3.3.3.3 Now having empathy for others.
  - 3.4 Role of self- help groups.
    - 3.4.1 Learning from other group members strategies for sobriety
    - 3.4.2. A reminder to remain sober
    - 3.4.3 Helping others to encourage continued sobriety.
    - 3.4.4 The group acting as a social outlet vs. dependence on the group
4. Re-construing the self
  - 4.1 Being a success
  - 4.2 Better cognitive functioning
  - 4.3 Feeling that others now see me as a trusted person.
  - 4.4 Gaining self- belief/self-respect
  - 4.5 Confidence
    - 4.5.1 Confidence with alcohol
    - 4.5.2 Confidence in sobriety
  - 4.6 Desire to maintain the new self
5. Re-construing the problem: a change of perspective
  - 5.1 From not finding reason to stop to now having a reason
  - 5.2 Different vision of life
    - 5.2.1 Looking to the future not the past
    - 5.2.2 Sense of being in control
  - 5.3 Accepting limitations of change
  - 5.4 Acceptance that change isn't easy
    - 5.4.1 The tensions/dilemmas
    - 5.4.2 Coping with relapse
    - 5.4.3 Developing coping strategies
      - 5.4.3.1 Avoiding 'risky' situations
      - 5.4.3.2 Occupying time

5.4.3.3 Making time for self

5.4.3.4 Recording past experiences

## TEMPLATE ITERATION THIRTEEN 16/03/19

### 1. Anticipating a new sense of self

#### 1.1 Initially imagining the 'new me.'

1.1.1 Imagined a sober life/ a life still drinking

1.1.2 Imagined a confident self

#### 1.2 Anticipations of keeping a 'new self'- aspirations to return to normality

### 2. Recognising the need to change

2.1 Being honest with myself: fear of change.

2.2 Stigma and the desire to maintain or regain a lost reputation.

2.3 Health, death, and the need to drink.

2.4 Making the change: choice and planning.

### 3. The role of social relationships in change

3.1 Turning points, anticipating loss, and owning the decision to change.

3.2 Role of family and friends in maintaining the changes

3.2.1 Family support for change

3.2.1.1 Showing approval

3.2.1.2 Practical help and involvement

3.2.1.3 Not wanting to let family down

3.2.2 Family and friends validating or not validating the new sober me

3.2.3 Re-construing and valuing relationships with others

3.2.3.1 Re-construing /Experiencing events and people differently without drink.

3.2.3.2 Recognising others' praise and encouragement

3.2.3.3 Recognising the effects on others

3.3 Role of self-help groups

3.3.1 Learning from other group members strategies for sobriety

3.3.2. A reminder to remain sober

3.3.3 Helping others to encourage continued sobriety.

3.3.4 The group acting as a social outlet vs. dependence on the group

### 4. Re-construing the self

4.1 Being a success



- 4.2 Past inability to see the consequences of their drinking, now experiencing clearer thinking.
- 4.3 Feeling that others (such as family) now see me as a trusted person.
- 4.4 Gaining self- belief/self-respect
- 4.5 Confidence
- 4.6 Recording past and not recognising their old self
- 4.7 A new anticipated future self
- 4.8 Looking to the future not the past
- 4.9 Sense of being in control
- 5. Understanding the process of change
  - 5.1 A change of perspective
  - 5.2 Accepting the limitations of change

#### TEMPLATE ITERATION FOURTEEN 26/05/19

- 1. Anticipating a new sense of self
  - 1.1 Imagining the 'new me'.
    - 1.1.1 Imaging a sober life/ a life still drinking
    - 1.1.2 Imaging a confident self
  - 1.2 Anticipations of keeping a 'new self'- aspirations to return to normality
- 2. Recognising the need to change
  - 2.1 Being honest with myself: fear of change.
  - 2.2 The desire to maintain or regain a lost reputation
  - 2.3 Health, death, and the need to drink
  - 2.4 Making the change: choice and planning
    - 2.4.1 Owning the choice and the decision to change
    - 2.4.2 Planning change
- 3. The role of social relationships in change
  - 3.1 Turning points, anticipating loss, and owning the decision to change.
  - 3.2 Role of family and friends in maintaining the changes
    - 3.2.1 Family support for change
      - 3.2.1.1 Showing approval
      - 3.2.1.2 Practical help and involvement
      - 3.2.1.3 Not wanting to let family down
    - 3.2.2 Family and friends validating or not validating the new sober me.

### 3.2.3 Re-construing and valuing relationships with others

3.2.3.1 Re-construing events and people differently without drink.

3.2.3.2 Recognising others' praise and encouragement

3.2.3.3 Recognising the effects on others

### 3.3 Role of self-help groups

3.3.1 Learning from other group members strategies for sobriety

3.3.2. A reminder to remain sober

3.3.3 Helping and encouraging others in continued sobriety

3.3.4 The group as a social outlet v. dependence on the group

## 4. Re-construction

### 4.1 Re-construing self

4.1.1 Being a success

4.1.2 Feeling trusted

4.1.3 Gaining self- belief/self-respect

4.1.4 Confidence

4.1.5 Sense of being in control

### 4.2 Understanding change

4.2.1 'Seeing the light' – now experiencing clearer thinking

4.2.2 Looking to the future self

4.2.3 Understanding the limitations and being aware of and re-construing the consequences of change.

## TEMPLATE ITERATION FIFTEEN

### 1. Anticipating a new sense of self

#### 1.1 Imagining the 'new me.'

1.1.1 Imagining a sober life/ a life still drinking

1.1.2 Imagining a confident self

1.2 Anticipations of *keeping a 'new self'*- aspirations to return to normality

### 2. Recognising and owning the need to change

2.1 Being honest with myself: fear of change.

2.2 The desire to maintain or regain a lost reputation.

2.3 Health, death and the need to drink.

2.4 Choice and planning.

2.4.1 Turning points, anticipating loss, and owning the decision to change,

2.4.2 Planning change

### 3. The role of social relationships in change

#### 3.1 Role of family and friends in maintaining the changes

##### 3.1.1 Family support for change

3.1.1.1 Showing approval

3.1.1.2 Practical help and involvement

3.1.1.3 Not wanting to let family down

3.1.2 Family and friends validating or not validating the new sober me.

##### 3.1.3 Re-construing and valuing relationships with others

3.1.3.1 Re-construing events and people differently without drink.

3.1.3.2 Recognising others' praise and encouragement

3.1.3.3 Recognising the effects of my drinking on others

#### 3.2 Role of self-help groups.

3.2.1 Learning strategies for sobriety from other group members

3.2.2. A reminder to remain sober

3.2.3 Helping and encouraging others in continued sobriety.

3.2.4 The group as a social outlet v. dependence on the group

### 4. Re-construction

#### 4.1 Re-construing self

4.1.1 Being a *success*, gaining self -belief/self-respect

4.1.2 Confidence and sense of being *in control*

4.1.3 Feeling *trusted*

4.1.4 Feeling more *rational*

4.1.5 Change in values

#### 4.2 Looking forward and looking back

4.2.1 Life to look forward to

4.2.2 Change process wasn't what I expected

## Appendix P

### EXAMPLE OF OPTIONS FOR QUOTES FOR SMALL SEGMENT OF CHAPTER 5 'ANTICIPATING CHANGE' (using template fifteen)

Key: [P = Participant number followed by p. = page in transcript]

#### 1. Anticipating a new sense of self

##### 1.1 Imagining the 'new me.'

'I knew it was just a matter of time before I would stop, I even pictured my self-having stopped the new me all sober walking down the street and feeling good about myself not being pissed and meandering, great? I just needed to commit myself to putting my thoughts into practice' [P3p.5]

'Well, I read this book once about changing your identity you know like all your image and that I was only a teenager, but it really affected me, I thought what if I could do that for real, and become this different person, not just my name but the whole job lot, how I could handle things differently' [P4p.4]

##### 1.1.1 Imagined a sober life/ a life still drinking

'It was alright telling yourself not to drink and imagining that I wasn't and was sober but in the early days it didn't go any further I found it difficult mentally to get my head round it all' [P3p.4]

'So, I was talking to myself even whilst I was drunk about what I knew I should do trouble was I just couldn't carry it out even though I knew that it made perfect sense I talked to myself and told myself that I would do it next time for good' [P15p.4]

I 'You said earlier that you also imagined yourself sober and well?'

P 'Well yes that was it really for a long time I was flitting about between not seeing any solutions to my problem and just carrying on drinking for ever more and seeing myself dead in a gutter and moving from this scene to a happy one where I am fit and well and sober. I was talking to myself all the time. I used to have those flashes more and more and I thought it now makes some sense to me why don't I try and achieve what I am imagining all the time, sobriety, why don't I just go for it. [P3p.7]

'I think you imagine stopping and what it would be like and then you put it into practice if you believe in yourself and that you can do it and you have to want it, you need the desire to get back the control of your life, don't let alcohol control you. I had already made the decision to stop before I came to this group, and I used the group just to help me' [P10.p.8]

'I used to think a lot about what it would be like if I stopped properly. Sometimes I would go into my own world when I was on my own and think about how it would be and what my life would be like if I was not drinking at all. I could see my wife and my kids being a lot happier and I would imagine the surprise on the faces of my workmates gob smacked when I said I was just having a coke at dinnertime' [P13p.4].

'this thinking about what it would be like sober was when I would be about fifty I was sort of practising in my head what it would be like in different situations like meeting up with my sister in law again because last time I saw her we had had a fall out because I had been a bit drunk .I imagined myself talking properly again and sensibly and it felt good I also imagined doing a speech at a wedding sober and this thought scared me because I had done best man speeches but always under the influence of alcohol a lot of alcohol' [P13p.4]

'eventually just imagining and wanting new things out of life developed into me having a real determination to carry it out properly and stop drinking for good' [P13p.5]

'I could see myself living a life of misery, I couldn't look at myself in the mirror, without thinking this is me the man who has lost his wife, his friends, his job and his life all because of alcohol I wasn't scared of dying believe you me as you know alcohol takes that fear away permanently but as I said earlier I was scared of dying in alcoholism so to speak alone and not being able to make any sense of things that

had happened to me. I saw myself as not being able to make any sense or meaning of why I had been born in the first place, pointless really' [P3p.9]

'Well, I was aware I was reaching my forties and I needed to get myself sorted out and I would dream at times about doing this not drinking and smartening myself up getting my mind cleared of the alcohol and doing a proper day's work...the only trouble was doing more than just daydreaming about it I needed to put it into practice' [P19p.4]

'My wife pointed out to me nearly five years ago that I needed to sort myself out and this was probably just when I can remember, and she claims to have said I was drinking too much years earlier. The issue for me in deciding whether or not to stop drinking was to weigh up' whether it was better to drink and rid myself of worry or not drink and face all the people I had fallen out with' [P20. p.2]

#### 1.1.2 Imagined a confident self

'imagining myself having not had a drink, feeling confident and all that' [P3p.6]

'When I was coming round from the booze, I would sometimes go into a sort of daydream and began to imagine myself as a real confident person but in reality, I knew I wasn't that confident really I began to think that if only I could kick the habit, I could be confident without the drink' [P16p.1]

'Oh definitely, like I say at first I was imagining myself having not had a drink, feeling confident and all that feeling that people liked me, accepted me and didn't want to clobber me. This imagining gradually grew into something where I saw the need, in fact I wanted to do something definite about it and stop just thinking about it. I wasn't really living I was just existing.' [P3p.6]

## Appendix Q Initial matrix

	Date	Aim	Sample	Methods	Location	Findings
1. Jellinek, E.M.	1946 study 1960 (book)	To attempt to define alcoholism and classify different types.	98 AA members (all men).	Self-reporting questionnaire. Quantitative	America	Identified & defined 5 categories of alcoholism.  Alcoholism found to be a progressive disease, without a cure.
2. Cadoret, Gath	1978	Examined the incidence of alcoholism among adoptees	84 adoptees 18 and older who had been separated at birth from their biological parents	Quantitative	Britain	Alcoholism was found more often in those participants whose relatives included a person who was alcoholic.
3. Cloninger, Sigvardsson & Bohman	1996	To formulate classifications of alcoholics into different sub-types	Adoptees + parents	Developed from the findings of a study of adoptees and their biological parents  Quantitative	Sweden	Developed 2 classifications Type 1 + 2. Type 1 affects both men and woman. Starts later in life. Type 2 affects males at a younger age.
4. Babor, Hoffmann, DelBoca et al	1992	To find evidence for an empirically derived classification of alcoholics	321 male and female alcoholics	Quantitative  Utilised clustering techniques	American	Identified 2 types, younger alcoholics, and older onset drinkers.
5. Babor & Caetano	2006	To evaluate the relevance of a form of diagnosis classification (clinical subtyping)	A review of previous studies	Quantitative  Review of previous studies	American	Validation of the studies produced mixed results. Recommended no further adoption of new classification schemes until further research is conducted.
6. Kendler, Neale, Heath, Kessler & Eaves	1994	Aimed to determine familial resemblance to alcoholism and how parents transmit this vulnerability to their daughters	Interviewed 1030 pairs of female twins and 1468 parents	Twin-family structural equation models were fitted to the observed correlation matrices.  Quantitative	American	The familial resemblance for alcohol was due to genetic factors with the heritability of liability estimated at 51-59%. Genetic vulnerability to alcoholism was equally transmitted from fathers and mothers and alcoholism in parents was not

						environmentally transmitted to their children.	
7.	Goodwin, Schulsinger, Hermansen et al.	1973	Aimed to study drinking practices and problems in a group of alcoholic men.	55 men separated from their biological parents in early life when one parent had a diagnosis of alcoholism	Sample was compared to a matched control group of adoptees  Quantitative	America	Significantly more of them had a history of drinking problems and psychiatric history. Findings suggest that genetic factors may play a role in the development of alcohol problems.
8.	Pompo & Lesch	2009	Aimed to compare alcoholic subtypes or classifications	318 alcoholic dependent patients	A cross sectional analysis.  Quantitative	Portugal	There were many commonalities in the classifications. Several types of medications such as Naltrexone and Acamprosate were found to be helpful in some subtypes but not in others.
9.	O'Malley, Jaffe, Chang, Schottenfield, Meyer, Rounsiville	1992	To evaluate Naltrexone and 2 psychotherapies	97 alcoholic patients treated for 12 weeks	Quantitative  Double -blind placebo-controlled study. Patients randomised to receive either Naltrexone or placebo and either coping skills or relapse prevention therapy or a supportive therapy to help with the patient's own efforts at abstinence.	America	Naltrexone found to be better than placebo indicators of drinking e.g., abstinence rates, no. of drinking days, relapse, and severity of alcohol related problems. Abstinence was highest amongst those receiving both drug and supportive therapy. They were also the least likely to relapse.
10.	Volpicelli, Alterman, Hayashida, O'Brien	1992	A trial of Naltrexone as an adjunct to treatment following alcohol detoxification	70 male alcoholics	Quantitative 12 week, double-blind, placebo controlled	America	Subjects taking Naltrexone reported less craving and days alcohol was drunk. During the 12 weeks only 23% of the Naltrexone treated subjects met the criteria for a relapse whereas 54.3 % of the placebo treated subjects relapsed. Results suggest Naltrexone may be safe and



						effective as an adjunct to treatment with alcoholics in preventing relapse.
11. Garbutt, Kranzler, O'Malley et al.	2005	To determine the efficacy and tolerability of a long-acting IM formulation of Naltrexone for treatment of alcoholics	899 individuals screened, 627 diagnosed as active alcoholics who were randomised to receive treatment. 624 received at least one injection	6 months, double-blind, randomised, placebo-controlled trial.  Quantitative	America	Naltrexone was well tolerated resulting in reductions in heavy drinking during 6m of therapy. Long-acting Naltrexone can be of benefit to alcohol dependent individuals.
12. Kranzler & Cage	2008	Aim to present data from the re-analysis of 3 double-blind, placebo-controlled trials on acamprosate in which abstinence was the primary outcome.	998 alcohol dependent people were included in the studies with the majority abstinent at randomization.	Quantitative  Using a more stringent definition of abstinence	America	Rate of complete abstinence was significantly higher with acamprosate than with placebo
13. Paille, Guelfi, Perkins et al.	1995	A study of Acamprosate at 2 different dose levels in alcoholics followed up for 12 months.	538 patients, 177 received a placebo. 188 received Acamprosate at 1.3g/daily and 173 received 2.0 g/daily for 12 months.	Quantitative  A placebo controlled randomised double-blind study. After detox. Patients were randomly assigned to one of three groups	America	Found that acamprosate was effective when accompanied with psychotherapy
14. DiClemente & Prochaska	1982	Using Prochaska's (1979) Integrative biopsychosocial model aimed to conceptualise the process of behaviour change. Attempted to	Meta-analysis of other theories	Meta-analysis of other theories	America	TTM – people move through stages when changing.  There are dynamic principles and processes related to each stage of change.  Motivation essential for change.

		integrate key constructs from other theories.				
15. Project Match	1997/1998	To test whether outcomes for alcoholics could be improved by matching clients to MI, TSF, CBT	Multi-site clinical trial.	8 year long multi-site clinical trial.  Quantitative	America	Found that all methods were equally effective.  Little support for matching intervention methods based on motivation
16. Vaillant. G.	1995	To consider long term outcomes for alcoholics	724	Longitudinal study 1940-2003  Interviews, questionnaires, physical examination  Quantitative	America	Highest success rates from people attending AA or having a stable environment.  Clinical treatment helped only in crisis work. It was no better than if the person had let their recovery take its natural course.
17. Vaillant, Clark, Cyrus et al.	1983	Considering Long term outcomes for alcoholics	100	Monitored for 8 years following discharge from clinic involving detox, AA.  Interviews, questionnaires, physical examination  Quantitative	America	95% had relapsed at some point.  Can benefit from non-medical treatment i.e., informal support
18. Laudet, Savage and Mahmood	2002 (actual research 2000)	Studied people in long term recovery from alcoholism/drugs looking at intervention measures used.	90 'recovering' alcoholics	Self-administered questionnaire.  Quantitative	America	Treatment was only one method of recovery  More informal 'non-professional interventions needed.
19. Laudet & Stanick	2010	Looking at motivational predictors which may indicate a person's level of commitment to continue abstaining after they had completed a	250 (Poly substance users)	Semi-structured computer assisted interviews.  Quantitative	America	They found 4 main motivational predictors,  Perceived harm of future drug use, abstinence self- efficacy, quality of life satisfaction and the number of 12 step members in their social network.

		treatment programme				
20. Yeh, Che, and Wu	2009 Research completed in 2003-2004	Looked at the process of 'recovery' through perspective of alcoholic. Wanted a deeper understanding of why people maintain abstinence and why some relapse	32 from two settings: a psychiatric hospital and AA group	Semi-structured interviews using purposive sampling.  Qualitative	Taiwan	Found that the abstinence process is an ongoing progressive process. Alcoholics had 3 stages of transition to sobriety: Indulgence, Ambivalence and Attempt (IAA Cycle).  Found they reached rock bottom before recovery. They felt it was similar to the TTM. Stages. Group support essential
21. Yeh, Che, Lee and Horng	2008	To examine the influences which may affect the alcoholics chances of maintaining sobriety	9 participants who had achieved sobriety  Attendance at AA	In depth interviews using open-ended questionnaires. Used grounded theory.  Qualitative	Taiwan	The participants needed to be empowered to maintain sobriety  Family relationships, employment, finance etc needed to be at rock bottom to instigate change
22. Hill and Leeming	2014	Exploring how to construct a positive self when you are an alcoholic wanting to recover and maintain this recovery.	6 adults who attended AA who had been in recovery for between 5-35 years	Semi-structured interviews  Qualitative	Britain	Participants could partly reduce shame by them seeing an alcohol aware self that was different from their previous alcoholic self.
23. Laudet, A.	2007	To examine recovery definitions amongst those who self- identify as in 'recovery'  Is it total abstinence? Or does it extend to	334 AA Participants	Interviews giving quantitative data and qualitative life history interviews with an additional 50 people.	America	Recovery remains poorly understood and ill defined.  Their results found that recovery does require abstinence but also it is a process of self- improvement and an opportunity for a new and better life.

		other areas of functioning?		Quantitative		
24. Dyson,	2007	Looked at the experiences of alcoholics both in the drinking period and in recovery	Sample from AA of 8 participants	Used an in-depth narrative method, Content analysis and the use of grounded theory.  Qualitative	Britain	Alcoholism carries a stigma and people deny the problem to outsiders  AA was a significant factor in recovery.
25. Klingemann, I.	2012  (Study completed 2006/7)	To provide an in-depth qualitative understanding of the maintenance stage of recovery	29 treated and non-treated alcoholics	In depth semi-structured interviews analysed with computer software.  Qualitative	Poland	There are a wide range of strategies potentially contributing to recovery. There are more commonalities than differences at the maintenance stage regardless of the pathways out of alcoholism
26. Saunders & Kershaw	1979	Original study looked at the prevalence of alcohol problems in Clydeside. In this follow up study 162 participants were re-interviewed to look at what they saw as significant now in their recovery.	162	Interviews  Qualitative	Scotland	Spontaneous recovery was cited as a precipitator and a small number cited treatment. Spontaneous recovery does happen but only in less severe cases and involves life changes e.g., marriage, job change. Spontaneous remitters more likely to be still regular alcohol users. Those using treatment were mainly tee total.
27. Humphreys, Moos and Cohen	1997	Evaluate role of demographics. e.g., alcohol problems + depression, prof. treatment, AA + other social/comm resources in predicting	628 untreated alcoholics. 395 were monitored 3 and 8yrs. Later.	Participants completed a self-administered inventory which assessed their current problems, use of treatment, use of AA + the quality	America	Short term interventions have little long-term impact. Social + community resources available for longer periods are more likely to have a lasted influence on the course of alcoholism.

		remission + other psycho-social outcomes over 8 yrs.		of their relationships.  Quantitative		
28. Sobell, Ellingstad, and Sobell	2000	Look at studies on people who recovered from alcohol/drugs without formal help or treatment.	Meta-analysis of 40 studies	Meta-analysis	America	Low risk drinking was commonly reported in the outcomes of natural recovery studies
29. Rychtarik, Foy, Scott, Lockey and Prue.	1987	Long-term outcome of broad-spectrum behavioural treatment for alcoholism were examined in a 5-6 yr. follow up of the alcoholics studied in Foy, Nunn and Rychtarik 1984	43 people	Structured interviews  Quantitative	America	Long-term outcomes of behavioural treatment which allowed controlled drinking, didn't appear to differ from more traditional treatments for chronic alcoholism.
30. Vaillant, G.	2003	Studied the course of male alcohol abuse from 20-70 to 80 yrs.	724	Follow up summary of longitudinal study.  Quantitative	America	Alcohol abuse can persist for decades without remission, death, or dependence. Level of prior alcohol dependence and AA attendance were the two best predictors of sustained abstinence.  Few life-time symptoms of abuse were the best predictors of a sustained return to controlled drinking.
31. Kubicek, Morgan and Morrison	2002	Explored likely attributes to successful recovery	13 participants with 6 or more years sobriety  7 were AA members 6 were spontaneous remitters.	Descriptive pilot study.  Qualitative	America	These recovering alcoholics used the support of other people, accepted the help of God or a higher power, had a strong desire to get well, strove to be honest with self + built self- confidence+ remembered past consequences of drinking.
32. Spinelli and Thyer	2017	Look at people who had achieved	Review of 16 published findings	Potential studies were identified through	America	Sobriety can be achieved + maintained without formal treatment.

		sobriety for at least 12 months without formal treatment.		electronic bibliographic data bases Meta-analysis Quantitative		
33. Rowan & Butler	2014	Understanding how older, 50-70 lesbian adults attain & maintain sobriety	20 older lesbian adults	Qualitative phenomenological study of 20 female adults using purposive and snowball sampling. Used structured interviews to gain a deeper understanding of their lived experiences.	America	5 themes emerged, 'wake up calls', impact of formal treatment, TSF, Consequences from other sources. Close support from family and friends aided attaining sobriety. Some had wake up calls through experiencing loss due to their drinking. 12 participants (60%) found formal treatment helpful. 'Formal Treatment' included psychotherapy. Most successful in both attaining and maintaining sobriety (75% of participants) was TSF. Such as AA and Alan on. Further 40% of participants mentioned experiencing the consequences of their drinking from schools, employers, religious groups, health care providers as being the catalyst that got them to attain sobriety.
34. Best, Gow, Taylor, Knox & White	2011	to understand the long- term process of recovery by investigating the recovery journeys of alcoholics or	100 alcoholics + 100 heroin users. Now abstinent	Qualitative study using semi-structured interviews and self-completed questionnaires	Scotland	'recovery' was understood as being free from dependence and an ongoing process rather than a time-limited milestone. The motivating factors

		heroin addicts in Glasgow				were usually experiencing negative experiences e.g., for alcoholics their behaviour and health problems. Further - more positive factors were issues around <u>personal identity</u> . Social factors were seen as factors in maintaining sobriety especially peer support. An understanding of those that have successfully attained sobriety can help and improve recovery services.
35. Agosti, Nunes & O' Shea	2012	test whether psychosocial measures would reduce the frequency of relapse when used with various medications (naltrexone) or a placebo.	6 studies	Quantitative Meta-analysis analysed data from six studies	America	The benefit of using CBT in addition to medication in preventing relapse maybe limited.
36. Rosner et al.	2010	determine the effectiveness and tolerability of Acamprosate in comparison to placebos or other medications in relapse	6915 participants	Quantitative 24 RCTs	Germany	found to be an effective treatment in relapse after detoxification. When seen relatively against the limited other therapeutic facilities that are available. The addition of medication to a psychosocial programme could be beneficial.
37. Lund	2016	Finding out if religious faith can contribute to recovery long term	21 participants. Age 30-70. majority 50-60.	Qualitative retrospective study using one to one interviews.	Finland	Recovered for at least 3 yrs. Various kinds of Christian faith were found to be supportive and useful.

38. Mori et al.	1993	To look at sobriety factors which abstinent alcoholics understood as helpful to them in their recovery	31 abstinent and 31 non-abstinent male alcoholics. Aged 39-69	Self- completed questionnaire of 31 abstinent and 31 non-abstinent male alcoholics. Aged 39-69 in Japan. Abstinent participants attending a Japanese AA group for an average of 5 yrs. non-abstinent patients in a mental health hospital for an average of 7 months.  Quantitative	Japan	Abstinent alcoholics were significantly more likely to be married, employed, not hospitalised, and had insight into the disease of alcoholism. They were continuously abstinent for at least two years and more experienced in AA than non-abstinent participants. The successful abstinent participants cited attendance at AA meetings and their families as important in their recovery. Stable employment, stable marriage, recognising at risk situations, the support of family and having insight into their condition as also important.
39. Dunlop, W.L. & Tracy, J.L.	2013	Whether an alcoholic has a narrative of describing a positive personality change following the negative experiences they have had and whether this predicts a positive future behaviour change.	37 participants. Sober 4yrs & 95 for 6 months	Compared participants 37 (Self- identified alcoholics) who had maintained sobriety for 4+ yrs. with those 6 months or less (95 participants). Describing their last drink, the former was more likely to show self-redemption than the latter. In a second study they used a longitudinal design + followed the 6 months or less participants over time  Qualitative longitudinal study	Canada	Those that showed self-redemption were more likely to maintain sobriety in the following months compared with those who were non-redemptive. The production of self-redemptive narratives may stimulate prolonged behavioural change and indicate a psychological process which is useful in maintaining change.
40. Strom & Barone	1993	Looked at beliefs about alcoholism,	106 participants	Quantitative. Self - completed questionnaire 106 participants It	America	Long-term recovering abstainers had a greater drink related internal



		drinking control & self-esteem		consisted of approx. 25 alcoholics in each of 4 stages, 'active abuser', 'commitment to change', 'early' & 'late recovery'		locus of control, self-efficacy about abstaining and self-esteem than those still in detoxification. Active drinker's positive beliefs about drinking control and self-esteem were associated with high self-deception. Self-beliefs at commitment to change were negative but self-deception was still high. Early & late recovery = positive self-belief & much lower self-deception.
41. Singhal et al	1992	Compared psychosocial aspects of abstinent alcoholics contrasted with those of relapsed alcoholics.	16 relapsed + 20 abstinent alcoholics	Qualitative. Studied the coping behaviour of relapsed alcoholics e.g., locus of control, decision making, and interpersonal conflicts in a group of 16 relapsed participants compared with those of 20 participants who had remained abstinent after two months of treatment	India	Relapsed group cited 'sensation seeking,' interpersonal conflicts with spouse and conflicts with family as precipitators of relapse. Relapsed participants had more difficulty making decisions than those who remained abstinent. The abstinent group had a higher 'seeking social support' coping behaviour and were more external in their locus of control.
42. Kihara, M & Kitaoka, K	2019	To elucidate the emotional experiences of AA participants <b>striving</b> for sobriety & to identify new methods of support.	36 males from AA	Quantitative interviews. 36 males from AA. From varying regions in Japan.	Japan	Long term sobriety was achieved through gaining objectivity, an attitude of acceptance, sticking to their goals, and recovering their contradictory self. They dealt with potential risks emotionally after they had stopped drinking by making daily efforts to

						regulate their emotions. Nurses & health care staff could learn from AA members such as the 12-step culture and the alcoholics regulating their emotions. Also creating environments conducive to AA activities from which alcoholics derive emotional support.
43. Gubi, P & Marsden-Hughes, H.	2013	To find a definition of recovery which is inclusive and achievable	8 alcohol dependent participants All long-term AA members	interviewed 8 alcohol dependent participants (applying DSM IV criteria) achieving long-term recovery from 8-48 yrs. Involving their lived experiences using IPA. Qualitative	England	Identified the processes as: 'sober,' 'maintaining sobriety' and 'recovery.' Suggests a move away from an acute model with time limited therapy towards a model of sustained life-long recovery management combined with pro-social aid resources. Also, people need to hear and observe the success stories of others under the conditions of empathy, unconditional positive regard, and congruence.

44. Connors, Maisto, Zywiak	1998	Examined male and female attributions associated with the onset and termination of specific relapse events and factors associated with the achievement and maintenance of abstinence periods.	77 male & 65 female alcoholics in 'treatment'	77 male & 65 females entered alcoholism treatment & were followed for 12 months. American quantitative longitudinal study.	America	2 most common precipitants to relapse reported by men were desire to drink and feel good. Women= desire to drink, psychological craving, letting their guard down, feeling down and a spouse/partner issue. Women most often reported letting their guard down and issues with their spouse/partner as precipitants relative to men. Factors associated with termination of a relapse = 'just decided to stop' and among women 'feeling bad emotionally.' Factors for achieving & maintaining sobriety = avoiding risky people & places, recalling drinking problems (especially men), using self-help groups, and receiving treatment.
45. Moos & Moos	2006	Examined indices of personal and social resources drawn from social learning, behavioural economic and social control theories pertaining to alcoholics.	461 individuals who sought help due to their alcoholism	American quantitative. 461 individuals who sought help due to their alcoholism were surveyed at baseline, followed by 1,3,8 and 16 years later. At each of these stages the participants reported on their personal and social resources as well as alcohol-related and psychosocial functioning.	America	Self-efficacy & the participants approach to coping (social learning) health, financial and resources related to AA and bonding with family, friends, and co-workers (social control theory) predicted better alcohol related and psycho-social outcomes. Application of these 3 theories may help to identify predictors of remission and therefore allocate

<p>46. Russel, M. et al.</p>	<p>2001</p>	<p>To gain a better understanding of those who recover without treatment and maintain this recovery 'natural recovery.'</p>	<p>83 'naturally recovered' &amp; 138 problem drinkers</p>	<p>Quantitative</p> <p>Followed up 4 previous community surveys, conducted a brief physical examination and an interview assessing factors thought to be associated with natural recovery.</p>	<p>America</p>	<p>treatment more efficiently.</p> <p>During the period when their drinking was most problematic the natural. recoverees had discussed their alcohol problems with fewer network members &amp; had been advised to stop or reduce their alcohol by fewer network members. Natural recovery = marriage, lower levels of coping by avoiding situations, higher self-esteem, social networks with those who drank less &amp; lower frequencies of intoxication. There is a need to encourage and promote these attributes in problem drinkers who don't have them.</p>
<p>47. Dennis, Foss &amp; Scott</p>	<p>2007</p>	<p>Examines the relationship between the duration of abstinence (1 month- 5+ yrs.) and other aspects of recovery e.g., Health, coping responses, legal &amp; vocational involvement, housing, peers,</p>	<p>1,162 participants entering treatment and followed up (94%) for 8 yrs.</p>	<p>Quantitative</p>	<p>America</p>	<p>Findings suggest there are rich patterns of change associated with long term sobriety.</p> <p>Key influences relating to duration of abstinence included mental health, coping responses and the level of housing, peers, social and spiritual support.</p>

		social & spiritual support, including looking at trends and at which points changes occur. Also, how the duration of abstinence at any given point relates to the chances is related to sustaining the abstinence in the following year.				
48. Snow, Prochaska, Rossi	1994	Examination of the change strategies associated with successful long-term recovery	191 participants	Recruited people in various stages of sobriety 1 month - 27 yrs. Continuous sobriety. Quantitative, surveyed on demographic, problem history, degree of self-help use, process of change use & self-efficacy measures. Looked at different experiences of AA. Participants were divided based on varying experience of AA. Analysis= comparisons on demographic, problem history, process of change & self-efficacy (i.e., self-change vs self-help; differing levels of self-help utilization.	America	Few differences were found between groups on demographic or self-efficacy indices. Past & current members drank more before stopping compared with self-changers. Consistent, positive relationship between the use of TTM change processes & increased involvement in AA., current attenders using them more than self-changers & past attenders
49. Klingemann, H.K.	1992	To gain an understanding of the coping and maintenance strategies of spontaneous	97 respondents	Qualitative study in Switzerland. Telephone interview with 120 alcoholics and 82 heroin users. The statements of 97 respondents were supplemented by follow up telephone interviews.	Switzerland	With spontaneous remission 3 phases were identified: a motivation phase, a stage of decision implementation and a struggle for maintenance. The

		remitters from substance use.		The life histories collected were then analysed. Concerning the maintenance phase, the perception of possible relapse situations and intuitive predictions were analysed.		coping mechanisms identified included, diversion, self-monitoring, and 'distancing' oneself from risks.
50. Keyes et. al.	2010	To test whether perceived stigmatisation of alcoholism was associated with a lower likelihood of receiving alcohol related services	34,653 adults	Quantitative face to face epidemiologic survey of 34,653 adults in 2004-2005 aged 20 or older living in the United States. Alcohol abuse/dependence was diagnosed using DSM IV. Stigma measure= Perceived Devaluation-Discrimination Scale.	America	People with a life-time diagnosis of an alcohol use disorder were less likely to use alcohol services if they perceived a higher level of stigma because of this diagnosis. Higher perceived stigma was associated with males who were non-white compared to non-Hispanic white race ethnicity, lower income, education and being previously married. Highly stigmatised views of alcoholism + lack of services suggests that stigma reduction should be part of treatment.
51. Callaghan, R.C.	2007	Test 2 assumptions of the TTM. People make a forward transition to the action stage will = greater drinking improvements whereas those	-----	*Secondary data analysis of project MATCH data on alcoholism recovery	Canada	The majority of the tests of assumptions failed to support this notion. Alcoholics progressing to the action stages do not necessarily show greater improvements, than people remaining in the pre-action stages

		still in pre-action stages will not show improvement.				
52. Prochaska	1979	To analyse present therapeutic methods to obtain a synthesis between therapeutic systems dealing with change	300 therapy outcome studies which had used stages of change models	Quantitative  Looked at a comparative analysis of 18 of the most successful leading systems	America	Alcoholics move through progressive stages of recovery, pre-contemplation, contemplation, preparation, action, maintenance
53. Prochaska & DiClemente	1983	TTM applied to smokers trying to change on their own and to test whether different processes are used at different stages and what are these?	872 participants divided into 5 stages of change	Quantitative 40 item questionnaire self-reporting 2 yr. longitudinal study. 872 smokers divided into long term quitters 247, recent q. 134, contemplators 187, pre-contemplators 108, & relapsers 129 female & 67 males	America	Self-changers use fewer processes of change during pre-contemplation, emphasised consciousness raising during contemplation, self-re-evaluation in contemplation & action stages, self-liberation, helping relationship & reinforcement management during the action stage. Use counter conditioning & stimulus control in action and maintenance stages. Relapsers responded like contemplators & people in action.
54. DiClemente & Prochaska	1982	To compare smokers who stop on their own with those who with those	Self -stopped 29 Therapy 34	Were given a Change Process Questionnaire and a smoking history Questionnaire to complete within 7 wks. of stopping.	America	The stages of change interacted with the processes in the stopping. 'Verbal' processes were important in making the decision to

		who receive therapy		Then re-interviewed in 5 months. Using the TTM the processes and 3 stages, decision, action, and maintenance were analysed. The analyses of the stopping differentiated between the self-quitters and therapy quitters and the 2 groups of therapy quitters on 5 variables		change and 'action' processes were critical in breaking the habit. Maintenance was related to but not dependent on how people actively changed smoking behaviour.
55. Miller, Benefield, Tonigan	1993	To look at the effectiveness of 2 different counselling styles	18 women, 24 men all problem drinkers	Assigned to 3 groups. 1- confrontational, 2.- client centred 3.- delayed check-ups. Outcomes checked after a year. quantitative	America	A confrontational counselling style showed much more resistance, whereas less confrontational style showed significant reduction in drinking.
56. Hser, Hoffman, Grella & Anglin	2001	To follow their progress over 33 yrs.	581 male heroin addicts	Follow up from face-to-face interviews conducted in 1974. Follow up conducted in 1996-97 -284 dead,242 interviewed. Quantitative	America	The remaining group showed a surprising amount of stability indicating that relapse diminishes over time.
57. Etter& Sutton	2002	Assess the validity of 3 staging questionnaires and the concept of stage of change itself	1025 smokers	318 were retested after 8 days and 451 people after 32 days 3 measures of stages of change quantitative	Switzerland	18-24% of smokers who had decided to stop (whilst they were in the preparation stage) in the next 30 days were down-graded to the contemplation stage as they had not attempted to stop in the previous year. The action stage included 5-7 % of occasional smokers Quit attempts during



						the past 7 days & 30 days were better predictors of smoking cessation than quit attempts during the past 12 months. Baseline stage and a continuous measure of intention predicted smoking abstinence at follow up Stage covers 4 different variables: current behaviour, quit attempts, intention to change and time since last quitting. Combined in a haphazard manner, not comprehensively measured and intention and time are continuous variables categorised by arbitrary cut points.
58. Buirs & Martin	1997	Change through imagination. To what extent is the psychological construction of self-constrained by your past and present experiences?	6 substance abusers	Qualitative study All participants. we're contemplating change. 6 participants asked to express feelings and experiences during 2 role plays of negative and positive scenarios.	Canada	Imagination is an important vehicle for helping to change  It is possible to imagine positive possibilities of yourself.
59. Luciano et al.	2015	To examine long-term strategies for men with co-occurring disorders	12 men with psychosis and substance use disorders	Qualitative	America	Had maintained sobriety for at least a year by building a supportive community, self-help group attendance, monitoring attitudes and engaging in meaningful activities.
60. Littell & Girven	2002	To review the effectiveness of the stages	Reviewed 87 studies	Quantitative	America	Stages are not mutually exclusive and found scant

		of change model (TTM)		Review of previous studies		evidence of sequential movement between stages
61. Larabie	2005	To consider the extent to which stopping attempts are planned	146 smoking and no-smokers over 14 years of age	Qualitative in-depth face to face semi-structured interviews	Canada	51.6% of stopping attempts seen as unplanned. Most were unaided (64%)
62. Janz & Becker	1984	Aimed to review Health Belief Model investigations	29 studies 1974-1984 + 17 pre-1974 = 46 total. 18 prospective & 28 retrospective	Quantitative	American	Many behaviours such as smoking may become habitual and therefore outside the normal process of conscious decision making.
63. O'Malley, Croop, Wroblewski	1995	To consider the effectiveness of Naltrexone	Re-examined data from two previous clinical trials- O'Malley et al (1992; Volpicelli (1992)	Quantitative clinical trial	American	Patients who had relapsed managed to refrain from drinking for longer periods having taken Naltrexone instead of a placebo
64. Sureshkumar, Kailash, Kumar Dalal, Reddy & Sinha,	2017	To find the association of various psychosocial factors connected to relapse of alcoholics	2 groups of alcoholics. Abstinent =31 and relapsed =35	Quantitative cross-sectional study. Demographic, clinical, and psychological variables were compared. Used statistical analysis to find the extent of the association between various factors and relapse.	India	relapse is influenced by how the alcoholic copes with stressful events including family conflict, pressure from peers, finance, and a temptation to drink.
65. Schachter	1982	Examined the intractability of smoking and obesity in a non-self-selected population	83 university personnel and 78 blue collar workers (20-64 yrs. old)	Qualitative interviews	America	People have an ability to learn new ways of coping with their addiction. The general consensus that addictions are hopelessly difficult to correct is wrong

<b>66.</b> Gokbayrak, Paiva, Blissmer & Prochaska	2014	Investigation of relapse variables	521 people who were abstinent at 12 months	Longitudinal Quantitative study	America	One assumption that relapsers tend to relapse not just due to their severity of addiction but also due to emotional distress.
<b>67.</b> Laudet & White	2008	Aim to test the notion that higher levels of recovery capital prospectively predict sustained recovery, higher quality of life and lower stress levels.	312 recovery persons	Quantitative  Participants (primary substance crack or heroin – interviewed twice at a one-year interval) were classified into one of four stages: under 6 months, 6-to 18-months, 18- to 36 months and over 3 years.	America	Multi regression findings supported the idea that different domains of recovery capital were effective at different recovery stages.
<b>68.</b> Beattie & Longabaugh	1999	Aimed to consider the relative influence of general and alcohol specific support from this network following treatment.	152 subjects in a private non-profit psychiatric hospital in New England	Quantitative	America	Treatment is only a small part of achieving change and is limited to short term treatment. Over the long term the client's social network will dominate.
<b>69.</b> Blomqvist	1999	To compare treated and untreated alcoholics to ascertain what initiated and maintained recovery		Qualitative	Sweden	Receiving social support from family, friends and significant others can help to change addictive behaviour. It can also be compensated by religious support
<b>70.</b> Kelly et al.	2006	What kinds of people attend self- help groups	227 males + females	Quantitative	Canada	Beneficial for all types of people even for modest attendance levels
<b>71.</b> DiClemente, Prochaska, Fairhurst et. al	1991	To test the TTM as smokers move through stages	Pre-contemplation n=166, contemplation n=794, preparation n=506	Quantitative stages were compared on smoking history, 10 processes of change, pre-test self-efficacy, and decisional	America	All groups were similar on smoking history but differed dramatically on stopping activity. Stage differences

				balance and 1 month and 6 month stopping activity		predicted attempts to stop at 1 and 6 months follow up.
72. Pompo, Levy, Bicho, Ismail, & Neves Cardoso	2008	Attempted to classify alcoholics into sub-groups	42 alcohol dependent patients	Quantitative	Portugal	Identifying subgroups could improve treatment choices and prediction of future disease
73. Kaij	1960	To examine whether fraternal twins could inherit a predisposition towards alcoholism	174 male fraternal twin pairs	Quantitative interviews	Sweden	Found they had a 28% concordance rate
74. Cloninger, Bohman Sigvardsson	1981	Studied the inheritance of alcoholism. Genetic v. environmental factors & biological vs. adoptive parents	862 Swedish males	Quantitative	Sweden	Heritability is a factor which needs considering amongst other environmental factors.
75. <a href="#">Eiroa-Orosa</a> , <a href="#">Gebac</a> , <a href="#">Braquehais</a> , <a href="#">Llavayol</a> , <a href="#">Garcia-Gutierrez</a> , & <a href="#">Feixas</a>	(2019)	Analysis of the constructs of health professionals with substance abuse problems	30 health professionals. 15 with an alcohol problem	Qualitative	Spain	<a href="#">health professionals whose construct system is conflicted in some way have more difficulties coping and resolving work-related tensions which could ultimately result in burnout</a>
76. Orford et al.	2006	To develop a model of change emphasising the participants accounts	211 alcoholics	Qualitative	British	The models should be broadened so that treatment is seen as part of a much wider and complex system involving cognitive, social, and behavioural changes
77. Hrubec, Omenn	1981	Examined the medical histories of male twin pairs to determine	Medical histories of 15,924 male twin pairs	Quantitative	America	Found evidence in favour of a genetic disposition to alcoholism.

		concordance rates for alcoholism				
78. Dawson, Grant, et al.	2005	The effects of help-seeking on the likelihood of recovery from alcoholism	4422 alcoholics	Quantitative	America	People who use 12-step programmes + formal treatment are twice as likely to recovery than those using formal treatment alone.
79. Heather et al	2009	Testing the TTMs assumptions re recovery. (See Callaghan)	.....	Quantitative, randomised controlled trial	English	In a contrast to previous studies, they supported the TTMs account of recovery.
80. Pettersen, H. et al.	2018	To explore the factors that influence reasoning and decision making about stopping substance abuse after a long-term substance abuse disorder. Also ascertain how alcoholics reach a 'turning point.'	18 participants abstinent for 5 yrs.	Semi-structured interviews  Qualitative	Norway	Pressure & concern from close family members were important in the early stages in efforts to abstain. Imaging a different life & an awareness of treatment options promoted hope & further reinforced the determination to abstain. Greater focus on why they want to abstain may help future treatment. Also, treatment completion may be more likely if the persons reasons for seeking help are addressed.
81. Webb, Clayson, Mikulin & Cox	2020	Explore transitions of identity over time of substance abuse recoverees	6 participants Purposively sampled	Qualitative. Captured narratives from all stages of recovery from treatment exit up to four years in recovery.	English	People grew from early stage of recovery showing gratitude & reliance on support groups to becoming self-determined and making decisions on their own.

<b>82.</b> Kennedy & Gregoire	2009	Consider the links between TTM & SDT	10,010 participants	Quantitative face to face interviews	American	Significant relationship between the source of motivation- intrinsic or extrinsic and a person's stage of change. Higher levels of internal motivation are much more important than external motivation.
<b>83.</b> Chan et al.	2019	Considered the links between motivation and SDT and how they may be important to recovery.	103 participants	Qualitative	China	The highest motivators for staying away from addictive substances was a person's relatedness to others a new work lifestyle, religion and setting clear goals for their futures.
<b>84.</b> D'Amico et al.	2015	Effectiveness of using MI and change talk with alcohol and marijuana users	Analysed 129 group MI sessions	Randomised clinical trial of a group of adolescent drinkers and /or drug users	America	both the group facilitator's speech and the subsequent responses from the participant's each had an effect on either changing or remaining as a substance user, which were then associated with individual changes.
<b>85.</b> Sarpavaara	2014	Considered the meanings significant others such as family and friends	Based on 82 MI interview sessions	researchers studied the amount and quality of the change talk which was elicited from the MI sessions.	Finland	participants construed a variety of different meanings from the significant others which may have affected their motivation. The meanings that significant others convey to substance users should not be overlooked in either MI or any other intervention measure.

86. Laudet & White	2008	wanted to test whether higher levels of recovery capital would prospectively predict sustained recovery, better quality of life and people having lower levels of stress in their lives after one year.	312 participants	Qualitative.  sample consisted of inner-city ethnic minority people who were interviewed on two occasions at a one-year interval. They were divided into the following recovery stages: under six months, 6- to 18 months, 18- to 36 months, and over three years.	American	the amount and quality of recovery capital may be a strong predictor of a successful recovery.
87. Best et al.	2018	To identify the amount and quality of recovery resources available to each participant.	13 participants – 4 prisoners + 8 family members	Qualitative.  Used mapping of community/ social resources	England	Family groups had the potential to bridge the gap in terms of providing meaningful activities and linked positive social networks.
88. Longabaugh et al.	2010	To increase the understanding an interrelationship between a person's social network and their drinking	1373 participants	COMBINE randomized clinical trial	American	A persons' network of support needs to be assessed before any treatment planning is made.
89. Cano et al.	2017	To improve the understanding of long-term recovery pathways and how we apply them in practice	546 participants from 8 recovery residencies across America	Quantitative. Calculated internal consistency for RC and well- being, then assessed their factor structure using confirmatory factor analysis	American	Recognising the importance of meaningful activities in promoting both recovery capital developing and well-being.
90. Best et al.	2008	Study aimed to gain explanations for their sustained abstinence.	107 former heroin users who had now achieved long term abstinence on average for ten years	Qualitative survey	England	Others important to recover. Need to move away from substance using friends. TSF found to be useful

91. Beckwith et al.	2019	To examine the relationship between changes in social identity and the substance using norms of the social group.	Used 155 substance users from a residential community setting	Qualitative. Used Social Identity Mapping in Addiction Recovery (SIM-AR).and an extension to this approach.	Australia	A strong and positive recovery identity can be linked to the amount of non-substance using social networks a recoveree is exposed to.
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## Appendix R

The Construction corollary - '*A person anticipates events by construing their replication.*' In other words, we address the future by looking at similar personal experiences we have experienced in the past and using these past experiences to guide our future actions.

The Experience corollary - '*A person's construct system varies as they successively construe the replication of events*' - it is suggested this means our construct system is constantly changing as a result of our varied experiences.

The Individuality corollary - '*People differ from each other in their construction of events.*' It is suggested this means we as individuals see things differently from each other and therefore construct their meanings differently.

The Choice corollary - '*People choose for themselves that alternative in a dichotomised construct through which they anticipate the greater possibility for the elaboration of their system*' - it is suggested that this means we choose the option which enables us to have the best chance of extending and confirming our construct system.

The Sociality corollary - '*To the extent that one person construes the construction processes of another, they may play a role in a social process involving the other person*' - meaning it is suggested that if we can understand another person's 'whole being' we may be able to communicate productively with them.

The Commonality corollary - '*To the extent that one person employs a construction of experience which is similar to that employed by another, their processes are psychologically similar to that of the other person*'. It is suggested that this means sometimes we may communicate with like-minded people who have things in common with ourselves.

The Organisational corollary - '*Each person characteristically evolves, for their convenience in anticipating events, a construction system embracing ordinal relationships between constructs.*' It is suggested this means we employ a construct system which is hierarchal in its structure.

The Dichotomy corollary – ‘A person’s construction system is composed of a finite number of dichotomous constructs’- people must see similarities between events but also contrasts at the opposite ‘pole.’ These constructs are limited.

The Range corollary – ‘A construct is convenient for the anticipation of a finite range of events only.’ It is suggested that this means constructs are only appropriate for certain things but not for others. For example, we may describe a boat as reliable, sea-worthy, and beautiful to look at, but we may find describing a maths textbook in the same way as inappropriate.

The Modulation corollary – ‘The variation in a person’s construction system is limited by the permeability of the constructs within whose range of convenience the variants lie.’ It is suggested that this means we as individuals will only be as open to different views as we allow it to be.

The Fragmentation corollary – ‘A person may successively employ a variety of construction systems which are inferentially incompatible with each other’ – It is suggested this means we often use contradictory constructs simultaneously.